Report Copies and Project Information

You can access the Report at the Applied Social Research Unit’s Website at http://www.asru.ilstu.edu. At this Website, go to “Reports” and then to “Assessment, Evaluation, and Planning.” To obtain bound copies of the Report, contact the:

Ottawa Area United Way
1400 LaSalle St.
Ottawa, IL  61350
(815) 434-4003

The Report with Support Documentation provides detailed information about methods and findings for individual research activities. Please contact the Ottawa Area United Way for more information.
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1 The “n” in this report refers to the number of cases (e.g., number of survey respondents, number of households, or number of residents).
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Executive Summary

What is Community F.O.C.U.S. 2001?

In 2000, organizations including the Community Hospital of Ottawa Foundation, the Ottawa Area United Way, Illinois Valley Community College, the Cities of Marseilles and Ottawa, and the Illinois Valley Building Trades, Labor & Management commissioned the Applied Social Research Unit (ASRU) of Illinois State University to conduct research assessing resources and needs for health and human services in eastern LaSalle County including Waltham and Utica Townships (hereafter referred to as the study area). This research, entitled Community F.O.C.U.S. 2001, was designed and implemented with broad and ongoing participation from study area leaders and service providers. The acronym, F.O.C.U.S., stands for “Facing Our Concerns and Understanding Services.” Emphasizing teamwork among diverse community members, the Community F.O.C.U.S. 2001 project employs a holistic approach that recognizes a wide range of factors contributing to the health and well-being of study area residents. The general goal of the project is to support planning of health and human service provision in the study area during the next 5 to 10 years.

The focus of Community F.O.C.U.S. 2001 research was defined very broadly to include health care and traditional social services provided to special populations in the study area. These special populations include, but are not confined to, low-income residents, people with disabilities, at-risk families and individuals, and others facing special challenges in attaining a good quality of life. Although services offered to the entire population, such as K-12 and community college education and primary, specialist, and hospital medical care provided to people with insurance coverage, were not the primary targets of Community F.O.C.U.S. 2001 research, providers and users of those services contributed information that enriched researchers’ general understanding of community needs and resources.

Community F.O.C.U.S. 2001 concerns the population and geographical area of eastern LaSalle County, including Waltham and Utica Townships. Although health and human services, along with many other resources, are concentrated in Ottawa, over one-half of the study area’s population lives in small communities or rural areas at some distance from Ottawa. Rural residents have the same needs as their neighbors who live in town, but encounter special challenges in meeting these needs. In its research plan, reporting, and conclusions, Community F.O.C.U.S. 2001 considers both rural and urban needs, resources, and strategies.

Research activities

An early challenge for the Community F.O.C.U.S. 2001 project was to identify the specific geographical area to be covered by the project. This decision was important because it determined which service providers and residents should be included in research activities. After consideration of a variety of factors, the Steering Committee decided that the following ZIP codes should be included in the study area: 60518, 60549, 60557, 61325, 61341, 61350, 61360, and 61373. This area covers all or parts of Fall River, Farm Ridge, Dayton, Ottawa, Rutland, South Ottawa, Earl, Freedom, Manlius, Brookfield, Serena, Grand Rapids, Miller, Utica, Wallace, and Waltham Townships.
Once the study area was defined, research activities began. Community F.O.C.U.S. 2001 used a mixed research approach that incorporates quantitative and qualitative methods to build a picture of the study area’s resources and residents’ needs for health and human services, and to identify opportunities for service provision in the future. Research activities include:

- Review of public data from government agencies and local reports, directories, and planning documents;
- A survey of 2,142 randomly selected study area households yielding 564 responses (response rate = 26%);
- A comprehensive survey of 149 organizations providing health and human services to study area residents yielding 83 responses (response rate = 55.7%);
- 11 focus groups representing a wide range of perspectives on needs and resources for and delivery of health and human services in the study area (85 participants, 274 invited);
- 24 key informant interviews with County leaders, service providers, and residents representing a wide range of perspectives, interests, and expertise; and
- Review of best practice and models literature focusing on current issues affecting the study area’s health and human service system.

Information resulting from these research activities was used to develop this Report and its Support Documentation. Information about research methods, surveys, and focus group summaries is included in section 5 of the Report and in the Report with Support Documentation, both available through the Ottawa Area United Way. The Report is also available via the Applied Social Research Unit’s Website at:  http://www.asru.ilstu.edu.

**Study area residents say . . .**

In all, at least 780 study area residents participated directly in the Community F.O.C.U.S. 2001 project. They worked as committee members, filled out survey instruments, participated in focus groups or interviews, and responded to data requests. They provided most of the information included in the project reports and informed development of conclusions and recommendations. Thus, Community F.O.C.U.S. 2001 truly represents the efforts and achievements of County residents; the research process itself is one of its products.

1. Executive Summary:
Study area residents say . . .

### Income, employment, and training

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many low-wage workers.</td>
<td>Education and training for higher-paid employment. Development of strategies to attract employers offering “good” jobs.</td>
</tr>
<tr>
<td>Many jobs without benefits.</td>
<td>Opportunity for employers to join together to offer benefits.</td>
</tr>
<tr>
<td>Need for services to retain employment.</td>
<td>Opportunity for greater communication and collaboration between employers and service providers.</td>
</tr>
<tr>
<td>“Invisibility” of the poor to more prosperous study area residents.</td>
<td>Media focus on challenges and conditions faced by various categories of low-income study area residents (e.g., single parents, persons with disabilities, retired people, people moving from welfare to work, etc.).</td>
</tr>
</tbody>
</table>

### Housing and homelessness

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>High cost of housing for low-income residents.</td>
<td>Address need for affordable housing in community development planning.</td>
</tr>
<tr>
<td>High property taxes.</td>
<td>Restructure local taxation and public expenditure to provide property tax relief. Attract businesses to increase tax base.</td>
</tr>
<tr>
<td>Need for homeless shelter.</td>
<td>Counter Not In My Back Yard (NIMBY) sentiment frustrating identification of a permanent shelter location.</td>
</tr>
<tr>
<td>Need of homeless individuals and families for multiple services.</td>
<td>Case management across agencies.</td>
</tr>
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## Transportation

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable transportation needed by rural residents, young people, older adults, low-income families, people with disabilities, and people whose licenses have been suspended or revoked.</td>
<td>Collaborative planning, involving appropriate organizations and consumers, to design, develop financial support for, and implement a transit system serving all parts of the study area.</td>
</tr>
<tr>
<td>Strained resources of current transportation providers.</td>
<td>Communication and coordination among existing providers. Enhancement of current services through development of an area-wide transit system. Advertisement of existing services.</td>
</tr>
<tr>
<td>General assumption that everyone has access to a car.</td>
<td>Information provision through appropriate media (newspaper, television, radio, etc.) highlighting circumstances and needs of study area residents without access to cars.</td>
</tr>
</tbody>
</table>

## Health and health care

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for dental care among uninsured, low-income, and Medicaid recipients.</td>
<td>Collaboration of health care providers to design, resource, and sustain provision of dental services to needy populations. Pressure on State legislators to raise Medicaid reimbursement for dental services.</td>
</tr>
<tr>
<td>Some providers unwilling to accept Medicaid and Medicare assignment.</td>
<td>Raise awareness of providers and residents about issues associated with access to health care and problems/expenses resulting from lack of access to care.</td>
</tr>
<tr>
<td>Lack of specialists to deal with mental health problems in children and older adults.</td>
<td>Targeted recruitment activities. Development of appealing employment conditions as incentive.</td>
</tr>
<tr>
<td>Lack of transportation—particularly in rural areas—for doctor’s visits and other health care needs.</td>
<td>Collaboration of study area organizations to expand current transportation services.</td>
</tr>
<tr>
<td>Some duplication of physical and mental health services.</td>
<td>Increased communication and collaborative planning to provide complementary services.</td>
</tr>
</tbody>
</table>
### Family welfare and child care

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting skills.</td>
<td>Enhance parenting support services and skills training. Develop alternatives to educational programs delivered by &quot;experts.&quot;</td>
</tr>
<tr>
<td>Family violence.</td>
<td>Enhance current collaborative efforts to combat domestic violence and child abuse. Provide services to offenders. Recognize link between substance abuse and family violence, and provide appropriate services.</td>
</tr>
<tr>
<td>Need for additional after school and summer programs for school-aged children.</td>
<td>Collaboration of schools, social service providers, and local government to develop programs.</td>
</tr>
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### Youth issues and services

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teens dropping out of high school.</td>
<td>Further development of alternative and “second chance” educational programming. Preventative counseling before students “fall through the cracks.” Attractive school-to-work programs.</td>
</tr>
<tr>
<td>Teen parenthood.</td>
<td>Programming and support to raise self-esteem, develop goals, and stimulate perception of personal responsibility among teens. Provision of accessible and appropriate sex education to children and teens.</td>
</tr>
<tr>
<td>Need for mental health services including counseling, psychiatric services, alcohol and drug treatment, and therapy for eating disorders.</td>
<td>Continued collaboration of health care providers and schools to develop targeted services.</td>
</tr>
<tr>
<td>Negative image and behavior of teens.</td>
<td>Further inclusion and engagement of teens in community planning and activities. Development of mentoring and support programs. Provision of positive recreational opportunities. Creation of meaningful alternatives to counseling or “slap on the wrist” for teens at risk of serious criminal activity.</td>
</tr>
</tbody>
</table>
1. Executive Summary:
Study area residents say . . .

Senior issues and services

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
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</thead>
<tbody>
<tr>
<td>Need for more home-based services to maintain seniors’ independence</td>
<td>Continued and expanded collaboration between local service providers and the Area Agency on Aging.</td>
</tr>
<tr>
<td>Need for outreach to seniors in rural areas.</td>
<td>Creative use of information technologies. Opportunity to develop mobile services.</td>
</tr>
<tr>
<td>Lack of knowledge about available services.</td>
<td>Increased communication to seniors from sources they trust (e.g., churches, social organizations, etc.).</td>
</tr>
<tr>
<td>Need for recreational activities including exercise classes.</td>
<td>Collaboration between service providers, educational institutions, businesses, and local government to provide amenities and activities tailored for seniors’ needs.</td>
</tr>
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People with disabilities

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
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</thead>
<tbody>
<tr>
<td>Categorical funding and reimbursement levels dictate services.</td>
<td>Enhance local funding to meet needs not covered by public programs.</td>
</tr>
<tr>
<td>Need for additional small group facilities for people with developmental disabilities and inappropriate use of nursing homes.</td>
<td>Collaborative planning among agencies and advocacy organizations to develop plans and funding strategies for appropriate facilities.</td>
</tr>
<tr>
<td>Lack of accessible and affordable transportation.</td>
<td>Address needs of persons with disabilities in general planning for area-wide transit system.</td>
</tr>
<tr>
<td>Perceived increase in diagnoses of attention deficit disorder and autism.</td>
<td>Improve training and processes for diagnoses and educational planning. Pressure legislature to increase funding for special education. Develop local support for special education teachers.</td>
</tr>
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## 1. Executive Summary:
Study area residents say . . .

### Recreation, parks, downtown development, and other community issues

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</thead>
<tbody>
<tr>
<td>Enhancement and maintenance of existing parks.</td>
<td>Establishment of park district. Mobilization of volunteers for park maintenance.</td>
</tr>
<tr>
<td>Downtown revitalization.</td>
<td>Reduction of barriers to downtown use. Collaborative planning to take advantage of future opportunities for business and recreational development.</td>
</tr>
<tr>
<td>Lack of alternatives to incarceration and coordinated services for ex-offenders.</td>
<td>Identification of model programs that have been successful in other areas. Collaboration among criminal justice organizations, service providers, employers, educational institutions, and religious organizations to provide coordinated services for ex-offenders.</td>
</tr>
<tr>
<td>Fear of outsiders coming to study area communities.</td>
<td>Community activities and events celebrating diversity. Information sharing between members of minority and majority communities.</td>
</tr>
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### Organization and management of health and human services

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<th>Opportunities</th>
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</thead>
<tbody>
<tr>
<td>Need for additional operating funds.</td>
<td>Seek grants from public and private funding organizations. Target allocation of local funds to greatest current needs and most efficiently run organizations. Collaborate and share resources.</td>
</tr>
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<td>Fragmentation and turf protection.</td>
<td>Multi-organizational taskforces around issues of common concern. Bridge-building among LaSalle County’s three United Ways and their member agencies.</td>
</tr>
<tr>
<td>Difficulty recruiting and retaining staff and volunteers.</td>
<td>Opportunity for multi-agency collaboration for volunteer recruitment, coordination, and training; and for innovative projects to recruit, educate, and support health and human service professionals. Raise wages for health and human service staff.</td>
</tr>
<tr>
<td>Need for better communication among providers and between providers and members of the public.</td>
<td>Willingness to share information and resources. Existing resource directories.</td>
</tr>
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<td>Need for translation and culturally appropriate services for growing minority population.</td>
<td>Develop volunteer networks for translation services. Recruit minority students for health and human service occupations and training. Offer diversity education to current health and human service workers.</td>
</tr>
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Conclusions

The study area is rich in many ways. It enjoys a strong social and employment base. It has abundant amenities and services. Its people share a diverse wealth of intelligence, experience, skills, spiritual strength, and good will. Its health care and social agencies offer a wide range of programs, services, and volunteer opportunities. The study area has more than enough of everything necessary to support the needy, empower the powerless, include the marginalized, and develop innovative approaches to challenges. Its leaders, service providers, and residents are in the enviable position of merely having to agree on the health and human service goals they wish to achieve and combine their considerable resources and energies to accomplish these goals.

The greatest challenges for the study area’s health and human service delivery system during the early years of the 21st century are fragmentation, turf protection, and competition. Communities and organizations operate as resolutely independent entities, defending their boundaries and competing for resources and loyalties. One Community F.O.C.U.S. 2001 focus group participant spoke for many when s/he said, “We are very territorial in this area.”\(^1\) This culture results in lost opportunities. Coordinated planning, fundraising, and service provision maximize resources and minimize both duplications and gaps in services.

Another continuing challenge for the study area’s health and human service delivery system is providing services to rural residents. Service organizations are concentrated in Ottawa and other large communities neighboring the study area and, with the exception of emergency services, tend to operate only during regular business hours. Rural residents, thus, have unequal access to services and often do without. In addition, service organizations often focus attention on town-based programs and clients and devote little interest or energy to rural needs. Expanded outreach to rural residents will both improve their quality of life and expand the market of service organizations employing this strategy. Furthermore, enhancement of transportation services will increase access to services of both rural- and town-dwellers.

Finally, the study area’s health and human service system faces the challenge of maintaining elements of the system that are strong and effective, jettisoning elements that have outlived their usefulness, and incorporating new organizations and approaches to service provision. Community F.O.C.U.S. 2001 project participants are most generous with their praise for collaborative projects that have been designed to address specific community needs. They are most critical of traditional support of local organizations, which ultimately undermines system strength. The lesson to be learned is that planning for health and human services must be driven by the changing needs of residents, rather than by the existence of longstanding programs and service organizations.

Where possible and appropriate, planning should be collaborative and involve participation of funders, service providers, and consumers. Local allocation of funds also should be driven by this type of planning, and should encourage and facilitate development of innovative approaches to design and delivery of services. Funded programs should be evaluated on a regular basis—if possible, by an external evaluator—to determine whether programs are meeting their objectives and identify elements of best practice. To facilitate funding decisions and evaluation, appropriate and comparable program data should be collected and maintained.

1. Executive Summary:
Recommendations

Recommendations

Information emerging from research activities suggests the following recommendations for improvement and enhancement of health and human service provision in the study area:

**Improve information provision and communication among service providers and between service providers and residents.**

This could be done by:
- Establishing and marketing a single point of contact for information provision, referral, and screening of clients;
- Co-locating information and services;
- Creating and maintaining a health and human services Website providing complete and up-to-date information about services, eligibility requirements, and current availability of resources; and
- Developing an interagency information system to aid data collection and client tracking.

**Enhance information links and collaboration among health and human service organizations, schools, and religious organizations.**

This could be done by:
- Improving information sharing among these three types of organizations;
- Enhancing and developing topic-focused taskforces composed of representatives from all three types of organizations; and
- Developing collaborations to deliver services.

**Plan and implement an area-wide, Countywide, or multi-county transit system serving the diverse needs of rural and town residents, low-income individuals and families, and persons with disabilities.**

This system should be designed to support employment, health care, child care, shopping, and recreational needs. It should, ideally, run seven days a week, 24 hours a day. It should be based on a solid and diversified financial strategy including grants, tax funds, employer contributions, user fees, and entitlement program reimbursement. It should result from collaborative planning involving representatives from all major stakeholder groups, including consumers.

**Enhance workforce development and support.**

This could be done by:
- Enhancing adult education and occupational training to meet employers’ needs for skilled workers in targeted (“good”) jobs and residents’ needs for well-paid employment;
- Developing imaginative and flexible solutions to transportation and child care challenges, particularly for low-income workers;
- Developing community-based affordable health insurance (covering dental and eye care and prescription drugs);
- Enhancing partnerships between health and human service organizations and local employers to provide information and services in the workplace, identify workers in need of services, and facilitate workers’ access to services; and
- Making job quality an important component of business attraction strategies.
1. Executive Summary: Recommendations

**Improve attraction, retention, and support of health and human service workers.**
This could be done by:
- Raising wages;
- Offering benefits;
- Offering flexible, family-friendly working conditions;
- Employing imaginative recruitment strategies for health and human service jobs (e.g., targeting older adults, stay-at-home parents, persons with disabilities, Spanish-speaking youth and adults, etc.);
- Offering local, affordable, accessible training for in-demand health and human service occupations; and
- Developing innovative employment strategies (e.g., employee sharing, job sharing) to meet needs of both employers and workers.

**Use results of this report.**
This could be done by:
- Assimilating, discussing, and prioritizing report findings and recommendations;
- Assembling a taskforce composed of representatives from health care, social service, education, local government, trades and labor, business, religious organizations, service consumers, and other interested groups;
- Developing specific goals associated with priorities and identifying projects to meet those goals; and
- Putting together project teams to plan and implement projects.
Acknowledgements

The Applied Social Research Unit (ASRU) and Project Funding Partners sincerely thank the organizations and individuals who contributed to the Community F.O.C.U.S. 2001 project. In all, at least 780 people participated in project planning and activities. Without this support, Community F.O.C.U.S. 2001 research and the opportunity to address issues raised by this report would not have been possible.

Project Funding Partners

These organizations provided funding and other support to the Community F.O.C.U.S. 2001 project:
- Community Hospital of Ottawa Foundation
- Illinois Valley Building Trades, Labor & Management
- Illinois Valley Community College
- Ottawa Area United Way
- The City of Marseilles
- The City of Ottawa

Project Development Committee

In 1999-2000, the Project Development Committee worked to determine the scope of the project, recruit and select a consulting organization to design, implement, and report on the project, and secure project funding. Ottawa Area United Way Board members that served as the Project Development Committee include:
- Russell Berg
- Gail Davis-Cooper, Reliable Corporation
- Mike Driscoll, G.E. Plastics
- John Knudson, City of Marseilles
- Shelli Ocepek, Ottawa Area United Way
- Bruce Rhodes, ComEd
- Colby Sawin, Illinois Power
- Robert Snyder, Aid Association for Lutherans
- Larry Windsor, Century 21 Windsor Realty

Steering Committee

Representatives of funding partners and other area organizations devoted time and expertise to refining project information needs; defining priority issues to be addressed; securing project funding; advising the Communication Committee; developing survey instruments; recommending participants for project activities; refining focus group methods; identifying local reports; and determining ways of communicating project findings. Several organizations provided space for committee meetings and focus group discussions. The Ottawa Area Chamber of Commerce and Industry made a financial contribution to the project. Members of the Community F.O.C.U.S. 2001 Steering Committee include:
2. Acknowledgements

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Dale Baxter, Ottawa Police Department
Russell Berg
Jeff Brodbeck, LaSalle County Health Department
Judy Christiansen, Community Hospital of Ottawa
Jim Conness, Illinois Valley Building Trades, Labor & Management
Randy Constantine, Department of Children and Family Services
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Kim Czyz, City of Ottawa
Tom Jobst, Ottawa Township High School
John Knudson, City of Marseilles
Lori Nall, Illinois Valley Community College
Shelli Ocepek, Ottawa Area United Way
Bill Owens, Ottawa Elementary School District 141
Joe Reynolds, LaSalle County Housing Authority
Robert Schmelter, Community Hospital of Ottawa
Robert Snyder, Project Chair, Aid Association for Lutherans
Larry Terpstra, Ottawa Area Chamber of Commerce and Industry

Communication Committee
The Communication Committee served the Community F.O.C.U.S. 2001 project by developing a project logo and cover letter design; drafting press releases; corresponding with local media; and determining ways of communicating project findings. Members of the Communication Committee include:

Fran Brolley, Committee Chair, Illinois Valley Community College
Harold Clemens, AdVenture Advertising and Marketing
Jill Drennen, Community Hospital of Ottawa
Shelli Ocepek, Ottawa Area United Way
Robert Snyder, Project Chair, Aid Association for Lutherans

Contributors
The Community F.O.C.U.S. 2001 project depended on the participation of local residents and professionals in project activities. A special thanks goes to:

- LaSalle County residents who completed household surveys;
- County residents, health and human service providers, clergy, government officials, business representatives, and others who served as key informants and focus group participants; and
- Health and human service providers who completed a survey about their organizations and programs.
2. Acknowledgements

Applied Social Research Unit
The ASRU appreciates the opportunity to serve LaSalle County through the Community F.O.C.U.S. 2001 project. The following ASRU staff members served as consultants on project committees, designed and implemented project activities, compiled and analyzed project information, and wrote project reports.

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Introduction: Assessing Health and Human Services in Eastern LaSalle County

Project scope and purpose
In 2000, organizations including the Community Hospital of Ottawa Foundation, the Ottawa Area United Way, Illinois Valley Community College, the Cities of Marseilles and Ottawa, and the Illinois Valley Building Trades, Labor & Management commissioned the Applied Social Research Unit (ASRU) of Illinois State University to conduct research assessing resources and needs for health and human services in eastern LaSalle County including Waltham and Utica Townships (the study area). This research, entitled Community F.O.C.U.S. 2001, was designed and implemented with broad and ongoing participation from study area leaders and service providers. The acronym, F.O.C.U.S., stands for “Facing Our Concerns and Understanding Services.” Emphasizing teamwork among diverse community members, the Community F.O.C.U.S. 2001 project employs a holistic approach that recognizes a wide range of factors contributing to the health and well-being of study area residents. The general goal of the project is to support planning of health and human service provision in the study area during the next 5 to 10 years.

The World Health Organization defines health as “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” 3.1 A healthy community is one that fosters an environment where all residents have optimal access to the information, resources, and services they need to attain and maintain a good quality of life. In a healthy community, services are planned and coordinated to make the best possible use of resources to meet the widest range of needs. In a healthy community, service users are resources and contributors—not merely problems and consumers. In a healthy community, all residents put their diverse talents and perspectives to work for the collective good.

In the 1998 Final Report of the Governor’s Commission on the Status of Women in Illinois, Gale Keeran, former Director of Managed Care at St. Joseph Medical Center, Bloomington, was quoted as saying, “Health care cannot . . . operate in a vacuum. We need to consider the relationship between wellness and the components of our living and working environments [such as] quality education, adequate housing, meaningful employment, access to job training, efficient public transportation, clean and safe environments and access to health education and services. If a person’s basic needs are not being met, forget mammograms and PAP smears. They won’t happen.” Similar statements could be made from the perspectives of other key community services and systems. Educators know that children with good family environments, housing, and health care are usually better students than children who are deprived in one or more of these areas; good teaching methods and computerized classrooms cannot compensate for deficiencies in a child’s world outside

the classroom. Employers are aware that job applicants and workers with nurturing home lives and access to high-quality child care, transportation, housing, and health care are more likely to be reliable and productive employees than are people lacking these resources and services. Economic developers realize that strong health and human services attract new businesses and residents.

With these issues in mind, the focus of Community F.O.C.U.S. 2001 research was defined very broadly to include health care and traditional social services provided to special populations in the study area. These special populations include, but are not confined to, low-income residents, people with disabilities, at-risk families and individuals, and others facing special challenges in attaining a good quality of life. Although services offered to the entire population, such as K-12 and community college education and primary, specialist, and hospital medical care provided to people with insurance coverage, were not the primary targets of Community F.O.C.U.S. 2001 research, providers and users of those services contributed information that enriched researchers’ general understanding of community needs and resources.

Community F.O.C.U.S. 2001 concerns the population and geographical area of eastern LaSalle County, including Waltham and Utica Townships. Although health and human services, along with many other resources, are concentrated in Ottawa, over one-half of the study area’s population lives in small communities or rural areas at some distance from Ottawa. Rural residents have the same needs as their neighbors who live in town, but encounter special challenges in meeting these needs. In its research plan, reporting, and conclusions, Community F.O.C.U.S. 2001 considers both rural and urban needs, resources, and strategies.

Study area
An early challenge for the Community F.O.C.U.S. 2001 project was to identify the specific geographical area to be covered by the project. This decision was important because it determined which service providers and residents should be included in research activities. Members of the Community F.O.C.U.S. 2001 Steering Committee worked with Applied Social Research Unit staff to identify the study area for Community F.O.C.U.S. 2001 research. Primary criteria for this decision included:

- Service areas of organizations contributing to the project; and
- Familiarity with area residents’ affinity to communities and patterns of service use.

After consideration of these and other factors, the Steering Committee decided that the following ZIP codes should be included in the study area: 60518, 60549, 60557, 61325, 61341, 61350, 61360, and 61373. This area covers all or parts of Fall River, Farm Ridge, Dayton, Ottawa, Rutland, South Ottawa, Earl, Freedom, Manlius, Brookfield, Serena, Grand Rapids, Miller, Waltham, Wallace, and Utica Townships. (See Figure 3.1.)

Research activities
Community F.O.C.U.S. 2001 used a mixed research approach that incorporates quantitative and qualitative methods to build a picture of the study area’s resources and residents’ needs for health and human services, and to identify opportunities for service provision in the future. Research activities include:

- Review of public data from government agencies and local reports, directories, and planning documents;
- A survey of 2,142 randomly selected study area households yielding 564 responses (response rate = 26%);
3. Introduction: Assessing Health and Human Services in Eastern LaSalle County: Study area

Figure 3.1: Study Area in LaSalle County, Illinois
Community F.O.C.U.S. 2001:

3. Introduction: Assessing Health and Human Services in Eastern LaSalle County: Report structure

- A comprehensive survey of 149 organizations providing health and human services to study area residents yielding 83 responses (response rate = 55.7%);
- 11 focus groups representing a wide range of perspectives on needs and resources for and delivery of health and human services in the study area (85 participants, 274 invited);
- 24 key informant interviews with County leaders, service providers, and residents representing a wide range of perspectives, interests, and expertise; and
- Review of best practice and models literature focusing on current issues affecting the study area’s health and human service system.

Information resulting from these research activities was used to develop this Report and its Support Documentation. Information about research methods, surveys, and focus group summaries is included in section 5 of the Report and in the Report with Support Documentation, both available through the Ottawa Area United Way. The Report is also available via the Applied Social Research Unit’s Website at: http://www.asru.ilstu.edu.

In all, at least 780 study area residents participated directly in the Community F.O.C.U.S. 2001 project. They worked as committee members, filled out survey instruments, participated in focus groups or interviews, and responded to data requests. Thus, Community F.O.C.U.S. 2001 truly represents the efforts and achievements of County residents; the research process itself is one of its products.

The highly collaborative nature of the Community F.O.C.U.S. 2001 study should support planning and implementation of projects to enhance health and human service provision in the study area. Success of volunteer and collaborative agency efforts in the past suggests that study area agencies and residents have both the experience and the will to target and prioritize health and human service needs based on the Community F.O.C.U.S. 2001 study.

Report structure

This Report is composed of narrative and figures. Sections 1 and 2 provide a brief Executive Summary and acknowledge contributions to the Community F.O.C.U.S. 2001 project. Section 3 (this section) provides an introduction to project philosophy, scope, and methods. Section 4 depends largely on public data and local reports to describe study area population and economy. Section 5 uses information elicited by surveys, focus groups, and key informant interviews to discuss needs and resources for specific categories of health and human services. Section 6 discusses the study area’s organization and management of health and human services based on information provided by focus group participants, key informants, and provider survey respondents. Section 7 considers potential applications of ideas gleaned from the best practices and models literature about innovative approaches to organization and delivery of health and human services that have been employed in other communities. Section 8 summarizes major conclusions of Community F.O.C.U.S. 2001 research and offers recommendations for future action based on these conclusions. Section 9 provides a list of all data, reports, secondary literature, and on-line resources used for this Report.
Population Profile

Needs and resources of residents of eastern LaSalle County including Waltham and Utica Townships (the study area) for health and human services depend upon factors including the composition and geographical distribution of its population and households; educational attainment; employment; income and housing; and residents’ health status and access to care. This section briefly profiles selected factors contributing to the quality of life in the study area as an introduction to section 5’s in-depth discussion of Community F.O.C.U.S. 2001’s research findings regarding specific health and human service issues.

Population

Having declined by 3.4 percent between 1980 and 1990, from 40,883 to 39,504, the study area population is estimated to have increased by 5.4 percent between 1990 and 2000 to 41,648. The population is projected to grow slightly (0.5%) to 41,874 between 2000 and 2005.\(^4\) Study area population is concentrated in Ottawa, which has an estimated 18,380 residents—44 percent of the total. The next largest community, Marseilles, has an estimated 5,074 residents.\(^2\) Both of these communities have experienced moderate growth during the past few years; however, the fastest-growing study area community is Seneca, whose population increased from 1,859 in 1994 to 2,502 in 1999 (35%). (See Figure 4.1.) Approximately two-thirds of study area residents live in towns, while the rest live in the country.\(^3\)

\[\text{Figure 4.1: Selected Study Area Communities’ 1990 Population, 1999 Estimated Population, and Percent Change}\]

<table>
<thead>
<tr>
<th>Communities*</th>
<th>1990 population</th>
<th>1999 estimated population</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earlville</td>
<td>1,466</td>
<td>1,556</td>
<td>6.1%</td>
</tr>
<tr>
<td>Grand Ridge</td>
<td>556</td>
<td>555</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Marseilles</td>
<td>4,811</td>
<td>5,074</td>
<td>5.5%</td>
</tr>
<tr>
<td>Naplate</td>
<td>573</td>
<td>614</td>
<td>7.2%</td>
</tr>
<tr>
<td>Ottawa</td>
<td>17,462</td>
<td>18,380</td>
<td>5.3%</td>
</tr>
<tr>
<td>Seneca</td>
<td>1,859</td>
<td>2,502</td>
<td>34.6%</td>
</tr>
<tr>
<td>Utica</td>
<td>867</td>
<td>833</td>
<td>-3.9%</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, Population Estimates for Places: Annual Time Series, July 1, 1990 to July 1, 1999, [Internet], (October 2000). Data are based on U.S. Census Bureau “place” information. U.S. Census Bureau information will not match ZIP code level information estimated by Claritas, Inc. presented in other parts of this report due to differences in geographic levels and estimation methods. *Census data for the populations of Harding and Serena are not available.

\(^{4}\) Claritas, Inc., Connect Study Report, [Internet database], (Arlington, VA, 2000). Data are based on sums of estimated ZIP code level information. Sums will not match “place” level U.S. Census Bureau information presented in other parts of this report due to differences in geographic levels and estimation methods.

\(^{2}\) U.S. Census Bureau, Population Estimates for Places: Annual Time Series, July 1, 1990 to July 1, 1999, [Internet], (October 2000).

\(^{3}\) This estimate was calculated using 1999 Census estimates for place populations and Claritas’ estimate of the 2000 study area population.
4. Population Profile:

Age

Almost all study area residents are white (95%) and non-Hispanic (97%). Nonetheless, the study area’s population is becoming increasingly diverse. At an estimated 1,277, the Latino/a population is the study area’s largest minority group and is projected to increase to 1,441 by 2005. The Black population is expected to grow by 20 percent, from 193 in 2000 to 232 in 2005 and the Asian population is projected to grow from 328 to 387 between 2000 and 2005.4.4

Implications for health and human services:

√ The lack of major change in population size is good news for planners and providers of health and human services. Comparatively stable population size will facilitate long-range planning and enhancement of services.

√ The geographical distribution of population across the study area outside of Ottawa makes it difficult for rural residents to obtain and providers to supply needed health and human services.

√ With a dominantly White but growing minority population, the study area’s health and human service providers must remain aware of the need to deliver services in culturally appropriate ways.

√ As the study area population becomes more diverse, service providers must make it a priority to recruit minority staff members and volunteers.

√ There is an increasing need for health and human service providers to offer translation services, particularly for Spanish-speaking consumers.

Age

The median age of study area residents is 38. Approximately one-quarter (26%) of the population is age 17 or younger and another quarter (27%) is between the ages of 25 and 44. Almost one-tenth (8%) of residents are young adults aged 18 to 24, almost one-quarter are between the ages of 45 and 64, and 17 percent are 65 or older.4.5 (See Figure 4.2.) The sizes of all age groups composing the study area population are projected to remain stable during the next 20 years.4.6

Implications for health and human services:

√ Compared to most areas in Illinois and the United States, the study area will be affected little by the aging of the baby boomers. With age distributions in the study area’s population predicted to remain essentially the same as they are now, planners and providers of health and human services have a stable basis upon which to plan services for the future.

√ With approximately 55 percent of the study area population being in the traditional service-providing age group, between the ages of 20 and 64, and approximately 45 percent of the study area population being in the traditional service-consuming age groups, between age 0 and 19 and age 65 and over, study area providers will be challenged to find skilled and reliable staff at all levels to supply services to residents.

4.4 Claritas, Inc., Connect Study Report, [Internet database], (Arlington, VA, 2000).
4.5 Claritas, Inc., Connect Study Report, [Internet database], (Arlington, VA, 2000).
4. Population Profile: Household and families

Despite population decline in the study area between 1980 and 1990, the number of households increased 1.4 percent, from 15,045 to 15,253, between 1980 and 1990, and is estimated to have increased 8.3 percent to 16,552 between 1990 and 2000. The number of households is expected to increase at a slower rate between 2000 and 2005, by 1.9 percent to 16,829. Following national trends, study area household size is decreasing. In 1980, the average household had close to three people (2.7). In 2005, households are expected to be smaller, with an average of 2.4 members.

Sixty-one percent of study area residents aged 15 or older are married. Of those who are not married, approximately half are divorced or widowed, and half have never been married. Married couples head most study area families with children. For example, there are 5,402 married couple families with children aged 5 or younger and 5,434 married couple families with children between the ages of 6 and 17. By contrast, 4 percent of study area households are single-parent families—452 with children aged 5 or younger and 473 with children between the ages of 6 and 17.

Source: Claritas, Inc., Connect Study Report, [Internet database], (Arlington, VA, 2000).
Study area households are less likely than in the past to be composed of family members. Three-quarters of study area households were made up of families in 1980 (11,289 of 15,045), but less than 70 percent of households are expected to be composed of family members in 2005. While over one-half (58%) of persons aged 65 and older live in family households, one-third (34%) of them live in non-family households, with most of these seniors living alone. More than three times as many older women (1,626) as older men (464) live by themselves.  

**Implications for health and human services:**

As the study area population ages, increasing numbers of people—particularly women—will be living alone. Persons living alone who find themselves in need require comparatively more support from service providers than persons living with someone else. Service providers must plan to deliver age- and gender-appropriate services to persons who live alone.

### Educational attainment

Over three-fourths of study area residents aged 18 and older have at least a high school education. Of all residents 18 and older, 41 percent have attained a high school education, 19 percent have some college, 6 percent have an Associate’s degree, and 11 percent have a Bachelor’s or graduate degree. However, almost one-quarter of these residents have less than a high school education.  

According to 1997 figures, high school dropout rates are somewhat low in LaSalle County (6.1%) compared to the State of Illinois (6.9%). Dropout rates are much higher in the County for Blacks (19.6%) than for Whites (5.9%). These percentages are deceptive, however, since the County’s Black population is very small. In terms of actual numbers, there are many more White than minority dropouts. In 1997, 324 White students quit school, compared to 9 Blacks and 4 “Other” minority students.

County rates mask variations among high schools. According to the Illinois Board of Education’s *1999 School Report Cards*, within the study area graduation rates were highest at Serena High School (97%), where 9 students dropped out, and Seneca High School (94%), where 14 students dropped out. Graduation rates were lower at Ottawa Township High School (78%), where 104 students dropped out, and Earlville High School (78%), where 13 students dropped out. The average graduation rate for Illinois public high schools in 1999 was 82 percent.

**Implications for health and human services:**

Its educated population is an important resource for the study area, supplying skilled workers for local employers, serving as an attraction for businesses considering locating in the area, and providing volunteers for community organizations and services.

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48 U.S. Census Bureau, Tables C90STF3B and C90STFC1, [Internet database], http://venus.census.gov/cdrom/lookup/981409922, (October 2000).
4. Population Profile: Educational attainment

√ In a period of economic prosperity and unprecedented demand for skilled workers, it is unacceptable that many young people drop out of study area high schools each year. Low educational attainment fuels crime and other social problems, and helps to perpetuate a culture of poverty. A full range of services—from early childhood and family support programs to alternative and “second chance” educational and mentoring programs for young adults—should be designed to meet local conditions, and then applied, evaluated, improved, and nurtured to bring dropout rates down.

√ As the institution of higher education with primary responsibility for serving study area residents, the Illinois Valley Community College will be a key player in addressing education and training challenges.

Figure 4.3: Educational Attainment for Persons 18 Years Old and Older in Study Area and State of Illinois, 1999

Source: U.S. Census Bureau, Tables C90STF3B and C90STFC1, [Internet database], http://venus.census.gov/cdrom/lookup/9814099922, (October 2000).
5

Needs and Resources for Health and Human Services

Introduction
The Community F.O.C.U.S. 2001 project is concerned with the health and well-being of study area (eastern LaSalle County including Waltham and Utica Townships) residents, their communities, and organizations providing health and human services to them. (See Figure 3.1 in section 3 for a map of the study area.) The project’s goal is to support planning of health and human service provision in the study area during the next 5 to 10 years.

The project used research methods including review of public data, local reports, and secondary literature; surveys; interviews; and focus group discussions to gather information about organizations, communities, specific services and programs, people, and special populations regarding:

- Strengths and weaknesses of health and human services;
- Unmet service needs;
- Availability of formal and informal resources for addressing identified needs;
- Communication methods and provider networks that help to address needs;
- Past and future trends in service provision;
- Gaps or duplications in service provision;
- Barriers to access and/or utilization of health and human services;
- Under-used or unrecognized resources for service provision; and
- Recommendations for improving health and human services.

Section 5, “Needs and Resources for Health and Human Services,” begins with a description of project research activities and a profile of health and human service provision. It then draws on information from each research activity to explore selected issues associated with residents’ quality of life.

Research activities
Community F.O.C.U.S. 2001 employs a mixed research approach that incorporates quantitative and qualitative methods to build a picture of the study area’s resources and residents’ needs for health and human services, and to identify opportunities for service provision in the future. Research activities include:

- Review of public data from government agencies and local reports, directories, and planning documents;
- A survey of 2,142 randomly selected study area households yielding 564 responses (response rate = 26%);
- A comprehensive survey of 149 organizations providing health and human services to study area residents yielding 83 responses (response rate = 55.7%);
- 11 focus groups representing a wide range of perspectives on needs and resources for and delivery of health and human services in the study area (85 participants, 274 invited);
5. Needs and Resources for Health and Human Services: Research activities

- 24 key informant interviews with County leaders, service providers, and residents representing a wide range of perspectives, interests, and expertise; and
- Review of best practice and models literature focusing on current issues affecting the study area’s health and human service system.

Each of these activities is briefly outlined below. Information resulting from these research activities was used to develop this Report and its Support Documentation. Detailed information about research methods, surveys, and focus group summaries is included in the Report with Support Documentation. The Report is available from the Ottawa Area United Way and via the Applied Social Research Unit’s Website at: http://www.asru.ilstu.edu. Contact the Ottawa Area United Way for information about accessing the Report with Support Documentation.

Review of public data, reports, and secondary literature

The Applied Social Research Unit (ASRU) reviewed public data to profile the study area’s population, income, housing, economic and employment situation, health status, and other demographic information. The ASRU staff obtained and analyzed public data from a variety of sources including Federal, State, and local agencies and organizations, and Claritas, Inc. (a private data vendor). Local agencies and organizations were also asked for previously released reports, to help identify priority study area issues and provide information not available from other sources.

In addition, ASRU staff reviewed secondary literature for information, models, and best practices associated with:
- communication, collaboration, and resource sharing within and among service networks;
- coordination of health and human services planning, administration, and delivery; and
- transportation programs and services.

The ASRU staff obtained secondary literature by attending conferences; doing library research; reviewing United Way of America practices and models; and visiting Federal agency and nonprofit organization Websites to obtain reports on social services issues, statistics, and practices. The bibliography of this report includes a full listing of sources for public data, reports, and secondary literature.

Household Survey

The eight-page survey of adult representatives (18 years of age and older) of randomly selected study area households was conducted by mail. The survey sought information about residents’ experiences with health care, employment and training, child care, transportation, downtown issues, recreational opportunities and parks, and social services. The first section of the survey asked for information about the respondent and his or her household members. “Household” was defined for respondents as “yourself and anyone living with you—people in your family and not in your family.” The last section of the survey asked respondents about their volunteer activities, greatest concerns about their area, and what they like most about living in their area.

Community F.O.C.U.S. 2001 Steering Committee members and ASRU staff worked together to develop Household Survey questions. The survey was piloted with 13 people from the study area. The Steering Committee determined the study area for the Household Survey. (See section 3 of this report for discussion of identification of the project study area; see Figure 3.1 for a map of the study area.) Survey Sampling, Inc., a commercial sampling firm, provided a random sample of 2,500 study area households with listed tele-
5. Needs and Resources for Health and Human Services: Research activities

phone numbers approximately proportionate to the total number of households for each study area ZIP code in Survey Sampling, Inc.’s database. Of the 2,500 original households in the survey sample, 2,142 households proved to be eligible for the survey. Ineligible households included persons who had moved from the study area or persons who did not receive the survey because they had passed away or were “temporarily away,” their “forward order” had expired, or the post office returned the piece indicating it was “undeliverable.” Respondents completed 564 surveys for a response rate of 26 percent (564/2,142).51

Health and Human Service Providers’ Survey
The ASRU mailed 152 surveys to health and human service organizations that provide services to residents in the study area. The eight-page survey requested information about the organization and health and human service provision including:

- Organization’s needs for maintenance, enhancement, and expansion; resource sharing and communication; and staffing, training, and accessibility;
- Organization’s major services or programs; and
- Strengths and challenges, and gaps and duplications associated with health and human service provision in the study area.

ASRU staff members worked with the Steering Committee to develop the survey. The goal was to send a Health and Human Service Providers’ Survey to every organization serving the study area that met the selection criteria of providing outreach services and assisting families and individuals. Surveyed organizations include: police and fire departments, food/housing/utility assistance programs, social service agencies, nursing homes, charitable and trust funds, health outreach programs, child care facilities, townships, agencies serving children and teens, employment agencies, and Illinois Valley Community College. Schools, mayors, ambulance services, private pay employment agencies, and in-patient hospital services were not included in the survey. With a few exceptions, the selection was limited to nonprofit organizations. Surveyed organizations are either located within the study area or, if located outside the area, provide an important service to some study area residents.

Members of the Steering Committee developed a mailing list using the LaSalle County Health Department’s Resource Guide with Supportive Services, 1999, a local telephone book, and input from local agencies and individuals. Of the 152 organizations and departments sent surveys, 149 organizations proved to be eligible. Ineligible organizations included one that had a change of address that could not be traced, one that felt they did not meet the criteria, and one that was no longer in existence. Health and human service providers completed 83 questionnaires yielding a 56 percent response rate (83/149).

Focus group discussions
The Community F.O.C.U.S. 2001 project utilized focus groups—facilitated small group discussions on a particular topic—to collect information from a broad range of community members, health and human service providers and consumers, and other professionals involved with community governance, planning, and development. The ASRU conducted 11 focus groups involving a total of 85 participants.

5. Needs and Resources for Health and Human Services: 
Research activities

Based on *Community F.O.C.U.S. 2001* project information objectives, the ASRU developed a list of potential focus group participants and the issues to be discussed by focus groups. The ASRU consulted local telephone and organization directories, Steering Committee members, and other study participants to develop an invitation list for focus groups. The ASRU invited 274 people representing health services, social services, education, seniors, youth, housing services, criminal justice, social clubs, philanthropic and service clubs, religious organizations, business and labor, and local government. In addition, local media advertised focus group dates and times and invited members of the public to participate.

Focus groups were held at the Community Hospital of Ottawa; each focus group discussion lasted for 1½ hours. Participants were assured that information they provided would not be personally identified with them in project reporting. Focus group discussions offered an opportunity for participants to respond to broad open-ended questions and elicited qualitative information to aid interpretation of survey results. Professional ASRU staff members facilitated focus groups, took notes, and assisted with set-up and clean-up. Participants at focus groups addressed these questions:

- What are the strengths of the health and human services in eastern LaSalle County including Waltham and Utica Townships?
- What are the unmet health and human service needs in the area?
- What recommendations would you make to improve health and human service provision in the area?

After each focus group discussion, the facilitator completed a short written summary of the information participants provided. To analyze this information, report writers examined summaries for both consistent and unique themes.

Key informant interviews

The ASRU conducted structured key informant interviews to elicit qualitative information about study area health and human service needs and provision. For the *Community F.O.C.U.S. 2001* project, a key informant is:

- in a position of leadership in LaSalle County, a community, an agency, or other organization;
- an informal leader or service provider within a community; or
- an expert in a particular field or someone with a particular experience of living in the County.

Most key informants have lived or provided service in the study area for a considerable period of time.

*Community F.O.C.U.S. 2001* project committees and the ASRU identified a list of individuals for potential key informant interviews and developed a guide for structuring interviews. The final list of 24 key informants included persons representing various organizations and communities: social services including education; health care; media; criminal justice; city government; business; churches; and other organizations.

Three ASRU staff members conducted key informant interviews. Staff members informed key informants that their comments would not be associated with them personally in project reporting. The ASRU interviewers began each meeting by asking for information about the key informant’s job title and responsibilities or other relevant personal information. Interviewers also described the study area. The interviewer then used the following questions to structure the interview:

- Overall, how well does the Ottawa region’s health and human service delivery system work?
- What are the strengths of the Ottawa region’s health and human service delivery system? Why?
- What are the weaknesses of the Ottawa region’s health and human service delivery system? Why?
5. Needs and Resources for Health and Human Services:
Profile of health and human service provision

- How has provision of health and human services in the Ottawa region changed during the past few (5?) years?
- What trends do you observe in provision of health and human services in the Ottawa region?
- Can you identify gaps or duplications in health and human service provision in the Ottawa region?
- Can you identify barriers to access and/or utilization of health and human services in the Ottawa region?
- Can you identify under-used or unrecognized resources for health and human service provision in the Ottawa region?
- How could health and human service delivery in the Ottawa region be improved?
- Can you suggest people who should be included in Community F.O.C.U.S. 2001 focus group discussions?

Each interviewer summarized her notes for each interview. ASRU report writers utilized key informant interview summaries to help interpret information coming from other project research and inform conclusions and recommendations in project reporting.

Profile of health and human service provision

*Community F.O.C.U.S. 2001* takes a holistic and “healthy community” approach to examining health and human service provision in eastern LaSalle County including Waltham and Utica Townships (the study area). This approach assumes that health and human services address residents’ physical, mental, emotional, and spiritual needs and provide access to a variety of goods, services, and amenities that support well-being (e.g., food, shelter, clothing, health care, education, training, employment). This section briefly summarizes the types of health and human services available for study area residents.

One of the strengths of the health and human service system mentioned by many *Community F.O.C.U.S. 2001* participants is the presence of a wide range of organizations, services, and programs. The LaSalle County Health Department’s *Resource Guide with Supportive Services, 1999*, outlines the scope of service provision to LaSalle County. In addition to the Community Hospital of Ottawa, other regional hospitals, and primary and specialist health care providers, there are professionals, agencies, organizations, and programs that:
- support specific populations (e.g., children, teens, adults, seniors, persons with disabilities, families, parents, consumers, and businesses);
- treat specific health conditions;
- provide education, training, and counseling;
- provide equipment, supplies, and household goods;
- help meet basic needs (e.g., housing, utilities, food, and clothing);
- provide services and/or support for persons experiencing particular situations (e.g., divorce, abuse, bereavement);
- offer recreational opportunities;
- provide employment support services; and
- protect study area residents and property (i.e., police and fire departments).

Health and human service organizations are located throughout LaSalle County and the study area. However, study area residents tend to obtain services in the City of Ottawa or other cities within LaSalle County (i.e., LaSalle/Peru, Streator, or Mendota) or outside LaSalle County (e.g., Morris). Eighty-three organizations that completed the *Community F.O.C.U.S. 2001* Health and Human Service Providers’ Survey listed...
5. Needs and Resources for Health and Human Services:
Residents’ perspectives on quality of life issues

126 total sites available to serve study area residents. Of 118 sites for which the location was specified, 42 percent are located in Ottawa, 42 percent are located outside of the study area or outside of LaSalle County, and only 16 percent are located in places other than Ottawa in the study area. One-third of responding organizations (33%) serve only communities or townships within the study area. The remaining responding organizations (67%) serve residents throughout LaSalle County; in addition, some organizations provide services beyond LaSalle County boundaries.5.2

Faith-based organizations (i.e., churches), also located throughout the study area, are sometimes overlooked in their role as health and human service providers within a community. In addition to supporting the religious and spiritual needs of members, many study area churches provide services such as counseling, food, shelter, clothing, child care, financial assistance, information, and education to both members and non-members. One Community F.O.C.U.S. 2001 key informant commented, “There are many churches in this community and I think people don’t recognize and use the services they offer. These are organizations with resources and power.” Another key informant said that study area residents feel more comfortable with services delivered through the churches than with government-funded support. However, s/he called for better coordination of church-provided services.

Residents’ perspectives on quality of life issues

In addition to the many focus group participants, key informants, and respondents to the Health and Human Service Providers’ Survey, 564 study area residents participated in the Community F.O.C.U.S. 2001 project by completing a survey about their perceptions of and experiences with a range of quality of life and health and human service issues. This section summarizes residents’ opinions about what they like most about living in the study area and what they are most concerned about. Their opinions inform implications for health and human services. Specific topics (e.g., health care), populations (e.g., youth, older adults), and organizational issues (e.g., resource and information sharing, staffing) are discussed later in this report.

Who are Household Survey respondents?

Responses to the Household Survey came from throughout the study area from men and women, young and old, with varying levels of education and income. Figure 5.1 provides a summary of Household Survey demographics.

To determine how well survey respondents represent the study area population as a whole, survey responses for demographic questions (i.e., age, education level, income) were compared to public data. The percentage of Household Survey respondents is nearly proportionally distributed geographically to the LaSalle County population living in Ottawa, Marseilles, and other parts of the study area. More survey respondents, though, describe themselves as living “in town” than the proportion of persons living in urban areas according to census data. Household Survey respondents are older, have more education, and have higher incomes than the study area’s population generally.5.3


5. Needs and Resources for Health and Human Services:
Residents’ perspectives on quality of life issues

5.1 Selected Demographics of Household Survey Respondents

<table>
<thead>
<tr>
<th>Variables</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>What community do you live in or closest to? (n=528)</td>
<td></td>
</tr>
<tr>
<td>Earlville</td>
<td>4.9%</td>
</tr>
<tr>
<td>Grand Ridge</td>
<td>2.5%</td>
</tr>
<tr>
<td>Harding</td>
<td>0.2%</td>
</tr>
<tr>
<td>Marseilles</td>
<td>17.6%</td>
</tr>
<tr>
<td>Naplate</td>
<td>0.8%</td>
</tr>
<tr>
<td>Ottawa</td>
<td>62.3%</td>
</tr>
<tr>
<td>Serena</td>
<td>6.6%</td>
</tr>
<tr>
<td>Utica</td>
<td>4.2%</td>
</tr>
<tr>
<td>Respondents live (Do you live:) (n=557)</td>
<td></td>
</tr>
<tr>
<td>In town</td>
<td>79.7%</td>
</tr>
<tr>
<td>In the country</td>
<td>20.3%</td>
</tr>
<tr>
<td>How long have you lived in the area? (n=562)</td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>0.4%</td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>11.4%</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>11.4%</td>
</tr>
<tr>
<td>11 to 20 years</td>
<td>9.3%</td>
</tr>
<tr>
<td>More than 20 years</td>
<td>67.6%</td>
</tr>
<tr>
<td>Age (What year were you born?) (n=533)</td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>3.6%</td>
</tr>
<tr>
<td>30-39</td>
<td>13.7%</td>
</tr>
<tr>
<td>40-54</td>
<td>30.8%</td>
</tr>
<tr>
<td>55-64</td>
<td>15.9%</td>
</tr>
<tr>
<td>65-74</td>
<td>18.4%</td>
</tr>
<tr>
<td>75-84</td>
<td>14.4%</td>
</tr>
<tr>
<td>85+</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variables</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (n=558)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>55.0%</td>
</tr>
<tr>
<td>Male</td>
<td>45.0%</td>
</tr>
<tr>
<td>What is the highest grade you finished in school? (n=558)</td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>8.6%</td>
</tr>
<tr>
<td>High school diploma or GED</td>
<td>34.2%</td>
</tr>
<tr>
<td>Some college, no degree</td>
<td>23.7%</td>
</tr>
<tr>
<td>Associate’s or similar degree</td>
<td>11.6%</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>14.5%</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>7.3%</td>
</tr>
<tr>
<td>Marital status (n=558)</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>7.2%</td>
</tr>
<tr>
<td>Married or live with partner</td>
<td>68.3%</td>
</tr>
<tr>
<td>Separated or divorced</td>
<td>6.8%</td>
</tr>
<tr>
<td>Widowed</td>
<td>17.7%</td>
</tr>
<tr>
<td>1999 household income before taxes (n=476)</td>
<td></td>
</tr>
<tr>
<td>Up to $9,999</td>
<td>4.8%</td>
</tr>
<tr>
<td>$10,000 to $14,999</td>
<td>7.6%</td>
</tr>
<tr>
<td>$15,000 to $19,999</td>
<td>8.2%</td>
</tr>
<tr>
<td>$20,000 to $29,999</td>
<td>12.0%</td>
</tr>
<tr>
<td>$30,000 to $39,999</td>
<td>13.4%</td>
</tr>
<tr>
<td>$40,000 to $49,999</td>
<td>12.0%</td>
</tr>
<tr>
<td>$50,000 to $59,999</td>
<td>14.3%</td>
</tr>
<tr>
<td>$60,000 to $99,999</td>
<td>21.4%</td>
</tr>
<tr>
<td>$100,000 to $199,999</td>
<td>5.3%</td>
</tr>
<tr>
<td>$200,000 or more</td>
<td>1.1%</td>
</tr>
</tbody>
</table>


*Percents do not add to 100.0% due to rounding.

Strengths

It is important for a health and human services assessment to identify strengths and resources of community quality of life and service provision. These strengths and resources are the foundation upon which improvements can be built; strengths are highlighted throughout this report. Community F.O.C.U.S. 2001 Household Survey respondents were asked about what they like most about living in their area; 385 respondents commented. 54 (See Figure 5.2.) Many residents believe they have the best of two worlds. They like their community’s atmosphere (i.e., rural, small, quiet), but also appreciate their proximity to goods, services, and larger metropolitan centers. In addition, residents value other community members and describe their many positive characteristics. One respondent mentioned valuing “Small town friendliness, sense of security concerning safety, love, caring, and compassion for each other.” Another likes the “Small town atmosphere, always running into a friend at the store, feeling like church is a family, our two rivers are beautiful, we are close to museums, ball parks, large malls, zoos, without the risks of living there.”

Eastern LaSalle County’s natural environment and recreational opportunities add to its appeal. One rural respondent wrote, “I love my home and living in the woods. It’s so peaceful and no one bothers me. I love watching the deer in the woods across the street and all the other small animals that live in the woods. The birds are so beautiful, I’ve never seen so many kinds.” Many residents commented on the beauty of the area, the rivers, parks, and recreational activities. Also, many residents indicate that they feel safe in their communities and perceive there is a low crime rate. One respondent wrote, “I feel safe walking the streets at any time of the day or night.”

Survey respondents are optimistic about the future. One respondent wrote:

"It is a nice area to raise a family. It does have its share of problems but nothing that cannot be fixed if we put an honest effort to it. We need to invest in our youth so that when it comes time to hand over the reins of leadership, they will have the knowledge, skills, abilities, and compassion to carry our community forward, just as our parents and grandparents entrusted us with."
5. Needs and Resources for Health and Human Services: Residents’ perspectives on quality of life issues

Concerns
The Community F.O.C.U.S. 2001 Household Survey also asked about respondents’ greatest concerns. Health care and social services were less often mentioned than other issues related to community and economic development. More than one-third of respondents (34%) are concerned about taxes, services received for taxes, and government spending and accountability. About one-quarter (26%) commented unfavorably on job availability or business attraction and retention issues. (See Figure 5.3.) For example, one respondent commented:

Our real estate taxes have nearly tripled in 10 years, but services and schools, streets, certainly have not improved commensurate with that increase; don’t increase services, lower taxes. We are concerned about waste in government and schools. We are also concerned about people being conditioned to believe government should take care of them. They should take care of themselves and their families.

Figure 5.3: Concerns Household Survey Respondents Have About Their Areas (n=324)*

<table>
<thead>
<tr>
<th>Percent</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.0%</td>
<td>High taxes; government spending and accountability; poor provision of services for taxes spent; education funding and quality</td>
</tr>
<tr>
<td>26.2%</td>
<td>Economic development (e.g., lack of jobs; low-paying jobs; business attraction and retention; high cost of living)</td>
</tr>
<tr>
<td>18.8%</td>
<td>Crime and safety (e.g., gangs; police; enforcement of laws; juvenile crime)</td>
</tr>
<tr>
<td>12.3%</td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td>10.8%</td>
<td>Community maintenance, restoration, and beautification (including maintenance of personal property)</td>
</tr>
<tr>
<td>10.5%</td>
<td>Lack of programming (related to recreation, entertainment, cultural activities, and youth/teen activities)</td>
</tr>
<tr>
<td>10.2%</td>
<td>Decline in values, morals, or respect; lack of parental supervision; concern for youth/teens</td>
</tr>
<tr>
<td>10.2%</td>
<td>Miscellaneous (e.g., housing, social services, other)</td>
</tr>
<tr>
<td>8.6%</td>
<td>Transportation (e.g., traffic congestion; infrastructure work/repair—roads; interstate travel; transportation to Chicago and to goods and services)</td>
</tr>
<tr>
<td>8.0%</td>
<td>Growth concerns (e.g., too much growth; urban expansion concerns; concerns about people moving in from other areas)</td>
</tr>
<tr>
<td>8.0%</td>
<td>Environment and pollution</td>
</tr>
<tr>
<td>6.2%</td>
<td>Health care (e.g., concerns about doctors, insurance, and prescription drugs)</td>
</tr>
<tr>
<td>3.1%</td>
<td>No concerns</td>
</tr>
<tr>
<td>0.9%</td>
<td>Don’t know</td>
</tr>
</tbody>
</table>


*Some respondents listed multiple concerns in answering this open-ended question. Therefore the percents total more than 100%. The “n” is the total number of Household Survey respondents who answered this question.

5. Needs and Resources for Health and Human Services: Income, employment, and training

Household Survey respondents’ top concerns echo several of the top ten issues determined at a town meeting associated with the 1997-1999 City of Ottawa Competitive Communities Initiative process.5.6

Implications for health and human services:
- Community organizations can point to the strengths of the study area highlighted by this and other reports to both celebrate and market the region.
- Community and economic development planners and professionals should offer prospective businesses and residents information and promotional material about health and human services. Health and human service organizations should make sure that they provide these materials to regional business and government agencies.
- Residents’ enthusiasm for their communities and optimism about maintaining strengths and addressing weaknesses will serve as enormous resources in future planning and development initiatives.

The following sections discuss strengths, resources, needs, and challenges associated with providing specific types of health and human services to residents of the study area. Please see section 6 for specific information about the organization and management of health and human services.

Income, employment, and training

Income
A major component affecting need for support from health and human service providers is income. Income determines prosperity and poverty, self-sufficiency and need. Income is also the key factor enabling access to basic necessities—food, shelter, clothing, health care, transportation, and other building blocks of daily life.

Residents of eastern LaSalle County including Waltham and Utica Townships (the study area) have low incomes compared to State of Illinois averages. The estimated study area median per capita income is $19,363, while the estimated median per capita income of Illinois residents is $28,873.5.7 Estimated median study area household income is $38,534 compared to $46,392 for Illinois households.5.8

According to 2000 estimates, almost one-fifth (18%) of study area households have incomes of less than $15,000. An additional 21 percent of study area households have incomes of between $15,000 and $29,999. One-fourth (25%) of study area households have incomes of between $30,000 and $49,999. Just under one-third (31%) of study area households have incomes of between $50,000 and $99,999, while 6 percent of study area households have incomes of over $100,000. (See Figure 5.4.)

Prosperity and poverty are related to age. Incomes are highest in households headed by people between the ages of 55 and 64. Household income is lowest among young people (ages 15-24) and in those households headed by people 85 and over. (See Figure 5.5.)

Approximately 11 percent or 1,645 of study area households have incomes below the poverty level. The residents of the largest number of households in this category are persons living alone (606 or 4% of households). There are four times more female-headed households with incomes below the poverty level (380 or 2.5%) than male-headed households (94 or 0.6%). Households composed of married couple families account for 461 (3%) of study area households with poverty-level incomes. In 1995, approximately 1,539 (14%) study area children under age 18 were living in poverty. Figure 5.6 provides 2000 Federal poverty guidelines by family size.

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5. Needs and Resources for Health and Human Services: Income, employment, and training

**Figure 5.4: Household Income of Survey Respondents and Study Area Residents, 2000 Estimates**

Respondents to the Community F.O.C.U.S. 2001 Household Survey have somewhat higher incomes than study area residents in general. For example, only 12 percent of survey respondents’ households, compared to 18 percent of study area households, have incomes of less than $15,000. However, the disparity is less in higher income ranges, with 36 percent of survey respondents’ households, compared to 31 percent of study area households, having incomes of between $50,000 and $100,000. It is noteworthy that cost of living, high taxes, and low wages were issues mentioned in approximately half of responses to the survey question asking what respondents are most concerned about in their area.5.11 (See Figure 5.3.) A typical comment was:

Property taxes have doubled in the last five years. I’m afraid I’ll have to sell my home because I can’t save enough to pay them each year. In 1995 my taxes were $1,250 a year. This year they were $2,380. Also, I want to keep my home in good condition and not let it start to look like a dump. But everything is getting so expensive and my income isn’t increasing to keep up with the high expense of everything.

Federal welfare reform legislation and an improving economy have affected the need for and provision of welfare benefits in the United States. Following National and State trends, the number of welfare recipients living in the study area declined dramatically during the late 1990s. For example, while an estimated 345 study area adults were receiving Temporary Assistance for Needy Families (TANF) cash benefits in 1996, only an estimated 48 study area adults are currently receiving TANF. Of these, approximately 29 are available to work and 8 have earned income. In 1995, 8,312 (8%) of LaSalle County residents were enrolled in Medicaid. This suggests that an estimated 3,075 study area residents of all ages had Medicaid coverage, approximately 1,540 of whom were under age 21. At present, 692 LaSalle County residents covered by Medicaid are nursing home patients.

Study area townships, nonprofit organizations, and churches also provide cash assistance to the needy. Information provided by 10 of the 16 study area townships indicates that most (6) provide General Assistance funds to people in need. However, these townships report assisting only between two and six people.

\[\text{Figure 5.6: Federal Poverty Guidelines by Size of Family\textsuperscript{\textregistered}, 2000}\]


\*For family units with more than 8 members, add $2,900 for each additional member.

Welfare

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5. Needs and Resources for Health and Human Services: Income, employment, and training

Each per year. Six other organizations responding to the Community F.O.C.U.S. 2001 Service Providers’ Survey also provide emergency cash assistance to help with utilities, rent, transportation, and other needs. These organizations help between 15 and 351 individuals each year. 

Employment

Employment is crucial to individual, family, and community quality of life. The income, benefits, training, and experience derived from employment build the conditions necessary for prosperity, security, and health. Plentiful good jobs and a high-quality workforce are key to community economic development. Good relationships between employers and workers and a flexible, stimulating, nurturing work environment support recruitment, retention, and success of businesses and employees.

At 4.8 percent, LaSalle County’s unemployment rate is at an all-time low. Indeed, unemployment in the County has been falling steadily in recent years, from 10.6 percent in 1993 to 8.0 percent in 1996 and 6.6 percent in 1999. (See Figure 5.7.) Sixty-two percent (18,363) of study area residents over 16 years old

Figure 5.7: Number in Labor Force* and Percent Unemployed in LaSalle County, 1978 to 1999


*Labor force includes civilians who are working or looking for work.


\[\text{Illinois Department of Employment Security, Local Area Unemployment Statistics (LAUS), [Internet], http://lmi.ides.state.il.us/laus/lauscur.htm, (November 2000).}\]
are currently in the labor force—either employed or looking for work. An estimated 11,267 residents over 16 years old are not in the labor force—neither employed nor looking for work.\(^5.17\)

Two-thirds of respondents to the Community F.O.C.U.S. 2001 Household Survey are employed. Of these, almost half work full-time and 13 percent work part-time. Nearly 4 percent of respondents work both a full-time and a part-time job, 1.5 percent work more than one full-time job, and 0.2 percent work more than one part-time job. Just over half (54%) of survey respondents’ spouses work full-time and one-tenth work part-time. (See Figure 5.8.) Two-fifths (42%) of respondents are retired.

3,572 study area residents suffer from a work-related disability. Of this group, 691 are employed and 101 are looking for work; 2,356 are prevented from working by their disability.\(^5.18\)

**Figure 5.8: Work Situation for Household Survey Respondents and Their Spouses or Live-in Partners**

![Figure 5.8: Work Situation for Household Survey Respondents and Their Spouses or Live-in Partners](image)


\(^5.17\) Claritas, Inc., Connect Study Report, [Internet database], (Arlington, VA, 2000).

\(^5.18\) Claritas, Inc., Connect Study Report, [Internet database], (Arlington, VA, 2000).
5. Needs and Resources for Health and Human Services: Income, employment, and training

Approximately four-fifths of study area workers are employed in the private sector. Approximately seven percent are self-employed. Most (89%) of the study area’s 1,890 employers are small, with fewer than 20 employees.5.19

What kinds of jobs do study area residents have?
- Services employ the largest number (5,017 or 25%) of local workers. Of this group, most work in education (1,842 or 37%), health care (1,785 or 36%), and social services (621 or 12%).
- 4,102 (20%) study area workers have retail jobs.
- Public administration employs the largest number of workers in the public sector (2,623 or 13%).
- 2,087 (10%) workers have manufacturing jobs.
- Other categories of study area jobs include personal services and recreation (1,770 or 9%); transportation, communication, and utilities (1,150 or 6%); finance, insurance, and real estate (1,382 or 7%); construction (922 or 5%); wholesale trade (861 or 4%); mining (175 or 1%); and agriculture, forestry, and fishing (147 or 1%).5.20

What do study area workers earn? Hourly wages for workers in manufacturing, construction, management, and health care are good. For example, the approximately 2,000 precision production, craft, and repair workers in the study area earn between $10.42 and $18.21 per hour. The approximately 600 general managers and top executives earn an average of $21.64 per hour. On average, registered nurses earn $15.96 and licensed practical nurses, $11.34 per hour. However, many study area workers are not high earners. Retail salespersons make an average of $7.24 per hour, and cashiers earn, on average, $6.35 per hour.5.21

Study area occupations for which there are the largest numbers of annual openings do not, in general, pay very well. Of the 10 jobs for which there is the greatest demand, only three—general managers and top executives, truck drivers, and registered nurses—pay more than $10 per hour.5.22 (See Figure 5.9.)

Wages determine the worker’s ability to maintain independence. According to The Self-Sufficiency Standard for Illinois, developed in 1996 by Wider Opportunities for Women, Inc., workers must earn enough to pay for basic expenses, including housing, child care, food, transportation, medical care, taxes, and minimal miscellaneous expenses. Since costs increase with the size and composition of families, the Self-Sufficiency Standard accounts for these factors. According to the Self-Sufficiency Standard, a LaSalle County adult living alone could maintain independence on the Federal Minimum Wage of $5.15 per hour. However, even at 1996 prices, an adult with one infant would need $7.98 per hour, an adult with an infant and a pre-schooler

5.21 Illinois Department of Employment Security, “Balance of State Wage Estimates,” IDES Wage Data 2000, [Internet], http://www.lmiIDES.state.il.us/, (October 2000). Occupational data for the study area were estimated based on the proportion of the study area population to the Illinois Valley Community College (IVCC) service area population. Study area population was obtained from U.S. Census Bureau, Census of Population and Housing, Summary Tape Files 1A and 3B, [database], (1990), and Treadway, R. and D.J. Ervin, Illinois Population Trends 1990 to 2020, (Springfield, IL: State of Illinois, 1997). Based on this proportion, the study area is estimated to make up 27 percent of the IVCC service area.
5. Needs and Resources for Health and Human Services: Income, employment, and training

Figure 5.9: Estimated Average Annual Job Openings, Median Hourly Wage, and Annual Income for the 20 Study Area Occupations with the Greatest Number of Job Openings

<table>
<thead>
<tr>
<th>Rank</th>
<th>Occupation</th>
<th>Average annual job openings in study area</th>
<th>Estimated median hourly wage</th>
<th>Estimated full-time median annual income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cashiers</td>
<td>31</td>
<td>$6.35</td>
<td>$12,700</td>
</tr>
<tr>
<td>2</td>
<td>Retail Salespersons</td>
<td>28</td>
<td>$7.24</td>
<td>$14,480</td>
</tr>
<tr>
<td>3</td>
<td>General Managers and Top Executives</td>
<td>18</td>
<td>$21.64</td>
<td>$43,280</td>
</tr>
<tr>
<td>4</td>
<td>Waiters and Waitresses</td>
<td>16</td>
<td>$5.83</td>
<td>$11,660</td>
</tr>
<tr>
<td>4</td>
<td>Combined Food Preparation and Service Workers</td>
<td>16</td>
<td>$5.90</td>
<td>$11,800</td>
</tr>
<tr>
<td>6</td>
<td>Farmers</td>
<td>15</td>
<td>$9.20</td>
<td>$18,400</td>
</tr>
<tr>
<td>6</td>
<td>Truck Drivers</td>
<td>15</td>
<td>$12.49</td>
<td>$24,980</td>
</tr>
<tr>
<td>8</td>
<td>Farm Workers</td>
<td>13</td>
<td>$7.14</td>
<td>$14,280</td>
</tr>
<tr>
<td>9</td>
<td>Food Preparation Workers</td>
<td>12</td>
<td>$5.99</td>
<td>$11,980</td>
</tr>
<tr>
<td>10</td>
<td>Registered Nurses</td>
<td>11</td>
<td>$15.96</td>
<td>$31,920</td>
</tr>
<tr>
<td>11</td>
<td>General Office Clerks</td>
<td>10</td>
<td>$8.33</td>
<td>$16,660</td>
</tr>
<tr>
<td>11</td>
<td>Miscellaneous Helpers and Laborers</td>
<td>10</td>
<td>$8.60</td>
<td>$17,200</td>
</tr>
<tr>
<td>13</td>
<td>Supervisors, Marketing and Sales</td>
<td>9</td>
<td>$13.76</td>
<td>$27,520</td>
</tr>
<tr>
<td>13</td>
<td>Miscellaneous Managers and Administrators</td>
<td>9</td>
<td>$19.66</td>
<td>$39,320</td>
</tr>
<tr>
<td>15</td>
<td>Nursing Aides and Orderlies</td>
<td>8</td>
<td>$7.37</td>
<td>$14,740</td>
</tr>
<tr>
<td>15</td>
<td>General Maintenance Repairers</td>
<td>8</td>
<td>$10.42</td>
<td>$20,840</td>
</tr>
<tr>
<td>15</td>
<td>Secretaries, Excluding Legal and Medical</td>
<td>8</td>
<td>$9.41</td>
<td>$18,820</td>
</tr>
<tr>
<td>15</td>
<td>Teachers, Secondary School</td>
<td>8</td>
<td>$19.07</td>
<td>$38,140</td>
</tr>
<tr>
<td>19</td>
<td>Janitors and Cleaners</td>
<td>7</td>
<td>$7.42</td>
<td>$14,840</td>
</tr>
<tr>
<td>19</td>
<td>Receptionists</td>
<td>7</td>
<td>$8.16</td>
<td>$16,320</td>
</tr>
</tbody>
</table>


would need $11.61 per hour, and an adult with an infant, pre-schooler, and a school-aged child would need $15.59 per hour to be self-sufficient.\(^{5,23}\)

Community F.O.C.U.S. 2001 Household Survey respondents commented about the difficulty of finding well-paid jobs in the study area. One respondent’s greatest concern about the area is “The lack of industry coming to this area that pays a wage that someone can actually live on. $6-8/hr. jobs don’t do that.” Another wrote, “BWD and Snap On Tools closed this past two years. Employment in Ottawa stinks. The only jobs there are for a blue collar worker pay $5-6 an hour.” Another respondent commented, “Jobs are low-paying, while rent, food, taxes are rising. All four adults in this household work out of [the] area because wages in

Ottawa are too low. Two adults are retiring soon and will be leaving this expensive area.” Still another mentioned the “Lack of employment opportunities—without more jobs the youth will have no choices but to leave town when employable.” A Community F.O.C.U.S. 2001 key informant commented, “We are losing businesses in the area—particularly corporate offices. Lots of jobs are coming to the community, but most are second income jobs.”

As one Community F.O.C.U.S. 2001 focus group participant pointed out, working poverty is a growing problem in the study area. Although low-income individuals and families may not qualify for cash benefits or other publicly provided support programs, they often need help to maintain self-sufficiency. Yet, as another focus group participant said, the poor—particularly those living in rural areas—are often “invisible.” A Community F.O.C.U.S. 2001 key informant commented that some community members are unwilling to “Face the fact that people need services, since most community members are doing okay. Yet, there are some who realize that, even if people are working hard, they are unable to make it for some reason or another.”

**Education and training**

The Community F.O.C.U.S. 2001 Household Survey asked respondents a series of questions about the training or education they need to improve their job opportunities. Of the 83 respondents who indicated a need for education or training, three-tenths said they need job training, while one-fifth (19%) need a two-year degree, 16 percent need a four-year degree, and another 16 percent need a graduate degree. One-tenth (10%) need an apprenticeship, while 19 percent need career planning services. (See Figure 5.10.) Respondents working multiple jobs, or those not employed but looking for work, report needing training at higher percentages than other respondents.

Most respondents (83%) indicate that they or their spouses are getting the training or education they need. The most significant barriers to obtaining training or education, according to respondents who indicate a need, are cost (46%), family responsibilities (39%), time (37%), lack of local availability (30%), and lack of availability through employer (29%).

What types of education or training do study area residents want? Seventy residents responded to this question. Those mentioning specific skills were most likely to require computer-related training (29%). Other respondents need training in specific occupations—for example, “Me, electronic tech. Her, biochemical engineering program.” Other careers mentioned were special education, machinery maintenance, refrigeration-electrical, business management, teaching, electronics, and medical BA. Several respondents commented on the lack of graduate program opportunities in the area.

Several respondents commented on their ultimate goals for obtaining more education or training. Some linked training to better paying jobs. One respondent wrote, “To help with child care and cost.” Another said, “I need at least $20,000 a year income.” Other respondents, however, mentioned personal development and psychological needs. One respondent commented, “Some specific job training to secure a degree or just better present skills.” Another wrote, “Computer training, vocational training, anything that could make me feel that I’m worth something and have a reason to be alive.”

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Employment support services

A number of job training and employment support services exist for study area residents. The Illinois Valley Education-to-Careers Partnership offers technical assistance and career information to public school students and teachers. Illinois Valley Community College (IVCC) administers a variety of programs to provide students with basic skills, English as a Second Language, job search, retraining, mentoring, specific vocational skills, certificates and degrees, and a comprehensive baccalaureate transfer curriculum. While the main campus is in Oglesby, IVCC has a satellite center in Ottawa and provides extension sites throughout the study area. The Illinois Valley Center for Independent Living provides independent living skills training to persons with disabilities. St. Mary’s Hospital offers career days and job shadowing opportunities to area high school students. All of these initiatives are designed to help study area residents qualify for employment and improve their employment opportunities.
5. Needs and Resources for Health and Human Services: Housing and homelessness

One respondent to the Community F.O.C.U.S. 2001 Service Providers’ Survey referred to the impact of the Federal Workforce Investment Act on the extent to which local providers are collaborating to provide employment support services:

This has resulted in a lesser amount of operating funds, changes in program service activities, confusion as to allowability of services and a move to more of a “work first” priority over training services. However, the Workforce Investment Act is also bringing about greater collaboration among various health and human services local programs.

Another survey respondent proudly reported a local computer training program that enables completers to find jobs with average hourly wages of over $10 per hour.5.25

Implications for health and human services:

- The large number of small employers in the study area means that it is difficult for employers to offer—and employees to afford—health care and other benefits. This suggests the opportunity for employers to group together to provide benefits.
- Study area business attraction initiatives should focus on bringing well-paid jobs to the area. High school and community college program planners should focus on developing a skilled workforce to fill well-paid jobs. Community developers and educators should work together to target specific industries, occupations, and companies for attraction and recruitment activities.5.26
- Existing study area businesses should partner with community college and other training providers to offer on-site training programs to build the skills of current workers.
- There is a need for flexible schedules and approaches for job-related training to meet the needs of study area workers who hold more than one job.
- Financial management training and support should be available to help individuals and families manage their incomes and debts to maximize opportunities for self-sufficiency.
- Diverse community organizations should collaborate to provide the support services—affordable and accessible transportation, child care, health care, housing, etc.—that low-paid workers need to maintain employment.
- Poverty is gendered. Single women with children and older women living alone are more likely to be poor than other members of the community and need appropriate support services to maintain their independence and dignity.

Housing and homelessness

Housing

Housing is a significant factor in individual and family quality of life. Affordable, accessible, clean housing with reliable utilities is necessary for health, employment, and family stability. Public and subsidized (“Section 8”) rental housing exists to provide low-income area residents with this important resource. Government policies also support low-cost mortgages for low-income people who wish to own their own homes. Because of the stability, personal satisfaction, and investment in a community of homeowners, homeownership is an important goal for governments, families, and individuals. Yet, for many low-income

5.26 The need for a skilled workforce was also emphasized in the recent Ottawa Area Chamber of Commerce and Industry, Team Research and Findings from the Ottawa CCI Process, (1999), 5-9.
5. Needs and Resources for Health and Human Services: Housing and homelessness

households, there are significant barriers to homeownership including lack of a down payment, excessive debt, or insufficient income.5.27

In addition, according to comments made by respondents to the Community F.O.C.U.S. 2001 Household Survey, the increasing cost of services and property taxes may make homeownership unaffordable for many. For example, one respondent said that a major concern was “Being able to afford my home due to continued rise in services (such as simple water). Property taxes will drive people out of their homes.” Another commented that the “Large amount of real estate taxes paid makes [a] normal house unaffordable with good income. People cannot keep up or get ahead. . . .” Eleven percent of survey respondents said that in the last year they couldn’t afford home repair.5.28

Most (71.5%) housing units in eastern LaSalle County including Waltham and Utica Townships (the study area) are occupied by owners. Just over one-quarter of study area housing units (28.5%) are occupied by renters. Most (68%) Community F.O.C.U.S. 2001 Household Survey respondents have lived in the area for more than 20 years.

The cost of housing is going up. For example, the average price of homes in the study area in 1990 was $55,421; in 2000, the average home price had risen by 30 percent to approximately $72,303 and is projected to be $79,841 in 2005.5.29 At present, the average cost of a new home in the study area is $146,865.5.30 In 1990, the average monthly rent in LaSalle County was $326.5.31 In 1996, according to The Self-Sufficiency Standard for Illinois, average rents were, for a one-bedroom apartment, $286, for a two-bedroom apartment, $382, and for a three-bedroom apartment, $516.5.32

In 1989, the most recent date for which data are available, most (71%) study area homeowners paid less than 20 percent of their household income for housing. By contrast, most (52%) study area renters paid more than 20 percent of their income for housing.5.33 The Federal Department of Housing and Urban Development (HUD) has determined as its criteria for housing affordability that housing should cost no more than 30 percent of a household’s gross income. According to this standard, an estimated one-tenth of study area households cannot afford a one-bedroom apartment; over 15 percent cannot afford a two-bedroom apartment; and just under one-quarter cannot afford a three-bedroom apartment.5.34

Community F.O.C.U.S. 2001 Household Survey respondents commented on the high cost of rental housing in the area. One respondent wrote, “We have [a] family living with us because rent is too high. Two families in one house is really sad this day and age.” An older respondent commented, “I would like to see more senior housing that would be affordable. The new housing that has come to town is $2,000 a month, and I

5.29 Claritas, Inc., Connect Study Report, [Internet database], (Arlington, VA, 2000).
5.30 Realtor.com, [database], (2000).
5.33 Claritas, Inc., Connect Study Report, [Internet database], (Arlington, VA, 2000).
5.34 These calculations are based on income figures from Claritas, Inc., Connect Study Report, [Internet database], (Arlington, VA, 2000) and average apartment rents from Wider Opportunities for Women, Inc., The Self-Sufficiency Standard for Illinois: Selected Family Types, (Washington, DC, Fall 1998), 59.
can’t afford that.” A third respondent, who is dealing with both a disability and a limited income, commented on his need to find affordable and accessible housing. Six percent of survey respondents said that in the last year they had had trouble finding affordable housing.5.35

According to the recent Team Research and Findings from the Ottawa CCI Process (1999), “There is a need for affordable single family homes and condominiums [in Ottawa]. Home loans are available at very favorable interest rates to qualified buyers with little or no money down, but the monthly payments must be manageable.” The same report indicated a need for additional multi-family rental housing and housing for retired persons in Ottawa. There is a 10-year waiting list for duplexes at the Pleasant View Luther Home.5.36 A Community F.O.C.U.S. 2001 key informant indicated that there is also need for affordable housing—apartments in particular—in Marseilles; this informant identified as “affordable” rents between $250 and $400 per month.

Waiting lists for public and subsidized housing indicate need for affordable housing among low-income residents. According to the Housing Authority of LaSalle County, at this time (November 2000), there are 377 families on the waiting list for public housing. Approximately 75 percent of these are single-parent families. There are 207 older adults waiting for public housing units designed for seniors. Finally, there are 202 on the waiting list for Section 8 housing.

The Community F.O.C.U.S. 2001 Household Survey asked respondents about the types of housing they think are needed in the study area. (See Figure 5.11.) Respondents were most likely to say that more assisted living for seniors and the disabled (43%), accessible housing for people with disabilities (36%), and housing for the homeless (31%) are needed. Respondents were most likely to say that less subsidized housing (18%) is needed. They were least likely to know about the housing needs of people with disabilities (53%), homeless people (52%), and nursing home patients (46%).

A number of public and nonprofit organizations provide housing assistance to study area residents. The Housing Authority of LaSalle County administers public and subsidized housing. The Salvation Army manages Federal programs for utility and rent/mortgage assistance. The Tri-County Opportunities Council administers the Illinois Department of Commerce and Community Affairs’ Low-Income Home Energy Assistance Program (LIHEAP) and Weatherization and Housing program. In addition, most organizations offering emergency assistance help with rent, mortgage, and utility payments in crisis situations.5.37 The annual volunteer United Way Labor of Love program also helps the needy with home repairs and improvements.

It is noteworthy that several Community F.O.C.U.S. 2001 Household Survey respondents registered dissatisfaction with managers and residents of subsidized housing. One respondent commented, “We have a lot of slum landlords who do not take care of their property. Especially those who rent to Section 8. We have had people on drugs, sell drugs, even a child molester, wife beaters, hookers, people who neglect their children, people who use loud and foul language, thieves, you name it, they have lived next door to us.” Another wrote, “Subsidized housing in my neighborhood has deteriorated the area. Lawns and houses unkept. Po-

lice intervention in these homes. We have put off making improvements to our property based on the instability of the neighborhood.”


Homelessness

There is lack of agreement about the extent to which homelessness is a major problem in the study area. One Community F.O.C.U.S. 2001 focus group participant said that people in the area deny that homelessness exists. Nonetheless, according to a recent newspaper report, during its months of operation (October through April) the number of guests at Ottawa’s Public Action to Deliver Shelter (PADS) ranges from 6 to 25 per night, depending on the weather.5.39 Several Community F.O.C.U.S. 2001 key informants and focus group participants indicate that these numbers may underestimate the problem, because many study area residents have no permanent residence, but have relatives or friends in the area who provide temporary and occasional shelter. It is also likely that not all area homeless use PADS, since the shelter requires guests to be drug- and alcohol-free and only provides service from 7 p.m. to 7 a.m.


Having used the Salvation Army building in 1999-2000, PADS has recently moved to a temporary location in the Ottawa City offices. PADS’s attempts to find a permanent location have been frustrated by opposition from the residents of neighborhoods where it has attempted to re-locate. According to a Community F.O.C.U.S. 2001 key informant, currently, some homeless use the Sands Motel, Ottawa, for which they or agencies pay $38 per night.

How can the problem of homelessness in the study area be addressed? One focus group participant noted a need for transitional housing for singles and families in “cyclical” homelessness. A key informant agreed, saying that sometimes people without housing “have what it takes to be self-sufficient but are relegated to homeless shelters. What is needed is support and guidance to bridge the gap for self-sufficiency. There are no guidelines at the homeless shelter (other than rules of behavior), but there is a gap between caring for the homeless and helping people become self-sufficient.” Other focus group participants pointed out that homeless individuals and families often have multiple problems and find it difficult to navigate the current fragmented health and human service system. These people would be better served by more coordinated services and a better referral system. In any case, the community will want to avoid the situation described in a recent newspaper report: “We have a lot of homeless people that would be spending time on park benches, in empty sheds, or in back yards without permission if there were not a public shelter to provide a place to go, where they are supervised and have at least two good meals a day.”

Implications for health and human services:

- ✓ There is a continuing need for affordable rental and owner-occupied housing in the study area. If low-income people pay too much for housing, they may not be able to afford other necessities affecting health and quality of life—health care and child care, for example. It is the responsibility of the community to ensure that sufficient affordable housing is built, made accessible for people with physical limitations, and supported with services such as transportation.
- ✓ Affordable housing must be coupled with affordable property taxes. Otherwise, low-income homeowners may be unable to stay in their homes.
- ✓ Community planners will be well advised to think imaginatively about uses of existing property and planning of new housing developments to take account of the housing needs of all study area residents. Not all study area residents drive—particularly children, low-income residents, people with disabilities, and older adults; thus, planning should take transportation needs into account. In addition, new housing is being developed for the prosperous in zero-lot line subdivisions; yet, current trends suggest, on the one hand, continuing need for affordable housing and, on the other hand, the desirability of “smart growth” strategies to minimize urban sprawl and protect farmland and the natural environment.
- ✓ Community organizations should continue to work together to find a permanent location for the PADS shelter and also work toward development of transitional housing with appropriate support services and case management. Homeless individuals and families often have multiple problems that must be addressed before they can become stable and self-sufficient. It is in the community’s best interest to provide coordinated services to address these problems.

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Transportation

Reliable and accessible transportation is critical for gaining and retaining jobs, transporting children to and from child care, and accessing medical care, social services, education, and shopping.\textsuperscript{5.43} Transportation emerged as an important issue in \textit{Community F.O.C.U.S. 2001} research. According to participants, lack of transportation—as a barrier to access to work, health care, and other services—is related to age, income, disability status, marital status, and other factors.

Existing transportation resources

Several organizations serve as transportation resources within the study area (this is not an all-inclusive list):

- The City of Ottawa provides Mini-Bus transportation on two routes within the corporate limits Monday through Friday between 9:30 a.m. and 3:30 p.m. A wheelchair-accessible bus is also available and must be scheduled. This is a free service open to the public.
- G & R Cab Company, located in Ottawa, provides taxi service Monday through Thursday from 7 a.m. to 6 p.m. and Friday and Saturday from 7 a.m. to midnight. The City of Ottawa subsidizes this service by providing rent-free property for operation and offering cards to income-eligible adults age 62+ that allow them one round trip per day in the taxi at half price.
- The Community Hospital of Ottawa (CHO) Care-A-Van provides transportation for medical purposes within an eight-mile radius of the Ottawa City limits Monday through Friday, 8 a.m. to 5 p.m. There is no fee for this service. Patients’ doctors must be affiliated with CHO, although a limited number of dialysis patients are transported to and from Midwest Kidney which leases CHO space. The Care-A-Van vehicle is wheelchair-accessible. A friend or family member can accompany patients. An adult must accompany minors under age 16. As of December 1, 2000, CHO Rehabilitation Services will be transporting rehabilitation patients to and from the hospital with a vehicle purchased for this purpose.\textsuperscript{5.44}
- Other County and regional hospitals, i.e., St. Mary’s Hospital in Streator, Morris Hospital in Grundy County, and St. Margaret’s Hospital in Bureau County, also provide transportation services for medical purposes to patients with hospital-affiliated health care providers. These services are either free or charge a small fee.
- Lowe’s Medical Transportation Services, located in Ottawa, transports mobile and semi-mobile clients to and from hospitals, physician appointments, dialysis, nursing homes, physical therapy, and private homes. A wheelchair-accessible van is available. Lowe’s accepts private pay, Medicaid, and payment from private foundations, Department of Rehabilitation, and the Veterans’ Administration. Lowe’s will transport anywhere in Illinois.
- In addition to Lowe’s, other private pay transporters exist within the region. One example is Angels Private Care in Bureau County that transports clients anywhere they need to go including, but not limited to, church, shopping, and medical purposes. The service is available 24 hours, 7 days per week. An hourly rate of $11 to $11.35 per hour depending on the time of day plus a fee for mileage is assessed. Angels does not accept Medicare or Medicaid.
- The Department of Human Services (DHS), with an office in Ottawa, supports several transportation programs for clients. DHS can authorize payment or reimbursement for transportation (provided by

\textsuperscript{5.43} “DHS’ Role in Transportation” presented at the \textit{Transportation Forum} hosted by Work, Welfare, and Families, the People’s Resource Center, and the Metropolitan Planning Council, (Wheaton, IL, 2000).

\textsuperscript{5.44} A CHO staff member communicated information about the CHO Care-A-Van and Rehabilitation Services transportation on November 21, 2000.
another organization) for medical purposes. Clients must have prior approval for DHS payment. Clients have to be income/asset eligible. DHS also provides “A Way to Work” program that takes and grants car donations to assist people in getting to and from work. DHS coordinates this program and works with other agencies. Finally, DHS uses “Front Door Money” to repair cars for individuals receiving Temporary Assistance for Needy Families to help keep them employed and from needing other types of financial assistance.

- The Department of Rehabilitation Services, also part of DHS, reimburses clients for transportation services to appointments, job interviews, and training. Eligibility is based on U.S. citizenship, disability status, and income. Reimbursement must be applied for in advance of needing transportation. The Department serves LaSalle, Bureau, and Putnam Counties.

- Project Neighborly Older Americans (NOA), located in Oglesby, has wheelchair lift-equipped vans available for transportation for medical purposes and shopping when space is available. A person must require minimal assistance for transfer. This service is for persons 60 years and older and must be scheduled in advance. A donation of $1.50 per one-way ride is requested, but no one is denied service for inability to pay.

Several other health organizations, social agencies, and social clubs (e.g., Illinois Valley Eye Institute, Veterans’ Assistance Commission of LaSalle County, and the Tri-County Opportunities Council) provide transportation support to clients (within all or part of the study area) for medical, educational, and other purposes. Although a number of transportation resources exist within and outside the study area, many respondents believe these are insufficient to cover the need for transportation support.

**Transportation issues and gaps**

Most focus groups (9 of 11), nearly half of key informants (11 of 24), and many Health and Human Service Providers’ Survey respondents (18 of 61 organizations) raised transportation issues. Some participants specifically cited the Ottawa Mini-Bus and CHO’s Care-A-Van as strengths. Generally, though, participants view lack of transportation as a weakness or gap in the health and human service system and a barrier to health and human service access. According to participants, this is especially true for rural areas of LaSalle County that lack transportation and/or available services.

Many services are located in Ottawa—some distance from rural areas. Of 118 sites that identified their specific location on the Service Providers’ Survey, 42 percent are located in Ottawa and 42 percent are located outside of the study area. Also, providers report that most (69%) of the 118 service sites serving study area residents are not within walking distance of a public transportation route. When asked about the three greatest challenges they experience in providing services and programs, Service Providers’ Survey respondents indicated transportation as the third greatest challenge (22% or 17 of 79 organizations). Lack of community awareness of services was the number one organizational challenge (27% or 21 of 79 organizations).

Study participants also cited these transportation-related issues:

- Affordable transportation is needed by rural residents, young people, older adults, teen parents, single parents, people with disabilities, persons with low incomes, Medicaid and Medicare patients, families without cars or with only one driver, and people whose licenses have been suspended or revoked.

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5.  Needs and Resources for Health and Human Services: Transportation

5. Needs and Resources for Health and Human Services: Transportation

- Lack of information about existing transportation services leads to the underutilization of services.
- There is a lack of transportation for non-health related purposes such as getting to and from grocery shopping, work, and child care.
- Cab services end at six p.m.; people working past this time have more difficulty with transportation.
- Transportation services are needed in early mornings and evenings.
- Transportation exists but is scattered and not coordinated. This is due in part to LaSalle County being the second largest Illinois County in square miles.\(^\text{5.46}\)
- Some people call 911 to get transportation to a medical facility when there isn’t a true emergency.
- There is a need for transportation to get to medical care outside Ottawa.
- A few health and human service providers said they have a difficult time attracting and retaining bus and van drivers and bus aides.

Finally, of 324 Household Survey respondents providing comments, 9 percent mentioned transportation issues as one of their greatest concerns for their area. In addition to suggesting increased public transportation options within their communities and to Chicago, respondents cited concerns such as traffic congestion and the need for road repair and maintenance.\(^\text{5.47}\)

Demand for services

Most Community F.O.C.U.S. 2001 Household Survey respondents (92%) report using a household vehicle to get to medical appointments and most study area workers 16 years of age and over (93%) use a household vehicle or carpool to get to work.\(^\text{5.48}\) Although most residents have their own transportation, over 1,000 (7%) study area households did not have a vehicle available to them in 1989. Furthermore, people over age 65 are less likely than younger people to have a vehicle available in the household (706 or 17% of householders over 65 did not have a vehicle available in the household; whereas, 316 or 3% of younger householders did not have a vehicle).\(^\text{5.49}\)

Over one-third of study area residents over 16 do not work in the city or town in which they live (35%).\(^\text{5.50}\) Some Household Survey respondents said they or household members lacked transportation to get to work (2%) or to the doctor (4%) in the last year. (547 people responded to the question.) Also, some respondents (2%) indicated having difficulty obtaining services because of transportation issues. (549 people responded to the question.)\(^\text{5.51}\)

\(^\text{5.49}\) Claritas, Inc., Connect Study Report, [Internet database], (Arlington, VA, 2000).
\(^\text{5.50}\) This number may be conservative as a slightly smaller percentage of workers are not classified as living in a city or town or classified as working or not working in the area in which they live. U.S. Census Bureau, Census of Population and Housing, Summary Tape File 3B, [database], (1990).
Household Survey respondents were asked to identify the extent of local need for various types of transportation services. The greatest percentages of respondents said more transportation to Chicago (54%) is needed followed by more transportation from small communities to large communities in the area (46%). (See Figure 5.12.) Less than three percent of respondents indicated needing less of each of the services specified. Generally speaking, respondents with lower incomes were more likely than those with higher incomes to call for more transportation services for older adults, medical appointments, and persons with low incomes.

Household Survey respondents’ (n=183) suggestions for improvements to transportation services in their areas paralleled their indication of need for increased services. The two topics that emerged most often, illustrated with selected comments, appear below:

1. **Increase local transportation services and information (56%)**:
   - “Just by having some kind of transportation available, buses, anything!” (Marseilles resident)
   - “Cab could be available after 6 p.m. Bus schedule could be in the paper.” (Ottawa resident)
   - “Completely free transportation for necessary medical/social services for the disabled, working poor, and seniors on fixed income.” (Ottawa resident)
   - “More scheduled transportation routes at cost to provide convenient pick-up and drop off. It need not be or become a profit situation.” (Ottawa resident)

**Figure 5.12: Household Survey Respondents’ Opinions About Need for More Transportation Services**

<table>
<thead>
<tr>
<th>Transportation service</th>
<th>n</th>
<th>Need more</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>To Chicago</td>
<td>449</td>
<td>53.5%</td>
<td>36.3%</td>
</tr>
<tr>
<td>From small communities to large communities in the area</td>
<td>436</td>
<td>46.3%</td>
<td>42.9%</td>
</tr>
<tr>
<td>For older adults</td>
<td>429</td>
<td>42.7%</td>
<td>40.1%</td>
</tr>
<tr>
<td>Bus</td>
<td>424</td>
<td>41.7%</td>
<td>40.6%</td>
</tr>
<tr>
<td>To the community college</td>
<td>412</td>
<td>38.3%</td>
<td>50.7%</td>
</tr>
<tr>
<td>For persons with disabilities</td>
<td>418</td>
<td>38.3%</td>
<td>46.9%</td>
</tr>
<tr>
<td>For people with low incomes</td>
<td>420</td>
<td>36.9%</td>
<td>49.3%</td>
</tr>
<tr>
<td>To medical appointments</td>
<td>422</td>
<td>36.0%</td>
<td>46.7%</td>
</tr>
<tr>
<td>On the weekend</td>
<td>403</td>
<td>29.3%</td>
<td>58.6%</td>
</tr>
<tr>
<td>In the evening</td>
<td>404</td>
<td>28.5%</td>
<td>58.9%</td>
</tr>
<tr>
<td>To social services</td>
<td>404</td>
<td>28.2%</td>
<td>58.2%</td>
</tr>
<tr>
<td>For young people</td>
<td>400</td>
<td>25.3%</td>
<td>57.5%</td>
</tr>
<tr>
<td>Taxi</td>
<td>406</td>
<td>21.9%</td>
<td>47.0%</td>
</tr>
</tbody>
</table>

5. **Needs and Resources for Health and Human Services: Transportation**

- “We are well cared for with cab and bus. However, on Sunday it would be a help to get to church.” (Ottawa resident)
- “Run city bus and CHO Care-a-Van later and possibly over weekend.” (Ottawa resident)
- “Need more attention to the fact that there are bus schedules and route maps available.” (Ottawa resident)
- “More advertising of existing services. The elderly especially need help with errands. Their families do it all. The elderly cannot/are not encouraged to be independent since many cannot drive and most shouldn’t because of safety issues.” (Ottawa resident)

### 2. Increase transportation to other areas (19%):

- “High speed transportation to Chicago would spur growth in city.” (Ottawa resident)
- “Low-cost transportation to larger communities/community college.” (Grand Ridge resident)
- “Tri-county system to major shopping areas and to other connecting transportation systems.” (Ottawa resident)
- “Don’t like to drive to Chicago, have to drive to Joliet to take train, would like to take train from Ottawa.” (Ottawa resident)
- “Need transportation to Silver Cross or Saint Joe’s Hospital for substance abuse program from Seneca.” (Seneca resident)
- “Since LaSalle County is a large rural community, maybe public transportation could be initiated and operate around the clock such as trains and buses to help people get to their jobs, doctors’ appointments, babysitters, look for work, daycare center, etc.” (Ottawa resident)
- “Doctors want you to go to St. Francis, Loyola, etc. with no way of getting there for older people.” (Ottawa resident)
- “If there was transportation to the community college I could figure out a way to get the money to get schooling to better my life.” (Marseilles resident)

Many respondents (16%) were unsure about possible improvements to transportation services. Some respondents (9%) suggested lowering transportation costs (e.g., decrease gas prices and other automobile expenses), while others (8%) made miscellaneous comments (i.e., comments that could not easily be categorized). Some respondents (8%) said that no improvements are needed or that they are satisfied with current services. Finally, a few respondents (2%) suggested improvements to transportation infrastructure (e.g., repair roads and bridges; install lights at main intersections).  

City of Ottawa Mini-Bus and CHO Care-A-Van statistics indicate that many people are using these services and that utilization is increasing. The Mini-Bus has averaged 648 riders per month in 2000 (average for January through October), compared to 561 riders per month in 1999 and 574 riders per month in 1998. The CHO Care-A-Van made 5,692 one-way patient trips in fiscal year 1999-2000 (an average of 474 trips per month), compared to 5,180 one-way patient trips in fiscal year 1998-1999 (an average of 432 trips per month). Nearly half of Care-A-Van riders (45%) are in wheelchairs. The Care-A-Van is at maximum capacity now and works weekly with eight to ten riders to reschedule appointments so they can use the van.

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and denies an additional eight or more riders per week because the van is booked. Despite increasing ridership and the need for 37 volunteer drivers per week, the Care-A-Van achieves a 98 percent on-time delivery rate.5.54

**Implications for health and human services:**

√ A taskforce of health and human service organizations, transportation providers, businesses, government entities, and residents should collaborate to prioritize transportation issues, recommend solutions, take action to implement improvements, and provide direction for coordination of services. To be successful, this taskforce must have County Board support and representation.

√ The taskforce should identify appropriate transportation models to help with problem-solving and decision-making about effective approaches for LaSalle County. Several models are outlined in this report (see section 7). Service models exist in LaSalle County and are provided by townships, cities, hospitals, and other organizations that provide transportation or reimbursement for service use. Other downstate Illinois counties have developed countywide or multi-county transportation options (e.g., ShowBus in Livingston and McLean Counties and RIDES Mass Transit District serving nine southeastern Illinois counties). These organizations could serve as information resources to advise taskforce members about service/program issues including financing and liability.

√ This taskforce should consider options including development of a coordinated Countywide system, expansion of operating hours for existing services (e.g., City of Ottawa Mini-Bus), expansion of service area for existing services (e.g., Care-A-Van), and extension of programs to increase the number of people with low incomes who can afford to purchase and maintain a car, registration, and insurance. (The Department of Human Services’ “A Way to Work” program already manages this type of program in the study area.)

√ A taskforce should research State, Federal, and private sources for grant and loan funding to support regional, community, and organizational transportation programs.

√ LaSalle County health and human service providers should market and disseminate information about available transportation services and eligibility more widely.

√ Eastern LaSalle County should collaborate with other areas to develop feasible plans for daily train service to Chicago. This service would support current commuters and facilitate the region’s economic growth and prosperity.

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5.54 Community Hospital of Ottawa, [personal communication], (November 2000).
5. Needs and Resources for Health and Human Services: Health and health care

Health and health care

Health indicators
In 1998, there were 1,423 live births in LaSalle County, an estimated 527 of which were to residents of eastern LaSalle County including Waltham and Utica Townships (the study area). Between 1990 and 1998, the annual number of LaSalle County births ranged from a low of 1,320 to a high of 1,508 (approximately 488 to 558 in the study area). The number of infant deaths in the County during the 1990s ranged between 8 in 1990, 1994, and 1998 to 14 in 1993; the average annual number of infant deaths in the County during that period was 10, yielding an infant mortality rate of between 7.3 and 7.5 per 1,000 live births. Between 1993 and 1997, 420 low birth weight babies were born in the County. In 1998, a total of 168 births were to teenaged mothers, with one being to a child under age 15, 54 being to 15- to 17-year-olds, and 113 being to 18- to 19-year-olds.

In 1998, there were 1,171 deaths in LaSalle County. The leading causes of death were heart disease, cancer (including lung cancer), and stroke. Between 1990 and 1998, crude death rates fluctuated between a low of 1,062 per 100,000 in 1998 and a high of 1,161 per 100,000 in 1996; in this time period, crude death rates were consistently higher for LaSalle County than for the State of Illinois.

Health status
Respondents to the Community F.O.C.U.S. 2001 Household Survey were most likely to say that their health is good (44%) or very good (26%). One-tenth reported their health as excellent (10%), 16 percent as fair, and 4 percent as poor. Self-reported health status was related to household income, with lower-income respondents reporting poorer health; health status was also related to age, with younger respondents reporting better health.

Community F.O.C.U.S. 2001 Household Survey respondents were asked to estimate the number of days during the last month when their physical and mental health were not good. Respondents were more likely to report days when their physical health was not good (than their mental health), with just over one-half (51%) saying there were zero days when their physical health was not good, approximately one-quarter (23%) reporting ill-health for one or two days, 13 percent having had poor health for between three and seven days, and 12 percent having been ill for eight days or more. The income and age of respondents were related to their responses, with both higher income and younger respondents reporting fewer days when physical health was not good.

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5.55 Illinois Department of Public Health, “IPLAN Data System Report, Live Births,” Illinois Project for Local Assessment of Needs, [Internet], http://app.idph.state.il.us/index.htm, (November 2000). The calculation for study area births was based on the estimate that 37 percent of the LaSalle County population lives in the study area.
5.61 These questions duplicate questions asked on the Behavior Risk Factor Surveillance System survey. Mental health issues will be discussed at greater length later in this section.
The majority of Household Survey respondents (84%) reported zero days during the last month when their mental health was not good. Nearly one-tenth (10%) said their mental health was not good for between one and two days, and just over three percent respectively reported that their mental health was not good for between three and seven days (3.3%) or eight days or more (3.5%). Respondents who are single, separated, or divorced were more likely than married or widowed respondents to report days when their mental health was not good.

More than one out of ten (16%) of Household Survey respondents indicated that someone in their household has a disability. A wide range of disabling conditions, including both physical and mental disabilities, were reported. Many respondents and their household members suffer from more than one disability. For a discussion of services available to study area residents with disabilities, please see “People with disabilities” in section 5 of this report.5.62

Much ill-health and mortality stems from behavior and lifestyle choices. Between 1993 and 1998, 24 percent of LaSalle County adults were smokers, 22 percent were overweight, 24 percent had a sedentary lifestyle, and 17 percent seldom or never used seatbelts. Just over half (53%) had regular physical exercise. Behavior choices contribute, at least in part, to physical conditions that can lead to illness and death. Between 1993 and 1998, nearly one-fifth of LaSalle County adults (19%) had high blood pressure, while 17% had high cholesterol.5.63

**Access to health care**

Access to health care involves factors including number and location of providers, ability of residents to see providers in a convenient and timely manner, availability of health insurance, affordability of health care and insurance coverage, and willingness of providers to accept patients. Access is affected by where health care consumers live (in the country or in town) and their transportation, income, employment, health status, mobility, and insurance coverage (or lack thereof).

LaSalle County has a large number of health care providers. Although primarily rural, the County has not been designated medically underserved at the Federal level. The County is home to 77 physicians’ offices (two of which are psychiatrists), 46 dentists’ offices, 17 chiropractors’ offices, and 11 optometrists’ offices.5.64 In 1998, there were 124 physicians in the County yielding a ratio of 885 County residents per physician. Unlike many downstate counties, LaSalle County has not just one, but four, community hospitals—Community Hospital of Ottawa, St. Mary’s (Streator), Illinois Valley Community Hospital (Peru), and Mendota Community Hospital. Three more hospitals frequently used by LaSalle County residents are located just over County boundaries in Bureau, Grundy, and DeKalb Counties: St. Margaret’s Hospital (Spring Valley), Morris Hospital, and Valley West Community Hospital (Sandwich). LaSalle County has 3 home health agencies, 22 drug stores, and 10 nursing homes with 1,183 beds total.5.65

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5.64 U.S. Census Bureau Register Analysis Branch, 1998 County Business Patterns for LaSalle, IL, [Internet], http://www.census.gov/epcd/cbp/map/98data/17/099.txt, (November 2000).
Most (93%) Community F.O.C.U.S. 2001 Household Survey respondents and members of their households have family doctors. However, although 97 percent of respondents indicate receiving primary medical care (care for minor illnesses, check-ups, routine care for chronic conditions, etc.), many respondents report receiving care from the hospital emergency room (11%) and the County Health Department (2%). An additional six percent indicate receiving primary health care from other providers including chiropractors, medical specialists, the VA Clinic, Carle Clinic, Sandwich Community Hospital, and the Friendship Facility.

Household Survey respondents were asked whether they or members of their households obtain specified types of health care in Ottawa, LaSalle/Peru/Oglesby, Streator, Morris, Mendota, or some “other community.” Most Household Survey respondents and their household members receive basic health care (73%), emergency room care (72%), dental care (71%), and vision care (65%) in Ottawa. One-third of respondents and household members receive specialist health care in Ottawa, although 11 percent receive specialist care in Morris and 29 percent travel to another community for health specialist services. Many respondents and household members receive vision care in LaSalle/Peru/Oglesby (13%) and emergency room care in Morris (9%). Of the health care services specified in the survey, respondents and their household members were least likely to have used alcohol and drug treatment (97%), mental health care (87%), and specialist health care (22%). Those using mental health care were mostly likely to obtain services in Ottawa (10%).

Location of respondent’s residence is related to their choice of health care provider location. For example:

- Respondents living in Marseilles or other rural areas are less likely to go to Ottawa for basic care than respondents living in Ottawa; rural residents use Ottawa, Morris, and Mendota for basic care more often than they use other specified areas. Respondents also obtain basic care in Marseilles (n=33), Seneca (n=27), Earlville (n=7), Joliet (n=6), Spring Valley (n=6), and other communities (“n” is the number of respondents).
- Respondents living in Ottawa, Marseilles, and rural areas obtain specialist care in Ottawa at nearly equal rates, although rural residents are somewhat less likely to do this than Ottawa residents. Respondents living in Marseilles and rural areas consult specialists in Morris at greater rates than Ottawa residents. Rural residents go to Mendota for specialist care more often than do Ottawa or Marseilles residents. Respondents leaving the area for specialist care most frequently go to Peoria (n=38), Chicago (n=21), Joliet (n=18), Rockford (n=8), and Aurora (n=5).
- Rural and Marseilles residents are less likely to use the emergency room in Ottawa than respondents living in Ottawa. Rural residents use LaSalle/Peru/Oglesby, Morris, and Mendota facilities at greater rates than Ottawa and Marseilles residents. Marseilles residents also frequently use Morris facilities.
- Respondents living in rural areas obtain dental and vision care in Ottawa less frequently than Ottawa or Marseilles residents. In addition to Ottawa, they most often go to Morris, Mendota, and Oglesby for services. (See Figures 5.13A-C.)

How do study area residents choose health care services? Community F.O.C.U.S. 2001 Household Survey respondents indicate that location is most important (64%), followed by reputation (51%), doctor’s recommendation (42%), past experience (41%), and insurance requirements (40%). Less important are cost (19%) and recommendation of a friend or relative (15%).

The great majority (92%) of survey respondents get to medical appointments in the household car. A few get a ride from someone not in the household (3%), in a hospital or medical van (0.7%), some combination of these options (1.9%), or other ways including the bus, on foot, the senior citizen van, and the train from
Figure 5.13A: Where Household Survey Respondents Go to Receive Health Care Services by Where Respondents Live

**Basic health care (n=517)**

- Ottawa: 100%
- Marseilles: 0%
- Other: 0%

**Specialist health care (n=434)**

- Ottawa: 75%
- Marseilles: 25%
- Other: 0%


Note: Respondents were asked to check all communities where they received services, therefore the percents total more than 100%.
Figure 5.13B: Where Household Survey Respondents Go to Receive Health Care Services by Where Respondents Live

**Emergency room care (n=478)**

- Ottawa: 100%
- LaSalle/Peru/Oglesby: 50%
- Streator: 25%
- Morris: 25%
- Mendota: 25%
- Other: 75%

**Dental care (n=496)**

- Ottawa: 100%
- Marseilles: 75%
- LaSalle/Peru/Oglesby: 25%
- Streator: 25%
- Morris: 25%
- Mendota: 25%
- Other: 25%


Note: Respondents were asked to check all communities where they received services, therefore the percents total more than 100%.
Joliet to Chicago. Married respondents were more likely to depend on the household car (97%) than separated (90%), single (80%), and widowed (77%) respondents, who tend to get rides from someone not in the household or use “other” means to get to medical appointments.5.66 (See “Transportation” in section 5 for a discussion of the service provided by the Community Hospital of Ottawa’s Care-A-Van.)

How do study area residents pay for health care? Most people who live in LaSalle County have some kind of medical insurance. Medicaid and KidCare cover 8,191 residents, with 2,896 living in the study area. 692 County Medicaid beneficiaries are nursing home residents.5.67 About 369 children were enrolled in KidCare in 1999.5.68 Medicare covers just over one-fourth of County residents (26%). In 1998, 11 percent of County residents between the ages of 18 and 64 lacked health insurance; this percentage was higher than the State rate of 10 percent.5.69

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5.67 LaSalle County Department of Human Services, [facsimile communication], (November 2000); Illinois Department of Human Services, Bureau of Research and Analysis, “Persons Receiving Assistance in Selected Programs, October 2000,” [facsimile communication], (November 2000).


Considering their differences from LaSalle County residents as a whole, particularly regarding income and educational attainment, it is not surprising that Community F.O.C.U.S. 2001 Household Survey respondents were uninsured at a lower rate (6%) than County residents generally. It is, however, noteworthy that many respondents or members of their households are not covered by dental insurance (39%), vision insurance (57%), or prescription drug insurance (24%).

Respondents (n=559) provided information about specified health care payment problems that had affected them or a household member during the past year. They were most likely to have experienced the following:

- Insurance company refused to pay for treatment recommended by doctor (11.6%).
- Needed but couldn’t afford dental care (11.3%).
- Needed but couldn’t afford vision care (9.3%).
- Couldn’t afford basic medical insurance (7.5%).
- Needed but couldn’t afford prescription medicine (7.3%).

Through a recent study involving an interagency group of area professionals, the LaSalle County Community Health Needs Assessment 1999-2004 identified as the County’s main health priorities:

1. Substance abuse
2. Family violence
3. Access to dental care
4. Access to health care

These priorities are substantially the same as those identified in 1994—access to health care, abuse in families, and substance abuse including alcohol, tobacco, and other drugs. Two of these priorities, substance abuse and family violence, will be discussed later in this section with other “Mental health and substance abuse issues” and in the next section, “Family welfare and child care.” The two access issues are discussed below.

LaSalle County Community Health Needs Assessment committee members agreed that “Dental care in LaSalle County is in crisis,” largely because of a lack of dentists who will accept Medicaid patients.

Clients who are indigent, having neither Medicaid nor private insurance, are in an even worse predicament. Dental emergencies are referred to hospital emergency rooms and private physicians for a Band-Aid treatment of antibiotics and/or pain medication. This only buys us time in order to make a referral out of county to Rockford, Joliet or Chicago involving transportation which for the majority is impossible due to their financial situation.

This problem exists throughout Illinois, but lacking a Statewide policy solution, local areas are forced to try to find local solutions.

Community F.O.C.U.S. 2001 focus group participants agree about the crisis in dental care for people on Medicaid, the elderly, and dislocated workers. One focus group noted that Medicaid reimbursement rates are so low that dentists turn Medicaid patients away. Another reported that no dentist in LaSalle County takes Medicare or Medicaid patients, and said that using dentists in other counties “Can be a long trip for elder patients and care giver to get to dentist’s office for a 5-minute dental hygiene procedure. . . .” This participant recommended putting pressure on the State legislature to change supervision requirements for

5.71 LaSalle County Health Department, LaSalle County Community Health Needs Assessment 1999-2004, (1999), 49.
5.72 LaSalle County Health Department, LaSalle County Community Health Needs Assessment 1999-2004, (1999), 60.

5.74 LaSalle County Health Department, LaSalle County Community Health Needs Assessment 1999-2004, (1999), 49.


5.76 NationsHealth, Quickstats, [Internet database], www.nationshealth.com, (2000). The study area figure is estimated as 37 percent of the total LaSalle County population.


5.74 LaSalle County Health Department, LaSalle County Community Health Needs Assessment 1999-2004, (1999), 49.


5.76 NationsHealth, Quickstats, [Internet database], www.nationshealth.com, (2000). The study area figure is estimated as 37 percent of the total LaSalle County population.

dent indicated that they or members of their households had experienced an emotional problem or mental illness during the past year. Although there are care resources in the study area including Community Hospital of Ottawa’s Choices Unit, North Central Behavioral Health Systems, and independent practitioners including psychiatrists and social workers, Community F.O.C.U.S. 2001 focus group participants and key informants identified needs including:

- In-patient services for children under age 13;
- Special facility for elderly with dementia and behavioral problems;
- Support and respite care for parents and foster parents with troubled children;
- Service for people with eating disorders;
- Medical specialists (psychiatrists and neurologists) specializing in care of children and adolescents, at one end of the age spectrum, and older adults, at the other;
- Increased numbers of and pay for qualified mental health staff;
- Greater coordination of mental health services;
- Mental health services for displaced workers;
- Mental health services in area high schools; and
- Mental health services for rural residents.

Community F.O.C.U.S. 2001 study participants agree that substance abuse is a major problem in the study area, affecting people of all ages. The 1999 LaSalle County Health Needs Assessment identified alcohol as the main substance abused in the County. Using indicators including numbers hospitalized for alcohol dependence and motor vehicle fatalities involving alcohol, the Assessment found that despite declining numbers of people hospitalized for alcohol dependence, LaSalle County residents are more likely than Illinois residents generally or residents of a comparable county (Tazewell) to have serious problems as a result of alcohol consumption. Reasons for across-the-board declines in rates of hospitalization for alcohol dependency are unclear, but may include declines in inpatient care in general. (See Figure 5.14.) Chronic and binge drinking are common in the County. In 1996, 5 percent of LaSalle County residents aged 18 and older displayed chronic drinking behavior compared to 4 percent of rural Illinois residents generally. In the same year, 16 percent of LaSalle County residents aged 18 and older were binge drinkers compared to 11 percent of rural Illinois residents in general.

According to the Assessment, these problems stem from “The pervasive community acceptance and family tolerance of alcohol. Contributing factors include social acceptance, limited access to treatment, lack of education on health risks and low self-esteem.” Assessment findings are echoed in the recent survey conducted by the Ottawa Youth Advisory Committee; surveyed teens identified drug and alcohol abuse as one of the two most serious problems for youth in Ottawa, second only to “things to do.” While noting several organizations that provide services to substance abusers, Community F.O.C.U.S. 2001 study participants noted the need for more local residential treatment programs and for quick response to drug and

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5.80 LaSalle County Health Department, LaSalle County Community Health Needs Assessment 1999-2004, (1999), 50 and 55a.
5.81 Ottawa Youth Advisory Committee, Teen Survey Results, (January 2000).
alcohol abusers when they are ready for help. According to one focus group participant, “Currently there is a wait for services. There is a need for more options to address the issue closer to the area.”

The Assessment links substance abuse with family violence. Family violence was the second health priority identified in 1999. Risk factors cited by the Assessment are “Substance abuse, economic situation of the family, media influence, cultural acceptance and family dynamics.” Contributing factors are “Denial, shame, lack of sufficient countywide abuse treatment facilities and programs, lack of sufficient family violence data resulting in lack of funding and an overloaded social support system.”

Community F.O.C.U.S. 2001 study participants also link substance abuse with youth problems and bad parenting. One key informant referred to an apparent increase of substance abuse among parents, with negative impact on children. Key informants and focus group participants agreed that young people in the study area regularly drink alcohol and use illegal drugs. This opinion is supported by findings of the Teen Survey conducted by the Ottawa Youth Advisory Committee in 1999. Survey results indicate that high school students are more likely to drink alcohol or use illegal drugs than they are to smoke cigarettes or

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5. Needs and Resources for Health and Human Services:
Health and health care

Figure 5.14: Hospitalization Rates for Alcohol
Dependence Syndrome in LaSalle County,
Tazewell County, and the State of Illinois

![Hospitalization Rates Chart]

Note: Rates were calculated based on populations interpolated from Treadway, R. and D.J. Ervin, Illinois Population Trends, 1990 to 2020, (Springfield: State of Illinois, 1997).

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5. Needs and Resources for Health and Human Services: Family welfare and child care

engage in sexual activity. When indicating their greatest concerns about the area, 12 percent of Community F.O.C.U.S. 2001 Household Survey respondents mentioned drugs and alcohol.

Implications for health and human services:

√ Enhancing outreach and mobile services would improve health care access for people living in rural areas who find it difficult to travel to town.
√ According to a recent study, the greatest influence on health status is behavior (50%), followed by environment (20%) and heredity (20%); health care, at 10 percent, is least important. Many study area health problems are linked to behavior; prevention is the key to addressing these problems.
√ Physical and mental illneses are exacerbated by poverty and low educational attainment. Increasing skills and wages of area workers would improve their health status.
√ Community F.O.C.U.S. 2001 key informants were more likely to mention duplications in hospital and mental health services than in any other type of health or human service. Increased collaborative planning and coordination of services among study area health care providers could minimize duplication, maximize resources, improve access, and enhance quality of service.
√ One way of addressing study area shortages in specified services would be to provide or support training for providers of those services.

Family welfare and child care

The environments children encounter within and outside the home determine their health, happiness, and success. Family income, housing, transportation, health care, education, and child care have an enormous impact on children’s quality of life. Equally, the educational and employment status, mental and physical health, and coping skills of parents affect the well-being of children. This section provides a brief overview of some issues associated with child welfare and child care in eastern LaSalle County including Waltham and Utica Townships (the study area).

There are approximately 2,931 children aged 4 and under, and 6,160 children between the ages of 5 and 14 living in the study area. Together, children in these two age groups account for 22 percent of the study area’s population. The number of children in the study area is projected to remain stable during the next 20 years.

Most children living in the study area are in two-parent families. However, 4 percent of study area households are single-parent families—452 with children aged 5 or younger and 473 with children between the ages of 6 and 17. In 1999, 147 LaSalle County children were in foster or substitute care.

5.84 Ottawa Youth Advisory Committee, Teen Survey Results, (January 2000).
5.87 Claritas, Inc., Connect Study Report, [Internet database], (Arlington, VA, 2000).
5. Needs and Resources for Health and Human Services:
Family welfare and child care

In 1995, approximately 1,539 (14%) study area children under age 18 were living in poverty. School district data indicate that child poverty is concentrated in some geographical areas. For example, 50 percent of children attending Jefferson Elementary School, Ottawa, are designated “low-income,” compared to 2 percent of children attending Waltham Community Consolidated School, Utica. (See Figure 5.15.) In 1999, 3,800 LaSalle County children (approximately 1,406 in the study area) were on Medicaid and 369 (approximately 137 in the study area) were enrolled in KidCare. An estimated 2,261 LaSalle County children (approximately 837 in the study area) lacked health insurance in 1990.

Figure 5.15: Study Area Schools by Location, Grade, and Percent of Low-Income Students, 1999

<table>
<thead>
<tr>
<th>Location</th>
<th>School</th>
<th>Grades</th>
<th>Percent low-income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earlville</td>
<td>Harding Elementary School</td>
<td>k-8</td>
<td>16.4%</td>
</tr>
<tr>
<td></td>
<td>Earlville High School</td>
<td>9-12</td>
<td>15.0%</td>
</tr>
<tr>
<td></td>
<td>Earlville Grade School</td>
<td>k-8</td>
<td>14.7%</td>
</tr>
<tr>
<td>Grand Ridge</td>
<td>Grand Ridge School</td>
<td>pk-8</td>
<td>19.3%</td>
</tr>
<tr>
<td>Marseilles</td>
<td>Marseilles Elementary School</td>
<td>pk-8</td>
<td>35.6%</td>
</tr>
<tr>
<td></td>
<td>Miller Township Community</td>
<td>k-8</td>
<td>7.1%</td>
</tr>
<tr>
<td></td>
<td>Consolidated School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ottawa</td>
<td>Jefferson Elementary School</td>
<td>pk-6</td>
<td>50.1%</td>
</tr>
<tr>
<td></td>
<td>Lincoln Elementary School</td>
<td>k-6</td>
<td>38.2%</td>
</tr>
<tr>
<td></td>
<td>Central Elementary School</td>
<td>pk-6</td>
<td>32.1%</td>
</tr>
<tr>
<td></td>
<td>Shepherd Jr. High School</td>
<td>7-8</td>
<td>24.4%</td>
</tr>
<tr>
<td></td>
<td>McKinley Elementary School</td>
<td>k-6</td>
<td>15.2%</td>
</tr>
<tr>
<td></td>
<td>Deer Park School</td>
<td>k-8</td>
<td>11.6%</td>
</tr>
<tr>
<td></td>
<td>Wallace Community Consolidated</td>
<td>k-8</td>
<td>9.2%</td>
</tr>
<tr>
<td></td>
<td>School</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ottawa Township High School</td>
<td>9-12</td>
<td>8.4%</td>
</tr>
<tr>
<td>Rutland</td>
<td>Rutland Community Consolidated</td>
<td>k-8</td>
<td>13.2%</td>
</tr>
<tr>
<td></td>
<td>School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seneca</td>
<td>Seneca Elementary, North</td>
<td>pk-4</td>
<td>16.6%</td>
</tr>
<tr>
<td></td>
<td>Seneca Elementary, South</td>
<td>5-8</td>
<td>13.9%</td>
</tr>
<tr>
<td></td>
<td>Seneca Township High School</td>
<td>9-12</td>
<td>11.2%</td>
</tr>
<tr>
<td>Serena</td>
<td>Serena Community Grade School</td>
<td>k-8</td>
<td>10.2%</td>
</tr>
<tr>
<td></td>
<td>Serena High School</td>
<td>9-12</td>
<td>6.4%</td>
</tr>
<tr>
<td>Utica</td>
<td>Utica Elementary School</td>
<td>k-8</td>
<td>17.6%</td>
</tr>
<tr>
<td></td>
<td>Waltham Community Consolidated</td>
<td>k-8</td>
<td>2.1%</td>
</tr>
<tr>
<td></td>
<td>School</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: State poverty rate is 31.6% for K-12.

5.89 Voices for Illinois Children, Illinois Kids Count 1999-2000: Communities Helping Families, (Chicago, IL, 1999), 67. Study area estimates based on the assumption that 37 percent of LaSalle County population is in the study area, are extrapolated from U.S. Census Bureau, Census of Population and Housing, Summary Tape File 3B, [database], (1990).

5.90 “Low-income students may come from families receiving public aid, may live in institutions for neglected or delinquent children, may be supported in foster homes with public funds, or may be eligible to receive free or reduced-price lunches.” Illinois Board of Education, Illinois Report Card, (1999).

5. Needs and Resources for Health and Human Services:
Family welfare and child care

Family welfare
Many Community F.O.C.U.S. 2001 research participants commented on the need for services to support parents and develop parenting skills. These comments fell within the following general categories:

- Teen mothers’ need for education and support;
- Need for a range of services on the part of single mothers and mothers moving from welfare to work;
- Apparent increasing number of parents with substance abuse or family violence problems; and
- General need for development of parenting skills.

Adolescent and single parents
According to a recent study, “Young parents face a variety of barriers to maintaining economic security and raising healthy, well-educated children. Most teen parents have not completed high school, many are raising children without the support of another parent, and most are still growing up themselves.”5.92 One Household Survey respondent commented, “Although teenage pregnancy is down, I still see too many high school age parents.” A focus group participant said “Teenagers are trying to be parents, but they seem lost; they need support services.”5.93 Research indicates that “Reaching out to and designing programs targeted at teens will help to ensure that parents achieve self-sufficiency and children grow up healthy and strong.”5.94

Teen parents are more likely than parents in other age groups to become dependent on welfare because of their comparatively lower educational attainment and job skills. “As a result, about 75 percent of adolescent mothers joined the AFDC system by the time their child was 4 years old. Indeed, of welfare recipients who started to receive assistance before they were age 23, 31 percent were likely to receive assistance for more than 10 years.”5.95

Single parents—usually mothers—bear the lion’s share of both economic and emotional responsibility for their children. This challenge is exacerbated by poverty. As indicated in section 5, “Income, employment, and training” above, there are four times more female-headed households in the study area with incomes below the poverty level (380 or 2.5% of households) than male-headed households (94 or 0.6% of households).5.96 Thus, family poverty is a gendered issue. One Community F.O.C.U.S. 2001 key informant commented, “Many single moms have problems, even if they want to do well, since it is so difficult to get out of the ‘cycle’ [of poverty] with so many responsibilities.” Another key informant said, “Mothers are caught in and out of the welfare system—mobility between houses disqualifies them.” Several focus group participants talked about the problems experienced by mothers moving from welfare dependence to employment, who often face the decision about whether to be a “good” worker, putting their employers’ needs first, or a “good” mother, prioritizing their children at the risk of losing their jobs.5.97

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5.96 Claritas, Inc., Connect Study Report, [Internet database], (Arlington, VA, 2000).
Family violence and child abuse
Family violence severely damages children’s current quality of life and prospects for future happiness and success. In the State of Illinois, domestic crimes are those committed by “family or household members including spouses, former spouses, parents, children, stepchildren and other persons related by blood or marriage, persons who share or formerly shared a common dwelling and persons who have or allegedly have a child in common.” Statewide reporting of domestic violence began in Illinois in 1996. Thus, it is too early to identify trends over time. Current data indicate that most domestic crimes in Illinois (67%) are simple assault/battery. Spouses or ex-spouses commit half of domestic crimes within families; the vast majority (81%) of non-family domestic crimes are committed within the boyfriend/girlfriend relationship. Between three and four percent of domestic crimes in Illinois are committed in violation of Orders of Protection. Recent figures for LaSalle County indicate a decline in reported crimes of domestic violence, down from 756 in 1997, to 717 in 1998, and to 479 in 1999.

Child abuse and neglect occurs in families of all kinds. However, low-income children are at increased risk. Research indicates that “A child whose family has housing, food, and utility problems is three times more likely to be abused or neglected than a child whose family [does] not.” Reported cases of child abuse in LaSalle County increased from 541 (18.1 per 1,000) in 1997 to 585 (19.5 per 1,000) in 1998. In the same years, the comparable rates for the State of Illinois were 10.7 per 1,000 and 9.7 per 1,000, respectively. One Community F.O.C.U.S. 2001 Household Survey respondent commented about, “Conflicts within some families—this may involve only a small percentage of families, but is upsetting to a whole neighborhood when the conflicts arise.” A key informant talked about the difficulty of getting victims to follow through with use of services, obtaining an Order of Protection, or staying away from the abuser once the Order of Protection has been obtained. Furthermore, s/he said that follow-through may be related to income status; lower income victims don’t have the resources to enable them to leave the abuser.

Family violence and child abuse are often related to substance abuse. Many Community F.O.C.U.S. 2001 study participants mentioned alcohol and drug abuse as major problems in the study area—a perspective emphasized by the priority given these issues by the 1999 LaSalle County Health Needs Assessment. A focus group participant said, “Because parents are addicts, there is a need for outreach to the school districts for kids who are involved with parental addicts.” A Household Survey respondent complained about “Parents partying all day and night, not watching or caring for their kids.” (See section 5, “Health and health care,” of this report for a discussion of mental health and substance abuse issues.)

Parenting skills
Above all, Community F.O.C.U.S. 2001 study participants noted the general and widespread need for parenting skills in the study area. One focus group talked about this issue at length, making the following points:
- It is more difficult today to deal with parents than kids within the educational system. There is a need for parenting programs—programs to help parents become parents or become better parents.

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5.102 LaSalle County Health Department, LaSalle County Community Health Needs Assessment 1999-2004, (1999), 50, 55a.
5. **Needs and Resources for Health and Human Services:**

**Family welfare and child care**

- There are differing views about what is an acceptable level of parenting. Trying to define this is difficult.
- Some attempts to offer parenting education have been made in this area, but there is a lack of coordination among organizations providing programs.
- Getting voluntary buy-in from parents at the front end is difficult. Some programs are only used if they are mandated.

Another focus group had a similar discussion, reflecting on the need for parenting classes and the fact that “People who need the help most won’t come. There is a lack of parental responsibility in the community—a lot of kids whose parents have given up. The community needs to give parents the tools and skills to help them ‘buy back in.’” A key informant commented, “Lots of parents are not ready or willing to truly parent their child. What the child needs is a parent or parent substitute.”

**Family welfare resources**

Almost all of the study area’s health and human service providers offer support for children and families; thus it is difficult to limit this section’s discussion. In addition to services discussed in this report, primary and specialist health care providers, educational institutions, and religious organizations operate individually and collaboratively to meet the needs of children and families.

Notwithstanding this disclaimer, some specific services and providers must be identified. Catholic Social Service, the Family Room (Community Hospital of Ottawa), and LaSalle County Health Department offer a variety of services for young children and families including education, access to low-cost supplies, counseling, foster home and adoption services, and referrals to other service providers. The Youth Service Bureau of Illinois Valley helps young people and families by offering counseling, foster care, child care, and other family support services. ADV/SAS manages a domestic violence shelter and telephone hotline, and offers counseling and advocacy services to victims of domestic violence. The 13th Judicial Circuit Family Violence Prevention Council brings area agencies together to collaboratively address domestic violence issues. Choices (Community Hospital of Ottawa) and North Central Behavioral Health Systems offer counseling and treatment for people suffering from substance abuse problems. Community F.O.C.U.S. 2001 Service Providers’ Survey respondents and key informants made the following observations about family welfare service provision in the study area:

- “Rural citizens [are] underserved. [There are] transportation problems of all kinds.”
- “Some parenting classes overlap, offered by Catholic Social Service, Health Department, County Cooperative Extension Service, although none seem to be offered simultaneously.”
- “It would be nice to have one person to call for service referrals.”
- There is a need for “Counseling for family violence perpetrators (especially women and gays) and wrap-around services for families where there are juvenile perpetrators of family violence.”

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5. Needs and Resources for Health and Human Services: Family welfare and child care

- There are many organizations serving families with children, birth to age 3. There is both duplication of services and poor coordination. It is necessary to make sure that families do not get inundated, but do get a full range of services.\(^{5.104}\)

Finally, a *Community F.O.C.U.S. 2001* Household Survey respondent summarized the comments of many study participants, indicating concern “That area youth have a chance to succeed without regard to their home life. The schools are having to play a bigger part in a child’s upbringing than ever before. Any services that would improve a child’s home life would be a great benefit to the community.”\(^{5.105}\)

**Child care**

Good quality affordable child care is a growing need in a society where most parents are employed. Women are primary caregivers, but increasing numbers of mothers are in the workforce.\(^{5.106}\) In Illinois, 59 percent of women with children under the age of 6 and 76 percent of women with children between the ages of 6 and 17 work outside the home.\(^{5.107}\) With welfare-to-work legislation, public policy places increasing pressure on mothers to work. According to Voices for Illinois Children, “Quality early childhood education programs—including child care, Head Start and Pre-Kindergarten [Pre-K]—can provide young children with important skills and encouragement, and can increase their chances of success in school.” In fiscal year 1998, 15 percent of LaSalle County children between the ages of 3 and 5 were enrolled in Head Start and Pre-K programs.\(^{5.108}\)

Eleven percent of respondents to the *Community F.O.C.U.S. 2001* Household Survey needed or used child care during the past year. Respondents were least likely to need child care for second or third shift (17%) or weekend child care (21%). Of respondents needing the service specified, respondents found it most difficult to obtain care for a disabled (83%) or sick (72%) child and to find infant care (63%), any child care provider (49%), high quality child care (46%), affordable child care (43%), and conveniently located child care (37%). (See Figure 5.16.)

One hundred Household Survey respondents have children between the ages of 5 and 13 living with them. After school, most (62%) of these children are cared for by their parent or step-parent, 24 percent are looked after by a brother or sister, 22 percent look after themselves, 17 percent are cared for by an unpaid relative, friend, or neighbor, and 16 percent are cared for by a paid child care provider (respondents could indicate more than one type of care). Summer child care patterns are similar. It is noteworthy that very few respondents’ children participate in after-school (7%) or summer (8%) programs—perhaps because there are few

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such programs or because parents are unaware of the services offered by the YMCA, Campfire Boys & Girls, and Camp Tuckabatchee. (See Figure 5.17.) One survey respondent commented, “We need before and after school care in our school for young working parents. We need summer care programs for working parents’ children.” A focus group participant mentioned the gap between 3:30 p.m. and the time parents come home as problematical.5.109

During the past few years, welfare reform legislation has stretched the capacity of both parents and child care providers to make certain that children are in safe appropriate care when parents are working. One preschool program serving low-income study area families reports that staff are carrying caseloads of 50 to 60 cases each—“too much for anyone with paperwork, etc.” A child care center licensed for [between 50 and 100] children currently has [over twice the licensed number] of children on its waiting list.5.110 Participants in two separate focus groups used almost the same language to describe a common situation: “Single mothers on Public Aid are mandated to return to work. This often puts the children at risk because suitable

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day care providers are difficult to find. So the mother is faced with the choice of not working and losing Public Aid benefits or placing her child in the care of unknown and/or unsuitable child care providers.” Two other focus groups said that “Pre-school care is needed that is affordable and of good quality” and that there is a “Need for affordable child care.”

Affordability is likely to remain an important issue. The average annual cost of child care in the U.S. for a pre-school child is $4,921—40 percent more than the $3,535 average annual cost of public university tuition. Although the Illinois Department of Human Services and the Department of Children and Family Services provide help with child care costs for families meeting income criteria, many study area families are not eligible for assistance and struggle to deal with child care expenses. Thus, respondents to the Community F.O.C.U.S. 2001 Service Providers’ Survey repeatedly commented on study area needs for

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Figure 5.17: Summer and After School Child Care Arrangements of Household Survey Respondents


Note: Respondents were asked to check all providers that applied, therefore the percents total more than 100%.

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5.113 Illinois Department of Children and Family Services, “How to Pay,” Child Care Choices, [Internet], http://www.aces.uiuc.edu/~IL CARE/CCC/, (December 1999).
5. Needs and Resources for Health and Human Services: Youth issues and services

various types of child care—“affordable sick child care for low-income working moms”; “additional subsidized child care providers”; “2nd, 3rd shift, weekend, and sick child day care”—and, simply, “There is a huge demand for child care.”

Implications for health and human services:

√ Service providers should identify alternative approaches to developing parenting skills, other than classroom education, which has proven unpopular. No one wants to admit to being a bad parent, regardless of the evidence. Age, social class, racial, ethnic, or educational differences between “teacher” and “student” can also undermine the effectiveness of parent education. Thus, programs enabling parents to contribute something, in addition to benefiting from the wisdom of “experts,” might increase willing participation.

√ Recent declines in reported incidence of domestic violence suggest that coordinated efforts to educate study area residents and support families are bearing fruit. This suggests that a similar approach to the problem of child abuse and neglect might be effective.

√ Low-wage workers face particular challenges in obtaining affordable, high quality child care—particularly out of regular working hours and for emergency situations (i.e., sick child, back-up care, etc.). Employers and human service providers should work together to develop flexible child care options to support job retention and family stability.

√ There is a need for additional accessible and affordable after-school and summer programs for school-aged children in the study area.

√ There is no Child Care Resource and Referral Network organization in LaSalle County. (The nearest location is Peoria.) With growing demand of local residents for child care of all kinds and increasingly strained capacity of local child care providers, a single point of contact matching demand and capacity would be of great value to all concerned.

√ There is a need for professionally trained child care workers in the study area.

Youth issues and services

There are currently about 6,424 residents of eastern LaSalle County including Waltham and Utica Townships (the study area) between the ages of 10 and 20—15 percent of the total population. Both the size and percentage of the youth population are expected to remain stable during the next 10 years. Most study area young people participate in the good quality of life enjoyed by residents in general. The majority (92%) of youth between the ages of 16 and 19 are in school or are high school graduates. Just under half (45%) of members of this age group are employed. Many study area young people volunteer for religious and service organizations and provide informal help to family members and neighbors.

However, many study area young people do not have a good quality of life. In 1995, approximately 1,539 (14%) study area children under age 18 were living in poverty. An unacceptable number of students

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5.117 Voices for Illinois Children, Illinois Kids Count 1999-2000: Communities Helping Families, (Chicago, IL, 1999), 67. Study area estimates, based on the assumption that 37 percent of LaSalle County population is in the study area, are extrapolated from U.S. Census Bureau, Census of Population and Housing, Summary Tape File 3B, [database], (1990).
drop out before completing high school. In 1998, LaSalle County teenagers gave birth to 180 babies, of whom 59 (33%) were born to girls aged 17 or younger. Between 1990 and 2000, the LaSalle County Circuit Clerk, Criminal Division, recorded referrals to court services for an average of 331 juveniles per year. Of these cases, between 1997 and 2000, an average of 62 per year were for young people who had been abused or neglected; an average of 224 per year were for young people charged with delinquency. Last year, at least 212 study area young people received sexual abuse services. There are currently 20 children on the waiting list for sexual abuse services.

Every problem affecting study area families—poverty, divorce, neglect, violence, substance abuse, physical and mental illness, and lack of access to necessities including housing, transportation, health care, and child care—disproportionately affects adolescents. However, the very nature of their developmental stage makes young adults hard to help. They are not as small, helpless, and cute as younger children. By the time they come into contact with the health and human service delivery system, they are often angry and sometimes dangerous.

What do young people say?
In 1999, the Ottawa Youth Advisory Committee surveyed students at Ottawa and Marquette high schools and three Ottawa junior high schools. Although the 1,432 teens who completed surveys do not speak for young people living in other parts of the study area, they provide useful information about the perspectives of one important component of the area’s youth population. Survey respondents identified each of the following issues as “the most serious problems for youth in Ottawa”:

1. Lack of things to do (n=626)
2. Drug/Alcohol Abuse (n=618)
3. Curfew (n=533)
4. Teen smoking (n=488)
5. Disrespect, prejudice, or racism (n=321)
6. Peer pressure (n=310)
7. Teen pregnancy (n=280)
8. Few job opportunities (n=221)
9. Police treatment (n=221)
10. Unsafe sexual activities (n=206)

More students identified these issues as problems than admitted engaging in illegal or dangerous activities. For example, 207 said they “drink alcohol,” 120 “do illegal drugs,” 112 “smoke cigarettes,” and 96 engage in “sexual activity.”

The top 10 responses to the question, “What can be done to fight these problems?” were:
1. Create more job opportunities (n=451)
2. Make better use of buildings (n=377)

See this report’s discussion of “Educational attainment” in section 4, “Population Profile.”


LaSalle County Circuit Clerk, Criminal Division, [facsimile communication], (November 2000).

5. Needs and Resources for Health and Human Services:
Youth issues and services

3. Reduce drug dealing (n=367)
4. Build a rehabilitation center for drug/alcohol users (n=264)
5. Provide counseling services (example, teen phone line) (n=258)
6. Offer peer education about drug abuse (n=242)
7. Educate youth about decision making (n=219)
8. Improve family communication (n=213)
9. Offer peer education about sexual activity (n=212)
10. Improve policing (n=210)

Ottawa is responding to youth needs. The City has recently changed curfew restrictions and established a skateboard park and a toboggan run.

What do Community F.O.C.U.S. 2001 participants say?

Community F.O.C.U.S. 2001 study participants are concerned about local young people. Some of this concern focuses on teens’ bad behavior. One key informant talked about the “General frustration with kids standing around, causing trouble. We don’t know what to do.” A Household Survey respondent commented on the “Behavior of children; worry about juvenile crimes and don’t feel our community and judicial system take it seriously.” Another respondent wrote, “I am concerned when I see how young people ‘hang out’ on the streets and drive so fast endangering their lives instead of gathering at home with friends. Wish there were ways to interest them in reading, music, the arts, etc. Wish the newspaper would put more emphasis on the good people, young and old.”

Study participants also commented on parenting. One key informant mentioned problems with parents abandoning their own responsibilities and expecting the schools and police to make their teens behave. A Household Survey respondent wrote, “Mostly concerned about the youth. Need more people and parents to get involved in their lives. See too many children out by themselves on bikes or running without adult supervisor. Also see a lot of them on the streets at night. Need more mentors, big brothers, big sisters.”

Some study participants focused on teens’ general problems and needs. One focus group participant said, “There is a problem of self-esteem for youth; they are not very ambitious, and they don’t see themselves as part of the larger community.” A Household Survey respondent commented on “Youth! . . . The school gave so much attention to the students with promise and the kids that so desperately needed attention were falling through the cracks. . . . To have a healthy society, we need to encourage the underachievers.” Several survey respondents mentioned the lack of good job opportunities, one commenting, “My concern is for my grandchildren getting jobs that have benefits and good pay. One granddaughter is living in Chicago because that’s where she found a job with a living wage.” Many also called for more youth activities, one respondent writing that the community needs “Things for teens to do—other than sit in parks, smoke and drink. Wake Up—our young are the future to Ottawa. If we don’t keep them around, it will be just another community for the elderly and nobody to take care of us. We have some very good young people and could be the backbone to Ottawa.”

Other study participants mentioned specific teen problems. One Household Survey respondent wrote about the “Availability of drugs to anyone. Ottawa needs help for teens or pre-teens. Need local counselors/therapists, who really care about kids and are affordable. Vigorously attack Ottawa’s drug problem, not the users who need help, but the suppliers . . . who are beyond help.” Another survey respondent wrote, “Although teenage pregnancy is down, I still see too many high school age parents. We need to encourage our
children to feel good about themselves and that a baby is not a toy. I hear too many times that these girls want a baby so someone will love them. What a shame, their own parents/society are failing them.” One key informant mentioned the challenge for Latino/a young people who may be taken out of school to serve as interpreters for their parents. Another key informant mentioned several issues, saying:

The high school has not addressed issues of mental health for students. No meaningful prevention program. . . . No student assistance program. No drugs and alcohol counselor. Illinois offers a grant to get student assistance programs in schools; the high school chose not to go for it. There are more kids on the streets than there should be, higher level of drop outs, drug and alcohol issues.

A third key informant talked about the lack of local support services for young adults who are developmentally disabled and their families.5.122

**Implications for health and human services:**

√ The general concern about lack of good jobs for area residents—young people in particular—suggests there is an opportunity for high schools, the community college, local employers, and economic developers to work together to target specific high-demand skills, develop innovative educational programs to train workers in those skills, and market the area and its workforce to appropriate businesses seeking new locations.5.123

√ Low-wage young workers must be given encouragement and appropriate support to obtain the education and qualifications they need to transition out of poverty.

√ There is a need for mental health services for young adults in the study area including counseling, psychiatric services, alcohol and drug treatment, therapy for eating disorders, etc.

√ It is important for communities to nurture and involve all their young people. Inclusion makes better citizens than exclusion.

**Senior issues and services**

**Population and income**

There are now approximately 22,172 people aged 60 and older living in LaSalle County (20% of the total County population), of whom about 8,204 live in eastern LaSalle County including Waltham and Utica Townships (the study area). This number is expected to remain fairly stable for the next 20 years.5.124 The majority of these older adults (60%) are currently among the “young old,” between the ages of 60 and 74.5.125 Of this “young old” group, most are healthy, retired, and self-sufficient. The “old old,” over age 75, tend to require increasing support from both informal and formal sources. In this age group, health status declines and need for health care and other services increases. Because women live longer than do men, the

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5.123 There are a number of models for such collaborations which tend to combine classroom education and work experience to develop skills and job readiness. One Illinois example is the Youth Apprenticeship program initiated in the early 1990s by Teepak (a Danville manufacturing firm), area high schools, and the local community college. This successful program became a model for Illinois’ Education-to-Careers initiative.

5.124 This makes LaSalle County and the study area rather unusual, since, due to the aging of the baby boomers and increases in longevity, the elderly are the fastest growing segment of the American population. In McLean County, Illinois, for example, the population aged 60 and over is projected to increase by 31 percent between 2000 and 2020. Source: Treadway, R. and D.J. Ervin, Illinois Population Trends 1990 to 2020, (Springfield: State of Illinois, 1997).

5.125 Claritas, Inc., Connect Study Report, [Internet database], (Arlington, VA, 2000).
“old old” are more likely to be female. Women comprise 59 percent of the total LaSalle County population aged 60 and older, but 71 percent of the 80+ age group. (See Figure 5.18.)

Older women are more likely to live alone than older men. In Illinois, women are four times more likely to be widowed than men. Among respondents to the Community F.O.C.U.S. 2001 Household Survey, 84 percent of men, compared to 55 percent of women, were married; 5 percent of men, compared to 29 percent of women, were widowed. Statewide, 34 percent of older women live alone compared to 15 percent of older men. The proportion of women living alone rises as women age. According to the Illinois Department on Aging’s Profile of Illinois’ Elderly published in 1994, 40 percent of women over the age of 85 live alone and 30 percent live in group living situations (nursing homes, boarding homes, etc.), compared to 25 percent and 18 percent respectively, for men in the same age group. Nationally, 70 percent of residents in nursing homes are women. Thus, issues surrounding aging in general, and long-term care in particular, are highly gendered.

Figure 5.18: Percent of Females and Males in Senior Age Groups in LaSalle County

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<thead>
<tr>
<th>Age</th>
<th>Percent Female</th>
<th>Percent Male</th>
</tr>
</thead>
<tbody>
<tr>
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<td>77.8%</td>
<td>22.2%</td>
</tr>
<tr>
<td>80+</td>
<td>71.1%</td>
<td>28.9%</td>
</tr>
<tr>
<td>75+</td>
<td>66.0%</td>
<td>34.0%</td>
</tr>
<tr>
<td>70+</td>
<td>62.3%</td>
<td>37.7%</td>
</tr>
<tr>
<td>65+</td>
<td>60.7%</td>
<td>39.3%</td>
</tr>
<tr>
<td>60+</td>
<td>59.0%</td>
<td>41.0%</td>
</tr>
</tbody>
</table>


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5.126 Illinois Department on Aging, Profile of Illinois’ Elderly, (1994), Table 12.
5.128 Statewide data on living circumstances and marital status are from Illinois Department on Aging, Profile of Illinois’ Elderly, (1994), 9.
5.129 Illinois Department on Aging, “Facts on Aging: A Look at Nursing Homes,” [Internet], http://www.state.il.us/aging/onage06.htm, (June 1999).
5. Needs and Resources for Health and Human Services: Senior issues and services

Community F.O.C.U.S. 2001 Household Survey respondents were somewhat more likely to be older and have higher incomes than the study area’s population as a whole. Nonetheless, survey findings indicate that household income declines with age, with people aged 75-84 being nearly twice as likely as people between the ages of 65 and 74 to have annual household incomes of less than $15,000. No survey respondents over age 85 reported a household income of over $50,000. Older residents are more likely to live on a fixed income than their younger neighbors. Thus, rising costs of necessities such as prescription medications, home maintenance, and property taxes present a greater challenge to seniors.

Resources, services, and needs

The senior population is extremely diverse, incorporating a huge range of resources, interests, perspectives, and needs. Older adults make important contributions to the community. Many continue to work; in LaSalle County, approximately 29 percent of men and 18 percent of women aged 65 to 69 are employed. Approximately 17 percent of men and 10 percent of women between the ages of 70 and 74 participate in the County’s workforce. As property owners, seniors contribute to the tax base. They invest in local financial institutions and spend on local goods and services. Many are also active volunteers.

Not all seniors are able independently to meet the needs of themselves and others. Many study area elders require support ranging from help with home maintenance and getting to and from medical appointments to residential nursing care. Several study area organizations provide services—many of them funded through the Western Illinois Area Agency on Aging (WIAAA)—to support seniors’ nutritional, transportation, housing, and long-term care needs. Thus, in 1999, 829 people were served meals at congregate meal sites, 584 people received Meals on Wheels services, and 316 obtained transportation services from providers funded by the WIAAA. From 1997 to 1999, the number of congregate meals served increased from 41,990 to 77,997 (86%) and the number of Meals on Wheels delivered increased from 167,873 to 226,847 (35%). A key informant commented about home-delivered meal services, “We are feeding more meals to fewer people—frailer people at home who are unable to, at any time, get out and get groceries. They are truly becoming dependent on home-delivered meals.”

There is public housing for older adults in Ottawa. In addition, there are two assisted living facilities in Ottawa. There are three nursing homes in Ottawa and two nursing homes in Marseilles with a combined total of 544 nursing home beds. According to one key informant, more nursing home beds are needed. However, according to another key informant, “Better nursing home than home-based outreach care is provided to older adults” in the area.

5.131 See “Research activities” at the beginning of section 5 of this report.
5.134 The recent Assessment 2000: Health and Human Services in McLean County: Summary Report, (Normal, IL: Applied Social Research Unit, Illinois State University, 2000, 82) indicates that retired people in McLean County are more active than members of other age groups in voluntary religious activities. Community F.O.C.U.S. 2001 Household Survey cross-tabulations indicate that older adults are not disproportionately represented in any study area voluntary activity.
5.135 See, e.g., LaSalle County Health Department, Resource Guide with Supportive Services, 1999.
5.136 Western Illinois Area Agency on Aging, [telephone conversation], (November 2000).
A major challenge for service providers is attracting and retaining staff. According to one key informant, “It used to be that our meal providers depended on volunteers. Now they are having to go to paid drivers. This is not easy, since not many people are willing to work two hours a day, every day, for minimum wage.” Another commented:

We have people working in these agencies for 10 to 15 years who are still working for $6.50 per hour without benefits. These people are not scrubbing pots and pans; they have to know the system [and] help people with real needs, etc. These people could go to McDonald’s and make more, but they don’t because they are dedicated to their clients.

A third key informant mentioned the “Unhappiness of staff in nursing homes and the perception that workers are poorly paid or have bad working conditions. Secretaries are better paid than nursing assistants.”

What do older adults need?

Community F.O.C.U.S. 2001 project participants identified study area seniors’ needs for the following services and opportunities:

- Relief from increasing prescription drug costs;
- Additional transportation services, particularly in rural areas and for non-hospital services;
- Affordable, accessible, appropriate, non-subsidized housing for seniors with limited incomes;
- Geriatrician(s) serving the study area;
- Services and care facilities for older adults with mental illnesses—particularly those who are physically aggressive;
- Dental care for low-income elderly without insurance;
- In-home services including house and yard care, home repair, snow removal, help with diet and medication, shopping, and help with financial matters;
- Support and respite care for caregivers; and
- Recreational activities, including exercise classes, for older adults.

Several study participants commented about general issues affecting seniors’ quality of life.

Public policy and categorical eligibility

One Service Providers’ Survey respondent wrote:

There needs to be more programs for the elderly with government funding . . . when all they need is personal care like someone to help them with laundry, housekeeping, medicine reminders, grocery shopping, and some meal preparation. Grants through Western Illinois Area Agency on Aging don’t provide enough dollars and available services.

Another respondent commented:

A needs assessment of our service area has shown a number of isolated rural elderly individuals in need of social contact and perhaps physical assistance. The rules and regulations governing health care and Medicare prohibit rendering services and receiving reimbursement for providing care to these individuals unless they meet very restrictive guidelines allowing care.

Information needs

One key informant talked about, “Seniors’ lack of knowledge about services, programs, etc. They need to get information from people they trust.” Another said, “People have needs, but because of cost or red tape, they aren’t asking for services. The community needs education about seniors’ needs.” A Household Survey respondent indicated concern about “Getting help for the aged adults who cannot or will not ask for help because of pride.”
Finally, a focus group participant commented, “There’s not much around to help the elderly and their concerns. Seniors are often alone. There are no groups coalescing around this issue, compared to youth issues and domestic violence.”

**Implications for health and human services:**

- At 20 percent of its total population, the study area’s senior population is large compared to the average for Illinois’ urban counties (16%). However, the study area lacks the opportunities and support services available to seniors in many other areas. With increasing migration to the area of urban retirees, development of amenities and services for older adults would both serve the current population and attract valuable new residents.

- Because there are more older women than older men living in the study area, and because older women are more likely to live alone, services should be planned and delivered in gender-appropriate ways.

- Rural seniors have more difficulty accessing services than do their town-dwelling counterparts. Emphasis should be placed on providing appropriate outreach and transportation services to seniors living in rural parts of the study area.

- Health and human service providers should target retired people—particularly those among the “young old”—for voluntary service. Recruitment activities should be deliberate, coordinated, and sustained.

- Due to cost factors, the use of inpatient hospital services and nursing home beds is projected to decline, while the need for in-home care will increase. Meeting this challenge demands cooperation and coordination of services among service providers. It also requires new approaches to attracting and retaining home care staff including increased wages, provision of health care and other benefits, family-friendly support services (e.g., child care, flexible hours, transportation, etc.), and community recognition of the importance of this type of work.

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**People with disabilities**

**National and local data**

A significant number of Americans suffer from physical disabilities. In 1995, 15 percent of the U.S. population experienced limitations of physical activity due to chronic health conditions. Older people are more likely to be disabled than are younger people; 38 percent of Americans aged 70 and over report activity limitation compared to only 10 percent of people between the ages of 18 and 44. The prevalence of visual impairments was 33 per 1,000 people and the prevalence of hearing impairments was 86 per 1,000 people. In 1990, 1,564,000 people were using wheelchairs.

In addition, many Americans suffer from mental disabilities. According to the U.S. Department of Health and Human Services:

> Every year, more than 51 million Americans experience diagnosable mental disorders. Of them, more than 6.5 million are disabled by severe mental illnesses, including as many as 4 million chil-

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5. Needs and Resources for Health and Human Services: People with disabilities

... Yet only one in four affected adults receives treatment. And only one-third of children and adolescents who need mental health services get them.

More than 10 million children under age 7 grow up in homes where at least one parent suffers from significant mental illness or substance abuse. (See section 5, “Health and health care,” for discussion about mental illness and substance abuse issues.) Approximately one percent of the total population is affected by a developmental disability such as mental retardation, cerebral palsy, epilepsy, and autism.5.140

An estimated 2.3 million adults living in U.S. communities have severe disabilities and require help from another person with everyday activities. According to one authority:

Different forms of disability can pose different challenges. For example, individuals with physical disabilities often require significant help with daily activities of self-care. In contrast, individuals with Alzheimer’s disease or chronic mental illness may be able to perform everyday tasks and may need supervision more than hands-on assistance.

People with severe disabilities are less likely to work, have less education, and have lower incomes than the general population.5.141

Sixteen percent of 551 respondents to the Community F.O.C.U.S. 2001 Household Survey report having a physical, mental, or other disability. According to an IPLAN Data System Report, over the 5 year period 1993-1997, in LaSalle County there were 429.5 per 10,000 live births with congenital anomalies (i.e., any structural deformity present at birth). This compares to 329.6 per 10,000 live births with these anomalies for the State of Illinois as a whole. “Congenital anomalies contribute to childhood morbidity and long-term disability.”5.142

Availability of disability services
There are several organizations serving the study area whose specific missions are to support persons with disabilities. Organizations provide adult day care and respite services; technical assistance and information on the Americans with Disabilities Act (ADA), specific disabilities, and related issues; residential care; and services for children with disabilities and their families such as information, screening, diagnoses, rehabilitation, special education programming, equipment loans, financial assistance, and programming. Some specific organizations offering disability services to study area residents include the following:

- The Illinois Department of Human Services which provides home-based support services to adults with disabilities and cash assistance to families of children with severe mental, emotional, developmental, or multiple disabilities.
- Illinois Department of Rehabilitation Services which provides respite care, home assistance services, and workforce support services.
- The Illinois Valley Center for Independent Living (IVCIL) which provides advocacy information, referral, counseling, independent living skills, personal assistant services, and equipment loans to individuals with disabilities and their family members. In addition, IVCIL provides ADA accessibility audits to businesses for a fee.

5. Needs and Resources for Health and Human Services: People with disabilities

- Ottawa Friendship House which provides workforce support, community integration services, and residential services for adults with developmental disabilities aged 18 and older.
- Survivors’, disability, and Supplemental Security Income (SSI) insurance which is administered through the Social Security Administration.\(^{5,143}\)

Seven organizations serving people with disabilities responded to the Community F.O.C.U.S. 2001 Health and Human Service Providers’ Survey. Key informants and focus group participants also talked about issues affecting persons with disabilities. While some participants mentioned local services for persons with disabilities as strengths of the health and human service system, others focused on organizational, service, and individual needs and access barriers.

Needs, access barriers, and improvements for disability services

Several of the Service Providers’ Survey respondents (4) mentioned the need for additional organizational resources—primarily facility space and improvement, equipment (e.g., lift gate van), staff, volunteers, and operating funds—to maintain or expand services. Providers indicate that facility space is at capacity. One provider of services to “functionally impaired adults” said the “growing need for their care” is due to a “growing elderly population.” Another provider of home-based services to both the elderly and disabled said, “People are living longer and are healthier; due to the high cost of nursing home and skilled care people try to stay home as long as possible.”

Although services exist, there are challenges associated with providing and accessing them and for organization collaboration and resource sharing. Community F.O.C.U.S. 2001 Service Providers’ Survey respondents, key informants, and focus group participants identified the following challenges:

- Lack of knowledge of what is available is a barrier to resource sharing.
- Providers have difficulty attracting and/or retaining staff due to low salaries, poor benefits, the need for vehicles, shortage of qualified people, poor working conditions, and staff child care issues. Large caseloads and few staff reduce timely service provision.
- Funding and reimbursement levels dictate services that can be provided. One organization sees this as its greatest challenge to service delivery.
- Transportation needs affect service access.
- Categorical eligibility (i.e., eligibility for services based on disability status, income, or other pre-defined criteria) and funding restrict service access and provision. Red tape prevents timely and easy access to services. One focus group participant believes that an Office of Rehabilitation Services’ program for starting businesses has too much red tape, too few dollars, and too little help for real needs such as computers. A key informant believes the State discriminates in its funding for persons with disabilities, with Dupage County getting more money than downstate communities because of political connections.

One provider, commenting on working conditions and staff turnover, said, “We run into many situations [in] which people are living in horrible surroundings and environments—It is difficult to keep staff in these homes.” Another said, “Our low reimbursement rate is the largest factor in our tremendous turnover of staff. Legislators need to consider you ‘get what you pay for.’ We have a difficult time retaining employees. After training and giving them the needed experience, they work in other health & human service positions for a higher wage. . . .”

\(^{5,143}\) LaSalle County Health Department, Resource Guide with Supportive Services, 1999.
Several providers discussed transportation issues for people with disabilities. One organization wants to enhance or expand services “because our service area is so large that we can’t reach all of our potential consumers. Many don’t have transportation. . . .” Another provider commented, “Not enough transportation. Individuals, especially those with [a] disability, need public transportation so they can access all services in the County of LaSalle that they qualify for. DHS/ORS case loads are too high.” A third provider indicated the need for transportation because, often, specific services may only be available out of town.

Most organizations indicate some degree of resource sharing and/or collaboration with organizations in ways such as participating together in meetings, coordinating services, referring clients, and sharing information. One focus group cited as a strength increased information provided by the LEASE (LaSalle/Putnam County Educational Alliance for Special Education) office regarding ADHD (Attention Deficit/Hyperactivity Disorder) and other disabilities. Participants’ recommendations for improvements to disability-related health and human services include:

- Advocate for prescription drugs for the homeless and disabled.
- Increase awareness of availability of glasses for people with low incomes through the Lions Club.
- Establish support services for the elderly who have mental illness and/or who are physically aggressive. One focus group explained that long-term care facilities are ill-equipped to deal with these issues.
- Strengthen employment support and placement services and job opportunities for physically disabled, mentally retarded, and developmentally disabled populations.
- Strengthen special education services and the process for developing Individual Education Plans (IEPs).
- Create a clearinghouse for information about services and access.
- Increase the number of persons trained to work with persons with disabilities (e.g., trained in special education; trained to treat the developmentally disabled and persons with autism).
- Increase utilization of “wraparound” services provided by the LANS committee for children at risk of placement in residential care. According to the description of LANS in the Health Department’s Resource Guide, “Wraparound is a process through which an individualized plan is developed and coordinated to meet the specified needs, cultures and values of a child and family and to keep the child from being placed outside of the community.”5.144
- Overall, increase support for developmentally disabled children and adults and their families including residential placements and services provided by such facilities or homes. One provider said, “Need more small, integrated living facilities for the developmentally disabled. Some of the people now living in nursing homes could be reaching their potential better in a more age-appropriate center.”

Most Community F.O.C.U.S. 2001 Household Survey respondents who used child care services in the last year did not need services for a child with a disability; 5 of the 6 respondents who needed this type of care, though, said it was difficult to find. Some survey respondents who needed services in the last year said it was also difficult to find services for an elderly or disabled person. One respondent mentioned needing “Help w/ my child w/ disabilities, i.e., mental health, education, and care giving.”

**Special education**

Several focus group participants and key informants commented about special education processes and services provided to study area residents. One focus group participant commented on, “The issue of ADD [Attention Deficit Disorder] in students. They [the schools] need to review this methodology [of diagnosis].

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5.144 LaSalle County Health Department, Resource Guide with Supportive Services, 1999, 47.
5. Needs and Resources for Health and Human Services: People with disabilities

Right now they have teams of regular teachers making diagnoses that they are unqualified to make.” The participant said this is occurring particularly in the Ottawa school system and believes the number of kids labeled ADD in the Ottawa school system is “way out of line.”

Another focus group said that special education is serving more kids with severe developmental disabilities. A third focus group perceived that there has been a recent increase in the number of children diagnosed with autism. This group further explained that it is a challenge for smaller school districts to find resources and staff to deal with children with disabilities and that there are problems with reimbursement rates provided by the State for children in special education. One participant said:

We have a crisis in special education. Not just local, but national issue. I think academia is being asked to do too much with too little. There are too many children with more than minor problems in regular schools. There is the Circuit Breaker program in Seneca for children with behavior problems. But our special ed[ucation] teachers are trying to take care of too many cases. What we need is a health study force at state level to define the problem and get some answers. Too many special ed[ucation] teachers are burning out.

An administrator from a rural school district said the district is struggling to serve handicapped students and that the “nature of the rural setting” exacerbates the difficulty.

Board of Education data shows that Ottawa study areas schools have the same percentage—12 percent—of persons with IEPs for special education as the State and National averages. While some participants believe the education system too readily identifies children with disabilities, one key informant suggested that the system moves slowly when addressing disability issues. As an example, s/he said that IEPs do not have to be written until 60 days after a plan is requested. If other providers recognize a problem, the school system does not have to act on it unless and until it is recognized in the IEP.

Another key informant thinks there is a need for services to assist adults with disabilities to transition back into the community. S/he said, “The special education system is operating in the 1970s and needs to be updated to 2000,” and further explained that support and education for basic living and for work is what is needed in this system.

Implications for health and human services:

√ Enhance resource sharing and service coordination among organizations serving people with disabilities.

√ A central number for information about health and human services would benefit providers and persons with disabilities and their families.

√ The educational system in the study area and at the State level must review processes for diagnosing students and provide resources to allow disability issues to be addressed more quickly.

√ Organizations must consider how to promote participation in occupations serving people with disabilities (e.g., through provision of adequate salaries, benefits, and resources).

√ Increase child care slots and respite resources for families with disabled children.

√ Develop Countywide transportation services accessible to persons with disabilities that will allow them to access health and social services, employment, education, etc. (See “Transportation” in section 5.)

According to one service consumer and disability advocate, there is now more funding for persons with disabilities because they [persons with disabilities] have demanded it. Along with organizations and non-disabled advocates, persons with disabilities provide the strongest voice for informing elected officials, other organizations, and the public about themselves, their disabilities, and the challenges they face. Persons with disabilities can’t assume that others are aware of their issues and needs and must continue to advocate.

The community college can partner with other educational institutions and social agencies to provide education and support services for teachers and service providers.

Recreation, parks, downtown development, and other community issues
Access to health care, housing, employment, social services, and other goods and services affect quality of life and are related to community and economic development. Other related issues include a community’s or region’s natural environment and opportunities for recreation and other leisure activities. This section highlights information provided by Community F.O.C.U.S. 2001 project participants about recreational opportunities and parks, downtown development, and other community issues not addressed elsewhere in this report.

Recreational opportunities and parks
LaSalle County, its eastern portion, and the City of Ottawa are fortunate to be home to a number of parks, rivers, and recreational sites. The City of Ottawa Website lists 14 public tennis courts, 4 public golf courses, public access to Illinois and Fox Rivers, country clubs, health clubs, 4 public swimming pools, and 4 state parks. In addition, lodging is available in motels and hotels, campgrounds, and bed and breakfast establishments.

A number of civic, social, cultural, sporting, and hobby-based clubs and organizations serve eastern LaSalle County and City of Ottawa youth, families, and adults. Some youth organizations include the W.D. Boyce Boy Scouts of America, the Centrillo Council of Girl Scouts, the Camp Fire Boys & Girls, Camp Tuckabatchee, YMCA, the 4-H program through the University of Illinois Extension for LaSalle County, and the Starved Rock Area Special Olympics. The City of Ottawa sponsors a Recreation Department serving all ages and at least one study area township provides youth programming.

Household Survey respondents shared their opinions about recreational activities and parks. One-fifth of respondents (20%) mentioned recreation and entertainment opportunities and the natural environment (e.g., scenery, cleanliness, parks, rivers) as their favorite attributes about where they live. Examples of their written comments include:

- “Very good recreational opportunities, nice parks, good schools, many churches.”
- “Nice people living here, beautiful area, riverfest activities in July and August, can find work.”
- “Starved Rock.”
- “The seasonal changes, great location for my job, helpful neighbors, nice variety of stores, parks are beautiful, well-used and fantastically maintained, fabulous sports programs—especially softball/base-

5.146 See the City of Ottawa Website at www.Ottawa.il.us/welcome.html.
Community F.O.C.U.S. 2001:
Recreation, parks, downtown development, and other community issues

ball—our area is at the confluence of 2 wonderful rivers, lots of water activities, great fishing, really amazed and generous people involved in so many clubs, organizations and it all works together pretty well—and I believe we are a thriving and basically happy community. . . .”

- “Small town atmosphere, access to local recreation (rivers, trails and state parks).”
- “I love the area and the beauty of two rivers. Also has opportunity to view wildlife at the rivers, the canal and the parks in the area.”
- “Quiet, lots of wild life, many trees, lots of different birds, no noise.”

The majority of respondents rated both recreational activities (71%) and parks (89%) as good or excellent. More respondents rated recreational activities as poor (17%) than the percentage rating parks as poor (4%). Ratings of parks did not vary greatly by location of residence in the study area. A greater proportion of persons living in rural parts of the study area (29%), though, rated recreational opportunities as poor than those living in Ottawa (14%) or Marseilles (18%).

City of Ottawa teens in grades 7-12 participated in a survey in October 1999 “to identify activities, policies and service programs” they would like the Ottawa Youth Advisory Committee to sponsor. In response to a question about new activities they would like to have, their top three responses were more live bands, shopping opportunities, and a drive-in movie theatre. (See Figure 5.19.) Students identified not having “things to do” as the most serious problem for youth in Ottawa and suggested many possible improvements in Ottawa with their top two responses being building places for youth to hang out and creating youth activities.

Household Survey respondents are also concerned about there being enough programming and activities, especially for young people. Selected comments include:

- “Lack of recreational activities for teens-21 yrs. of age. There are no clubs, facilities to dance, listen to music, etc.”
- “I would like to see more opportunities for teens and young people—perhaps a youth center where they could gather, have fun & be safer. Maybe even get them involved in community service of all different levels.”
- “Teens—drugs/alcohol. Lack of programs or activities so that teens get bored & seek out excitement.”
- “I would like to see more activities that are supervised for children & teens—music, theater, athletics. . . .”
- “The youth to young adults and their gang/drug involvement. There’s nothing for them to do (ages 12-17).”

Household Survey respondents suggested the most important improvements that could be made to local recreational opportunities and parks. Of the 223 persons responding to the question, the greatest percentages want to see parks and facility additions; programming for different age groups and persons with disabilities; park upkeep; and additional activities and entertainment offerings. (See Figure 5.20.) Several key informants also suggested that recreational activities are needed for all age groups but especially for children and seniors.

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5.147 Ottawa Youth Advisory Committee, Teen Survey Results, (January 2000).
One key informant related health care services to the economic development opportunities offered by tourism, recreation, and natural areas. This informant said that tourism is a huge business in the Ottawa region; yet, health and human services are not advertised well. Thus, if a tourist gets hurt or sick, he or she doesn’t know where to go for care.

Despite their positive comments and suggestions for improvements, the majority of survey respondents (63%) indicated they would not vote for higher taxes for parks and recreation improvements in their communities. One-quarter (25%) of respondents “don’t know” how they would vote on this issue.

**Challenges and opportunities for parks and recreation:**

- **√** Civic and other community groups can assist with upkeep of parks. For example, they can “adopt a park,” portion of a park, or other recreation area and work to remove trash, clean out underbrush, plant flowers, etc.
- **√** Communities can involve citizens in planning for parks and recreation activities to ensure appropriate and adequate programming for various age groups and populations (e.g., people with disabilities).
- **√** Providers of recreation and entertainment must communicate their opportunities widely. Health care providers also must post information about their services for tourists and residents using natural areas and participating in recreation activities.
5. Needs and Resources for Health and Human Services:
Recreation, parks, downtown development, and other community issues

**Figure 5.20: Household Survey Respondents’ Suggestions for Local Recreational Opportunities and Parks Improvements (n=223)**

<table>
<thead>
<tr>
<th>Percent</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>26.9%</td>
<td>Parks and facility additions (e.g., add tennis court, community/recreation center, campgrounds, basketball court, biking/walking paths, baseball fields, soccer fields, playground equipment; improve sidewalks; plant more trees; improve lighting; add more tables)</td>
</tr>
<tr>
<td>22.4%</td>
<td>Programming for specific populations (e.g., need more programs for kids, teens, seniors, and people with disabilities; improve handicapped access)</td>
</tr>
<tr>
<td>21.1%</td>
<td>Park upkeep (e.g., beautify and maintain; clean restrooms; clean out underbrush)</td>
</tr>
<tr>
<td>20.6%</td>
<td>Activities and entertainment (e.g., more festivals and concerts; add craft and hobby classes, winter activities; provide indoor ice skating)</td>
</tr>
<tr>
<td>16.6%</td>
<td>Water-oriented (e.g., increase public access to Illinois River; other comments related to water resources and recreation including boat rentals, riverfront development, and the canal)</td>
</tr>
<tr>
<td>13.5%</td>
<td>Parks and recreation administration (e.g., make activities affordable; advertise parks and recreation opportunities; control loitering; control insects; decrease government control)</td>
</tr>
<tr>
<td>7.6%</td>
<td>Respondent doesn’t use parks and recreation services</td>
</tr>
<tr>
<td>6.7%</td>
<td>Miscellaneous</td>
</tr>
<tr>
<td>5.8%</td>
<td>Satisfied with parks and recreation</td>
</tr>
</tbody>
</table>


Note: Respondents were asked to list what they think are the three most important improvements, therefore the percents total more than 100%.

**Downtown development**

Project funders, especially the City of Marseilles and the City of Ottawa, want feedback from residents about downtown areas. Thus, two Household Survey questions addressed these issues. Household Survey respondents indicated the three most important improvements that could be made to their communities’ downtowns and suggested reasons for businesses not locating downtown. The majority of 543 respondents indicated that bringing in new retail businesses, filling empty storefronts, and supporting current businesses would improve their downtowns. (See Figure 5.21.) Respondents (11%) also suggested other improvements to their downtowns or communities including:

- lowering or subsidizing rents for tenants;
- beautifying/landscaping downtown areas and bulldozing blighted areas (several respondents urged the clean-up of the Jordan Hardware fire site);
- rerouting traffic (e.g., moving Route 23 out of downtown);
- improving riverfront areas;
- building a civic or convention center; and
5. Needs and Resources for Health and Human Services:
Recreation, parks, downtown development, and other community issues

Figure 5.21: Household Survey Respondents’ Suggestions for Downtown Improvements (n=543)

Source: Community F.O.C.U.S. 2001: Resources and Needs for Health and Human Services: Report with Support Documentation, “Support Documentation 2f,” Household Survey, question 37, (Normal, IL: Applied Social Research Unit, Illinois State University, 2001). Note: Respondents were asked to check what they think are the three most important improvements, therefore the percents total more than 100%.

- developing more “mixed use,” bringing in more factory or high-tech jobs, or bringing in more high paying jobs.

Household Survey respondents (n=553) indicated that a limited number of potential customers (45%), high rents (43%), condition of buildings (33%), limited parking (23%), and other issues (17%) keep businesses from locating in their downtowns. High rents were cited by a much greater percentage of Ottawa residents (57%) than the percentages of Marseilles (22%) or other rural residents (22%). Marseilles (53%) and rural (55%) residents more often than Ottawa residents (41%) indicated a limited customer base as a barrier to business attraction.

Selected comments typify Household Survey respondents’ concerns about downtowns and economic development:\n
- “Lack of industrial growth with good paying jobs. Too many jobs in the $8-12 range.” (Seneca resident)

Concerning broader development issues, one key informant commented:

LaSalle County is the [second] geographically largest County in the State yet [is] not perceived as such at the State level. The County has good soil, good highways, and a river. It is the best, most accommodating place in the State yet these attributes are not recognized and promoted from within. DCCA has helped through its Competitive Communities Initiative but its good location needs to be promoted to bring in dollars. Location could be promoted through beautification, organization, and attraction of people for people.

Another key informant connected economic development with health and human service provision saying that business loss, particularly corporate offices, has affected charitable giving. The informant further explained that lots of jobs are coming to the community, but most are “second income” jobs.

**Challenges and opportunities for communities, residents, businesses, and organizations:**
- Upkeep and beautification of downtown areas may make commercial and residential space more appealing and thus attract tenants and consumers.
- Residents can support community businesses by patronizing them.
- Community economic development strategies should strive for a good mixture of retail opportunities for their downtowns and surrounding areas. These strategies should also recognize the potential of tourism and foster development of businesses, amenities, and services attracting tourists to downtowns.
5. Needs and Resources for Health and Human Services:
Recreation, parks, downtown development, and other community issues

√ Business support organizations, e.g., Chambers of Commerce, should continue to seek input about sup-
port services that would be beneficial for community businesses and then work to provide or facilitate
development of such services.
√ Communities can work together to plan regional strategies for growth and development including tour-
ism.

Other community issues
Community response to issues
The City of Ottawa has taken positive steps toward building a bright future through participation in the
Illinois Department of Commerce and Community Affairs’ Competitive Communities Initiative (CCI) and,
more recently, initiating planning to envision Ottawa’s residential development, parks and public buildings,
transportation (i.e., roadways), and services. A few key informants said the CCI process “changed the
face” of Ottawa and helped to push the community in a new direction.

Several key informants and focus group participants said that study area communities are quick to respond
to problems when they recognize them. One key informant said, “When there is a need and the word is sent
out, the community responds.” A few participants, though, noted cases in which the community’s response
to an issue was less positive. One key informant said that Ottawans display a “not in my backyard” attitude
regarding the PADS homeless shelter. This informant further explained that a barrier to access and utiliza-
tion of health and human services is that “The community [is] not willing to ‘face the fact’ that people need
services since most community members are doing OK. Yet, there are some who realize that, even if people
are working hard, they are unable to make it for some reason or another.”

Another key informant suggested, “Some people are not willing to recognize the new problem of gangs and
the influx of drugs because of gangs.” This informant believes it is difficult for politicians to admit that “my
town has a problem with drugs because it turns into my problem as a politician.” One key informant said the
community is “slow to change.” A focus group participant said there are “walls” between small communi-
ties that interfere with health and human service provision and access.

Criminal justice: offenders and ex-offenders
Two groups often left out of assessments of needs and resources for health and human services are offenders
and ex-offenders. Yet, their service needs are great and their numbers are growing. Currently, the LaSalle
County Jail has 96 beds. With the completion of the jail expansion, LaSalle County will have 206 beds
available with double-bunking capability of another 206 beds. Currently, the average daily inmate popula-
tion is at capacity at 96 inmates. LaSalle County transfers inmates for housing to Ogle, Grundy, and Lee
Counties. Of the total LaSalle County inmate population that are housed in the County and in other coun-
ties, most are pre-trial, i.e., they have not been convicted. On average, 15-20 inmates have been sentenced
while an additional 90 are awaiting trial.

According to one key informant, overcrowding in the jails is a “multi-problem situation”: there are not
enough judges, state’s attorneys, or public defenders to move persons through the system. As a result, there
are more inmates in jail for longer periods of time. The informant continued by saying, “We are one of the
fortunate counties where the county showed foresight and is building a new jail. Calls are received weekly

from other counties to house their prisoners. Even though there is a problem, we have made the changes necessary to resolve the situation.”

In addition to a shortage of personnel to process those awaiting trial, LaSalle County’s ratio of sworn law enforcement officers (2.4 officers per 1,000 population in study area cities and towns) is less than the State average of 3 officers per 1,000 population. In rural areas (Sheriff’s Department), the study area ratio is 1.5 officers per 1,000 population compared to the State ratio of 1.9 per 1,000. Crime rates in the County, though, compared to U.S. crime rates, are less than one-half times as likely to occur for all crimes measured. This excludes homicide, which is slightly more likely to occur than other crimes, and excludes white-collar crime, which is not routinely reported and measured. About one in five (19%) of the 385 Household Survey respondents who commented said that a low crime rate and feelings of safety are what they like most about where they live. Only a few respondents reported that they or other household members had been a victim of crime (3.1%), felt unsafe at home (3.3%), or felt unsafe in their neighborhoods (4.8%) during the past year (the total n=547).

Household Survey respondents shared their concerns about a number of crime and safety issues. One respondent mentioned, “Drug traffic, people not stopping at stop signs and speeding.” Another called for “Police patrol and enforcement of existing laws and regulations. Too many people have a lack of respect for others rights. People don’t teach their children good values (religious and otherwise). I or me attitude is too prevalent today.” A third voiced concern “That the children are well protected against abduction, sexual abuse on those lines.”

Community F.O.C.U.S. 2001 participants other than Household Survey respondents did not comment about services for those leaving the prison system. Yet, ex-offenders often face greater challenges than other community residents in meeting basic needs and obtaining stable employment, housing, health care, transportation, etc. In addition, many offenders have problems including low educational attainment, poor job skills, and drug or alcohol dependency. Providing coordinated accessible services to ex-offenders can prevent recidivism and return to prison. Unfortunately, most Household Survey respondents (88%) reported that they don’t know where someone could go to obtain services to support ex-offenders.

Population growth
The study area population is projected to grow slightly (.5%) to 41,874 between 2000 and 2005. Ottawa, Marseilles, and Seneca have experienced growth during the past few years (see section 4, “Population Profile.”) Although almost all study area residents are white (95%) and non-Hispanic (97%), the study area’s population is becoming increasingly diverse. At an estimated 1,277, the Latino/a population is the study area’s largest minority group and is projected to increase to 1,441 by 2005. The Black population is expected to grow by 20 percent, from 193 in 2000 to 232 in 2005 and the Asian population is projected to grow from 328 to 387 between 2000 and 2005.
5. Needs and Resources for Health and Human Services:
Recreation, parks, downtown development, and other community issues

Some study area residents have strong opinions about population growth and increasing diversity. Household Survey respondents shared concerns about new residents, including:

- “Becoming populated by blacks from gangs or Chicago area . . .”
- “Lack of sidewalks and lack of neighborhood parks for children in the Countryside subdivision, rate of growth and overcrowding in elementary school.”
- “The influx of more and more people from Chicago. Where do these people work? Do they work? It seems drugs are more prevalent. Is there a connection?”
- “. . . Encroachment of outsiders. . . .”
- “The relocation of the poor from big cities to our town.”
- “Jobs, roads that have been in bad condition for years and years. I am concerned with people from the city moving into my town bringing gangs, drugs, crime and building out in the little country we have left.”
- “Too many people moving in from the Chicago area and they expect the same services as when they lived in the city but they don’t want to pay for them so the people who have lived here for years end up having their taxes raised.”
- “We grew up here and have lived here nearly all our lives. We liked the hometown ‘know everyone’ atmosphere that is quickly disappearing. With the influx of people has come the influx of crime and other problems!”

One respondent, though, recommended that the community “Bring new diversity.” A key informant believes that racial barriers are breaking down and that the “race issue is a health issue.” This informant explained that lack of understanding leads to race issues and health problems: “We are unhealthy when we fight with one another—physically and mentally unhealthy.” S/he talked about the importance of community residents getting to know one another through cultural activities.

Another key informant related the growth of the Latino/a community to increasing need for culturally appropriate and bilingual health, social, and employment services (see section 6, “Organization and Management of Health and Human Services”). S/he specifically mentioned lack of immigration services to assist with:

- renewing expired visas;
- getting forms for citizenship (individuals can send in forms by mail, but can’t get any consultation in the area); and
- deportation issues.

This key informant reported that there are no immigration consultants or attorneys in LaSalle County. Although s/he has helped with translations of documents needed for immigration services (e.g., a Mexican birth certificate that has to be translated into English), the informant is not certified to provide these services and thus does not advertise them. Some Chicago-based offices can help but are reluctant to take cases from LaSalle County because they don’t know the area or the legitimacy of cases.

**Food pantries**

It is difficult to determine levels of hunger in the study area. Only a small number of Household Survey respondents (n=9) reported that they and/or household members experienced not having enough to eat in the last year. However, local organizations provide food assistance to thousands of individuals and families per year.
Food pantries are located in several LaSalle County communities. The Community Food Basket, Salvation Army Food Pantry, Seneca Food Pantry, and the Marseilles Food Pantry are in the study area.

“Share Food” programs allow volunteers who sort and bag groceries for a few hours a month to purchase a package of groceries (i.e., meat, vegetables, fruits, staple items) at reduced cost. Share programs are administered by two churches in the Ottawa area and in other LaSalle County locations outside of the study area.

Mobile Meals of Community Hospital of Ottawa (CHO) and Project NOA (Neighborly Older Americans) deliver meals to individuals over 60 who have difficulty shopping for or preparing food. CHO and Project NOA also provide congregate meals to persons aged 60 or older.

WIC (Women, Infants, and Children) through the LaSalle County Health Department offers a food supplement program.

Project NOA (Neighborly Older Americans) delivers meals and provides congregate meals to individuals aged 60 or older in Earlville, Marseilles, and other areas of LaSalle County outside of the study area.

The Illinois Department of Human Services provides food stamps as a supplement to household income to income-eligible households.

Other organizations in the study area provide food vouchers and emergency food assistance.

To maintain services, organizations offering meals or other food assistance indicate needing more paid staff (e.g., administrative and program staff), volunteers, computers, software, computer training, operating funds, and timely reimbursement.

Commenting on the need to enhance or expand the organization’s service, one provider said, “Ottawa needs a feeding site for the homeless and low-income people. We have the facility but not the staff or the funds.” To enhance or expand services, food assistance providers report needing volunteers, paid staff (e.g., cooks, general kitchen staff, clerical), equipment (e.g., industrial dishwasher, tables, chairs, rechemalization system), a computer and computer training for a volunteer bookkeeper, and increased operating funds. A key informant suggested that food provision is okay, but there is a need for other types of items such as diapers and tampons. This key informant also was concerned about access to food for people without food preparation devices and on holidays. Another key informant said there is a need in the study area for long-term provision of food for people recovering from surgery or an illness.

One provider suggests that his/her organization may be underutilized, saying, “More families should participate. In this program, one receives approx[imately] twice the am[oun]t of food than when purchased at grocery stores.” A key informant believes the Ottawa Food Basket is underutilized due to the limited hours it is open. This informant suggested the Food Basket should be open in the evenings for people who work during the day. One focus group participant suggested that more individuals could sign up for Mobile Meals and NOA meals.

Several participants called for increased coordination among service providers through a process for screening, referral, and sharing information about clients. Referring to unnecessary duplication or excess capacity among emergency assistance providers, one Service Providers’ Survey respondent commented, “Some entities have chosen not to support the local community food pantry, preferring to continue to have their own and solicit donations to support theirs.” Another respondent said, “Many churches, Salvation Army, United Way, gov[ernment] agencies etc. provide many of the same services and direct people back and forth. It allows ‘users’ and frustrates those who really need help.”
5. Needs and Resources for Health and Human Services:
Recreation, parks, downtown development, and other community issues

This respondent continued by saying:

One agency should oversee all “claims” for emergency help or short-term help with each of the other organizations being able to communicate and share names. As it stands “clients” go to each church, each food pantry, United Way, etc. Those who are in a first time emergency situation don’t know where to go and often too do not get as much help as they might need simply because they don’t know who handles what funds. We do not so much need help expanding as we need help to be a support to a more extensive organization with better resources to check out the “claims” presented for help.

Challenges and opportunities for health and human services:

✓ Jail expansion is one way to curb prison over-crowding. LaSalle County should explore other alternatives to incarceration—particularly for offenders of non-violent crimes. The County should also implement alternatives to incarceration of people who are awaiting trial—a practice that disadvantages those who cannot afford bail.

✓ Health and human service providers must specifically consider how they can provide support to ex-offenders upon their release from prison. If and where services exist, they must be advertised. Provision of coordinated services are likely to make the difference between an ex-offender successfully transitioning back into the mainstream or re-offending and going back to jail.

✓ The City of Ottawa should make the cultural festival an annual event and establish other types of cultural entertainment. Other communities and organizations also can host events and entertainment that celebrate various cultures and ethnicities.

✓ A service organization (e.g., court services, attorney’s office, or other human service organization) should sponsor a bilingual employee to become certified to provide assistance with immigration issues.

✓ Food assistance providers and pantries should collaborate to serve those in need and safeguard against abuse of the system by developing a coordinated system for referral, screening, and information sharing. Increased coordination also may increase service efficiency and reduce the need for more staff, volunteers, equipment, etc.

✓ Food assistance providers perceived as underutilized should increase communication about service availability and consider providing evening open hours.
Organization and Management of Health and Human Services

The Community F.O.C.U.S. 2001 project identified needs and resources for health and human services in eastern LaSalle County including Waltham and Utica Townships (the study area) using information provided by residents, health and human service providers, County and community leaders, and local data and reports. Project information can support planning and coordination of information provision, resources, and services within and among organizations. In addition to sharing their experience and opinions about specific needs and populations, study participants provided information about strengths of health and human service provision; barriers to service provision and access; staffing and training issues; organizational funding, planning, collaboration, and resource sharing; and awareness of existing services.

Organization and system strengths for health and human service provision

LaSalle County has a wealth of health and human service organizations whose missions cover a range of populations and issues. Household and Service Providers’ Survey respondents, focus group participants, and key informants commented on strengths of health and human service provision including:

- Breadth, depth, and quality of services;
- Responsiveness, longevity, and accessibility of services;
- Ability to provide services at low or no cost;
- Quality, knowledge, and commitment of staff;
- Cooperation and communication among providers; and
- Community involvement, support, and volunteerism.

Participants commented positively on the number and variety of services available to study area residents. They named as strengths specific services and organizations (too many to list here). They also generally mentioned as strengths categories of organizations, such as churches; availability of services for specific populations such as kids, seniors, and persons with mental health issues; health care services and providers; dentists; civic organizations; townships; regional hospitals; nursing homes/assisted living facilities; daycare and preschool options; food pantries; the educational system; court services; and police department staff and programs.

In addition to naming organizations, participants highlighted qualities of organizations that make them assets to health and human service provision. Several Service Providers’ Survey respondents cited as strengths their own organization’s reputation and length of time in the community. One provider commented, “We have a strong history in adoption and continue to offer a quality adoption program. We are infant centered, value based, open adoption professionals.” Another commented, “A major strength is the [medical facility’s] established presence in the community for [number of years]. The [medical facility] has provided credible and necessary services without duplication through the years.”
Many Service Providers’ Survey respondents and focus group participants said their own personnel (including volunteers) and staff of other organizations are key strengths in health and human service provision. Study participants described staff as “well-trained,” “knowledgeable,” “experienced,” “committed,” “friendly,” “non-judgmental,” “professional,” “confidential,” “competent,” and “compassionate and caring.” Providers also pointed to their organizations’ ability to serve clients in a timely manner, at low or no cost, and in locations convenient to clients (e.g., service outreach, central location, or multiple locations). Finally, providers commented on approaches to service provision as strengths of their own and other organizations. One provider cited as strengths of his/her organization: “Youth programming is prevention, instead of intervention. Education/research based information.” Another said, “When programs for public awareness are presented our department goes out 100%.” A third said “the grass roots philosophy” is a strength of the health and human service system.

Many study participants also commented positively on relationships among health and human service organizations. Some said that services are coordinated well or that agencies communicate and collaborate with one another. Examples of coordination and collaboration mentioned in focus groups include the Public Health Department working with churches, churches working with one another, the Council on Domestic Violence, the Local Area Networks, and schools working with the court system and other social agencies.61

### Challenges to providing and accessing services

Providers and consumers discussed challenges they encounter when supplying and accessing services. Household Survey respondents listed services they had difficulty obtaining in the last year and indicated reasons for their difficulty. Of the 119 survey respondents who commented, most (43%) said they had no need for a service or did not have difficulty obtaining a service. The remaining respondents mentioned services they had difficulty obtaining:

- (19%) Miscellaneous services (service not specified in another category such as family support, assistance with phone bill, job placement, transportation, and child care);
- (16%) Health, dental, or vision services (e.g., difficulty finding a doctor or specialist, difficulty paying for care);
- (13%) In-home health care, assisted living, or housekeeping services;
- (11%) Services for repair or maintenance of property (e.g., car repair, house repair, lawn care, trash removal, septic system work, handyman);
- (10%) Mental health services including support groups;
- (6%) Services for an elderly or disabled person; and
- (5%) Legal or court services.

The 549 Household Survey respondents most often reported difficulties associated with paying for services, accessing services not located in the area, or meeting eligibility requirements. Providers (n=79) responding to the Service Providers’ Survey also indicated the greatest challenges both they and consumers face. While 17 percent said they encounter no major challenges to providing services or programs, other providers indicated challenges including lack of community awareness of services, insufficient operating funds, and transportation issues for clients. (See Figure 6.1.) Many Community F.O.C.U.S. 2001 study participants

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### Figure 6.1: Service Providers’ and Household Survey Respondents’ Challenges to Providing and Accessing Services

<table>
<thead>
<tr>
<th>Percent of Service Providers’ Survey respondents (n=79)*</th>
<th>Challenges to providing and accessing services</th>
<th>Percent of service consumers who had difficulty (n=87)**</th>
<th>Percent of all respondents (n=549)</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.6%</td>
<td>Lack of community awareness of services</td>
<td>Included in &quot;Other challenges&quot;</td>
<td>Included in &quot;Other challenges&quot;</td>
</tr>
<tr>
<td>24.1%</td>
<td>Insufficient operating funds</td>
<td>N/A***</td>
<td>N/A***</td>
</tr>
<tr>
<td>21.5%</td>
<td>Transportation issues for clients</td>
<td>11.5%</td>
<td>1.8%</td>
</tr>
<tr>
<td>17.7%</td>
<td>Lack of volunteers</td>
<td>N/A***</td>
<td>N/A***</td>
</tr>
<tr>
<td>17.7%</td>
<td>Other challenges</td>
<td>25.3%</td>
<td>4.0%</td>
</tr>
<tr>
<td>16.5%</td>
<td>Not enough staff</td>
<td>N/A***</td>
<td>N/A***</td>
</tr>
<tr>
<td>16.5%</td>
<td>Inability to attract or retain qualified staff</td>
<td>N/A***</td>
<td>N/A***</td>
</tr>
<tr>
<td>15.2%</td>
<td>Client difficulty affording service</td>
<td>39.1%</td>
<td>6.2%</td>
</tr>
<tr>
<td>15.2%</td>
<td>Too much paperwork for staff</td>
<td>N/A***</td>
<td>N/A***</td>
</tr>
<tr>
<td>12.7%</td>
<td>Client resistance; discomfort with obtaining service</td>
<td>Included in &quot;Other challenges&quot;</td>
<td>Included in &quot;Other challenges&quot;</td>
</tr>
<tr>
<td>12.7%</td>
<td>Not enough facility space</td>
<td>N/A***</td>
<td>N/A***</td>
</tr>
<tr>
<td>10.1%</td>
<td>Eligibility requirements for clients</td>
<td>21.8%</td>
<td>3.5%</td>
</tr>
<tr>
<td>8.9%</td>
<td>Child care issues for clients</td>
<td>3.4%</td>
<td>0.5%</td>
</tr>
<tr>
<td>7.6%</td>
<td>Language barriers</td>
<td>3.4%</td>
<td>0.5%</td>
</tr>
<tr>
<td>3.8%</td>
<td>Too much paperwork for clients</td>
<td>14.9%</td>
<td>2.4%</td>
</tr>
<tr>
<td>2.5%</td>
<td>Hours not convenient for clients</td>
<td>14.9%</td>
<td>2.4%</td>
</tr>
<tr>
<td>1.3%</td>
<td>Not accessible for persons with disabilities</td>
<td>Included in &quot;Other challenges&quot;</td>
<td>Included in &quot;Other challenges&quot;</td>
</tr>
<tr>
<td>N/A***</td>
<td>Service not available in area</td>
<td>29.2%</td>
<td>4.7%</td>
</tr>
</tbody>
</table>


*Service Providers’ Survey respondents were asked to check the three greatest challenges in providing services or programs. However, five respondents checked four challenges, one checked six, and one checked nine challenges.

**Household Survey respondents were asked to check all reasons why they had difficulty obtaining services; 87 respondents indicated at least one difficulty.

***Some items provided as choices on the Service Providers’ Survey were not provided as choices on the Household Survey and vice versa; these are indicated as “N/A” (not applicable).
6. Organization and Management of Health and Human Services: Staffing, training, and operations

mentioned transportation and lack of service awareness as challenges. (See section 5 for more information about transportation; funding issues and service awareness are discussed in section 6.)

Many Community F.O.C.U.S. 2001 key informants mentioned client discomfort and pride as barriers to obtaining services. In mentioning pride as a barrier, one key informant said, “If people need a service, there is a way to pay. We all need help at some point. People just need to ask.” Another key informant explained that past (and in some cases current) discrimination against minorities and persons with particular medical conditions (i.e., HIV/AIDS) reduces confidence and creates reluctance in these individuals to obtain services. Several participants explained that people in the rural areas (i.e., outside of Ottawa or Marseilles) lack informal networks and don’t identify with or are not integrated with the larger communities where most services are located; thus, they experience difficulty accessing services available in these communities.

Also related to cultural and diversity issues are language issues. Service providers participating in focus groups and key informant interviews discussed the growing Hispanic population, and thus, the growing number of non-English speakers in LaSalle County and the study area. Language barriers create problems for both consumers and providers. In addition, the language barrier places pressure on family members, often children, to serve as interpreters for their loved ones as they access health and human services. One key informant explained that this occurs at WIC, Hygienic Institute, Public Aid, the Health Department, Department of Employment Services, and doctor’s offices because these organizations do not employ bilingual staff or easily accessible telephone interpretation relay services.

Challenges and opportunities for health and human services:
√ To reduce transportation barriers, providers must look for ways to provide services in convenient locations and sites (e.g., in rural communities, businesses, schools, and homes). (See section 5, “Transportation.”)
√ Providers can offer ways (e.g., volunteer opportunity or sweat equity) for consumers to contribute something in return for services they receive.
√ Health and human service providers should find ways to deliver services to increasingly diverse consumers who vary in language, culture, and values (e.g., rural residents, Hispanics, persons with disabilities or particular medical conditions). Providers could collaborate to provide and obtain training about diversity issues to increase their tolerance, understanding, and appropriate delivery of services.
√ Providers or volunteers who speak Spanish can offer particularly valuable services to study area residents.
√ Communities and organizations must continue to recognize and celebrate diversity. Public education about cultural differences and opportunities for sharing cultural beliefs and practices should be enhanced and provided in public places (e.g., communities, schools, and churches).

Staffing, training, and operations
LaSalle County’s health and human service system is built on its workers. With an aging workforce and growth in service jobs—the largest employment sector in the study area—providers will find it increasingly difficult to recruit qualified workers for health and human service occupations. Community F.O.C.U.S. 2001 research, especially the Health and Human Service Providers’ Survey, asked respondents to provide information about organizational staffing, training, and operations issues (e.g., hours, accessibility for persons with disabilities, number of sites).
Volunteerism

*Community F.O.C.U.S. 2001* project participants affirm that the County is rich in health and human services as well as high quality agency staff and volunteers. About 68 percent of the 83 respondents to the Service Providers’ Survey say they use volunteers to help deliver many programs and services in ways such as:

- Supporting protective services (e.g., firefighters, first responders, police auxiliary);
- Serving on boards of directors, fundraising, and providing administrative support (e.g., filing, copying, mailing, answering phones and receiving visitors, making telephone calls, processing applications, developing newsletters, and accounting);
- Planning, organizing, and managing programs and events;
- Providing respite for case workers;
- Aiding teachers, training, tutoring, and mentoring;
- Collecting food, authorizing food vouchers, packing meals, and distributing food;
- Leading youth groups, church groups, and sports teams and chaperoning activities;
- Helping clients with chores, transportation, or paying bills;
- Providing companionship to shut-ins, the chronically ill, and people in nursing homes; and
- Serving in other ways (e.g., Speaker’s Bureau, maintenance projects).

Of respondents to the Household Survey, 355 (63%) say they or other adult household members volunteer for nonprofit organizations, clubs, and community events or help out family members or neighbors. (See Figure 6.2.)

Although a majority of residents volunteer, health and human service providers, key informants, and focus group participants believe there is a need to bolster volunteerism. Of the 56 organizations responding to the Service Providers’ Survey that use volunteers, 43 percent (24 organizations) say they have a difficult time attracting or retaining volunteers. They indicate as primary reasons for their difficulty: public unaware of volunteer opportunities (58%); lack of volunteer recruiting resources (46%); child care issues for volunteers (21%); inadequate time for training (17%); inconvenient hours (17%); inadequate resources for training (13%); and other reasons such as liability issues, undesirable working conditions, vehicle needed for job duties, and less availability of volunteers due to paid employment.

One focus group voiced concern that the community will not be able to rely on a dwindling pool of aging volunteers. A key informant said, “Volunteerism is down across the country and in a community of this size, it really matters.” Several key informants discussed the need for volunteer attraction and the untapped or underutilized resource represented by retirees and young people. One focus group participant highlighted child care and its relationship to volunteerism. S/he referred specifically to the need for child care during daytime hours for volunteer firefighters and people with EMS training. They suggested that child care be provided to working moms to enable them to become EMS volunteers. Another key informant said that the Labor of Love program, an asset in the community, could be expanded with increases in volunteers. One key informant suggested bringing young people and seniors together through volunteerism and activities.

**Staff recruitment and retention**

The service sector employs the largest number (5,017 or 25%) of study area workers. Of this group, most work in education (1,842 or 37%), health care (1,785 or 36%), and social services (621 or 12%).

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Illinois Department of Employment Security occupational projections for 1996-2006 show annual openings in many health and human service positions—most notably in teaching, social science and recreation, nursing, and health service occupations—for the Illinois Valley Community College district, LaSalle County, and the study area. (See Figures 6.3A-B.)

Staff attraction and retention are major issues for health and human service organizations. About one-third (33% or 26 providers) of Community F.O.C.U.S. 2001 Service Providers’ Survey respondents indicated they have difficulty attracting or retaining qualified staff. Household and Providers’ Survey respondents, key informants, and focus group participants identified as difficult to attract and retain:

- Nurses and CNAs (certified nurses aides);
- Mental health professionals (e.g., child adolescent psychiatrists, therapists, geriatric psychologists, and school social workers and counselors);
- Teachers, teachers’ assistants, and part-time faculty;
• Spanish-speaking staff members (primarily for health and human services);
• Child care providers and youth workers;
• Home care workers for the elderly;
• Pediatricians, neurologists, OB/GYNs, allergists, and specialists generally;
• Radiologists, laboratory staff, environmental health practitioners, and health educators;
• Medical office managers with coding experience, supervisory staff, and clerical staff;
• Parole officers;
• Health professionals and social service providers generally; and
• Other staff such as firefighters, specialized program staff, outreach workers, bus drivers and bus aides, lunch aides, information systems specialists, entry-level kitchen staff, and maintenance workers.

Study participants most often said there are shortages of nurses, teachers, and mental health professionals. One survey respondent commented, “We anticipate shortages in nursing, radiology and laboratory. Also anticipate problems in IS [information systems] and service classifications of lower paid positions.” The Illinois Hospital and HealthSystems Association also recognizes a State-wide nursing shortage stating in its 2000 report, “There are not enough nurses to staff Illinois hospitals, long-term care, and home health organizations. The prognosis is bleak. The shortage of qualified, competent nurses will become more acute and will last a long time.”

Other providers, instead of naming specific occupations, specified they are seeking degreed or licensed individuals (e.g., master’s level, clinical areas need specialized education and licensing) or people with certain characteristics (e.g., trained, qualified, dependable, trustworthy, professional, long-term, competent, and network well with others).

According to study participants (i.e., survey respondents, key informants, and focus group participants), there are many reasons why health and human service staff are difficult to attract and retain in the study area including: full employment; low salaries or lower salaries than those available in the suburbs or city; job demands; high caseloads; perceptions of poor working conditions and inequitable pay; and shortages of qualified people. (See Figure 6.4.)

A shortage of qualified people and noncompetitive salaries are the main reasons service organizations have staffing difficulties. One Service Providers’ Survey respondent commented:

It used to be that our meal providers depended on volunteers. Now they are having to go to paid drivers. This is not easy either since not many people are willing to work two hours a day, everyday, for minimum wage. We need to work on up-grading the “role” of human service work.

Another said:

We have people working in these agencies for 10 to 15 years who are still working for $6.50 per hour without benefits. These people are not scrubbing pots and pans; they have to know the system [and] help people with real needs, etc. These people could go to McDonald’s and make more, but they don’t because they are dedicated to their clients. This is not just [for people working with seniors], it is across the board with people who help people.

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6. Organization and Management of Health and Human Services: Staffing, training, and operations

**Figure 6.3A: Estimated Average Annual and Total Openings for Select Health and Human Service Occupations in the Illinois Valley Community College (IVCC) District, LaSalle County, and the Study Area, 1996 to 2006**

<table>
<thead>
<tr>
<th>Occupational Title</th>
<th>Estimated Average Annual and Total Openings, 1996-2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IVCC District</td>
</tr>
<tr>
<td></td>
<td>Per year</td>
</tr>
<tr>
<td>Line and Middle Management</td>
<td></td>
</tr>
<tr>
<td>Medicine and Health Service Management</td>
<td>3</td>
</tr>
<tr>
<td>Social Scientists, Recreation, and Religion</td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td>1</td>
</tr>
<tr>
<td>Social Workers, Medical and Psychological</td>
<td>4</td>
</tr>
<tr>
<td>Social Workers, Except Medical and Psychological</td>
<td>7</td>
</tr>
<tr>
<td>Residential Counselors</td>
<td>5</td>
</tr>
<tr>
<td>Human Service Workers</td>
<td>4</td>
</tr>
<tr>
<td>Recreation Workers</td>
<td>14</td>
</tr>
<tr>
<td>Teachers, Librarians, and Counselors</td>
<td></td>
</tr>
<tr>
<td>Computer Science Faculty</td>
<td>1</td>
</tr>
<tr>
<td>Teachers, Preschool, Education Specialist</td>
<td>3</td>
</tr>
<tr>
<td>Teachers, Kindergarten</td>
<td>2</td>
</tr>
<tr>
<td>Teachers, Elementary</td>
<td>25</td>
</tr>
<tr>
<td>Teachers, Secondary School</td>
<td>28</td>
</tr>
<tr>
<td>Teachers, Special Education</td>
<td>6</td>
</tr>
<tr>
<td>Teachers and Instructors</td>
<td>6</td>
</tr>
<tr>
<td>Instructors, Adult (Non-vocational)</td>
<td>4</td>
</tr>
<tr>
<td>Instructors and Coaches, Sports</td>
<td>3</td>
</tr>
<tr>
<td>Counselors</td>
<td>2</td>
</tr>
<tr>
<td>Teacher Aides, Paraprofessional</td>
<td>5</td>
</tr>
<tr>
<td>General Office and Secretarial***</td>
<td>126</td>
</tr>
<tr>
<td>Medical Secretaries</td>
<td>3</td>
</tr>
<tr>
<td>Service</td>
<td></td>
</tr>
<tr>
<td>Fire Fighters</td>
<td>6</td>
</tr>
<tr>
<td>Police Patrol Officers</td>
<td>14</td>
</tr>
</tbody>
</table>


*Average annual openings for the IVCC district were used to calculate LaSalle County’s and the study area’s annual average openings, using the multipliers of 0.72 and 0.27 respectively. These numbers were based on the ratio of their populations to the IVCC district’s population.

**The average annual openings were multiplied by 11 to obtain the total number of openings over the 11 years between 1996 and 2006.

***The number of openings for General Office and Secretarial also include the number of openings for Medical Secretaries.
Figure 6.3B: Estimated Average Annual and Total Openings for Select Health and Human Service Occupations in the Illinois Valley Community College (IVCC) District, LaSalle County, and the Study Area, 1996 to 2006

<table>
<thead>
<tr>
<th>Occupational Title</th>
<th>Estimated Average Annual and Total Openings, 1996-2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IVCC District</td>
</tr>
<tr>
<td></td>
<td>Per year</td>
</tr>
<tr>
<td>Health Practitioners and Technicians</td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td>6</td>
</tr>
<tr>
<td>Dentists</td>
<td>2</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>1</td>
</tr>
<tr>
<td>Physical Therapists</td>
<td>1</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>39</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>12</td>
</tr>
<tr>
<td>Medical and Clinical Lab Technologists</td>
<td>2</td>
</tr>
<tr>
<td>Medical and Clinical Lab Technicians</td>
<td>2</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>2</td>
</tr>
<tr>
<td>Medical Records Technicians</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatric Technicians</td>
<td>1</td>
</tr>
<tr>
<td>All Other Health Professional and Paraprofessional</td>
<td>4</td>
</tr>
<tr>
<td>Health Service</td>
<td></td>
</tr>
<tr>
<td>Dental Assistants</td>
<td>3</td>
</tr>
<tr>
<td>Medical Assistants</td>
<td>1</td>
</tr>
<tr>
<td>Nursing Aides and Orderlies</td>
<td>30</td>
</tr>
<tr>
<td>Home Health Aides</td>
<td>13</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>2</td>
</tr>
<tr>
<td>All Other Health Service Workers</td>
<td>2</td>
</tr>
<tr>
<td>Precision Production</td>
<td></td>
</tr>
<tr>
<td>Dental Laboratory Technicians</td>
<td>1</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
</tr>
<tr>
<td>Bus Drivers, Except School</td>
<td>3</td>
</tr>
<tr>
<td>Bus Drivers, School</td>
<td>6</td>
</tr>
</tbody>
</table>


*Average annual openings for the IVCC district were used to calculate LaSalle County’s and the study area’s annual average openings, using the multipliers of 0.72 and 0.27 respectively. These numbers were based on the ratio of their populations to the IVCC district’s population.

**The average annual openings were multiplied by 11 to obtain the total number of openings over the 11 years between 1996 and 2006.
Training
Because it is hard to find qualified individuals, training provided by organizations is very important. Some Service Providers’ Survey respondents perceive that inadequate time or resources for training is a barrier to attracting or retaining staff. (See Figure 6.4.) Although most providers indicated that training needs of employees and volunteers are being met, some providers say this is not the case (9 and 13 providers respectively say employees and volunteers have unmet training needs). Most providers said that lack of time, staff, and money for training prevents them from meeting training needs. A few Service Providers’ Survey respondents and key informants specified the types of training needed in their organizations. These included training on behavior management, delegation, recruitment skills, child development, conflict resolution, grant-writing, establishing organizational structure and policies, program-specific information, and information about other available services.

Operations: location, hours, and accessibility
Staff supply and service demand affect timely service provision, as do organizations’ hours of operation, location, and facility accessibility for persons with disabilities. The majority of health and human service sites are located in the City of Ottawa (42%) or outside of the study area (42%). (Service Providers’ Survey respondents listed 126 total sites available to serve study area residents; 118 sites were identified by specific
location.) Less than one-third (31%) of the 118 sites are described as being within walking distance of a public transportation route. Most sites (86%) are described as accessible for persons with disabilities. Sites’ opening hours vary. Few of the 123 sites indicating their hours of operation are open in the evening, on weekends, or on holidays, although nearly one-fourth (24%) are “on call.” (See Figure 6.5.) Several Household Survey respondents suggested that health care services in their areas could be improved with additional open hours, especially in the evenings and on the weekends. One respondent called for, “Better hours for working Americans. Early a.m. & p.m. & Saturday.”

**Challenges and opportunities for health and human services:**

- Study area service organizations should think broadly about their potential volunteer base to include older adults, young people, people not employed outside the home, persons with disabilities, and others. Organizations can partner with study area schools to recruit student volunteers and, at the same time, create valuable experiences for young people. Organizations also may consider structuring internships for junior high, senior high, and college students that will serve both parties.
- Study participants suggest developing mechanisms for volunteer coordination in the study area. Large organizations, such as the Community Hospital of Ottawa, may serve as models for how to coordinate and utilize volunteers.

**Figure 6.5: Hours and Days of Operation of Service Providers’ Sites (n=123)**


Note: Respondents were asked to check all hours and days of operation that applied, therefore the percents total more than 100%.
6. Organization and Management of Health and Human Services:
Organizational planning, funding, and resource needs

√ Organizations have the opportunity to communicate their needs for volunteers through local media and newsletters, businesses, churches, etc.
√ Study area Websites (e.g., the City of Ottawa and Community Hospital of Ottawa) could advertise volunteer opportunities or a new Website could be developed for this purpose.
√ Health and human service organizations must monitor current and proposed legislation regulating health and human services and professionals to ensure that legislation is needed and facilitates service delivery. Where legislation creates barriers for providers or consumers, organizations must advocate for more effective and appropriate legislation.
√ Health and social service organizations should collaborate with educational institutions to promote health and human service jobs—in particular, to regional junior and senior high school and college students, and to Spanish-speaking children and adults.
√ Employers and educators should work together to develop programs or emphases in in-demand occupational areas (e.g., counseling, nursing, nursing assistance, medical coding, and teaching).
√ Health and human service organizations must recognize turnover costs—recruitment, selection, and training costs—that could be spent on providing higher salaries to qualified individuals. Increases in pay levels, benefits (e.g., health, dental, child care), and paid time off for health and human service workers may help to increase retention and attract new workers into health and human service occupations.
√ Providers should consider how they could be open at non-traditional times (e.g., early morning and evening) or in non-traditional places (e.g., businesses) to accommodate study area workers.

Organizational planning, funding, and resource needs

Service planning and delivery depend on available funding and resources in addition to identification of a specific purpose or need. Key informants, focus group participants, and Service Providers’ Survey respondents mentioned that funding restrictions (e.g., based on geography and eligibility criteria), fluctuations, and reductions have adversely affected service provision in the study area over the past few years and likely will continue to do so. According to some key informants, one factor affecting funding of health and human services will be Commonwealth Edison’s decreased assessed valuation to be phased in over several years. A number of project participants questioned local elected officials’ approaches to taxation, service provision, addressing residents’ needs, and accountability. One key informant believes managed care insurance has had a negative effect on funding for substance abuse and mental health services.

To illustrate how State government funding cutbacks have strapped services, another key informant used the example of PADS funding. S/he said that PADS gets only $15,000 from the State between the Department of Commerce and Community Affairs, Illinois Department of Health and Human Services, and the Federal Emergency Management Agency; thus “only [the] generosity of local donations has compensated those [State funding decreases] deficits.”

Inadequate government reimbursement rates also are causing access barriers and organizational challenges. A Service Providers’ Survey respondent said, “There are patients falling into the gaps created by the federal/state government and Medicare reimbursement issues. . . .” A different provider said:
   Our low reimbursement rate is the largest factor in our tremendous turnover of staff. Legislators need to consider you “get what you pay for.” We have a difficult time retaining employees. After training and giving them the needed experience, they work in other health & human service posi-
tions for a higher wage. We cannot compete with a $10-15.00 per hour wage. Nor can we find affordable benefits to offer. In our five years of existence in LaSalle County we truly feel funding is our biggest obstacle. There is a tremendous amount of resources available to train our staff but “money talks.”

Despite these concerns, some study participants are not sympathetic to funding issues. One key informant believes that government involvement and bureaucracy have only complicated services. This informant further said that government programs come and go, are not stable, and thus do not work: reliance on families, churches, and local communities to support services are better options than reliance on the government. Another person commented that the Community F.O.C.U.S. 2001 project is about money—who has it and how can organizations get it. S/he believes there are more than enough health and human services available in LaSalle County and said, “. . . For someone to say that they do not have access to health care, means they have not had it handed to them on a silver platter at their whim or wish . . . .”

Funding for services, though, is not only about direct service delivery but is about financing infrastructure (e.g., staff, facilities, equipment, etc.) necessary to support service provision. In addition to commenting on gaps and duplications in services, over half of Service Providers’ Survey respondents indicated additional resources necessary to maintain, expand, or enhance services and programs. Staffing issues are at the forefront of organizational needs: of 49 respondents, 18 and 14 respectively indicate needing more staff and volunteers to maintain services. Other top maintenance needs include facilities improvements (n=17) and computer equipment replacement (n=15). (See Figure 6.6.)

To expand or enhance services, 49 survey respondents indicate the need for their organizations to increase staff (n=27) and volunteers (n=24), increase facility space (n=19), and add computer equipment (n=14). (See Figure 6.7.) Providers also commented on the reasons they need to enhance or expand services, including improving accessibility, services, and outreach; serving a growing community or specific population (e.g., seniors, Latinos/as); serving unmet needs; and other reasons. Examples of their comments include:

- “To make our services more accessible to the Hispanic community.”
- “Because our service area is so large that we can’t reach all of our potential consumers. Many don’t have transportation. Our services are needed in at least 2 more cities than we serve so people can access us easier.”
- “Lack of space at peak time.”
- “We have waiting lists, we turn away less serious cases.”
- “Facility is usually at capacity.”
- “Population is aging and have greater demand for services, our caseload thus has grown older and more frail.”
- “We are one of three centers in Ottawa. We all maintain waiting lists. We are licensed for [between 50 and 100] children—we currently have [over twice the licensed number] children on our waiting list. The welfare to work program has flooded the child care community.”
- “Community growth and health care needs.”

**Challenges and opportunities for health and human services:**

Health and human service providers must communicate and advocate regularly with local (including County), State, and Federal elected officials to inform them of local issues and needs. Area legislators can influence allocations and legislation to help ensure that services are funded appropriately.
6. Organization and Management of Health and Human Services: Organizational planning, funding, and resource needs

Figure 6.6: Service Providers Indicating Resources Needed to Maintain Services (n=49)

<table>
<thead>
<tr>
<th>Number of organizations</th>
<th>Need</th>
<th>Further description*</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>More staff</td>
<td>5 out of the 14 who specified a number, indicate needing 1 more staff member. Another 5 need between 2 and 4 more. Types of staff needs vary.</td>
</tr>
<tr>
<td>17</td>
<td>Facilities improvement</td>
<td>Needs described include more space (n=9) and new roofs (n=3).</td>
</tr>
<tr>
<td>15</td>
<td>Replace computer equipment</td>
<td>5 organizations need 1 new computer; another 5 need between 2 and 4 computers. Other needs include system upgrades, a scanner, etc.</td>
</tr>
<tr>
<td>14</td>
<td>More volunteers</td>
<td>4 of the 6 who specified the number need between 1 and 10 more volunteers.</td>
</tr>
<tr>
<td>10</td>
<td>Update software</td>
<td>Of the 5 respondents who described their software needs, 4 are specific to their profession.</td>
</tr>
<tr>
<td>7</td>
<td>Replace other equipment</td>
<td>Equipment needs include typewriters, self-contained breathing apparatus, a radiology laboratory, etc.</td>
</tr>
<tr>
<td>4</td>
<td>Computer training</td>
<td>Computer training needs are for Word and Excel, other new software, and to set up a client database.</td>
</tr>
<tr>
<td>4</td>
<td>Other staff training</td>
<td>3 of the 4 staff training needs are specific to their field.</td>
</tr>
<tr>
<td>16</td>
<td>Other</td>
<td>9 described needs for funds for things such as operating funds, hiring more staff, client training, etc. Other needs include expensive equipment, help from other agencies, doctors and dentists who accept Medicaid, special transportation, etc.</td>
</tr>
</tbody>
</table>


Note: Respondents were asked to check all resources needed, therefore the number of organizations total more than 49.

*Not all respondents who indicated a need described the need.

√ Area funding bodies should review and revise, where necessary, their own systems and processes to maximize their benefit to the community.

√ Health and human service organizations must seek out grant funding and in-kind goods and services available through private foundations and trusts, philanthropic and civic organizations, and State and Federal government agencies.

√ Local funding and other organizations can sponsor grant-writing workshops to which all social agencies would be invited at minimal cost.

√ Health and human service organizations must find ways to collaborate and evaluate the outcomes and impact of services and programs, as these are two requirements grantors often make for awarding funding.
6. Organization and Management of Health and Human Services: Collaboration, communication, and resource sharing

Figure 6.7: Service Providers Indicating Resources Needed to Enhance or Expand Services (n=49)

<table>
<thead>
<tr>
<th>Number of organizations</th>
<th>Need</th>
<th>Further description*</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>More staff</td>
<td>22 respondents indicated the number or type of staff needed. 9 need one additional staff member. A variety of staff types are needed.</td>
</tr>
<tr>
<td>24</td>
<td>More volunteers</td>
<td>21 respondents indicated the number or type of volunteers needed. The median range needed is between 6 and 10 volunteers. A variety of types of volunteers are needed.</td>
</tr>
<tr>
<td>19</td>
<td>More facility space</td>
<td>Of the 14 respondents who specified the additional square feet needed, 7 specified less than 5,000 square feet. Other specifications range from a need for a space they could use occasionally to 45,000 square feet.</td>
</tr>
<tr>
<td>14</td>
<td>Computer equipment</td>
<td>Half of the 12 respondents who listed the number of computers or related equipment said they need 3 or less computers. The types of related equipment needed are printers, scanners, Internet access, etc.</td>
</tr>
<tr>
<td>9</td>
<td>Other equipment</td>
<td>Respondents (n=7) described other equipment needs such as: dental equipment, an industrial dishwasher, a self-contained breathing apparatus, digital image equipment, a copier, a rechemalization system, and fitness equipment.</td>
</tr>
<tr>
<td>8</td>
<td>Computer training</td>
<td>Respondents (n=5) described types of computer training needed: Website development, database, digital imaging, all computer operations, and bookkeeping.</td>
</tr>
<tr>
<td>4</td>
<td>Other staff training</td>
<td>Respondents (n=3) described their staff training needs as: updating their skills, learning to operate new equipment, marketing, conflict resolution, and delegation training.</td>
</tr>
<tr>
<td>11</td>
<td>Other</td>
<td>7 respondents need additional funds. Other needs include in-kind donations and grant information.</td>
</tr>
</tbody>
</table>


Note: Respondents were asked to check all resources needed, therefore the number of organizations total more than 49.

* Not all respondents who indicated a need described the need.

Collaboration, communication, and resource sharing

By working together, organizations can increase their individual and collective “capital.” That capital may be in the form of goods and services, staff and volunteers, financial assistance through grants or other donations, and information. Community F.O.C.U.S. 2001 project participants provided information about the extent to which organizations collaborate, communicate, and share to serve study area residents and make efficient use of limited resources.
Taking the pulse on collaboration and resource sharing . . .

Some organizations serving study area residents are working together to serve clients and make good use of resources. Service Providers’ Survey respondents shared their own and used other organizations’ resources in the past year. (See Figure 6.8.) They shared and used meeting rooms, staff expertise, and training resources more often than other types of resources. In most cases, less than 20 percent of organizations charged or paid a fee for resources lent or borrowed. When fees were charged or paid, they most often were for meeting space (31% paid and 22% charged for meeting space), equipment (25% paid for equipment used in own facility and 25% charged for equipment loaned), staff expertise (30% paid for staff expertise), and training (52% paid and 21% charged for training).

In addition to supporting one another with goods and services, organizations work together in other ways. Responding providers (n=77):

- Share information with other organizations (75%);
- Participate together in meetings or programs (70%);
- Refer clients to other organizations (65%);
- Coordinate services (56%);

**Figure 6.8: Percent of Service Providers Borrowing and Sharing Resources**

6. Organization and Management of Health and Human Services: Collaboration, communication, and resource sharing

• Collaborate on projects (49%); and
• Participate together in other ways such as training (9%).
The majority (>50%) of participating organizations reported working with six or more organizations in most of these ways.

Barriers to collaboration and resource sharing
Some providers said there are no barriers to collaboration and resource sharing in the study area. One provider said, “I feel organizations in LaSalle County cooperate and assist each other openly.” Another wrote, “There is a willingness among many fine departments to share expertise.” However, more study participants described the health and human services system as: having “lack of coordination” and being a “patchwork system,” “fragmented,” and characterized by “turf protection” and “competition.” Providers’ comments on surveys and in focus groups and interviews further explain barriers to collaboration.

Staffing issues
• One provider said collaboration is weak due to already high caseloads and staff burnout and explained that agencies are afraid of influx of cases so they stay in their offices and don’t promote services.

Competition and turf protection
• “Groups protect their ‘areas’ to validate themselves and to obtain funding and for ‘power.’”
• “Perception of competition for clients promotes secrecy.”
• “Agency resistance (due to competition with one another). Time and money; takes both to explore possibilities and develop a plan.”
• “We are very territorial in this area. . . .”

Location
• “We are in the northeast corner of the county and a more sparsely populated area. Other organizations do not like to travel here often.”
• “Time, location, and travel.”
• “Rural area and the distance between resources is a continual problem.”

Information and resource sharing
• “Every organization tries to help using its own resources. Many of the same people [consumers] use [each] place—no one works together or shares its list [of consumers] except for [names of two organizations, and the second one] is supported by United Way.”
• “Lack of information on specific resources although Health Department’s guide helps.”
• “Not enough networking groups.”
• “We do not have extra space and minimal equipment to share. We probably could use more communication about what resources agencies have available.”
• “Time, money and communication—too busy to work at it—can’t afford it and don’t know all that is available.”

Funding issues
• “The resources in this county seem to be controlled by the United Way and it seems that the United Way has the[ir] favorite agencies.”
Opportunities for resource sharing and communication:

Although Service Providers’ Survey respondents, key informants, and focus group participants cited positive examples and indicated that some degree of communication, resource sharing, coordination, and collaboration exists among health and human service providers, many mentioned needs for improvement. Study participants call for:

- A centralized and coordinated referral and screening mechanism to ensure that agencies and churches are serving and understanding clients’ real needs. Both providers and consumers called for such a system.
- More communication and collaboration among churches and between churches and social agencies;
- Follow-up from service providers with clients;
- Regional health service planning that is collaborative versus competitive, particularly among hospitals;
- Outreach involving rural-based services and residents;
- Holistic approach to addressing needs (approach that considers mental, physical, and spiritual aspects of the person);
- Centralized services so that clients can get necessary help in one location;
- Increased communication and coordination among mental health services, parenting programs, birth-to-three services, and seniors’ services;
- Employers and health and human service agencies to work together; and
- Regular and formal contact among health and human service organizations.

One key informant commented on the “Need to develop [a] sense of collaboration and teamwork working toward higher ground from an already stable base by giving up and adding to pieces for the betterment of the whole. The whole being LaSalle County.” Service Providers’ Survey respondents were generally positive in their comments when asked about opportunities for resource sharing in eastern LaSalle County. They suggested specific resources that could be shared (e.g., training, speakers’ bureau), organizations that can serve as resources for information and collaboration (e.g., Workforce Investment Board, United Way), models for collaboration (e.g., 13th Judicial Circuit Family Violence Prevention Council), and resources that could be developed or expanded (e.g., resource directory, education of public about what is available). Organizations must continue to look for ways to communicate their resource availability. Organizations that recognize the benefits of collaboration must continue to develop this approach and invite organizations with which they have not collaborated in the past to become part of a sharing network.

Awareness of health and human services

Lack of awareness is an access issue

Although Community F.O.C.U.S. 2001 project participants characterized the number and range of services available to study area residents as a strength, residents, volunteers, and health and human service providers don’t always know they exist. The Household Survey asked respondents about where someone would go to obtain specific social services. Respondents were instructed to indicate “don’t know” if they were unaware of where a service is located. If they indicated a community, most respondents said someone could obtain a service in Ottawa; this isn’t surprising considering that most survey respondents are from Ottawa. Rural residents indicate availability of services in communities other than Ottawa more often than Ottawa or Marseilles residents.
6. Organization and Management of Health and Human Services: Awareness of health and human services

It is revealing that high percentages of people “don’t know” where services are located—one-third to one-half of respondents for most social services. Also, for most services, the percentage of rural respondents who “don’t know” where services are located is greater than the percentage of respondents from Ottawa or Marseilles. Respondents indicate being least aware of services available to support abuse and domestic violence victims, provide respite care for caregivers, and support ex-prisoners. (See Figure 6.9.) Not knowing where services are located and not having a service available in the area are two reasons Household Survey respondents indicated for having difficulty obtaining needed services in the past year.

Several Service Providers’ Survey respondents and more than half of key informants and focus groups commented on one or more of the following:

- lack of awareness of health and human service availability;
- lack of knowledge about service content;
- the need for education and advertisement of services; and
- the need for a coordinated system for referral.

A lack of awareness and knowledge is viewed as a barrier to service access for residents and for providers (including volunteers) who make referrals. Lack of awareness also leads to the underutilization of services. One key informant said, “ignorance [of services] is the biggest barrier” to access. One focus group said this

![Figure 6.9: Percent of Household Survey Respondents Indicating Availability of Specific Services by Location](image)

6. Organization and Management of Health and Human Services:
Awareness of health and human services

is a problem particularly in the rural areas, for seniors, and for people with low incomes. Key informants and focus groups pointed out related barriers to awareness of and access to services, including the lack of a single contact or referral point locally for information about services, the perception that some organizations don’t want to publicize services, and changes in services due to changes in public funding.

Although most participants spoke generally about health and human service awareness, several named specific services. For instance, one key informant said, “People don’t know what Planned Parenthood is.” This person also said that a dialysis program exists at the Community Hospital of Ottawa. People no longer have to travel for this service, but many do travel because they do not realize it is available locally. Another key informant said s/he doesn’t know about the services provided by churches. A third mentioned that the Department of Human Services could promote its services more—especially the KidCare insurance program and the Child Care Connection program that provides free child care and manages child support. One focus group also mentioned the need for promotion of KidCare and the Department of Human Services used car program. Finally, one key informant and several focus groups said that while services are probably adequate, information about them is lacking.

Informational resources

There are some resources available to combat lack of information. Many participants mentioned the LaSalle County Health Department’s *Resource Guide with Supportive Services, 1999*, which provides information and contacts for health and human services available to LaSalle County residents. One township supervisor views the *Resource Guide* as a tremendous help and has added information to his *Guide* for his needs. Many key informants and focus group participants, however, did not know the *Resource Guide* exists.

Some organizations serving residents in the study area, e.g., the Community Hospital of Ottawa and Illinois Valley Community College, have a Website and offer information about services and programs available through their organizations. The City of Ottawa Website has a directory of businesses, industry, organizations, and services that provides contact information for some health and human services. Most of the 82 responding Service Providers’ Survey organizations have access to the Internet (63%). They also use various methods to communicate about their services and programs. (See Figure 6.10.)

Study area organizations suggest improving their own communication by devoting time, staff, and money to public relations; developing printed materials; gaining Internet access; developing a Website and on-line resources; gaining better media coverage; meeting regularly with other social agencies; and increasing communication to targeted organizations (e.g., churches, schools). Some organizations, though, do not see a need or do not want to increase communication. One provider wrote, “This is a well known, long established program in this area. No further communication is needed at this time as we have limited resources.” Another said, “We do not want to advertise—this is emergency funding only.”

**Challenges and opportunities for health and human services:**

 Organizations have the opportunity to educate other health and human service providers, local governments, business organizations, and members of the public about the availability and scope of services. Participants suggest that organizational newsletters, meetings of civic groups (e.g., Pioneer meetings—a group that meets through the Stavanger Lutheran Church, seniors’ meetings), and churches are good places to publicize services. Also, services and individual success stories can be advertised through the media. Organizations should pay particular attention to communication and outreach to rural areas.
The LaSalle County Health Department’s Resource Guide with Supportive Services, 1999, and future editions can be made available to providers and study area residents at no charge via the Internet. This Guide should be advertised widely through health and human service organizations, churches, County, city, town, and township governments, schools, civic/social clubs and associations, etc. Organizations can use this Guide to educate the public and other entities about their own and others’ service provision.

The Resource Guide should be regularly updated to include current service and contact information. The Resource Guide could be expanded to include information about organizations’ resource sharing capabilities. Organizations should be responsible for providing updates to the Resource Guide.

Study participants call for a coordinated system or clearinghouse for health and human service information and referral whereby residents and providers could call one number to get information about a range of services. This system could also serve as a volunteer coordinating center. See section 7, “Best Practices and Models,” for examples of such systems.

Existing Websites with directories that list organizations and services could be expanded to include all health and human services available to eastern LaSalle County residents.
6. Organization and Management of Health and Human Services:
Awareness of health and human services

√ A small brochure or flyer about services could be distributed in public places (e.g., churches, schools, town halls, retail stores, and gas stations).
√ There is a need to market services in friendly, culturally appropriate ways to attract diverse study area residents.
√ Health and human service providers, including providers and residents from rural areas, could develop a council that meets regularly to discuss and prioritize issues and share information. The public could be invited to attend such meetings to provide input, ask questions, and receive information. Some participants offered examples of such groups that have met in the past in LaSalle County. They want to see these activities “re-energized.”
√ Participants recommend that this report be distributed to all health and human service providers, schools, government agencies and legislators, communities, and churches that serve the study area.
7

Best Practices and Models

Introduction

An important part of Community F.O.C.U.S. 2001 research was learning from the diverse experiences of residents of LaSalle County including Waltham and Utica Townships (the study area) who plan, provide, need, and use health and human services. Many asset and needs assessment studies stop at that point, limiting the scope of research to community boundaries. However, such an approach misses out on the benefits that can be gained from the experiences and insights of others—other communities, health and human service organizations, and researchers. Thus, one component of Community F.O.C.U.S. 2001 research is review of the literature on best practice and collection of information about model projects and programs implemented elsewhere. The idea is to identify practices or projects that could be adapted and emulated in the study area—to build on the knowledge and experience of others and avoid wheel re-invention.

There is a wealth of information about best practices and models regarding health and human services of all kinds. It is beyond the scope of this project to review the literature on all topical areas with which this report is concerned—housing, health care, family support, youth issues, senior services, services for people with disabilities, and other issues. Thus, Community F.O.C.U.S. 2001 confined inquiry to two topics that emerged repeatedly from project research:
1. Communication, coordination of service provision, and collaboration among providers of health and human services; and
2. Transportation issues.

Study area health and human service organizations have demonstrated their willingness and ability to work together on many types of initiatives. Indeed, the Community F.O.C.U.S. 2001 project itself is an example of a collaborative effort to which many individuals and organizations have contributed. Nonetheless, for the most part, study area health and human service organizations still operate in traditional agency- and program-driven ways. An important goal of Community F.O.C.U.S. 2001 is to inform planning that will, in turn, drive development of collaborative programs and services. Sections 4, 5, and 6 of this report provide information about a range of conditions, needs, and resources that are present in the study area. This section focuses on ways of designing coordinated, collaborative approaches to local health and human service issues.

Communication, cooperation, coordination, and collaboration

History of interagency collaboration

The history of attempts to get health and human services to work together dates back at least to the 1960s, beginning with Federally funded War on Poverty programs including Head Start, Community Action Agencies, and the Model Cities program, and continuing in the 1970s when the Federal Department of Health, Education, and Welfare tried to generate greater coordination and accountability among the multiple organi-
organizations serving the same children and families. While authorities agree that the goal of service integration was not achieved, and that fragmentation of services remained the norm throughout the 1980s and ‘90s, there is also consensus that interagency collaboration would meet the needs of service consumers more effectively and economically.\footnote{See, e.g., Kagen, S.L., \textit{Integrating Services for Children and Families: Understanding the Past to Shape the Future}, (New Haven and London: Yale University Press, 1993), 3-27; Waldogel, J., “The New Wave of Service Integration,” \textit{Social Service Review}, 71:3, (1997), 465; Bruner, C., L.G. Kunesh, and R.A. Knuth, \textit{What Does Research Say About Interagency Collaboration?} (Oakbrook, IL: NCREL, 1992), [Internet], http://www.ncrel.org/sdrs/areas/stw_esys/8agecycol.htm.} Indeed, many public and private funding organizations now require proposed projects to include collaborative elements. However, as is true of many good ideas, the devil is in the details.

With continuing Federal emphasis on devolution of planning and decision-making to states and localities, coordination of services and collaboration among service providers have increasingly become local responsibilities. Furthermore, with the decline of Federal funding for social programs, communities have an increasing obligation to plan, fund, and administer support services that specifically address local needs. Combined with the strong economy and new resources offered by computer and communication technologies, this obligation creates an unprecedented opportunity for collaboration—in the study area as elsewhere in the United States.

\textbf{Advantages of collaboration}

What “collaboration?” One authority uses the following working definition:

Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to a definition of mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards.\footnote{Mattessich, P.W. and B.R. Monsey, \textit{Collaboration: What Makes It Work}, (St. Paul, MN: Amherst H. Wilder Foundation, 1998), 7.}

Collaboration is different from coordination, on the one hand, and integration, on the other. Collaboration allows organizations to retain their individual identities while, at the same time, creating something new to which each partner makes a substantial contribution.

Why should health and human service organizations collaborate? This question should be addressed from both the service provider’s and the service consumer’s perspective. Advantages to service providers include:

- Reducing administrative costs;
- Diversifying and sharing resources;
- Enabling planning and community need to drive service provision;
- Facilitating innovation; and
- Meeting demands for collaboration made by government and nonprofit funders.

Advantages to service consumers include:

- Improving access to the range of services necessary to address complex family and individual problems;
- Matching real needs with appropriate services;
- Minimizing confusion, frustration, and the time it takes to identify and access appropriate services; and
- Fostering case management and continuity of service provision.
7. **Best Practices and Models:**
Communication, cooperation, coordination, and collaboration

In the current fragmented human service system, where individual agencies manage specific programs and referrals are haphazard and not always well informed, “Clients must act as their own case managers, piecing together a package of services that meet their multiple needs.”

**Barriers to collaboration**
Barriers to collaboration include:
- Categorical funding and eligibility requirements for services;
- Competition for scarce resources;
- Incompatible organizational cultures;
- Turf issues;
- Failure to allocate resources to planning, staff training, and other costs associated with change; and
- Inertia.

*Categorical funding and eligibility requirements* are challenges encountered particularly by publicly funded service providers and their clients. However, these restrictions inevitably influence local planning and the development of services to address issues not met by government-funded programs. *Competition for scarce resources* occurs in public, nonprofit, and for-profit sectors of health and human service provision. The challenge for communities, funders, and organizations is to develop strategies for resource allocation and service provision that offer incentives for collaboration that outweigh the disincentives.

*Incompatibility of organizational cultures* undermines the chance of successful collaboration, regardless of the degree to which organizations serve a similar clientele or offer complementary services. If staff members do not respect, trust, or understand each other, they will not be able to work together productively. *Turf issues* are often bread-and-butter matters to service agencies that compete for continued funding on the basis of the number of services they provide and the number of clients they serve. Turf issues are also related to power and influence in communities and with funders. Turf protection is inherently conservative, since it discourages the introduction to the community of new providers and approaches to service provision. *Failure to allocate resources* to processes involved in developing a collaborative effort is shortsighted. Change is expensive. Without investment in time spent planning collaborative initiatives, staff training for new responsibilities, reconfiguration of administrative space, and purchase of any necessary new equipment, collaboration is hampered before it starts. *Inertia* is the greatest enemy of innovation. Social agency staff tend to have done things in the same way for a long time. It is understandable that some have the attitude, “If we drag our heels, we can just wait for this new initiative to pass.”

**Factors influencing the success of collaboration**
According to a recent publication, the following factors influence the success of collaboration. Factors related to the ENVIRONMENT:
- History of collaboration or cooperation in the community;
- Collaborative group seen as a leader in the community;
- Favorable political and social climate.

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7. Best Practices and Models: 
Making it happen

Factors related to MEMBERSHIP CHARACTERISTICS:
• Mutual respect, understanding, and trust;
• Appropriate cross-section of members in the collaborative group;
• Membership that view collaboration as in their organization’s best interest;
• Ability to compromise.

Factors related to PROCESS and STRUCTURE:
• Members share a stake in and have a sense of ownership of both process and outcome;
• Multiple layers of decision-making;
• Flexibility and adaptability;
• Development of clear roles and policy guidelines.

Factors related to COMMUNICATION:
• Open and frequent communication;
• Established informal and formal communication links.

Factors related to PURPOSE:
• Concrete attainable goals and objectives;
• Shared vision;
• Purpose that differs in some key characteristics from that of any member organization.

Factors related to RESOURCES:
• Sufficient funds;
• Skilled and respected convener.7.6

These factors suggest both existing conditions that may or may not be favorable for development of collaborative initiatives and elements that can be built into plans for collaboration. The more of these elements that are present in the collaboration, the likelier it is to succeed. Thus, this list of factors can be used as a checklist to plan a collaborative initiative.

Making it happen

One authority identifies four primary ways funders, administrators, and providers can work together to improve health and human services:
• Client-centered collaboration, which “works within the fragmented delivery system to link individuals with needed services from disparate programs,” primarily through case management;
• Program-centered collaboration, which “Includes co-location, developing shared information systems, sharing staff, joint programming and planning, and fiscal linkages”;
• Organizationally-centered integration, which creates umbrella human service agencies at state and local levels; and

7. Best Practices and Models: Making it happen

- **Policy-centered integration** at Federal and State levels, which supports a service integration infrastructure, refinances publicly funded programs, and decategorizes human service funding.\(^7^7\)

All approaches, with the exception of policy-centered integration, are within the scope of community-based organizations. The following guidelines may aid the process of choosing and planning a collaborative strategy for health and human service management and delivery:

1. Involve all key players in the planning group, including both decision-makers and service consumers.
2. Identify roles and responsibilities of planning group members.
3. In the planning process, take care not to perpetuate traditional power structures and antagonisms.\(^7^8\)
4. Develop communication strategies for sharing information and accomplishing group objectives.
5. Develop a shared vision of desired outcomes of health and human service provision. During inevitable tensions and frustrations, continue to focus group attention on that vision.
6. Choose a realistic strategy to achieve these outcomes that reflects community needs, the limits of collaborating organizations, and available resources.
7. Set attainable objectives for group activities.
8. Establish a time-line or schedule for accomplishment of objectives.
9. Develop strategies for process and outcome evaluation to know how it’s working.
10. Encourage buy-in of participating organizations’ staff members by sharing information about proposed changes in service delivery, soliciting suggestions, and offering training.
11. Institutionalize change by incorporating the collaboration’s objectives into member organizations’ mandates and budgets.
12. Celebrate and publicize successes. “Well-publicized results that consistently meet reasonable objectives will go far to attract the funding necessary to replicate and expand innovation.”\(^7^9\)

**Creating a single point of contact**

How can people who need services find appropriate providers without being shunted from one office to the next? How can service providers make referrals effectively and quickly, without depending on a pocket full of telephone numbers that may or may not be obsolete? An approach that goes a long way toward meeting these needs is establishment of a single point of contact—an information clearinghouse for health and human services. Traditionally, these services have operated by telephone. In the future, they will increasingly be Internet-based.


\(^7^8\) E.g., at the December 1999 *Transforming Communities: Improving Health and the Quality of Life* conference, Dick Davidson, President and CEO of the American Hospital Association, referred to hospitals as the “thousand-pound gorilla” in community health planning. He and other conference speakers agreed that hospitals must review their traditional role in the planning process and take a seat at the table without dominating decision-making.

Model: Providing Access To Help (PATH), Bloomington, Illinois

PATH offers the following services:

- **24-hour Telephone Service**—Crisis response, information and referral services.
- **Answering Services**—Provided for a number of local agencies and support groups.
- **PATH’s Directory of Human Services**—Published annually each fall; available for purchase through the business office.
- **PATH Seminars**—Workshops on community resources held periodically throughout the year.
- **Volunteer Training**—Paraprofessional training classes are provided for crisis line operators and are offered throughout the year.
- **Senior Service Programs**—For individuals 60 and over:
  - **Elder Abuse Services**—PATH’s Senior Services Specialist is mandated by State law to investigate all reports of elder abuse or neglect.
  - **Senior Outreach Services**—PATH’s Senior Services caseworkers provide outreach and in-home assistance to residents of McLean County. Caseworkers will make an assessment of the seniors’ needs and help them obtain services. This outreach can help ensure that seniors become aware of the many government programs they are potentially eligible for and may provide assistance in applying for those benefits.
  - **In-Home Counseling for the Elderly**—This program provides confidential counseling to McLean County residents 60 years of age and older in their homes. The purpose of the program is to help maintain the independence of older adults. The program helps seniors and their families deal with problems related to aging and develop and/or strengthen coping methods to handle these problems.
  - **Outreach for the Homeless**—This program provides assessment and linkage to people who are homeless as well as administer funds for direct services through case managers at the local shelters.\(^{7.10}\)

This service is not perfect. A recent study of McLean County’s health and human services, *Assessment 2000*, recommended that PATH’s services and directory be better marketed, that its information about area services be expanded and regularly updated to provide more accurate information to clients and people making referrals, and that an on-line version of PATH’s directory be created.\(^{7.11}\) Nonetheless, an information “clearinghouse” such as PATH would support some needs identified by *Community F.O.C.U.S. 2001* research participants.

**Using space**

One effective way to inform consumers about available services and facilitate service provision is to house providers under the same roof. According to an authority, “Co-location attempts to coordinate programs by eliminating the geographic fragmentation of service providers, uniting them within a single, all-purpose facility. The proposed benefits of co-location are many, though the actual effects often fall short of expectations if co-location is not implemented in conjunction with other linkage strategies.”\(^{7.12}\) Advantages of co-location include:

- Increasing service visibility to consumers, agency staff members, and community members who make referrals;

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Co-location can work for certain categories of services (e.g., senior services, health services for low-income and uninsured persons, early childhood development and child care services, etc.) or for health and human services generally. It is a particularly appropriate strategy for communities interested in revitalizing and bringing people into their downtowns.

Model: Fort Howard/Jefferson Neighborhood Family Resource Center, Green Bay, Wisconsin
The Resource Center opened in 1995 and was created by inner-city, primarily low-income residents who wanted a central place to support and strengthen neighborhood families. Located in one neighborhood elementary school and providing satellite programs in another, the Resource Center is a one-stop shop for local residents who need help with school, jobs, transportation, child care, and other services. It receives financial support from the City, the Green Bay School District, Schrieber Foods, ShopKo, and other benefactors. Programs housed by the Resource Center include:
• The family-centered Early Childhood Program that recognizes and supports parents as their children’s first teachers;
• The Blockbuster Program that breaks down barriers of neighborhood isolation and brings a sense of unity across economic and cultural lines;
• A cooperative program with neighborhood beat police officers to curtail crime and drug-related activities;
• A partnership with the NEW Community Clinic to provide neighborhood health fairs, free screenings, and a neighborhood nurse practitioner for children; and
• English as a second language classes.
Resource Center staff members provide services both on-site and in residents’ homes. A Center staff member is on the Mayor’s Neighborhood Resource Board and a neighborhood resident is on the board of an inner-city revitalization project.7.13 While the Community F.O.C.U.S. 2001 study area is not urban, this model could be adapted to any size community.

Using technology
Computer and Internet technologies offer powerful tools for collaboration and service provision. According to one authority, “By establishing a centralized network for gathering, processing, and sharing data on clients, programs, and management issues, information systems can contribute toward the service integration goals of improved program management and increased accessibility, accountability, and service capability.”7.14 Information systems can be used for two important purposes:
1. Informing people who make referrals, caregivers, family members, and potential consumers about types of services in the community, eligibility criteria, current service availability, and processes for accessing services; and

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7.13 For further information, contact Donna Freeman, Resident, Organizer, Fort Howard/Jefferson Neighborhood Family Resource Center, 520 Dousman Street, Green Bay, Wisconsin 54303, (920) 448-2256, [Internet], http://www.ncl.org/anr/stories/greenbay.htm.
2. Enabling service providers to share program and client information to improve services and facilitate data management, reporting, and evaluation.

A well-designed and routinely maintained Website can accomplish the first purpose. One possible way of approaching the second is described in the following model.

**Model: Pathways Community Network, Atlanta, Georgia**

A coalition of 28 Atlanta social service agencies joined forces in 1999 to form the Pathways Community Network. This Internet-based information system allows participating agencies to share client information and maintain program data. According to a recent report:

With client’s consent, his or her data is entered into the network by caseworkers at Pathways agencies. The data is then made available to different agencies on a need-to-know basis. For example, a caseworker who does job screening will see only data relevant to employment, and because each page is custom-created, users don’t know that they’re seeing all the information in the file. There are currently some 110,000 client records in the system, and three levels of data are contained in each. The first includes demographic and household information such as a client’s age, race, address, and family information. Because this basic information is needed by all agencies that work with a client, it can be accessed by all caseworkers. This provides an immediate benefit to clients of Pathways. Instead of completing an intake form for each agency, they can now complete just one. The second level of information includes employment, income, and residence history; job skill and readiness data; and the types and quantities of social service assistance the client has received. Level three contains information about a client’s medical and mental health status, history of drug use, and specifics about prior financial assistance. This level of data is never shared outside of the agency in which it originated. The Pathways system complies with all federal regulations for confidentiality of medical and drug treatment records. The issue of security is paramount at Pathways. All information that is transferred between the agencies and the main database is encrypted, using the same technology that financial institutions use.7.15

Benefits to clients include convenience and better service integration. Benefits to providers include:

- The case notes section, which allows caseworkers to share strategies and goals for clients; and
- The system’s reporting capability, which enables production of customized reports to funders and internal evaluation of services.

**Using research to implement change**

It never seems to fail; community groups conduct research projects, then the reports sit on a shelf gathering dust. How can research results be used to make positive changes in health and human services?

**Model: The Community Advocacy Network (CAN), Bloomington, Illinois**

First organized in 1994 to commission a countywide needs assessment study, CAN is composed of representatives of social service and health care organizations, educational institutions, businesses, local government, trades and labor, media outlets, and other organizations dedicated to community well-being. After the Community Assessment of Needs study was completed in 1995, CAN stayed together to implement project results, focusing on developing services associated with support for young children and families and child

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abuse and neglect. After another major research project, *Assessment 2000: Health and Human Services in McLean County*, was completed in 2000, CAN came together to prioritize project recommendations and implement activities based on these priorities. Currently, CAN is involved in a regional transportation study and in activities designed to improve services for McLean County’s growing Latino/a community. Several CAN members are also associated with the United Way of McLean County’s efforts to allocate funding based, in part, on *Assessment 2000* results. For more information about CAN, contact Jada Rodts, Community Advocacy Network, 201 E. Grove Street, PO Box 3605, Bloomington, IL  61702.

Using grassroots resources and strengths
Experience indicates that top-down, provider-driven efforts to increase public participation in health related activities are often unsuccessful. The following models indicate that involvement of consumers in service planning and delivery can yield positive results.

**Model: Camden (New Jersey) Health Improvement Learning Collaborative**
Camden, with a population of 87,000, faces service access barriers common to low-income inner-cities—lack of health insurance and transportation, violence, substance abuse, cultural and language issues, and (perhaps most important) “a pervasive mistrust of ‘the system’ and its institutions.”7.16 ‘To overcome these barriers, the Learning Collaborative, a broad-based coalition of more than 100 individuals and groups brought together by Our Lady of Lourdes Medical Center, has set up “Neighborhood Living Rooms” to function as informal, people-friendly entry points into the health and human service system for low-income residents. Each living room is staffed by a community resident who is trained as a host or hostess to make visitors feel safe and comfortable. Social workers are on hand to offer counseling and referrals. Physicians and nurses provide primary and preventive care. Health educators lead classes. Local volunteers help coordinate activities. According to the volunteer site coordinator:

In the old model, the provider was the expert and the patient was the learner. . . . We’re turning that paradigm around, so that the provider is the learner, and health care is delivered in an environment that is the neighbors’, not the providers’. Anyone in the living room has to be sensitive to the culture of the people they’re working with.

The Learning Collaborative has a six-member staff that includes a director, two community health facilitators, a wellness and health coordinator, a social worker, and a violence prevention assistant. The collaborative is supported by grants from the William Penn Foundation, the Health Resources and Services Administration, the Department of Housing and Urban Development, and the Robert Wood Johnson Foundation. For more information, contact Nancy Flaherty, Director, Community Health Improvement, Our Lady of Lourdes Medical Center, 1600 Haddon Avenue, Camden, NJ  08103, (609) 635-2646.

**Model: South Central Health Network, Twin Falls, Idaho**
During the 1990s, teens in a rural southern Idaho county experienced increasing health challenges including substance abuse, teen pregnancy, and car accidents. The teens requested a coordinated approach to improving their quality of life. The South Central Health Network, formed in 1990 to broaden the focus of health providers to incorporate community needs, responded to this request by implementing a program called “Building Assets.” Developed by the Minneapolis-based Search Institute, “Building Assets helps a commu-

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Community identify and promote the building blocks of positive human development.”7.17 Community leaders used Building Assets to identify existing and needed assets associated with the youth population. The report from this study, presented to the public in town meetings across the county, resulted in an action plan to address priority issues. One program emerging from the action plan is a network of nine after-school homework clubs in school facilities organized to meet the needs of the 62 percent of youth home alone after school; prizes are awarded to students who spend 20 consecutive sessions in one of the clubs. For more information, contact Karyn Goodale, Coordinator, HealthNet, South Central District Health Department, 1020 Washington Street, North, Twin Falls, Idaho 83301, (208) 734-5900, ext. 284.

Transportation models

Due to Federal welfare reform legislation, welfare-to-work issues dominate recent public policy discussion of transportation needs. According to a 1997 report:

Finding work may be easier than getting there. The journey to life without welfare begins not at the time clock, but on the daily route from home, to child care, to work, and back again. Transportation can be the biggest hurdle. Recipients without cars often have no way to get to work or have to take three or four buses each way. Even for those with cars, money for gas, repairs and insurance is often in short supply.7.18

Another authority refers to the willingness of policymakers and decision-makers to “consign poor people to barely functioning public systems from which higher-income citizens routinely withdraw,” and says that this implicit attitude “Is expressed in the overhead comment of one senior official from a national public transit organization, ‘Show me a thirty-year-old man on a bus, and I’ll show you a failure.’” The policy answer, particularly in rural areas, is to use public funds and programs to help low-income workers get and drive cars.7.19

While some study area residents are making the transition from welfare to employment, Community F.O.C.U.S. 2001 research indicates that the transportation needs of the population in general go beyond the welfare-to-work challenge. Many low-income people who are not on welfare need transportation, not only to support employment but also to gain access to shopping, recreation, and a range of necessary services. Furthermore, not all study area transportation needs can be met by increasing access to automobiles. Many residents, including children, seniors, persons with disabilities, and people whose driver’s licenses have been taken away, cannot or should not drive. Since more than half of study area residents live outside of its largest community, Ottawa, most people must travel to meet their needs.

There are hundreds—perhaps thousands—of innovative and successful transportation programs supported by grants from public and nonprofit organizations, local taxation, employer investment, fee-for-service, volunteer support, and insurance/entitlement program reimbursement. This report focuses on selected Illinois projects and one Missouri-based program. Selection criteria included applicability to rural areas, inclusion of a range of service needs, and diversity of project designs.

7.17 Transforming Health Care: Lessons from Community Partnerships, Health Research and Educational Trust, (1999), 34.
7. Best Practices and Models: 
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Model: OATS, Inc. 
This program began in 1971 as a grassroots effort in Missouri to provide for the transportation needs of the rural elderly, persons with disabilities, and families without resources to buy and maintain a car. It now operates more than 260 vehicles, employs more than 300 people, and operates in 86 Missouri counties. Communities helped raise money for the initial vehicle acquisition and established county operating schedules. Twelve hundred volunteers provide valuable assistance and local grassroots support in everyday company operations. They work through the Area Agencies on Aging to provide transportation for seniors. For more information, contact OATS, Inc., 100 E. Texas St., Columbia, MO 65202, (572) 449-3789. 

Model: RIDES Mass Transit District 
RIDES is a coordinated transportation service with the ability to serve the general public and social service agencies in nine southern Illinois counties (Pope, Hardin, Gallatin, Saline, White, Hamilton, Wayne, Edwards, and Wabash). What started as a Section 147 Research and Demonstration Project in 1977 has become the largest rural public transportation system in the State of Illinois. RIDES provides a subscription service, requiring 24 hours advance notice to secure a seat; in some towns, RIDES maintains residential routes. RIDES operates from 6 a.m. to 6 p.m., Monday through Friday, although in some counties RIDES provides employment transportation seven days a week. For information, contact RIDES Mass Transit District, (618) 285-3342.

Model: Cars to Careers 
Operating in Franklin, Jackson, Perry, and Williamson Counties in southern Illinois, Cars to Careers supports car purchase, repairs, taxes, licenses, one year full coverage insurance for each vehicle, and gas certificates (limited to $50 per family for job retention). In the first nine months of operation, participants bought 27 cars and 139 cars were repaired. Cars to Careers was awarded a $373,332 grant by the Illinois Department of Human Services for the period 6/1/99-3/31/00.

Model: Transportation to Employment and Self-Sufficiency (TESS) 
Springfield, Illinois, is moving toward a 24-hour economy, but its transit system shuts down at 6 p.m. Thus, lack of transportation is a barrier to employment. TESS provides alternative evening, weekend, and holiday transportation to and from work. Riders pay a fee of $3.50 (one-way) for this service. Some employers are supporting the service by purchasing tickets for their employees. For information, contact TESS, 208 W. Cook Street, Springfield, IL 62704, (217) 524-8314.

Model: Trident Transportation 
Trident Transportation provides a fixed route service between Alexander and Pulaski Counties in Illinois and the Procter and Gamble Company in Cape Girardeau, Missouri, with pick-up and drop-off locations in Olmsted, Mounds, Mounds City, and Cairo. Trident provides two round trips daily, seven days per week, to coincide with the 7 a.m. and 7 p.m. work shifts. Trident meets the needs of both a major employer and workers living in an economically depressed area. Trident Transportation was awarded a $177,545 grant by the Illinois Department of Human Services for the period 8/1/99-1/31/01.

7.20 Columbia, Missouri Website, [Internet], http://www.projectation.org/paweb/mo/rs113.htm. 
7.21 RIDES Website, [Internet], http://www.ridesmtd.com/pages/contact.htm. 
7.22 Information about this and the following model transportation programs was provided at the Transportation Forum hosted by the Metropolitan Planning Council, People’s Resource Center, and Work, Welfare, and Families, (Wheaton, IL, September 27, 2000).
Additional resources for best practices and models

There is a large and growing body of information about best practices and models for organization and delivery of health and human services. The above discussion barely scratches the surface. The following list will help readers to identify additional information resources.

Selected Websites:


We Do It Best! Public Workers Create Innovative Programs for Low-income and Working Families, http://www.afscme.org/pol-leg/nobodtc.htm


National Governor’s Association, Center for Best Practices, http://www.nga.org/CBP/Center.asp


7. Best Practices and Models:
Additional resources for best practices and models

Selected publications:


*Increasing Affordable Housing Options for Rural Citizens*, (Iowa, 1996), [Internet], http://www.rurdev.usda.gov/ideas/case64.html.


City of Albuquerque, *Recommendations to Address Urgent Need for Affordable Housing*, (1997), [Internet], http://www.cabq.gov/family/afford.html.


National Community Care Network Demonstration Program, *Transforming Health Care: Lessons from Community Partnerships*, (Chicago, IL, 1999). To order, call (800) 141-2626.
7. Best Practices and Models:
Additional resources for best practices and models

Conclusions and Recommendations

Into the future

The study area (eastern LaSalle County including Waltham and Utica Townships) is rich in many ways. It enjoys a strong social and employment base. It has abundant amenities and services. Its people share a diverse wealth of intelligence, experience, skills, spiritual strength, and good will. Its health care and social agencies offer a wide range of programs, services, and volunteer opportunities. The study area has more than enough of everything necessary to support the needy, empower the powerless, include the marginalized, and develop innovative approaches to challenges. Its leaders, service providers, and residents are in the enviable position of merely having to agree on the health and human service goals they wish to achieve and combine their considerable resources and energies to accomplish these goals.

The greatest challenges for the study area’s health and human service delivery system during the early years of the 21st century are fragmentation, turf protection, and competition. Communities and organizations operate as resolutely independent entities, defending their boundaries and competing for resources and loyalties. One Community F.O.C.U.S. 2001 focus group participant spoke for many when s/he said, “We are very territorial in this area.”

This culture results in lost opportunities. Coordinated planning, fundraising, and service provision maximize resources and minimize both duplications and gaps in services.

Another continuing challenge for the study area’s health and human service delivery system is providing services to rural residents. Service organizations are concentrated in Ottawa and other large communities neighboring the study area and, with the exception of emergency services, tend to operate only during regular business hours. Rural residents, thus, have unequal access to services and often do without. In addition, service organizations often focus attention on town-based programs and clients and devote little interest or energy to rural needs. Expanded outreach to rural residents will both improve their quality of life and expand the market of service organizations employing this strategy. Furthermore, enhancement of transportation services will increase access to services of both rural- and town-dwellers.

Finally, the study area’s health and human service system faces the challenge of maintaining elements of the system that are strong and effective, jettisoning elements that have outlived their usefulness, and incorporating new organizations and approaches to service provision. Community F.O.C.U.S. 2001 project participants are most generous with their praise for collaborative projects that have been designed to address specific community needs. They are most critical of traditional support of local organizations that ultimately undermines system strength. The lesson to be learned is that planning for health and human services must be driven by the changing needs of residents, rather than by the existence of longstanding programs and service organizations.

Where possible and appropriate, planning should be collaborative and involve participation of funders, service providers, and service consumers. Local allocation of funds also should be driven by this type of planning, and should encourage and facilitate development of innovative approaches to design and delivery of services. Funded programs should be evaluated on a regular basis—if possible, by an external evaluator—to determine whether programs are meeting their objectives and identify elements of best practice. To facilitate funding decisions and evaluation, appropriate and comparable program data should be collected and maintained.

**Recommendations**

Information emerging from research activities suggests the following recommendations for improvement and enhancement of health and human service provision in the study area:

**Improve information provision and communication among service providers and between service providers and residents.**

This could be done by:

- Establishing and marketing a single point of contact for information provision, referral, and screening of clients;
- Co-locating information and services;
- Creating and maintaining a health and human services Website providing complete and up-to-date information about services, eligibility requirements, and current availability of resources; and
- Developing an interagency information system to aid data collection and client tracking.

**Enhance information links and collaboration among health and human service organizations, schools, and religious organizations.**

This could be done by:

- Improving information sharing among these three types of organizations;
- Enhancing and developing topic-focused taskforces composed of representatives from all three types of organizations; and
- Developing collaborations to deliver services.

**Plan and implement an area-wide, Countywide, or multi-county transit system serving the diverse needs of rural and town residents, low-income individuals and families, and persons with disabilities.**

This system should be designed to support employment, health care, child care, shopping, and recreational needs. It should, ideally, run seven days a week, 24 hours a day. It should be based on a solid and diversified financial strategy including grants, tax funds, employer contributions, user fees, and entitlement program reimbursement. It should result from collaborative planning involving representatives from all major stakeholder groups, including consumers.

**Enhance workforce development and support.**

This could be done by:

- Enhancing adult education and occupational training to meet employers’ needs for skilled workers in targeted (“good”) jobs and residents’ needs for well-paid employment;
- Developing imaginative and flexible solutions to transportation and child care challenges, particularly for low-income workers;
8. Conclusions and Recommendations:
Recommendations

- Developing community-based affordable health insurance (covering dental and eye care and prescription drugs);
- Enhancing partnerships between health and human service organizations and local employers to provide information and services in the workplace, identify workers in need of services, and facilitate workers’ access to services; and
- Making job quality an important component of business attraction strategies.

**Improve attraction, retention, and support of health and human service workers.**
This could be done by:
- Raising wages;
- Offering benefits;
- Offering flexible, family-friendly working conditions;
- Employing imaginative recruitment strategies for health and human service jobs (e.g., targeting older adults, stay-at-home parents, persons with disabilities, Spanish-speaking youth and adults, etc.);
- Offering local, affordable, accessible training for in-demand health and human service occupations; and
- Developing innovative employment strategies (e.g., employee sharing, job sharing) to meet needs of both employers and workers.

**Use results of this report.**
This could be done by:
- Assimilating, discussing, and prioritizing report findings and recommendations;
- Assembling a taskforce composed of representatives from health care, social service, education, local government, trades and labor, business, religious organizations, service consumers, and other interested groups;
- Developing specific goals associated with priorities and identifying projects to meet those goals; and
- Putting together project teams to plan and implement projects.
Public data and local reports


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