Sangamon County
ILLINOIS

2022-24

Community Health Implementation Plan

Springfield Memorial Hospital

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EXECUTIVE SUMMARY

In 2021, Springfield Memorial Hospital (SMH) completed a Community Health Needs Assessment (CHNA) for Sangamon County, Illinois. This report is the accompanying FY22-24 Community Health Implementation Plan (CHIP) that outlines steps SMH intends to take during this three-year cycle to address the priorities set forth in the CHNA, as required of nonprofit hospitals by the Affordable Care Act of 2010.

As an affiliate of Memorial Health (MH), SMH worked with four other affiliate hospitals to produce the overall CHNA and CHIP, but completed its Sangamon County assessment and plan independently from those hospitals in collaboration with local community partners. Final priorities selected by SMH are listed below.

- Mental/Behavioral Health (Mental health was approved as a priority across the health system.)
- Economic Disparities
- Access to Health

In order to narrow down potential projects and initiatives to address the final priorities, Community Health leaders used community input, internal input and strategic considerations to develop the CHIP. Access to health, the social determinants of health and racial inequities and inequalities were considered in all parts of the process as well.

Recognizing that initiatives often address multiple priorities, these plans have been organized into broader strategies that will be employed to address the priorities of the CHNA, as listed below.

1. Broadly support equity-focused, community-based initiatives that support our CHNA priorities.
2. Develop and implement a coordinated approach to improving transportation access for medical needs and discharges.
3. Develop and implement an equity, diversity and inclusion (EDI) structure and strategic plan which addresses disparities and provides meaningful support for patients, colleagues and the community.
4. Invest in pipeline and workforce development programs, with an emphasis on diversifying workplaces.
5. Provide substantial financial and operational support to SIU School of Medicine for the purpose of ensuring their ability to remain in central Illinois as a key part of the healthcare community, as well as to serve as a key EDI collaborator.
6. Support and invest in economic and community development on the east side of Springfield, as led by leaders from within the east side community.
7. Support community health worker (CHW) programs to increase residents' opportunities to access resources that address the social determinants of health.
8. Support planning and "housing-first" efforts to address homelessness in order to stabilize individuals needing care for mental wellness.

The Memorial Health Board of Directors Community Benefit Committee approved the FY22-24 Community Health Implementation Plan on Oct. 29, 2021. Approval was also received from the Springfield Memorial Hospital board of directors. This report is available online at memorial.health/about-us/community/community-health-needs-assessment/ or by contacting MH Community Health at communityhealth@mhsil.com.

INTRODUCTION

MEMORIAL HEALTH

Memorial Health of Springfield, one of the leading healthcare organizations in Illinois, is a community-based, not-for-profit corporation dedicated to our mission to improve lives and strengthen communities through better health. Our highly skilled team has a passion for excellence and is dedicated to providing a great patient experience for every patient every time.

Memorial Health includes five hospitals: Springfield Memorial Hospital in Sangamon County; Decatur Memorial Hospital in Macon County; Lincoln Memorial Hospital in Logan County; Taylorville Memorial Hospital in Christian County; and Jacksonville Memorial Hospital in Morgan County. Memorial Health also includes primary care, home care and behavioral health services. Our more than 9,000 colleagues, partnering physicians and hundreds of volunteers are dedicated to improving the health of the communities we have served since the late nineteenth century.

The Memorial Health Board of Directors' Community Benefit Committee is made up of board members, Community Health leaders, community representatives and senior leadership who approve and oversee all aspects of the MH community benefit programs, CHNAs and CHIPs. Strategy 3 of the MH Strategic Plan is to "build diverse community partnerships for better health" by building trusting relationships with those who have been marginalized, partnering to improve targeted community health inequities and outcomes and partnering to support economic development and growth of our communities. These objectives and strategy are most closely aligned with the MH goal of being a Great Partner, where we grow and sustain partnerships that improve health.

CHNAs are available for each of the counties where our hospitals are located—Christian, Logan, Macon, Morgan and Sangamon counties. These assessments and the accompanying CHIPs can be found at memorial.health/about-us/community/community-health-needs-assessment/. Final priorities for MH are listed in the graphic below.

Memorial Health

Our Mission

Why we exist:

To improve lives and build stronger communities through better health

Our Vision

What we aspire to be:

To be the health partner of choice

FY22–24 Final Priorities

Decatur Memorial Hospital
1. Mental/Behavioral Health
2. Economic Disparities
3. Access to Health

Jacksonville Memorial Hospital
1. Mental Health
2. Obesity
3. Cancers

Lincoln Memorial Hospital
1. Youth Mental Health
2. Obesity
3. Substance Use

Springfield Memorial Hospital
1. Mental/Behavioral Health
2. Economic Disparities
3. Access to Health

Taylorville Memorial Hospital
1. Mental Health
2. Obesity
3. Lung Health

Memorial Health Priority
Mental Health

INTRODUCTION TO SPRINGFIELD MEMORIAL HOSPITAL

SMH is a 500-bed acute care, nonprofit hospital in the state capital of Springfield, Illinois, that offers comprehensive inpatient and outpatient services. Since 1970, SMH has been a teaching hospital affiliated with Southern Illinois University School of Medicine for the purpose of providing clinical training for residents. In 2020, the hospital earned its fourth consecutive Magnet® Hospital Designation by the American Nurses Credentialing Center. The hospital is accredited by The Joint Commission and is a member of the American Hospital Association, the Illinois Hospital Association and Vizient.

SMH services include the Southern Illinois Level 1 Trauma Center, Memorial Heart Care, Memorial Therapy Care, Family Maternity Suites, Regional Cancer Center, Regional Burn Center, Orthopedic Services, Memorial Wellness Center and Memorial Transplant Care. Springfield Memorial Hospital is a Joint Commission-designated Comprehensive Stroke Center and maintains a TeleStroke network with other hospitals in the region whereby patients presenting with stroke symptoms can be diagnosed and triaged at their local hospital.

As a nonprofit community hospital, Springfield Memorial Hospital provides millions of dollars in community support each year, both for its patients and in support of community partnerships. During the past three years, SMH community benefit support has totaled more than $292 million.

COVID-19 AND COMMUNITY HEALTH

On the afternoon of Saturday, March 14, 2020, MH leaders gathered with their peers from other local healthcare organizations at a news conference announcing that Springfield Memorial Hospital was treating the first known patient hospitalized with COVID-19 in central Illinois. MH mobilized its Hospital Incident Command System (HICS). Incident Command protocols are intended to provide short-term leadership during a crisis, such as a severe weather event or an accident that brings a rush of injured patients to the hospital. Usually, Incident Command teams are only mobilized for a few hours or days. But the team handling the COVID-19 response quickly became the longest-running Incident Command in Memorial history.

Respiratory clinics sprang up overnight to test and treat patients. Colleagues sidelined by the cancellation of elective procedures were redeployed to new roles. Providers began using telehealth to connect with patients. In April and May, as COVID-19 restrictions began to lift statewide, many restaurants, businesses and churches reopened for the first time since the pandemic began. Community Health colleagues from Memorial Health distributed signs and educational materials organizations could use to encourage mask-wearing, handwashing, social distancing and other infection prevention practices. In partnership with the Office of Equity, Diversity and Inclusion at SIU School of Medicine, MH also distributed more than 2,500 signs to organizations that primarily serve people of color and other marginalized communities. Over 80,000 masks were provided throughout our region to more than 70 partnering organizations.

Our health system and the entire region came together to care for the sick and slow the spread of the virus during an unprecedented and unforgettable year. The impact of the COVID-19 pandemic is hard to overstate in regards to community health, racial disparities and the social determinants of health. As such, and in the wake of the murder of George Floyd, MH committed its support and resources to Equity, Diversity and Inclusion (EDI) and issued a pledge outlining ways it intended to advance EDI throughout our institution and communities. The pandemic influenced how we conducted our health needs assessments and, more importantly, strengthened our resolve to improve lives and build stronger communities through better health.

Equity, Diversity and Inclusion *Pledge*

- We will use our resources to work toward greater equity within our organization and community.
- We will promote a culture of respect, acceptance and understanding.
- We will examine and challenge the conscious and unconscious biases that create barriers to healthcare—not only outward displays of prejudice, but also the unacknowledged biases that can subconsciously affect our perceptions of people different from ourselves.
- We will create spaces where colleagues feel safe discussing concerns about equity, diversity and inclusion.
- We will listen to and elevate the voices of individuals from underrepresented communities in discussion and decision-making.
- We will expand our Community Benefit programs that increase access to care for people and communities of color, in collaboration with other organizations that share our mission and values.
- We will actively recruit, hire and promote diverse candidates so that our colleagues more accurately reflect the communities we serve.
- We will not tolerate and strongly reject expressions of discrimination or hate speech from anyone who enters our facilities, including patients, visitors and colleagues.

Our Values

Safety

- We put safety first.
- We speak up and take action to create an environment of zero harm.
- We build an inclusive culture where everyone can fully engage.

Integrity

- We are accountable for our attitude, actions and health.
- We honor diverse abilities, beliefs and identities.
- We respect others by being honest and showing compassion.

Quality

- We listen to learn and partner for success.
- We seek continuous improvement while advancing our knowledge.
- We deliver evidence-based care to achieve excellent outcomes.

Stewardship

- We use resources wisely.
- We are responsible for delivering equitable care.
- We work together to coordinate care.

COMMUNITY HEALTH FACTORS

Community health is produced at the intersection of a multitude of contributing societal factors, both historical and current. At times, these factors are the direct result of policies and practices, both current and historical, put in place by the healthcare industry; just as frequently, these factors are the result of larger societal structures of which healthcare is only a part. Three major contributing factors were identified as affecting many of the health indicators across our region and the communities we serve—access to health and healthcare, the social determinants of health and racial inequity and inequality.

ACCESS TO HEALTH AND HEALTHCARE

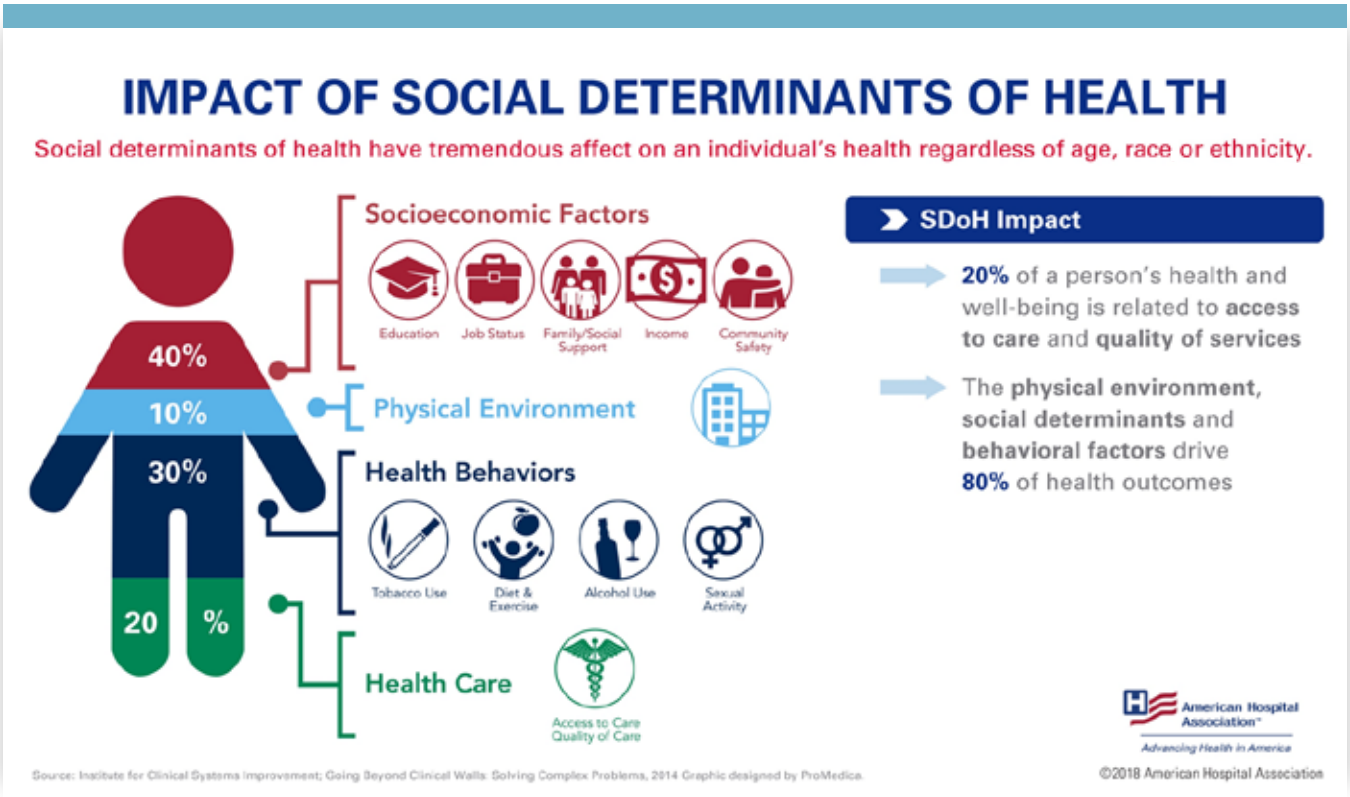
Access to health and healthcare is a multilayered contributing factor including structural, financial and personal components. The presence of facilities, availability of providers, hours of operation and access via public transportation all have a significant impact on access to health and healthcare as determined by the organization's structural decisions.

In addition to structure, access to health can be hindered by financial considerations when community members are uninsured, underinsured and/or unable to pay copays and deductibles. While financial considerations are beyond the dedicated control of healthcare providers, institutions can be creative and strategic in utilizing organizational resources to support publicly funded organizations that are working locally to bridge financial barriers.

Personal considerations may include questions of acceptability and general attitude toward seeking certain services, lack of trust with the healthcare industry, concerns over cultural norms being respected, language barriers and the like. While it is a challenge to change attitudes, access can be improved in many ways, such as ensuring that individuals do not face barriers due to language by providing clear guidance on how to access interpreters or ensuring there are supportive services available to meet a person's spiritual or cultural needs. It can also train colleagues to have high-impact encounters with patients in which individuals feel valued and respected.

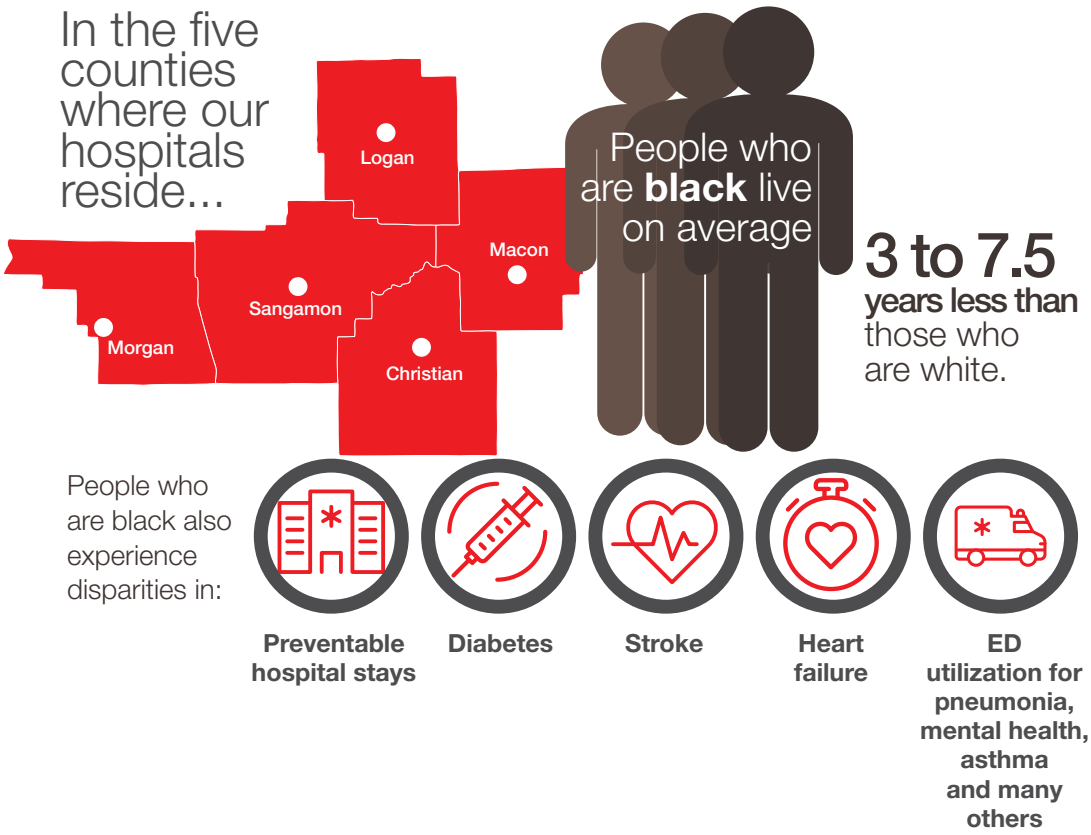
SOCIAL DETERMINANTS OF HEALTH

In addition to access to health and healthcare, another major contributing factor is the social determinants of health. If put into percentages, access to health as described above accounts for 20% of positive health outcomes. The other 80% are determined by socioeconomic factors (40%), physical environment (10%) and health behaviors (30%). Socioeconomic factors and physical environment, which represent 50% of positive health outcomes, can be largely attributed to the zip codes where community members reside. Socioeconomic factors include education, job status, family and social support, income and community safety. Health behaviors can include tobacco and alcohol use, diet and exercise, sexual activity and more. It is important to note that negative individual health behaviors can stem from unmitigated trauma brought on by structural factors like socioeconomic and physical environments. As such, it is critical for healthcare providers to be out in communities partnering with local residents, community leaders, schools and community groups to educate on healthy behaviors, advocate for structural change and to learn how to better serve patient populations.



RACIAL INEQUITY AND INEQUALITY

Racial inequities and inequalities negatively impact the health of minoritized community members. Equality – providing everyone the same thing – is often confused with equity, which refers to providing people what they need when they need it in order to achieve an outcome. As previously noted, the location of one's community has a profound impact on health outcomes. Through laws, policies and practices, both current and historical, black and brown communities are more likely to have underfunded public schools, fewer opportunities for stable employment, inadequate family incomes and diminished community safety. Within the U.S. context, racial segregation is high and communities of color are congregated in zip codes with lower life expectancy, income and resources. This segregation is evident locally as well, as each county where Memorial Health hospitals are located sees disparities in health outcomes and income across racial lines. These structures and the consequences thereof create a fundamental inequality that delivers inequitable supports.



SECTION I—COMMUNITIES SERVED & DEMOGRAPHICS

GENERAL INFORMATION

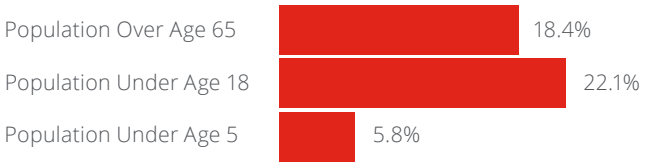
SMH is located in Springfield, Illinois, near the center of the state. Springfield is the capital city and the county seat. Sangamon County is largely rural and agricultural, with healthcare and state and local government being the largest employers. The majority of patients served by SMH come from Springfield and surrounding areas, though patients come from more than 40 other counties and also from out of state. Springfield is where the hospital focuses most of its community engagement and community health initiatives, due to its population density and resources for collaborative partnerships.

The following statistics, from the U.S. Census Bureau's Quick Facts, came from Healthy Communities Institute. Source: U.S. Census Bureau Quick Facts, last updated in December 2020.

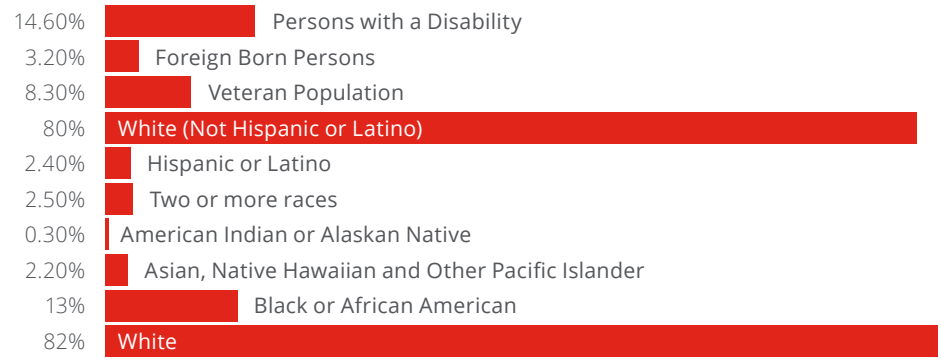
POPULATION

The population of Sangamon County is 194,672 and the largest urban setting in Sangamon County is Springfield, with a population of 114,694.

Population Age



Race and Hispanic Origin and Population Characteristics



EDUCATION AND HEALTHCARE RESOURCES

Southern Illinois University School of Medicine is located in Springfield. SMH serves as a major teaching hospital for SIU School of Medicine, which has more than 300 medical students studying in Springfield during their second through fourth years of medical school, as well as more than 300 residents and fellows participating in 32 different specialty programs. Springfield is also home to two higher education institutions: University of Illinois at Springfield and Lincoln Land Community College.

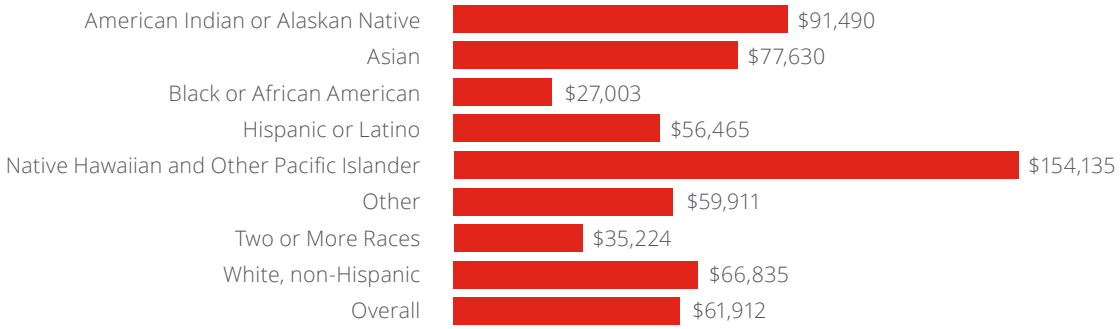
Thousands of patients come to Springfield annually for quality specialty care and surgery that is not available in their own communities. In addition to SMH, other Sangamon County healthcare resources include:

- Central Counties Health Center, FQHC
- Family Guidance Center
- Gateway Foundation
- HSHS St. John's Hospital
- Orthopedic Center of Central Illinois
- Sangamon County Department of Public Health
- SIU Center for Family Medicine, FQHC
- SIU Healthcare Clinics
- Springfield Clinic

ECONOMICS

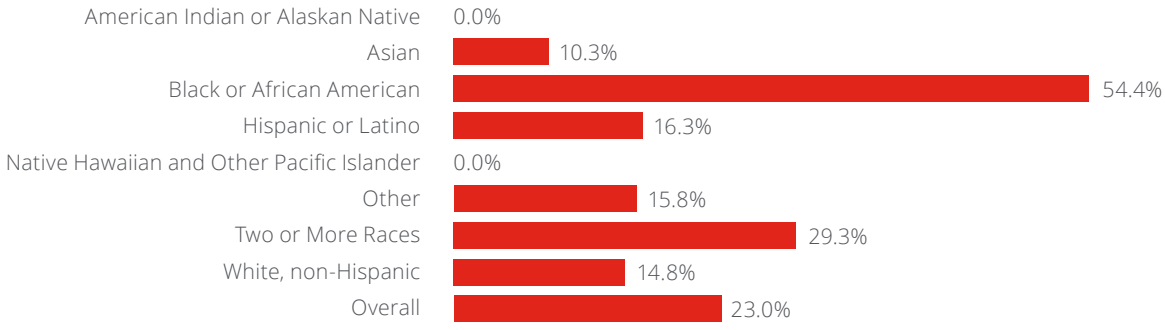
ALICE (Asset Limited, Income Constrained, Employed) is a way of defining and understanding financial hardship faced by households that earn above the federal poverty line (FPL), but not enough to afford a "bare bones" household budget. In Illinois, 12% of households live below the FPL, and an additional 23% qualify as ALICE. Sangamon County has 33% of households living below the FPL or qualifying as ALICE.

Median Household Income by Race/Ethnicity
County: Sangamon



Source: American Community Survey (2015–2019)

Children Living Below the Poverty Level by Race/Ethnicity
County: Sangamon



Source: American Community Survey (2015–2019)

EQUITY—RESIDENTIAL SEGREGATION, SOCIAL VULNERABILITY INDEX AND UNDER-RESOURCED ZIP CODES

Racial/ethnic residential segregation refers to the degree to which two or more groups live separately from one another in a geographic area. Although most overt discriminatory policies and practices, such as separate schools or seating on public transportation based on race, have been illegal for decades, segregation caused by structural, institutional, and individual racism still exists in many parts of the country. The removal of discriminatory policies and practices has impacted institutional and individual acts of overt racism, but has had little effect on structural racism, like residential segregation, resulting in lingering structural inequalities. Residential segregation is a key determinant of racial differences in socioeconomic mobility and, additionally, can create social and physical risks in residential environments that adversely affect health. The residential segregation index ranges from 0 (complete integration) to 100 (complete segregation). The index score can be interpreted as the percentage of either Black or white residents that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area.

Sangamon County has a residential segregation—Black/white score of 55, as compared to an overall score of 71 in Illinois, with county scores ranging from 19 to 85.

In other words, 55% of either Black or white residents would have to move to different geographic areas in order to produce a desegregated residential distribution.

Natural disasters and infectious disease outbreaks can also pose a threat to a community's health. Socially vulnerable populations are especially at risk during public health emergencies because of factors like socioeconomic status, household composition, minority status or housing type and transportation. The Social Vulnerability Index (SVI) ranks census tracts on 15 social factors, such as unemployment, minority status and disability. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability).

Sangamon County's 2018 overall SVI score is 0.4357. A score of 0.4357 indicates a low to moderate level of vulnerability.

Though county vulnerability could be low to moderate, the high level of residential segregation indicates vulnerability likely varies by tract or zip code. The 2021 SocioNeeds Index, created by Conduent Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes. The index is calculated from six indicators, one each from the following topics: poverty, income, unemployment, occupation, education and language. The indicators are weighted to maximize the correlation of the index with premature death rates and preventable hospitalization rates. All zip codes, counties and county equivalents in the United States are given an Index Value from 0 (low need) to 100 (high need).

In Sangamon County, the zip codes estimated with the highest socioeconomic need are 62701, 62703 and 62702.

SECTION II – CHNA PROCESS, CRITERIA USED & FINAL PRIORITIES

ASSESSMENT PROCESS

Springfield Memorial Hospital collaborated with HSHS St. John's Hospital (SJH), a 439-bed regional medical center and children's hospital, and the Sangamon County Department of Public Health (SCDPH), to complete the FY21 Community Health Needs Assessment. As part of the CHNA process, an extensive secondary data review was completed. In addition to individual health indicators, the three major contributing factors described earlier in this report – social determinants of health, access to health and racial inequity and inequalities – were identified as playing a key role in outcomes across all of the health indicators. Primary data was gathered through community focus groups, as well as input from the Community Advisory Council. These groups were asked to force-rank community health indicators by highest priority while considering the Criteria for Determining Need. They were also asked to share insight on how these priorities are experienced within the community and what the hospitals might do to address them. Internal Advisory Councils and the Community Health team reviewed and analyzed feedback from the process and recommended final priorities to the Memorial Health Board of Directors' Community Benefit Committee for approval. The general process steps illustrated below were used by the Core Team to conduct the CHNA. Members of key participant groups are also listed below.

CORE TEAM MEMBERS

The Core Team is responsible for planning, executing and reporting on all aspects of the CHNA and CHIP process.

- Becky Gabany, Memorial Health, System Director, Community Health
- Lingling Liu, Memorial Health, Coordinator, Community Health and EDI
- Kimberly Luz, HSHS St. John's Hospital, Division Director, Community Outreach
- Bill Dart, Sangamon County Department of Public Health, Assistant Director (through June 2021)
- Gail O'Neill, Sangamon County Department of Public Health, Director of Public Health (beginning June 2021)

INTERNAL ADVISORY COUNCIL (IAC)

(Decatur Memorial Hospital and Springfield Memorial Hospital)

The IAC is responsible for providing strategic direction and insight regarding internal operations and how those initiatives may align with and compliment addressing the health needs of the community. They are also responsible for recommending final priorities for board approval.

- Becky Gabany, Memorial Health (Core Team) System Director, Community Health
- Bob Scott, Memorial Health Senior Vice President & Chief Human Resources Officer
- Chuck Callahan, Memorial Hospital Group President, Springfield Memorial Hospital President & CEO
- Diana Knaebe, Memorial Behavioral Health System Administrator

- Drew Early, Decatur Memorial Hospital President & CEO
- Florence Holmes, Clinician, Memorial Behavioral Health, Equity, Diversity and Inclusion (EDI) Coalition Development Team (CDT) member, Sangamon County resident
- Harold Armstrong, Computer Operator, Decatur Memorial Hospital, EDI CDT Member, Macon County resident
- Jay Roszhart, MH Ambulatory Group President
- Julie Bilbrey, Decatur Memorial Hospital Foundation Executive Director
- Kristi Olson-Sitki, Springfield Memorial Hospital Magnet Coordinator
- Lance Millburg, Memorial Health System Administrator, Performance Improvement
- Linda Jones , Springfield Memorial Hospital Vice President, Ancillary Operations
- Lingling Liu, Memorial Health (Core Team) Coordinator, Community Health and EDI
- Rajesh Govindaiah, MD, Memorial Health Senior Vice President and Chief Medical Officer
- Robert Ellison, Memorial Health System Administrator, Business Development & Governmental Affairs
- Sharon Norris, Decatur Memorial Hospital Assistant Vice President and Chief Nursing Officer
- Tamar Kutz, Decatur Memorial Hospital Vice President, Quality and Operations

COMMUNITY ADVISORY COUNCIL (CAC) INVITEES

Charter: The CAC of the Sangamon County 2021 CHNA exists to help SMH review existing data and offer insights into community issues pertaining to that data. The CAC will help identify local community assets and gaps in the priority areas and will offer a ranking of issues by highest priority.

- Catholic Charities*
- Central Counties Health Centers, FQHC—Federally Qualified Health Center *
- Greater Springfield Chamber of Commerce
- Heartland Continuum of Care*
- HSHS St. John's Hospital (Core Team)
- Lincoln Land Community College Workforce Equity*
- Memorial Behavioral Health*
- Springfield Memorial Hospital (Core Team)
- NAACP – Springfield Branch*
- Sangamon County Department of Community Resources*
- Sangamon County Department of Public Health* (Core Team)
- Sangamon County Farm Bureau
- Senior Services of Central Illinois*
- SIU Center for Family Medicine, FQHC*
- SIU Office of Equity, Diversity and Inclusion
- Springfield Immigrant Advocacy Network*
- Springfield Police Department
- Springfield Public School District 186*
- Springfield Urban League*
- The Phoenix Center*
- United Way of Central Illinois*

**Indicates groups representing low-income, underserved and/or minoritized populations.*

COMMUNITY FOCUS GROUPS/INTERVIEWS

Community focus groups/interviews provide deeper insight to the Core Team, CAC and IAC about their personal experiences related to key health indicators.

- Asian Indian Women's Organization*
- Chinese American Association*
- Citizens Club of Springfield (open to general public)
- City Council: Alderman Shawn Gregory & Mayor James Langfelder*
- Community Foundation for the Land of Lincoln
- Divine Nine Sororities & Fraternities*
- Eastside Neighborhood Associations*
- Hispanic Women of Springfield*
- Islamic Society of Greater Springfield*
- Ministerial Alliance*
- NAACP - Springfield Chapter*
- Race Health Equity Partnership – Annual Alonzo Homer Kenniebrew, MD, Forum*
- Springfield Black Chamber of Commerce*
- Springfield Center for Independent Living*
- Springfield Coalition on Dismantling Racism*
- Springfield Immigrant Advocacy Network*
- Springfield Urban League*
- The Phoenix Center*
- United Way of Central Illinois: Vision Councils*
- University of Illinois at Springfield & Community Health Roundtable (open to general public)

**Indicates groups representing low-income, underserved and/or minoritized populations.*

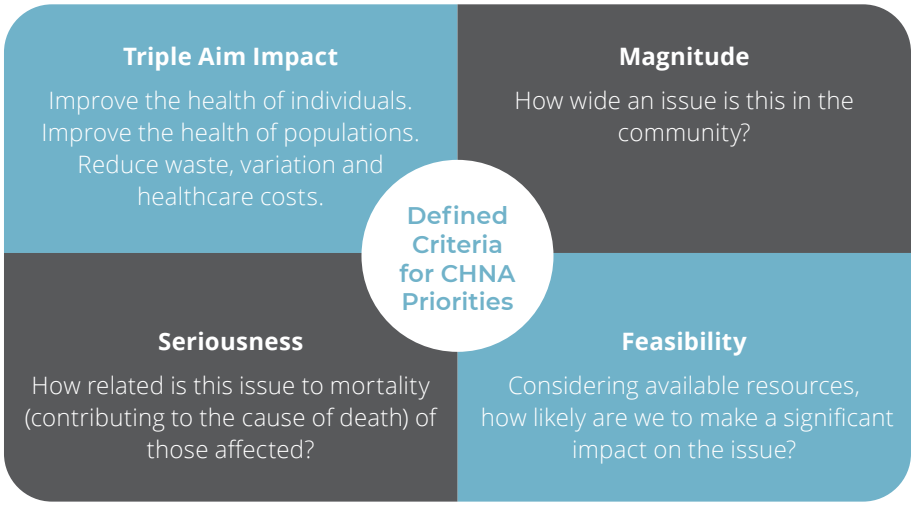
INTERNAL COMMUNITY HEALTH LEADERS

Community Health leaders are colleagues of MH who are responsible for the Community Health programming in their respective communities, as well as completion and execution of the CHNAs and CHIPs for the county in which their hospital is located.

- Memorial Health: Becky Gabany, System Director, Community Health
- Decatur Memorial Hospital: Sonja Chargois, Coordinator, Community Health & EDI (beginning 8/2021)
- Jacksonville Memorial Hospital: Lori Hartz, Director, Community Health
- Lincoln Memorial Hospital: Angie Stoltzenburg, Director, Community Health
- Springfield Memorial Hospital: Lingling Liu, Coordinator, Community Health & EDI
- Taylorville Memorial Hospital: Darin Buttz, Director, Community Health

CRITERIA FOR DETERMINING NEED

The following criteria were used by MH affiliates during the 2015 and 2018 CHNA processes for determining significant need, and were used for the first time for DMH during the 2021 CHNA.



SECTION III—SIGNIFICANT HEALTH NEEDS

SELECTED PRIORITIES

Springfield Memorial Hospital

1. Mental/Behavioral Health
2. Economic Disparities
3. Access to Health

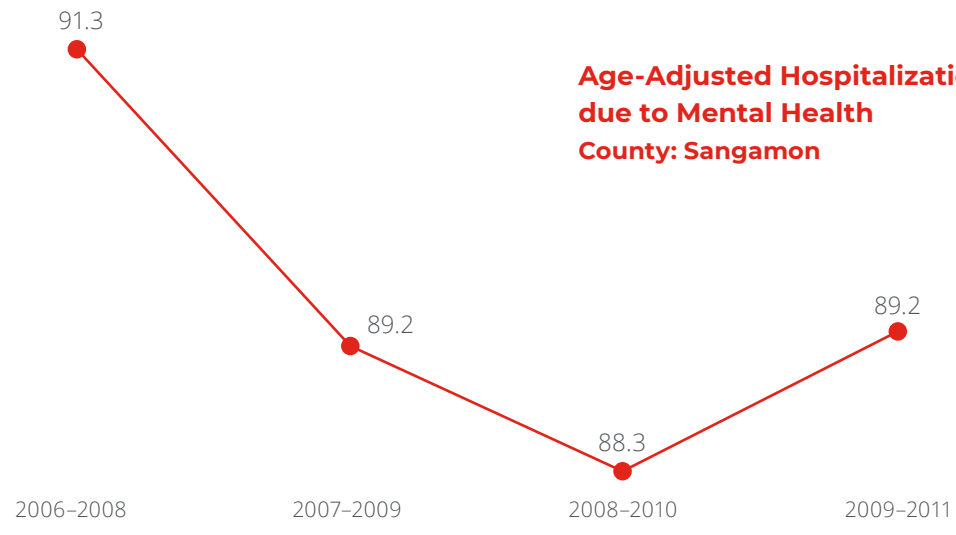
Memorial Health Priority: Mental Health

The below sections will provide deeper insight into the chosen priorities, as well as those that were not chosen as final priorities. While many were not chosen as final priorities, MH is committed to meeting the needs of our communities and will continue to collaborate with community partners to help address the needs identified in this assessment.

Mental/Behavioral Health

Following disparities in economy and education, access to mental health services was the next highest-ranked health indicator by focus group participants. Many community members also considered homeless issues and access to behavioral health services (including substance use) as closely related to this indicator, which, if combined, would result in an even higher score. (It was also noted, in relation to mental health and its connection to homelessness, that there is a need for safe and affordable housing advocacy and education in the community.) The COVID-19 pandemic has had a significant impact on mental health, which was already identified as a top concern pre-pandemic.

Compared to Illinois counties, Sangamon County has 89.3 hospitalizations due to mental health per 10,000 in populations 18 years and older. This ranks in the worst 25% of Illinois counties.



Source: Illinois Hospital Association (2009–2011)

While there are barriers to accessing mental healthcare for the broad community, such as cost and stigma, those who are marginalized face increased barriers, some of which are included below:

- There is a higher risk for people of color of being affected by the stigma of mental health from employers, the justice system and more.
- There is a lack of culturally competent care, diverse providers and services rendered in the primary language of many community members.
- Providers and the healthcare system are met with skepticism and deemed as untrustworthy.
- Mental health contributes to many of the social determinants of health, but is difficult to prioritize over other needs, such as food and shelter.

An additional common theme from community focus group/interview feedback is that people are unclear when to seek mental healthcare. Many people rely on their faith leaders to guide them through mental health issues and there was a strong sense of need to equip faith leaders for this role, as well as to help the community understand when mental healthcare is necessary.

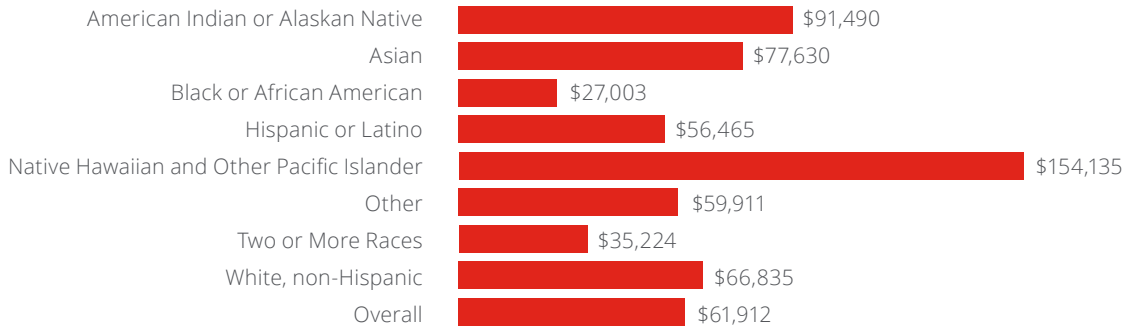
Memorial Behavioral Health, a Memorial Health affiliate, is well-positioned to help address these community needs and was considered when assessing our ability to make an impact for this priority.

Variations of mental health were identified as the highest priorities in the CHNAs for each county where a Memorial Health hospital is located. Community Health leaders across the system have committed to making mental health a priority and using our combined resources to make a regional impact for this priority area. Strategies for our approach will be outlined in our CHIPs.

Economic Disparities

This was the highest ranked priority throughout our community focus groups/interviews. Black or African American households are earning 40% of the income of white households. According to Governing Magazine, Springfield ranks the worst for severe disparities in white and Black household incomes – more so than any other metro area in the entire country.

Median Household Income by Race/Ethnicity
County: Sangamon



Source: American Community Survey (2015–2019)

Disparities in economy were strongly related to disparities in education by community members. As one of the largest private employers in the county, we have potential to make an impact in this area in a way that we cannot in the education sector. We recognize, however, that education, including job training, must be a key component of addressing these disparities. Additionally, significant disparities exist for children, seniors and those who have been disabled. A portion of the feedback from the community focus groups/interviews in Sangamon and Macon counties, regarding this indicator, included the below statements:

- "Disparities in economy are disturbing, but not shocking to us – we're living it every day."
- "Generational poverty, it's not just regular poverty, it's hopelessness embedded in the community, social and monetary wealth. There is no safety net of support if everyone's in that same boat."
- "This same data goes back for decades…"
- "Why does it take data to validate the experience we've been trying to tell you we're living?"

Access to Health

While access to health can be difficult to define, it continues to be centered as a top priority amongst community members. In the 2018 CHNA, access to health was not listed as a health indicator; however, it came up frequently among the CAC and survey respondents' open comments. During the 2021 CHNA process, we approached this as a major contributing factor, but did not include it on our list of indicators. We again saw community members organically indicate the importance of access to health. When community focus group/interview participants were asked to submit their top priorities, force-ranked via chat box or email, we continued to receive responses including access to health as their top choice. Community members independently identified the following as some of the barriers to accessing healthcare:

- Lack of insurance, particularly for families with mixed-immigration status
- Lack of culturally competent, diverse providers and those who speak their primary language
- Transportation
- Housing and safe living conditions, including lack of kitchens, heating and cooling, and landlord accessibility
- Economic instability
- Food insecurity

With existing infrastructure and collaboration between SIU, SJH and SMH around this priority, we hope to continue making an impact in our efforts to increase access to health.

PRIORITIES NOT SELECTED

Organizational capacity prohibits SMH from implementing programs to address all significant health needs. SMH chose to focus efforts and resources on a few key issues in order to develop a meaningful CHIP and demonstrated impact that could be replicated with other priorities in the future.

Access to Behavioral Health Services

Access to behavioral health services will be addressed as part of the comprehensive approach to mental/behavioral health. This includes substance use. While this was seen as a community need, it was widely viewed as a result of mental health issues and disparities in economy and was not highly prioritized in our final list.

Affordable Housing

Affordable housing is a health indicator for which healthcare professionals are not the experts or thought leaders. Recognizing that, and considering the defined criteria for CHNA priorities, we cannot make a meaningful impact in this area at this time. We will, however, consider advocacy and education around this issue as part of our mental health strategy.

Disparities in Education

Disparities in education were a highly ranked priority by community members. This was so closely related to disparities in economy that we deeply considered how both relate to each other and what can be done to address both. Being that we, as healthcare providers, are not in the education space, but are one of the largest private employers, we chose to prioritize disparities in economy instead of education.

Food Access

Food insecurity and access to safe and healthy foods became a top priority early in the pandemic. Many organizations are committed to this mission and are effectively combatting hunger in Sangamon County. While the need is great and we anticipate partnering with the leaders in this work as we consider access to health, we decided to focus our efforts on priorities not being as widely addressed.

Homeless Issues

Homelessness in Sangamon County has been, and continues to be, a serious problem. Homeless issues were ranked low in comparison to other health indicators, due to being considered a part of mental health challenges. We will continue efforts to address homelessness in the community through our mental health strategies and will partner with community organizations working to address this issue.

Other Health Indicators

Additional health indicators are in need of being addressed in our community; however, they were not ranked highly by the CAC and, therefore, have not been prioritized for our CHIP. These indicators include maternal/infant health, obesity, senior health, tobacco use, unemployment, unmanaged chronic conditions, utility and rental assistance and violence. Strategies to address these and other unselected priorities may be present in our final CHIP, as they relate to the final health priorities.

SECTION IV – CHIP DEVELOPMENT

The CHIP was developed with the input of the community, internal Memorial Health stakeholders and additional strategic considerations. Community Health leaders worked to balance these plans to be both broad and specific. It is important to be flexible and allow room for change as community partnerships evolve, while also being explicit and direct regarding MH's commitment to address the priorities of the community. After reviewing current Community Health work and the desires of the community, goals were established for each priority and broad strategies were developed to help meet those goals. Within the strategy templates, detailed information is included regarding which priorities the strategy addresses, resources we will commit, potential impacts, measures we can report on, community partnerships and more.

Community Input

- Several meetings have been held with community partners and organizations working to address the final priority areas. Through these meetings, gaps were identified that could serve as potential projects or initiatives for the hospital to be involved in.
- Meetings were held with the CHNA collaborative partners, SJH and SCDPH, to identify areas for collaboration.
- Many ideas were garnered through the CHNA focus groups. Notes from these events were analyzed for trends and ideas that address these priorities.

Internal Input

- Community Health leaders spend much of their time in the community, working alongside those who have been engaged in work around the final priorities for years. Community Health leaders' insight and expertise was relied on as the CHIP was developed.
- Members of the Internal Advisory Committees were consulted at various points to discuss general budget expectations, internal operations considerations and overall guidance and input.

Strategic Plans and Commitments

- Memorial Health's new strategic plan, Destination 2025, was reviewed and considered to be a guiding document as Memorial Health deepens its commitment to community health.
- Evolving work around equity, diversity and inclusion helped shape and prioritize strategies and potential projects Memorial Health will engage in. Organizations who are conducting their work in an anti-oppressive and inclusive way are prioritized for partnership.
- Current community health work was inventoried, as well as those projects and initiatives MH has committed to in the coming years. This work was incorporated into our CHIPs when it was applicable to addressing the final priorities.

Complexity and Intersectionality

As input was sought on the development of the CHIP, it was apparent that many initiatives and programs address multiple final priorities. It was also clear these priorities intersect in many ways and the interventions needed will often intersect as well. For these reasons, broader strategies were defined and detailed strategy templates were developed to highlight anticipated work, resources, and outcomes. Within those strategy templates are some of the potential projects to collaborate on, as well as which priorities those projects and strategies address. It was also recognized that this CHIP is developed, for this three-year cycle, during a global pandemic in which community needs and ways to address them are changing rapidly. For these reasons, the terms "potential programs" are used within the strategy templates to indicate work already being collaborated on, or intended to, so long as the current needs and plans continue during this CHIP cycle.

SECTION V—GOALS, STRATEGIES & POTENTIAL PROGRAMS

GOALS

Each of the final priority areas have a corresponding goal. The strategies employed are intended to help meet these goals.

Mental/Behavioral Health

- To meet the mental and behavioral health needs of the community, with a focus on the needs of those who are marginalized and/or unable to access mental healthcare.

Economic Disparities

- To invest in economic development, advocate for policy/process changes and provide equitable opportunity for those who have been impacted by the economic disparities present in the community.

Access to Health

- To increase access to health by addressing the social determinants of health.

System Priority: Mental Health

- To improve mental health in Christian, Logan, Macon, Morgan and Sangamon counties.

STRATEGIES

Multiple strategies will be employed to meet the aspirational goals previously outlined. Included in the strategy templates are the following details:

- The potential programs that will be pursued as part of the strategy
- The anticipated impact of the potential programs
- The resources the hospital will dedicate to those potential programs
- The community partners we intend to collaborate with for potential programs
- The social determinants of health that the strategy and potential programs help address
- The final priorities which will be addressed through the strategy and potential programs
- Any related inequities identified
- Whether this strategy will provide support to low-income and disadvantaged communities
- Outcomes we can measure and report on annually and in our next CHNA

The CHIP strategies are listed below and are detailed within the subsequent strategy templates.

1. Broadly support equity-focused, community-based initiatives that support our CHNA priorities.
2. Develop and implement a coordinated approach to improving transportation access for medical needs and discharges.
3. Develop and implement an equity, diversity and inclusion (EDI) structure and strategic plan which addresses disparities and provides meaningful support for patients, colleagues and the community.
4. Invest in pipeline and workforce development programs, with an emphasis on diversifying workplaces.
5. Provide substantial financial and operational support to SIU School of Medicine for the purpose of ensuring their ability to remain in central Illinois as a key part of the healthcare community, as well as to serve as a key EDI collaborator.
6. Support and invest in economic and community development on the east side of Springfield, as led by leaders from within the east side community.
7. Support community health worker (CHW) programs to increase residents' opportunities to access resources that address the social determinants of health.
8. Support planning and "housing-first" efforts to address homelessness in order to stabilize individuals needing care for mental wellness.

Every year, Memorial Health contributes millions of dollars in patient financial assistance and government-sponsored healthcare subsidies. You can find more details about these contributions in the Community Benefit Annual Reports on the Memorial Health website. Memorial will continue to provide these community benefits, in addition to the strategies outlined in this implementation plan.

STRATEGY TEMPLATES WITH POTENTIAL PROGRAMS

System Priority: MENTAL HEALTH

STRATEGY	Take a regional, collective-impact approach to selected interventions related to improving mental wellness in counties where Memorial Health hospitals reside.
POTENTIAL PROGRAMS	• Awareness Campaign • Trauma-Informed Care training • Memorial Behavioral Health Community Committee Participation • Emergency Department hand offs for Substance Use Disorder treatment
ANTICIPATED IMPACT	• Decreased stigma around mental wellness and seeking care. • Increased community residents seeking mental health care. • Community partners approaching their work in a trauma-informed way. • Increased connection to Substance Use Disorder treatment. • Improved collaboration and greater impact between Memorial Behavioral Health and MH hospitals.
HOSPITAL RESOURCES	☑ Colleague Time ☑ Marketing ☑ Financial Support ☑ Printing/Supplies ☑ Meeting Space/Virtual Platform ☑ Consultant/Expert ☑ Other Support
COMMUNITY PARTNERS	Memorial Behavioral Health, others as appropriate
AREA(S) OF IMPACT Social Determinants of Health	☑ Healthy Behaviors ☐ Social/Economic Factors ☑ Clinical Care ☐ Physical Environment
TARGETED PRIORITY(IES)	☑ Mental Health
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	Many people of marginalized identities expressed barriers to seeking and accessing mental healthcare during the CHNA process. These needs will be centered in our interventions.
Does this strategy provide support to low-income and disadvantaged communities	☑ Yes ☐ No
OUTCOME MEASURE	• Awareness campaign developed and implemented. • Number of organizations reached through campaign. • Usage data from 988 hotline. • Trauma-Informed Care training options evaluated, plan developed and executed. • Number of participants. • Tracked metrics from participants. • Number of meetings Community Health leaders attend on MBH Community Committee. • Reduced readmissions to EDs for SUD. • Impacts reported from work on MBH Community Committee.

Community Initiatives

STRATEGY	Broadly support equity-focused, community-based initiatives that support our CHNA priorities.
POTENTIAL PROGRAMS	• Kidzeum funding • SIAN Food Distribution • SING Reentry Program • Boys and Girls Clubs of Central Illinois funding • Community Gardens • Kumler United Methodist Church Pharmaceuticals Program • YMCA Funding and Scholarship Program • Recovery Oriented Systems of Care (ROSC) Council
ANTICIPATED IMPACT	• Resources provided for what the community needs, as requested by those already doing the work. • Partnership and collaboration increased between organizations and residents. • Valued assets maintained that promote community building. • Innovation around supporting the Social Determinants of Health and increasing equity. • Increased access to prescription medication. • Increased access to exercise facilities for those who have a cost barrier.
HOSPITAL RESOURCES	☑ Colleague Time ☑ Marketing ☑ Financial Support ☑ Printing/Supplies ☑ Meeting Space/Virtual Platform ☑ Consultant/Expert ☑ Other Support
COMMUNITY PARTNERS	Kidzeum, Springfield Immigrant Advocacy Network (SIAN), Shifting Into New Gear (SING) Reentry Program, Boys and Girls Clubs of Central Illinois (BGCCIL), Community Gardens, Kumler United Methodist Church, YMCA and more
AREA(S) OF IMPACT Social Determinants of Health	☑ Healthy Behaviors ☑ Social/Economic Factors ☑ Clinical Care ☑ Physical Environment
TARGETED PRIORITY(IES)	☑ Mental/Behavioral Health ☑ Access to Health ☑ Economic Desparities
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	Numerous disparities and inequities were identified during the CHNA process in every indicator. This strategy centers anti-racist partnerships and collaborations to address the most pressing issues in mostly under-resourced geographic locations.
Does this strategy provide support to low-income and disadvantaged communities	☑ Yes ☐ No
OUTCOME MEASURE	• Number of persons served. • Kidzeum operations maintained. • Expansion of BGCCIL. • Frequency and number of families fed through programs. • Client recidivism rates. • Community Garden(s) established and producing food. • Number of new partnerships and interventions implemented. • Number of prescriptions provided. • Number of scholarships provided by the YMCA.

Transportation

STRATEGY	Develop and implement a coordinated approach to improving transportation access for medical needs and discharges.
POTENTIAL PROGRAMS	• Legal and Patient Experience work group for comprehensive approach.
ANTICIPATED IMPACT	• Improved patient experience. • Decrease in inappropriate billing to indigent patients for transportation services. • Improved ability to access medical care and be discharged, when appropriate. • Improved health outcomes over time. • Increased availability of beds in the hospital setting.
HOSPITAL RESOURCES	☑ Colleague Time ☐ Marketing ☑ Financial Support ☑ Printing/Supplies ☑ Meeting Space/Virtual Platform ☑ Consultant/Expert ☑ Other Support
COMMUNITY PARTNERS	Internal MH work group, vendors to be determined.
AREA(S) OF IMPACT Social Determinants of Health	☐ Healthy Behaviors ☐ Social/Economic Factors ☑ Clinical Care ☑ Physical Environment
TARGETED PRIORITY(IES)	☑ Mental/Behavioral Health ☑ Access to Health ☑ Economic Desparities
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	Persons affected by poverty have decreased access to transportation.
Does this strategy provide support to low-income and disadvantaged communities	☑ Yes ☐ No
OUTCOME MEASURE	• Internal MH work group formed. • Scope of project and intervention needs determined. • Comprehensive plan developed and executed. • Vendors selected, as appropriate. • Persons served. • Cost of programming and/or vendors.

Internal Equity, Diversity and Inclusion

STRATEGY	Develop and implement an Equity, Diversity and Inclusion structure and strategic plan which addresses disparities and provides meaningful support for patients, colleagues and the community.
POTENTIAL PROGRAMS	• EDI Strategic Planning • Blue Cross Blue Shield Equity Pilot Program • EDI Community Collaborative
ANTICIPATED IMPACT	• Increased diversity and inclusion among MH workforce. • Improved patient outcomes. • Stronger relationships between MH and the communities we serve. • Culturally appropriate services, resources and interventions provided to the community.
HOSPITAL RESOURCES	☑ Colleague Time ☑ Meeting Space/Virtual Platform ☑ Marketing ☑ Consultant/Expert ☑ Financial Support ☑ Other Support ☑ Printing/Supplies
COMMUNITY PARTNERS	Korn Ferry, SIU School of Medicine, Blue Cross Blue Shield, MH Coalition Development Team (CDT), various community organizations who participated in the CHNA process and are serving marginalized members of the community.
AREA(S) OF IMPACT Social Determinants of Health	☐ Healthy Behaviors ☑ Clinical Care ☑ Social/Economic Factors ☐ Physical Environment
TARGETED PRIORITY(IES)	☑ Mental/Behavioral Health ☑ Economic Desparities ☑ Access to Health
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	People who identify or are typically identified with non-dominant dimensions of diversity experience emotional trauma, reduced employment and worse health outcomes than those who are typically identified by the dominant dimensions of diversity.
Does this strategy provide support to low-income and disadvantaged communities	☑ Yes ☐ No
OUTCOME MEASURE	• Comprehensive gap analysis completed. • Strategic plan developed with recommended strategies in implementation. • Metrics tracked related to diverse identities. • Continued commitment of resources to EDI work. • Annual report provided on progress and barriers. • Patient experience and colleague survey scores (stratified).

Pipeline Programs

STRATEGY	Invest in pipeline and workforce development programs, with an emphasis on diversifying workplaces.
POTENTIAL PROGRAMS	• Sangamon CEO • SIU P4 Pipeline • Healthcare Careers Training Program through CAP1908 • Project SEARCH
ANTICIPATED IMPACT	• Increased diversity among medical students at SIU. • Increased diversity among medical professionals. • Improved economic opportunities for those who are marginalized. • Reduction in gap between Black and white median household incomes over time.
HOSPITAL RESOURCES	☑ Colleague Time ☑ Marketing ☑ Financial Support ☑ Printing/Supplies ☑ Meeting Space/Virtual Platform ☑ Consultant/Expert ☑ Other Support
COMMUNITY PARTNERS	Black Chamber of Commerce, The Springfield Project, SIU School of Medicine, Sangamon County Growth Alliance, District 186
AREA(S) OF IMPACT Social Determinants of Health	☐ Healthy Behaviors ☑ Social/Economic Factors ☐ Clinical Care ☐ Physical Environment
TARGETED PRIORITY(IES)	☐ Mental/Behavioral Health ☐ Access to Health ☑ Economic Desparities
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	Springfield, located in Sangamon County, has the worst disparity between Black and white median household incomes in the country. Additionally, county economic disparities exist for those who are disabled, elderly and are single-parent households.
Does this strategy provide support to low-income and disadvantaged communities	☑ Yes ☐ No
OUTCOME MEASURE	• SIU Physician Pipeline Program (P4) expanded. • Number of students of diverse identities participating in Sangamon CEO. • Consistent collaborative meetings established with key stakeholders. • Development and implementation of programming for healthcare careers within the east side of Springfield. • Agreed upon metrics with Project SEARCH.

SIU Support

STRATEGY	Provide substantial financial and operational support to SIU School of Medicine for the purpose of ensuring their ability to remain in central Illinois as a key part of the healthcare community, as well as to serve as a key EDI collaborator.
POTENTIAL PROGRAMS	• SIU Block Grant Funding • SIU MLC Space • SIU Electronic Health Record • Blue Cross Blue Shield Equity Pilot Program Partnership • Alzheimer's Grant Funding
ANTICIPATED IMPACT	• Maintained SIU Center for Family Medicine FQHC. • Improved equity in healthcare outcomes. • Increased access to care for the communities we serve. • Ability and opportunities to train local residents as physicians. • Retain healthcare personnel needed in our region.
HOSPITAL RESOURCES	☑ Colleague Time ☑ Marketing ☑ Financial Support ☑ Printing/Supplies ☑ Meeting Space/Virtual Platform ☑ Consultant/Expert ☑ Other Support
COMMUNITY PARTNERS	SIU School of Medicine, Blue Cross Blue Shield
AREA(S) OF IMPACT Social Determinants of Health	☑ Healthy Behaviors ☑ Social/Economic Factors ☑ Clinical Care ☑ Physical Environment
TARGETED PRIORITY(IES)	☑ Mental/Behavioral Health ☑ Access to Health ☑ Economic Desparities
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	SIU is closely aligned with our intentions to promote equity, diversity and inclusion and serve as a key partner in advancing this work.
Does this strategy provide support to low-income and disadvantaged communities	☑ Yes ☐ No
OUTCOME MEASURE	• Total cost of 4th floor MLC space provided. • Persons served by additional MLC space for events. • Total financial contribution for general support. • Total financial contribution for EHR. • Key metrics tracked for P4 and Access to Health programs. • Annual reports from participation in BCBS Equity Pilot Program. • Number of physicians completing residency in Springfield. • Number of Medicaid, under/uninsured patients served.

Eastside Development

STRATEGY	Support and invest in economic and community development on the east side of Springfield, as led by leaders from within the East Side community.
POTENTIAL PROGRAMS	• CAP1908 redevelopment project • Next10 Economic Development Inititatives
ANTICIPATED IMPACT	• Increased financial supports through banking system. • Increase in partners investing on the east side. • Stronger relationships between MH and the communities we serve. • Revitalized neighborhood community centers. • Decreased disparities in median household incomes over time.
HOSPITAL RESOURCES	☑ Colleague Time ☐ Marketing ☑ Financial Support ☐ Printing/Supplies ☑ Meeting Space/Virtual Platform ☑ Consultant/Expert ☑ Other Support
COMMUNITY PARTNERS	Black Chamber of Commerce, The Springfield Project, Community Banks, The Community Foundation for the Land of Lincoln, Sangamon County Growth Alliance, elected officials
AREA(S) OF IMPACT Social Determinants of Health	☑ Healthy Behaviors ☑ Social/Economic Factors ☐ Clinical Care ☑ Physical Environment
TARGETED PRIORITY(IES)	☑ Mental/Behavioral Health ☑ Access to Health ☑ Economic Desparities
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	Sangamon County's Black residents are predominantly concentrated within the east side of Springfield and experience worse health outcomes, under-investment, reduced economic and community-building resources and negative economic disparities.
Does this strategy provide support to low-income and disadvantaged communities	☑ Yes ☐ No
OUTCOME MEASURE	• Amount of funds matched from MH financial support to the CAP1908 redevelopment project. • CAP1908 renovations completed and programming started. • Persons served. • Persons participating in health-specific programming. • Impact measures from loans provided to minoritized individuals through banking programs.

Community Health Worker Support

STRATEGY	Support Community Health Worker (CHW) programs to increase residents' opportunities to access resources that address the Social Determinants of Health.
POTENTIAL PROGRAMS	• CoEngagement Team (CoET) • MOSAIC • SIU's Access to Health
ANTICIPATED IMPACT	• Appropriate response to mental health calls involving law enforcement. • Increased connection to mental wellness services. • Improved health and decreased costs of care. • Accessible mental wellness services for youth. • Collaborative relationships between residents, law enforcement and schools.
HOSPITAL RESOURCES	☑ Colleague Time ☑ Marketing ☑ Financial Support ☑ Printing/Supplies ☑ Meeting Space/Virtual Platform ☑ Consultant/Expert ☑ Other Support
COMMUNITY PARTNERS	SIU School of Medicine, Memorial Behavioral Health, District 186, HSHS St. John's, Springfield Police Department
AREA(S) OF IMPACT Social Determinants of Health	☑ Healthy Behaviors ☑ Social/Economic Factors ☑ Clinical Care ☑ Physical Environment
TARGETED PRIORITY(IES)	☑ Mental/Behavioral Health ☑ Access to Health ☐ Economic Desparities
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	People of color and people living in poverty disproportionately experience difficulty accessing healthcare, including care for mental wellness. This strategy includes hiring from within the communities being served, a low-barrier approach and journeying alongside our neighbors to increase access.
Does this strategy provide support to low-income and disadvantaged communities	☑ Yes ☐ No
OUTCOME MEASURE	• Number of persons served. • Improvements in tracked metrics. • Number of individuals with a medical home/Primary Care Provider (PCP). • Number of engagements between programs and law enforcement and outcomes of those engagements.

Homelessness

STRATEGY	Support planning and housing-first efforts to address homelessness, in order to stabilize individuals needing care for mental wellness.
POTENTIAL PROGRAMS	• Homelessness Strategic Planning • Helping Hands Funding
ANTICIPATED IMPACT	• Homelessness will be rare, brief and nonrecurring. • Sangamon County will have a long-term strategic plan around homelessness with durable community consensus. • Individuals who have experienced homelessness will be stabilized and have increased opportunity to engage with mental wellness services.
HOSPITAL RESOURCES	☑ Colleague Time ☐ Marketing ☑ Financial Support ☐ Printing/Supplies ☑ Meeting Space/Virtual Platform ☑ Consultant/Expert ☑ Other Support
COMMUNITY PARTNERS	Heartland Continuum of Care, Memorial Behavioral Health, The Community Foundation for Land of Lincoln, Lathan Harris, Inc., Helping Hands, United Way, elected officials and more
AREA(S) OF IMPACT Social Determinants of Health	☑ Healthy Behaviors ☑ Social/Economic Factors ☑ Clinical Care ☑ Physical Environment
TARGETED PRIORITY(IES)	☑ Mental/Behavioral Health ☑ Access to Health ☐ Economic Desparities
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	People of color, veterans and those experiencing mental illness disproportionately experience homelessness. An equitable, community-consensus approach is being employed within this strategy, with deliberate efforts to include those with lived experience.
Does this strategy provide support to low-income and disadvantaged communities	☑ Yes ☐ No
OUTCOME MEASURE	• Strategic plan completed with Homebase & Lathan Harris, Inc. • Recommendations implemented from strategic plan. • Workspace secured for Helping Hands. • Financial contribution made to support Rapid Rehousing program through Helping Hands. • Recruitment, Retention, Development and Direction (R2D2) director role maintained through Helping Hands.

THE FY22-24 CHIP Report and Final Priorities were adopted by the Community Benefit Committee of the Memorial Health Board of Directors on Oct. 29, 2021.

The CHNA and CHIP are made widely available on the MH website, as well as through press releases, social media and presentations. Updates regarding this CHIP will be published in the MH Annual Report and posted on the website. If you are interested in copies of this report or have additional questions, please direct inquiries to communityhealth@mhsil.com.

Springfield Memorial Hospital

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