2015–2018

Sangamon County Community Health Needs Assessment

Memorial MEDICAL CENTER

A Memorial Health System Affiliate

Memorial MEDICAL CENTER

Sangamon County, Illinois
2015 COMMUNITY HEALTH NEED ASSESSMENT

Contents

This report was completed in September 2015 and posted online at http://www.choosememorial.org/MHS-Community-Need-Assessment.

Executive Summary

In 2015, Memorial Medical Center completed a community health need assessment (CHNA) for Sangamon County, Ill., as required of nonprofit hospitals by the Affordable Care Act of 2010. The hospital completed a previous need assessment in 2012.

As an affiliate of Memorial Health System, Memorial Medical Center worked with other affiliate hospitals on the overall timeline and process steps for the CHNA, but completed the assessment independently in collaboration with its local community partners. In order to help narrow down the multiple needs and issues facing the community to a set of final priorities the hospital would address, Memorial Health System (MHS) hospitals agreed to use the same defining criteria throughout the CHNA process. These defining criteria are:

1. Institute of Medicine Triple Aim Impact:
    - Improve the Care of Individuals
    - Improve the Health of Populations
    - Reduce Waste, Variation and Cost
2. Magnitude of the Issue – How wide an issue is this in the community?
3. Seriousness of the Issue – How related is the issue to the mortality of those affected?
4. Feasibility – Considering available resources to address the issue, how likely are we to make a significant impact on the issue?

In Sangamon County, Memorial Medical Center collaborated on the entire CHNA process with HSHS St. John's Hospital and Sangamon County Department of Public Health, which used the assessment as its IPLAN (Illinois Project for Local Assessment of Needs). Southern Illinois University School of Medicine assisted in the process. The CHNA included reviewing secondary data from numerous resources, including more than 150 health and socioeconomic indicators for Sangamon County through Healthy Communities Institute data on the Memorial's website. County Health Rankings and the 2013 Sangamon County Citizens Survey and other sources were also used. The University of Illinois at Springfield's Survey Research Department helped conduct five community forums and a community survey. An additional four focus groups were held within a specific neighborhood that faces socioeconomic and health challenges.

In addition, Memorial Health System convened an Internal Advisory Team to review common priorities identified in all four counties where MHS hospitals completed community health need assessments. Two goals from a system-wide perspective are included in the FY2016 implementation strategy.

At the conclusion of the CHNA, both Memorial and HSHS St. John's Hospital selected Access to Care as a joint priority and are working together to address access issues within a specific neighborhood that has documented health needs and socioeconomic risk factors.

Memorial Medical Centers final CHNA priorities to address in FY2016-FY2018 are:

1. Access to Care
2. Mental Health
3. Obesity

The Memorial Medical Center board approved the FY2016 implementation strategy on Sept. 9. 2015.

Introduction to Memorial Health System

One of the leading health care organizations in Illinois, Memorial Health System of Springfield is a community-based, not-for-profit corporation dedicated to patient care, education and research.

Our more than 6,700 staff members, partnering physicians and hundreds of volunteers are dedicated to improving the health of the communities we have served since 1897. In a year, we serve an average of more than 40,000 inpatients, more than 667,000 outpatients and more than 125,000 patients in our four Emergency Departments. 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 System includes four hospitals: Memorial Medical Center in Sangamon County, Abraham Lincoln Memorial Hospital in Logan County; Taylorville Memorial Hospital in Christian County and Passavant Area Hospital in Morgan County. Memorial Health System also includes Mental Health Centers of Central Illinois, Memorial Physician Services and Memorial Home Services.

Community health need assessments (CHNAs) were completed in 2015 in each of the counties where the hospitals are located. These need assessments meet the federal health reform's Section 9007 of the Patient Protection and Affordable Care Act of March 2010 and requirements of the IRS 990 Schedule H report. Memorial Health System hospitals also completed need assessments in 2012.

Our Mission **To improve the health of the people and communities we serve.**

Our Vision **To be a national leader for excellence in patient care.**

Our Values

Service to Humanity To care for life's precious gift of health is a calling of the highest order. We recognize the vulnerability that accompanies fear and hope. We accept the responsibility, entrusted to us every day, to serve humanity.

Excellence in Performance By bringing together talented, dedicated people and advanced technology, we strive to provide quality health care. We take pride in ourselves, our colleagues and our workplace. We demonstrate that pride in the quality of service we deliver each day.

Respect for the Individual We treat all people with dignity, respect and compassion. We believe that every person is unique and has the right to participate in decisions that affect them.

Value of Employees More than buildings and equipment, people are Memorial Health System. Our success depends on an atmosphere of fairness and mutual respect. We are committed to provide equal opportunity for employment, growth and advancement. Furthermore, all employees are provided the opportunity to make a meaningful contribution to the fulfillment of our mission and are recognized for their accomplishments.

Integrity in Relationships We are committed to fairness and honesty in all of our relationships. We recognize that our ability to sustain relationships based on mutual trust is the foundation of our success.

Community Responsibility We hold our assets in public trust and recognize that continued financial viability is essential to fulfill our mission within the context of this statement of values. We believe that our community service obligation can best be met as a not-for-profit organization. Furthermore, we accept the responsibility to support research, education and public service programs that enrich the quality of life in our community.

Equal Access We believe all people deserve equal access to care and services. In our pursuit of this belief, we are constrained by our financial resources. We must balance our commitment to provide equal access to care and services with our obligation to ensure the continuing availability of quality health care for the future.

Introduction to Memorial Medical Center

Memorial Medical Center is an acute care, nonprofit hospital in the state capitol of Springfield, Ill., that offers comprehensive inpatient and outpatient services. Since 1970, Memorial has been a teaching hospital affiliated with Southern Illinois University School of Medicine for the purpose of providing clinical training for residents.

Memorial is a Magnet ® Hospital recognized 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 VHA. In 2014, Memorial Health System and Southern Illinois University Health care launched a new partnership to develop innovative solutions for improving health care access, quality, safety and community outcomes across the region through the Midwest Healthcare Quality Alliance, a nonprofit limited-liability corporation.

Memorial Medical Center (MMC) has 500 licensed beds. Our hospital's featured services include the Southern Illinois Level 1 Trauma Center, Memorial Heart and Vascular Services, Memorial Rehab Services, Family Maternity, Regional Cancer Center, Regional Burn Center, Orthopedic Services, Memorial Center for Weight Loss and Wellness, Memorial Behavioral Services and Memorial Transplant Services. MMC is a Joint Commission-designated Primary 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. The Memorial Center for Learning and Innovation is a new 72,000 square foot building dedicated to expanding the capacities of our community's health care workforce, including physicians, nurses, allied health professions and community first responders. It contains state-of-the-art simulation centers and surgical skills lab. Conference rooms also offer space for community health education events.

MMC maintains a 24-hour emergency department that is a Level 1 Trauma Center. The emergency department has traditionally served as a safety net health care provider for the uninsured and underinsured who do not have primary care physicians. It provides services to all people regardless of ability to pay. To help meet community need and alleviate use of the emergency department for non-emergent care, Memorial Health System operates three ExpressCare walk-in facilities. These prompt-care sites use the same criteria as the emergency department: the uninsured and those on public insurance programs receive the same level of care and treatment as any other patients. Charity care is provided as needed.

As a nonprofit community hospital, Memorial Medical Center provides millions of dollars in community support each year, both for its patients and in support for community partnerships. For the past three years, MMC's community benefits have totaled $172.6 million. (FY15 totals were not available at the time this report was completed.)

MEMORIAL MEDICAL CENTER	FY2012	FY2013	FY2014	Total
Charity Care	$14.9 million	$15.4 million	$10.8 million	$41.1 million
Unpaid Medicaid	$16.0 million	$18.5 million	$24.8 million	$59.3 million
Other Community Programs	$19.9 million	$23.9 million	$28.4 million	$72.2 million
TOTAL COMMUNITY BENEFIT	**$50.8 million**	**$57.8 million**	**$64.0 million**	**$172.6 million**

In FY2014, Memorial Medical Center provided the following care:

Patient Discharges: 23,588
Births: 1,635
Surgical Procedures: 20,112
Outpatient Visits: 410,881

Recent Awards and Recognitions

- Healthgrades 2015 Quality Ratings – MHS earned several top ratings from Healthgrades, a for-profit external rating agency. In the 2015 Healthgrades Quality Ratings, Memorial Medical Center's top ratings included:
  - 1 of 100 Best Hospitals in America for General Surgery
  - Top 10% of U.S. Hospitals for Over-All Orthopedic Services
  - Top 10% of U.S. Hospitals for Spine Surgery
  - Top 10% of U.S. Hospitals for Gastrointestinal Surgery
- Women's Choice Award as one of the 2015 America's Best Hospitals for Cancer Care.
- Midwest Healthcare Quality Alliance achieved American Board of Medical Specialties Multi-Specialty Maintenance of Certification Portfolio Approval in 2014 to provide Continuing Medical Education credits for participating ABMS Member Boards
  - The Quality Alliance Patient Safety Organization (QAPSO), a component limited liability company of the Midwest Health care Quality Alliance, was federally certified by the Agency for Healthcare Quality and Research, which works to improve patient safety and reduce the incidence of adverse patient safety events. Currently, there are only 84 AHRQ-certified PSOs in the U.S. and only 10 in Illinois. QAPSO is the first outside of Chicago.
- For the tenth consecutive year, the National Research Corporation (NRC) awarded Memorial Medical Center the 2014 Consumer Choice Award for the Springfield market. The award is based on the hospital that possesses the (1) best overall quality, (2) best overall image/reputation, (3) best doctors and (4) best nurses. MMC was among just six hospitals in Illinois to earn this NRC designation.
- State Journal Register 2015 Readers Choice Awards recognized Memorial Medical Center for Best Hospital, Best Emergency Department, Best Surgical Weight Loss Program, Favorite Birthing Center, Favorite Community Event (Festival of Trees), Favorite Day Care (Memorial Child Care), and Favorite Trauma Center (MMC's Southern Illinois Trauma Center)
- Memorial Health System received the 2015 National Employer of Choice recognition by Employer of Choice International.
- Memorial Health System was recognized as a 2015 Learning Elite organization by Chief Learning Officer for 2015, among 70 organizations internationally, and one of seven in health care recognized as the best companies for learning and development.

Introduction to Sangamon County, Illinois

MMC serves a wide region of central and southern Illinois, which is largely rural and agricultural. Patients come from more than 40 other counties and also from out of state. However, the majority of MMC's community outreach efforts are focused on Sangamon County, where the Memorial Medical Center is located.

Sangamon County (population 198,997) comprises 877 square miles in central Illinois. It is primarily a rural area that includes the city of Springfield (population 117,000), which is both the county seat and the state capitol. The county has eight federally designated medically underserved areas (MUAs).

Health care, state and local government are the major employers in the county. Small business, several industries and agriculture are also significant contributors to the local economy. Corn and soybeans are the major agricultural products. Springfield is known for its numerous historic sites related to Abraham Lincoln, who lived in Springfield at the time he was elected to the United States presidency in 1861.

Southern Illinois University School of Medicine is located in Springfield. MMC serves is a major teaching hospital for SIU School of Medicine, which has about 300 medical students studying in Springfield during their second through fourth years of medical school, and more than 300 residents and fellows participating in 23 different specialty programs. Springfield is also home to three universities: University of Illinois at Springfield, Benedictine University and Robert Morris University, as well as Lincoln Land Community College, a junior college.

The population of Sangamon County is 83.4% white, 12.2% black and 4.4% other. The median household income is $55,449. Persons age 65 and older make up 15% of Sangamon County's population, which is higher than the state average of 13.5%. A total of 14.2% of all county residents live below the federal poverty level, including 21.8% of all children and 6.3% of seniors. County-wide, 92% of residents living in Sangamon County are high school graduates, including those who moved into the county for employment in the health care and government sectors. But within the city of Springfield, the four-year graduation rate is about 70% (compared to the state average of 86%).

Primary/Chronic Diseases and Health Issues of Uninsured, Low-Income and Minority Groups

According to reports from SIU Center for Family Medicine federally qualified health center and Central Counties Health Centers federally qualified health center, hypertension, asthma and diabetes are primary and chronic diseases affecting their patients. Mental health is an issue community-wide that is particularly prevalent in this population. Access to dental care continues to be an issue for this population as well.

Health Care Providers in Sangamon County

Sangamon County is a regional hub for health care services for people who live throughout central and southern Illinois. Thousands of patients come to Springfield for specialty care and surgery that is not

available in their rural communities. In addition to Memorial Medical Center, other Sangamon County health care resources include:

- HSHS St. John's Hospital, a 430-bed nonprofit hospital affiliated with Hospital Sisters Health System
- Sangamon County Department of Public Health (tenth largest public health department in Illinois)
- Southern Illinois University School of Medicine's Center for Family Medicine (a Federally Qualified Health Center [FQHC])
- Central Counties Health Centers (FQHC)
- Springfield Clinic (more than 400 physicians and advanced practitioners, practicing in 80 medical specialties and sub-specialties)
- SIU Healthcare (nearly 240 teaching physicians with SIU School of Medicine and more than 300 other providers including nurses, licensed clinical social workers, mid-wives, dietitians and audiologists)
- Memorial Physician Services (an affiliate of Memorial Health System with a primary care network more than 50 physicians and 30 advanced practice nurses and physician assistants)
- Memorial Home Services (an affiliate of Memorial Health System providing home health and hospice services in a 14-county region)
- Mental Health Centers of Central Illinois (an affiliate of Memorial Health System, this behavioral health services program serves more than 9,000 individuals annually; services include crisis intervention, psychiatric and medical services, screening and assessment, outpatient therapy, case management, group education and support, employment services, residential care, psychiatric response teams for three area hospital emergency departments, and is a member of the National Suicide Prevention Lifeline network)
- HSHS Medical Group, (a multi-specialty physician group affiliate of Hospital Sisters Health System)
- Prairie Cardiovascular (more than 45 physicians at 35 clinic sites of care)
- Vibra Hospital (a 50-bed, long-term, acute-care facility)
- Orthopedic Center of Central Illinois (a group of orthopedic surgeons and physiatrists located in Springfield)
- Lincoln Prairie Behavioral Health Center (provides provides psychiatric treatment to children and adolescents that present with a broad range of psychiatric and behavioral disorders)

Memorial Health System Leadership of Community Benefit and Community Health Need Assessment

Memorial Health System has an appointed board committee that oversees the health system's community benefits as well as the community health need assessment. This committee, made up of board members, community representatives and senior leadership, approves and oversees all aspects of Memorial's community benefit programs and community health need assessments.

Community benefit and outcomes of the hospital community health need assessments are included in the Memorial Health System Strategic Plan, which contains five goals:

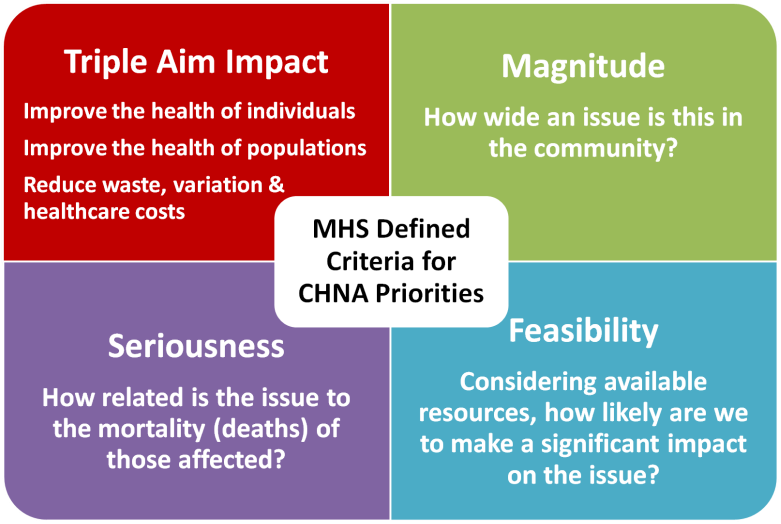
1. Great Patient Outcomes
2. Great Place to Work
3. Great Partner for Physicians
4. Great Regional Presence
5. Great Financial Stewardship
    - Under the final goal of Great Financial Stewardship, all MHS affiliates are responsible to "Achieve 100% of approved Community Benefit targets."

The MHS Board's Community Benefit Committee oversight includes:

- MHS charity care policies
- Tri-annual community health need assessment processes for the four MHS hospitals
- Annual review and approval of CHNA strategies/community benefit plans for the four MHS hospitals
- Annual review of measures of success in meeting the goals of the CHNA strategies.

During the 2015 CHNA process, the four MHS hospitals followed the timeline below, and the MHS Community Benefit Committee was apprised of progress throughout the process. Following completion of its 2015 CHNA, MMC submitted its implementation strategy to the board of Memorial Medical Center, which approved it on Sept. 9, 2015.

Because hospitals cannot address every identified community health need, Memorial Health System hospitals also discussed criteria to use when narrowing down the priorities during the CHNA process. They determined to use four criteria for selection of priorities: whether the priority would demonstrate an impact on the Institute of Medicine's Triple Aim; the magnitude of the issues; the seriousness of the issue; and the feasibility of addressing the issue.



Outcomes of 2012 Community Health Need Assessment

During the 2012 CHNA process, Memorial Medical Center collaborated closely with two other Memorial Health System hospitals. Abraham Lincoln Memorial Hospital is a rural critical access hospital located in Logan County, adjacent to Sangamon County. Taylorville Memorial Hospital, also a rural critical access hospital, is in adjacent Christian County. (Passavant Area Hospital did not become a Memorial Health System affiliate until 2014 and was not a part of this 2012 CHNA.)

All three hospitals selected the following four priorities:

1. Access to Care
2. Cardiovascular Disease
3. Diabetes
4. Obesity.

Memorial Medical Center addressed these priorities in a variety of ways throughout FY13-FY15. Following is a summary of the outcomes.

2012 Community Health Need Assessment Implementation Plan
Outcomes from FY2013-2015
MHS STRATEGIC PLAN: GREAT FINANCIAL STEWARDSHIP
Achieve 100% of approved Community Benefit targets.

PRIORITY: ACCESS TO CARE

Goals	Measures/Results FY2013-2015
MHS affiliates will provide care to people regardless of ability to pay in accordance with Memorial's charity care policy(s).	• Provide medically necessary care to all patients, regardless of ability to pay; provide charity care as needed and in accordance with the System's policy(s). For FY13-FY14, MHS affiliates provided $34 million in free care and $42 million in unpaid costs of Medicaid. (FY15 totals were not yet available when this document was completed.) • Memorial provided provide patient care support for two Federally Qualified Health Centers: Central Counties Health Center and Southern Illinois University School of Medicine's Center for Family Medicine.
MMC will provide needed hospital care at sliding-scale rates consistent with our charity care policy to Sangamon County's uninsured adult patients as referred by the CATCH program (Coordinated Access to Community Health).	• MMC, in collaboration with St. John's Hospital, provided financial operating support and patient care for the CATCH program in 2013-2015. Due to the decrease in uninsured residents due to the Affordable Care Act and Illinois Medicaid Expansion, CATCH closed in spring 2015.
Collaborate with SIU School of Medicine to maintain the Family and Community Medicine Residency Program at the current site and position the program for future Federally Qualified Health Center growth.	• Finalized construction plans and gained Board approval to fund the expansion of SIU Family and Community Medicine Federally Qualified Health Clinic.
MHS affiliates will increase access to pharmaceutical prescriptions for indigent persons.	• MMC provided $72,000 to support Kumler Outreach Ministries' pharmaceutical access program for low-income and uninsured members of the community from FY13-FY15. • MMC provided nearly $300,000 in necessary short-term prescription medications for indigent patients being discharged from the medical center.
MMC will support SIU Community and Family Medicine's homeless clinic initiative, which helps prevent use of the emergency department to address primary care issues.	• MMC provided more than $5,000 to assist with supplies for this program and purchasing healthy breakfast food for a homeless program. The MMC Lab provided free lab tests for three homeless clinics conducted in the fall of 2012, 2013 and 2014.
MMC will increase the supply of trained health care professionals.	• MMC serves as a teaching hospital/training site and provides significant financial support for Southern Illinois University School of Medicine. Memorial commits an annual grant for academic support and provides in-kind support by providing office, clinic and classroom space, and staff to support the work necessary to be a teaching hospital. • MMC serves as a clinical site for more than 10 schools of nursing and 40 schools that offer allied health programs. Memorial provides clinical experiences for hundreds of students annually.

PRIORITY: ACCESS TO CARE	
MMC will promote clinical research that will benefit the communities we serve.	• Memorial collaborates to support the local research institutional review board with SIU School of Medicine, providing one-third of the financial support and three representatives for the Springfield Committee on Research Involving Human Subjects. Memorial also serves as annually as a clinical site for more than 450 for approved clinical trials.
PRIORITY: CARDIOVASCULAR DISEASE	
Expand Memorial Medical Center's Heart Smarts Education Group.	• Free Heart Smarts Education Groups are conducted more than six times a year for people diagnosed with or at risk of heart failure. A variety of important education topics are presented at each meeting.
Offer Memorial's Kids Heart Advantage program in conjunction with local schools and organizations.	• Memorial offers more than three programs annually and also collaborates with Sangamon County 4-H Health Jam to offer elements of the Kids Heart Advantage program for elementary students attending schools in low-income neighborhoods. Kids Heart Advantage is a hands-on, activity-based program for elementary-school children. It addresses good nutrition, heart-healthy exercises and the dangers of tobacco use. Teachers receive education packets for follow-up classroom activities and physical exercises.
In partnership with the American Heart Association, provide access to CPR, ACLS and PALS training/certification for targeted groups in the community.	• MMC collaborates with numerous community organizations to train and recertify people in these programs. More than 2,000 non-MMC employees receive training annually.
PRIORITY: DIABETES	
Increase access to diabetes education programs, including access for Medicaid and uninsured populations.	• From 2013-2015, MMC achieved American Association of Diabetes Educators certification for its diabetes education program. Classes are available at a variety of days and times to expand opportunities for people to attend, and are reaching more people. MMC also started a new free Diabetes Support Group that offers education and support on numerous topics. MMC participates in numerous community events and health fairs annually to offer free diabetes screenings and education. • MMC also collaborated with community stakeholders to create a new diabetes education task force. The Prairie Diabetes Alliance is coordinated by the American Diabetes Association and includes two Federally Qualified Health Centers, HSHS St. John's Hospital, Sangamon County Department of Public Health, SIU Health care, Springfield Clinic, Illinois Pharmacists Association, Illinois Department of Public Health, Springfield YMCA, Springfield Urban League, Sangamon County Medical Society and others. The Alliance is collaborating on diabetes education in the community.
GOALS THAT ADDRESS MORE THAN ONE PRIORITY	
MMC will sponsor Girls on the Run program.	• Memorial's support helps underwrite program expenses, CPR education for coaches, printing costs, and scholarships for lower income girls to participate in the program. The program has grown significantly from 2013-2015, reaching more communities and families. About 700 people participate in each of the bi-annual 5k races. As a result of the Girls on the Run program season and 5k race event, 75% or more of GOTR participants and their families re-

GOALS THAT ADDRESS MORE THAN ONE PRIORITY	
MMC will utilize the Be Aware Women's Fair to educate women about cardio-vascular disease, obesity and diabetes.	• Attendance at this annual event averages 1,200+. For the three events held in FY2013, FY2014, and FY2015, a total of 8,673 health screenings were completed, as well as 5,951 educational contacts on a range of health topics. Each event included screenings and education related to cardiovascular dis-ease, diabetes and obesity.
MMC will collaborate with community partners on initiatives that address cardiovascular disease, diabetes or childhood obesity, including programs that serve low-income populations.	• Memorial provided educational support, equipment and supplies for the East-side Health Initiative project, a project initiated by students at SIU School of Medicine to address issues of cardiovascular disease, diabetes and obesity at churches in underserved neighborhoods. MMC also provided clinical train-ing for students in how to conduct screenings and provided educational mate-rial. Although the program had a modest outreach, outcomes were positive for helping people lose weight and lower their blood pressure. • Memorial supported genH Kids new Seeds of Possibility community garden project in 2013 and 2014, helping to provide access to fresh foods and nutri-tion education in a low-income neighborhood. In 2015, Memorial supported genH's new MacArthur Park Apartments Outreach Center and Community Garden, reaching low-income children and families. • Memorial provided significant financial support for the Springfield YMCA to lay the groundwork for a new collaborative community initiative to address obesity.
MMC will support prevention education through the Parent University Newslet-ter in collaboration with community providers and MHS professionals.	• This free quarterly newsletter reaches 2000+ families. Targeted to parents, every issue addresses topics such as family nutrition, healthy activities, chil-dren's physical and mental health or ways to obtain access to care through the Affordable Care Act or services available through the Federally Qualified Health Centers. More than 24,000 copies of the newsletter were distributed in 2012-2015.

2015 Community Health Need Assessment

Collaboration with HSHS St. John's Hospital

In 2012, both Memorial Medical Center and HSHS St. John's Hospital completed separate CHNAs, but participated on each others' community advisory committees. Although the hospitals are key competitors within the same market, senior leadership at Memorial do not regard community benefit as an area of competition.

In 2011, Memorial contracted with Healthy Communities Partnership of Berkeley, Calif., to obtain county -specific health and socio-economic indicators. Before the data was available to the public on our hospi-tal website, MMC provided both St. John's and the Sangamon County Department of Public Health full access to the information. At the conclusion of the 2012 CHNA, both hospitals, despite separate proc-esses, had identified similar priorities. Rather than completing a third need assessment on the heels of the two CHNAs, the Sangamon County Department of Public Health (SCDPH), which had participated on both hospital CHNAs, obtained permission from the Illinois Department of Public Health to use these

CHNA processes as a major component of its IPLAN (Illinois Project for Local Assessment of Need), which had to be completed every five years.

Verbal feedback from the community as well as Memorial's Community Benefit Committee suggested that the hospitals should collaborate on the next CHNA in 2015. Memorial and St. John's met on Oct. 25, 2013 to begin exploration of whether a joint CHNA could be accomplished. Issues they discussed included recent clarification of rules from the Internal Revenue Service regarding joint CHNAs, what each hospital had learned in its previous CHNA process, defining the geographic scope of the community to be included in the CHNA, methodology and timing. The timeline issue was particularly important, because the hospitals operate on different fiscal years (Memorial's fiscal year runs Oct. 1 through Sept. 30 and St. John's runs July 1 through June 30). It was going to be difficult for both hospitals to meet IRS regulations and timeline for completion of the CHNA. During this first meeting, it was also agreed to invite the Sangamon County Department of Public Health as third entity in the CHNA process.

Subsequent meetings produced a timeline that would work for both hospitals, as well as an agreed-upon list of parameters of the CHNA:

Intention to Collaborate: HSHS St. John's Hospital and Memorial Medical Center Community Health Need Assessment to be Completed in 2015

- Memorial Medical Center and St. John's Hospital will collaborate on a community health need assessment to be completed in each hospital's FY2015 (6/30/2015 for SJH and 09/30/2015 for MMC).
- The overall CHNA process will assist both hospitals in meeting the requirement of the Affordable Care Act and Internal Revenue Service.
- The hospitals will invite Sangamon County Department of Public Health to participate in the entire process, which will assist SCDPH in meeting IPLAN requirements.
- Each hospital will establish an internal advisory group to assist throughout the process.
- The geographic area for this joint CHNA will be Sangamon County.
- Each hospital may have additional CHNA responsibilities with hospitals within their respective health systems. These processes will be separate from this CHNA.
- MMC and SJH will identify and agree upon pre-established criteria to use when evaluating the needs and opportunities that arise from the CHNA process.
- MMC and SJH will review the priorities from each hospital's previous CHNA and its implementation plans. Consideration will be given to whether those priorities are still valid.
- MMC, SJH and SCDPH will identify additional community groups to participate in the CHNA.
- Once priority needs are identified, community focus groups will provide input into effective ways to address the need locally. An outside consultant will conduct the focus groups.
- MMC and SJH will select one priority need to address jointly. The implementation plan must include measurable outcomes for community health improvement. Additional community partners will be included in this program.
- MMC and SJH may choose to create separate or joint implementation plans resulting from the CHNA, but both agree to collaborate on at least one initiative.

Early in 2014, Sangamon County Department of Public Health accepted the invitation to collaborate on the CHNA process. The health department received permission from the Illinois Department of Public Health to conduct a pilot project to complete its IPLAN in a three-year cycle to align with the hospitals' CHNA requirements. A representative from Illinois Department of Public Health, Division of Health Policy, which oversees IPLAN, requested to observe the CHNA process, and later participated on the Community Advisory Committee.

In February 2014, Dr. Julie Willems Van Dijk, Deputy Director, County Health Rankings & Roadmaps, University of Wisconsin, came to Springfield at the invitation of SIU School of Medicine's Office of Community Health and Service. Sangamon County ranked 81 out of 102 Illinois counties in the 2013 release of Health Outcomes data, and 22 out of 102 for Health Factors. Dr. Van Dijk met with representatives from both hospitals, the county health department and school of medicine to discuss the results. At that time the hospitals and health department shared their intention to collaborate on the next CHNA process, which Dr. Van Dijk commended. She spoke at a community-wide meeting held the evening of Feb. 10 about the county's low rating on health outcomes. The meeting spiked interest from the community in overall community health and socioeconomic issues.

Establishment of the CHNA Core Team

Following initial planning meetings of Memorial, St. John's and SCDPH, it was determined that SIU School of Medicine's Office of Community Health and Service would be an additional partner to bring into the CHNA process. The School of Medicine did not have a mandate to complete a need assessment but offered resources that would benefit the process.

The Sangamon County Community Health Need Assessment Core Team was established and held ongoing meetings from spring 2014 through September 2015, guiding every step of the CHNA process.

Memorial Medical Center

- Mitchell Johnson, MBA, FACHE, Senior Vice President and Chief Strategy Officer
- Paula Gramley, BA, Community Benefit Program Manager

HSHS St. John's Hospital

- Kimberly Luz, MS, CHES, Director of Community Outreach; Community Benefit Coordinator
- Brian Reardon, System Director of Communications & Public Relations, Hospital Sisters Health System
- Angela Hall, Hospital Sisters System Director, Mission Integration & Community Benefit

Sangamon County Department of Public Health

- Jim Stone, MA, CPHA, Director of Public Health
- Gail O'Neill, BS, Assistant Director of Public Health
- Mary Hart, Community Planning Fellow, Western Illinois University

SIU School of Medicine

- David Steward, MD, MPH, Associate Dean, Community Health and Service

Core Team Charter: The Core Team of the Sangamon County Community Health Need Assessment (CHNA) exists to ensure that Memorial Medical Center (MMC), St. John's Hospital (SJH) and Sangamon County Department of Public Health complete their respective CHNA/IPLAN process requirements while obtaining meaningful outcomes that will improve the health of the community. Additionally, MMC and SJH agree to collaboratively address one joint priority at the conclusion of the CHNA process.

Early in its process, the Core Team established the following Defined Criteria to use throughout the CHNA process to help identify the top priority issues.

Defined Criteria for Community Health Need Assessment

1. **Institute of Medicine Triple Aim Impact:**
   - Improve the Care of Individuals
   - Improve the Health of Populations
   - Reduce Waste, Variation and Cost
2. **Magnitude of the Issue** – How wide an issue is this in the community?
3. **Seriousness of the Issue** – How related is the issue to the mortality of those affected?
4. **Feasibility** – Considering available resources to address the issue, how likely are we to make a significant impact on the issue?

Identifying Scope of Work and Timeline

The Core Team identified significant community organizations that represented underserved, vulnerable and minority members of the community that would be asked to participate on a Community Advisory Committee.

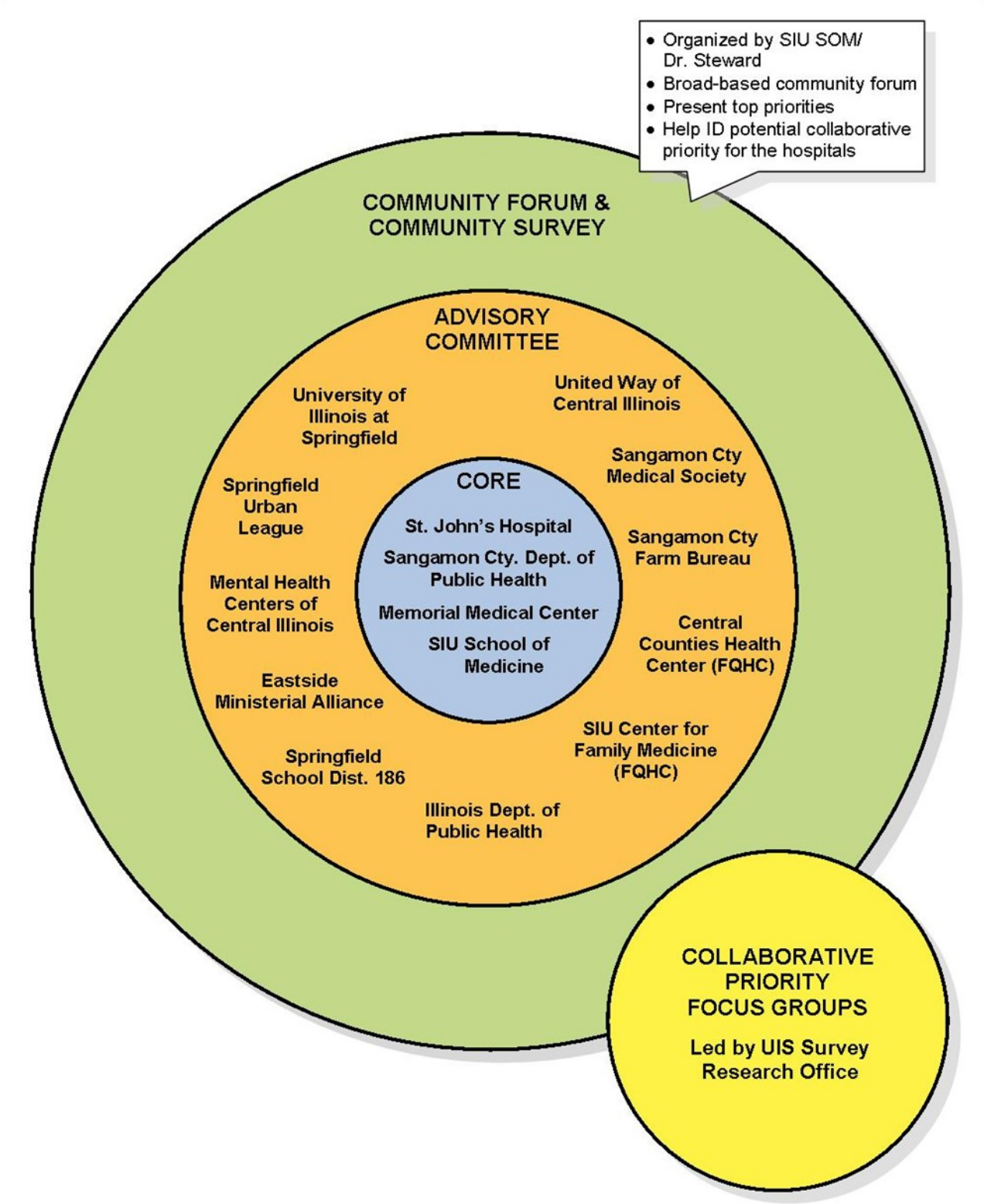
They decided that the CHNA process would include a community survey and community forums to solicit feedback on identified issues.

Memorial and St. John's also agreed they would share a joint priority and address that issue in a collaborative initiative. Following identification of final priorities and a joint priority for the two hospitals, they would conduct focus groups to do a deeper dive into that specific issue. They agreed to contract with University of Illinois at Springfield (UIS) Survey Research Department to conduct the focus groups.

Additionally, the two hospitals and health department contracted with Western Illinois University's Peace Corps Fellows/AmeriCorps Program to provide an 11-month fellowship opportunity to assist with the CHNA process. The hospitals paid the stipend and the health department provided office space and supervision.

Sangamon County

2015 Community Health Need Assessment



Sangamon County Community Health Need Assessment Process

St. John's Hospital, Memorial Medical Center, Sangamon County Department of Public Health

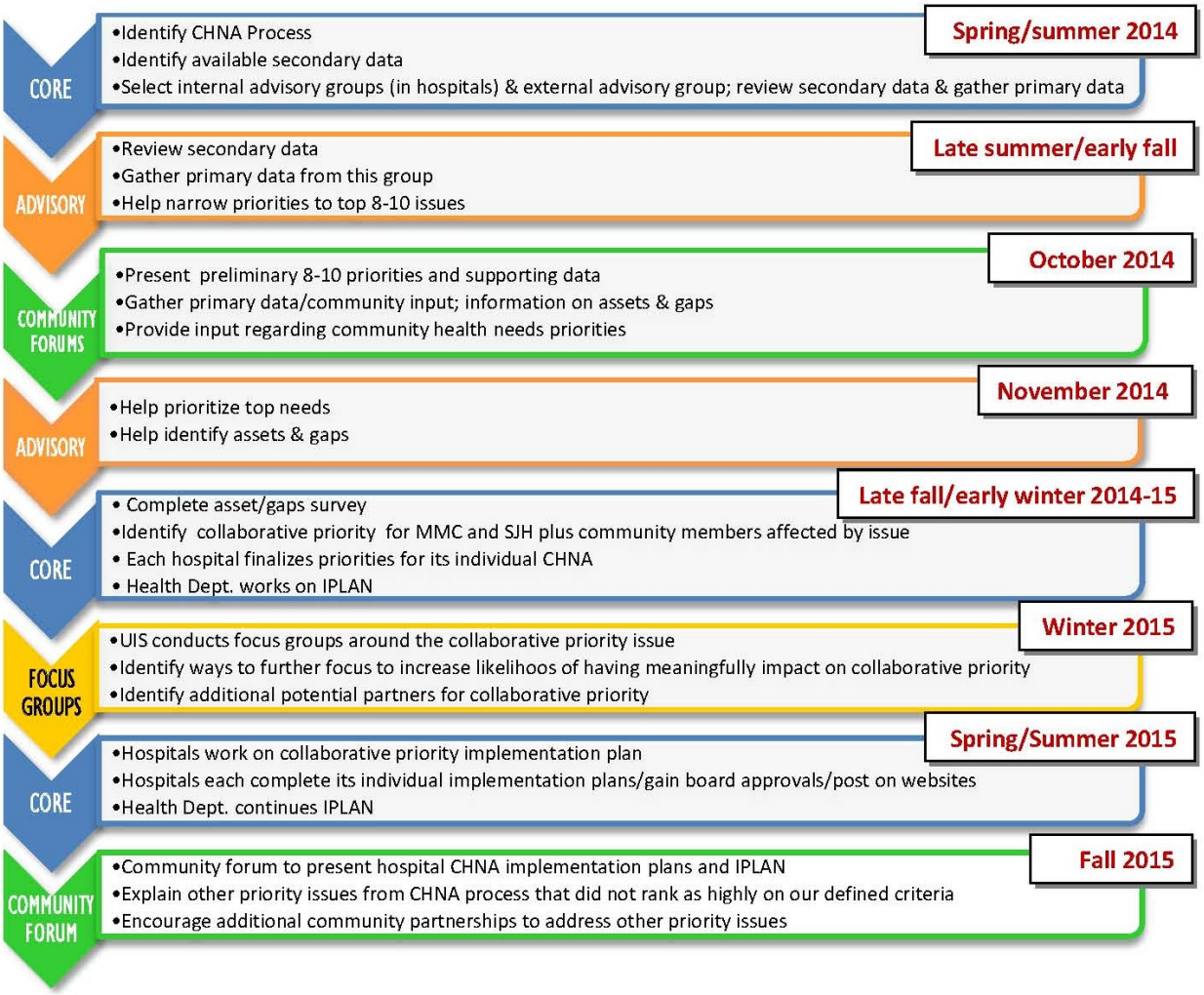
Defined Criteria for Community Health Need Assessment

Defined Criteria

1. **Triple Aim Impact**
2. **Magnitude of the Issue – how wide an issue is this in the community?**
3. **Seriousness of the Issue – how related is the issue to the mortality of those affected?**
4. **Feasibility – Considering available resources to address the issue, how likely are we to make a significant impact on the issue?**

Final priorities must be in line with the Institute of Medicine's Triple Aim:

- Improve the health of individuals
- Improve the health of populations
- Reduce waste, variation & healthcare costs



Data Review

Secondary Data Sources

The CHNA Core Team gathered and thoroughly reviewed the following secondary data sources. (Details of that review are in Appendix A.)

1. Sangamon County Citizen's Survey (2013)
2. County Health Rankings of Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute
3. Voices for Children: Illinois Kids Count
4. Food Atlas of United States Department of Agriculture
5. State Health Improvement Plan of the Illinois Department of Public Health
6. Greater Springfield Q5 Competitive Assessment
7. Coordinated Access to Community Health (CATCH)
8. Sangamon County Department of Community Resources Need Assessment & Action Plan
9. Central Counties Health Centers Federally Qualified Health Clinic
10. Southern Illinois University Center for Family Medicine Federally Qualified Health Clinic
11. UIS Center for State Policy and Research 2013 Annual Report
12. Springfield Urban League Head Start/Early Head Start Community Assessment 2012-2013
13. Sangamon County Schools
14. School Report Card, Illinois Board of Education

Since 2011, Memorial Medical Center has contracted with Healthy Communities Institute in Berkeley, Calif., to obtain community health and social determinant indicators specific to Sangamon County, as well as the three other counties that are home to MHS hospitals. The data is available on the Memorial Health System's website (www.choosememorial.org/healthycommunities) for all in the community to use. It includes information from national resources, including Healthy People 2020, state resources, and local hospital utilization data. The Healthy Communities Institute data played a major role in examining and narrowing down significant health issues affecting Sangamon County during the 2015 CHNA process.

Following the review of available secondary data listed above, several members of the Core Team went to the Healthy Communities Institute data on Memorial's website. The data provides more than 150 health and socioeconomic indicators, rated with a green/yellow/red dashboard, indicating best measures (green) to worst measures (red). The Core Team arranged all the indicators by severity, with the worst (red) indicators first, followed by yellow. They reviewed every red and yellow indicator, and, when available, also looked at disparities for each indicator, noting those that disproportionately affected African Americans, children and seniors. They also looked at whether an indicator was trending over time toward improvement or worsening.

Some green (top 50%) indicators were also reviewed, because in light of the other secondary data sources, the hospitals and health department knew that some of the green-ranked topics were still posed significant issues. There are several reasons for this, primarily based on availability of information from the data sources. For example, some indicators have to rely on the Illinois Behavioral Risk Factors Surveillance System (BRFSS), which is a self-reported response to a telephone survey by Illinois Department of Public Health. Often the survey information dated back to 2007-2009. The Core Team identified other information resources to use in such cases. The CHNA Core Team did not identify information gaps that limited its ability to assess all community health needs.

Following the examination of all the secondary data, the following 22 items were brought back to the full Core Team for review of the data and discussion. Each Core Team member then force-ranked the issues, using the CHNA Defined Criteria:

1. Institute of Medicine Triple Aim Impact:
   - Improve the Care of Individuals
   - Improve the Health of Populations
   - Reduce Waste, Variation and Cost
2. Magnitude of the Issue – How wide an issue is this in the community?
3. Seriousness of the Issue – How related is the issue to the mortality (deaths) of those affected?
4. Feasibility – Considering available resources to address the issue, how likely are we to make a significant impact on the issue?

The12 top-ranked issues were selected for presentation to the CHNA Community Advisory Committee.

TOP IDENTIFIED ISSUES	12 TOP-RANKED ISSUES
1. Access to Care	1. Access to Care
2. Affordable Housing	2. Asthma
3. Alcohol Abuse	3. Cardiovascular Disease
4. Asthma	4. Child Abuse
5. Cancer	5. Dental Care
6. Child Abuse	6. Diabetes
7. Dental Care	7. Food Insecurity
8. Diabetes	8. Infant Mortality/Mother-Infant Issues
9. Food Insecurity	9. Mental Health
10. Heart Failure	10. Overweight/Obesity
11. Hepatitis	11. Sexually Transmitted Diseases: Chlamydia and Gonorrhea
12. Hypertension	12. Violent Crime
13. Infant Mortality	
14. Mental Health	
15. Orthopedic	
16. Overweight/Obesity	
17. Pneumonia	
18. Sexually Transmitted Diseases	
19. Substance Abuse	
20. Teen Births	
21. Urinary Tract Infection	
22. Violent Crime	

Primary Data Collection: Community Advisory Committee

Primary data was gathered by convening a Community Advisory Committee made up of representatives that serve low-income, minority and vulnerable populations.

> **Charter:** The Advisory Committee of the Sangamon County Community Health Need Assessment exists to help Memorial Medical Center, St. John's Hospital and Sangamon County Department of Public Health review existing data and offer insights into community issues affecting that data. The Committee will help identify local community assets and gaps in the priority areas, and will offer advice on which issues are the highest priority.

The CHNA Core Team met three times with the Community Advisory Committee on:

- Sept. 3, 2014, 12 p.m. – Introduction to CHNA process
- Sept. 23, 2014, 3:30 p.m. – Data review and forced ranking using Defined Criteria
- Nov. 10, 2014, 3:30 p.m. – (1) Review outcomes of CHNA need assessment and the five community forums; (2) Identify community assets and gaps in services

The following organizations had representatives serving on this community.

ORGANIZATION	ORGANIZATION DESCRIPTION	SERVES
Central Counties Health Centers (Federally Qualified Health Center)	Central Counties Health Centers is a community health center which provides the underserved access to primary medical and dental care. CCHC provides primary medical care, general dentistry, health care for the homeless and a low-cost pharmacy program. CCHC is open to everyone and offers sliding scale discounts to aid the uninsured. Mission: To provide high-quality, affordable, non-discriminatory, and accessible primary medical and dental care that meets the personalized needs of the underserved people of Central Illinois.	Underserved and low-income residents
Eastside Ministerial Alliance	The Serving Jesus Willingly Urban Ministry represented the Eastside Ministerial Alliance. This program is an outgrowth of 24 years of various ministries led by Rev. Sam Winger. It focuses on meeting the physical and spiritual needs of people in Springfield, Ill. and other places.	Low income, minority residents
Illinois Department of Public Health, Division of Health Policy	The Division of Public Health Policy oversees the Illinois Project for Local Assessment of Needs (IPLAN). The IPLAN process is a requirement for certification of local health departments in Illinois.	All residents of Sangamon County
Mental Health Centers of Central Illinois	Mental Health Centers of Central Illinois is a private, not-for-profit organization providing high-quality, comprehensive behavioral health and rehabilitation services. An affiliate of Memorial Health System, MHCCI is one of the largest providers of behavioral health services in central Illinois, serving more than 9,000 individuals each year in six counties. Behavioral services include crisis intervention, psychiatric and medical services, screening and assessment, outpatient therapy, case management, group education and support, employment services, as well as residential care. Mission: To improve the health of the people and communities we serve.	Residents with mental health needs, with particular assistance for low-income, vulnerable and homeless individuals

ORGANIZATION	ORGANIZATION DESCRIPTION	SERVES
Sangamon County Farm Bureau	Mission: Advocating the voice of agriculture through education and grass-roots legislation	Those living in rural areas of Sangamon County
Sangamon County Medical Society	The Sangamon County Medical Society is a professional membership organization dedicated to the health of our community, and an advocate for the highest standards in medicine. Mission: To provide leadership in health care through service, education and advocacy for our members, patients and community.	All members of the community
SIU Center for Family Medicine (Federally Qualified Health Clinic)	Center for Family Medicine is a Federally Qualified Health Center (FQHC) and Patient Centered Medical Home (PCMH). Its goal is to provide the best possible care to its patients and to make them feel that the Center is their personal medical home. Its clinicians: • Provide integrated, accessible health care services • Are accountable for addressing a large majority of the patients health care needs • Develop sustained partnerships with patient • Practice within the context of the family and community	Underserved and low-income residents
Springfield School Dist. 186	This public school district serves approximately 15,000 students. Mission: The District, in collaboration with parents and community, shall develop in all students the knowledge, understanding, skills, and attitudes to empower them to be responsible life-long learners and productive citizens in an ever-changing world. This will be accomplished in a climate that promotes high expectations, strives to meet individual needs, and values diversity.	All children and their families living in Springfield
Springfield Urban League	The Springfield Urban League, Inc. is a nonprofit, nonpartisan, civil rights and community-based movement that serves nearly 9,000 people annually, providing direct services, research and policy advocacy to assist individuals and communities in reaching their fullest potential. It primarily works with African Americans, Hispanics, and other emerging ethnic communities. Mission: The mission of the Springfield Urban League is to empower African-Americans, other emerging ethnic groups and those who struggle to secure economic self-reliance, parity, power, and civil rights. In order to implement the mission of its movement, the Springfield Urban League employs a strategy of: • Civic Engagement & Social Justice Empowerment • Economic and Workforce Empowerment • Education & Youth Empowerment • Health and Quality of Life Empowerment	Minority and low-income individuals
United Way of Central Illinois	United Way is a community partner and the largest non-governmental funder of health and human service programs aligned with the community's education initiative. It also funds specific programs providing food, shelter, health care and victim services. Mission: Mobilizing Resources to Meet Community Needs	All residents, with particular focus on low-income and vulnerable populations
University of Illinois at Springfield Survey Research Office	The Survey Research Office specializes in public affairs research with the goal of advancing scholarly and practical research, while playing a leadership role in state and national policy development.	Collaborates with numerous local and state organizations

The top 12 priorities ranked by the Core Team were presented to the CHNA Community Advisory Committee. Review of data, including disparities for minority populations, was included in the presentation.

1. Access to Care
2. Asthma
3. Cardiovascular Disease
4. Child Abuse
5. Dental Care
6. Diabetes
7. Food Insecurity
8. Infant Mortality/Mother-Infant Issues
9. Mental Health
10. Overweight/Obesity
11. Sexually Transmitted Diseases: Chlamydia and Gonorrhea
12. Violent Crime

The committee discussed the 12 items, providing input on the issues affecting the populations they served and contributing factors to the issues. The committee was given the opportunity to identify whether the Core Team had missed any significant issues that should have been included on the list. No additional issues were identified.

Following an explanation of the Defined Criteria, the Advisory Committee force-ranked the issues in light of the Triple Aim impact, magnitude, seriousness and feasibility. The intention was to take the top eight issues for the next step in the CHNA process, but two issues tied, so nine were selected for inclusion in a community survey and presentation in five community forums.

The three items not ranking as high and left off of the survey were Infant Mortality/Mother-Infant Issues, Sexually Transmitted Diseases and Violent Crime. The nine issues selected for inclusion in the community forums and community survey were:

- Access to Care
- Asthma
- Child Abuse
- Dental Care
- Diabetes
- Food Insecurity
- Heart Disease
- Mental Health
- Overweight/Obesity

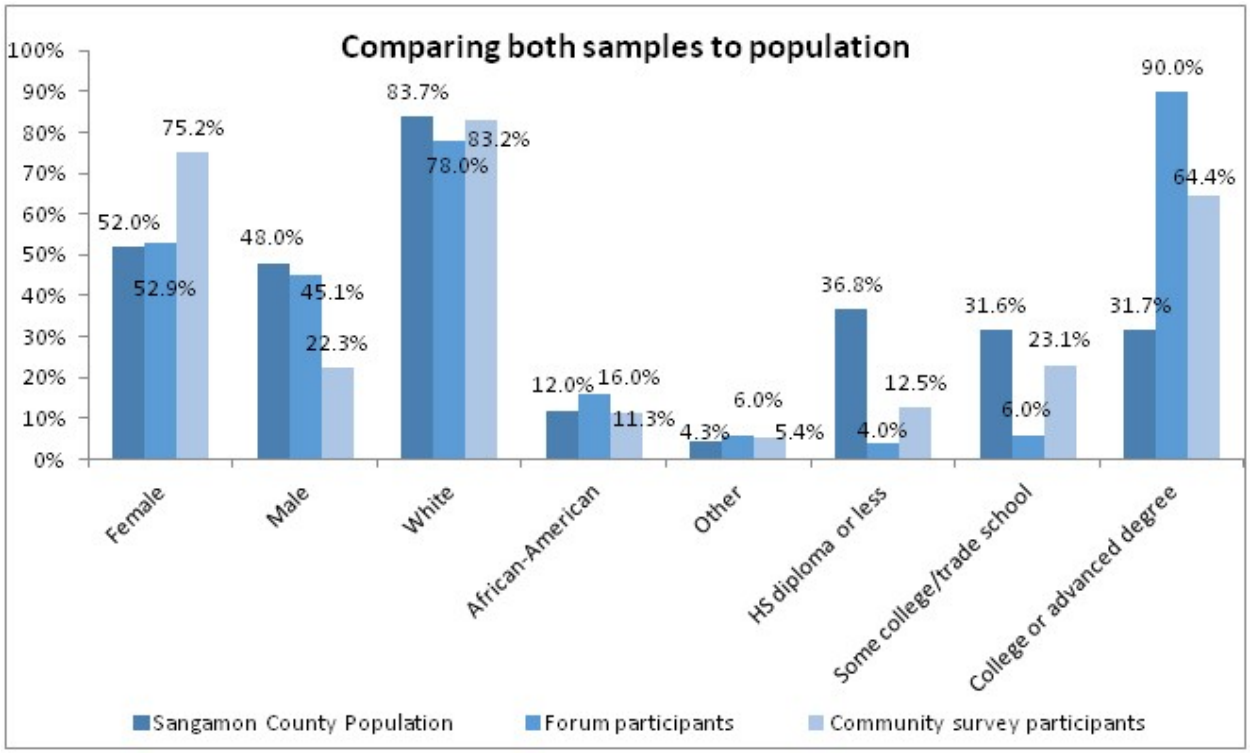
Primary Data Collection: Community Forums and Community Survey

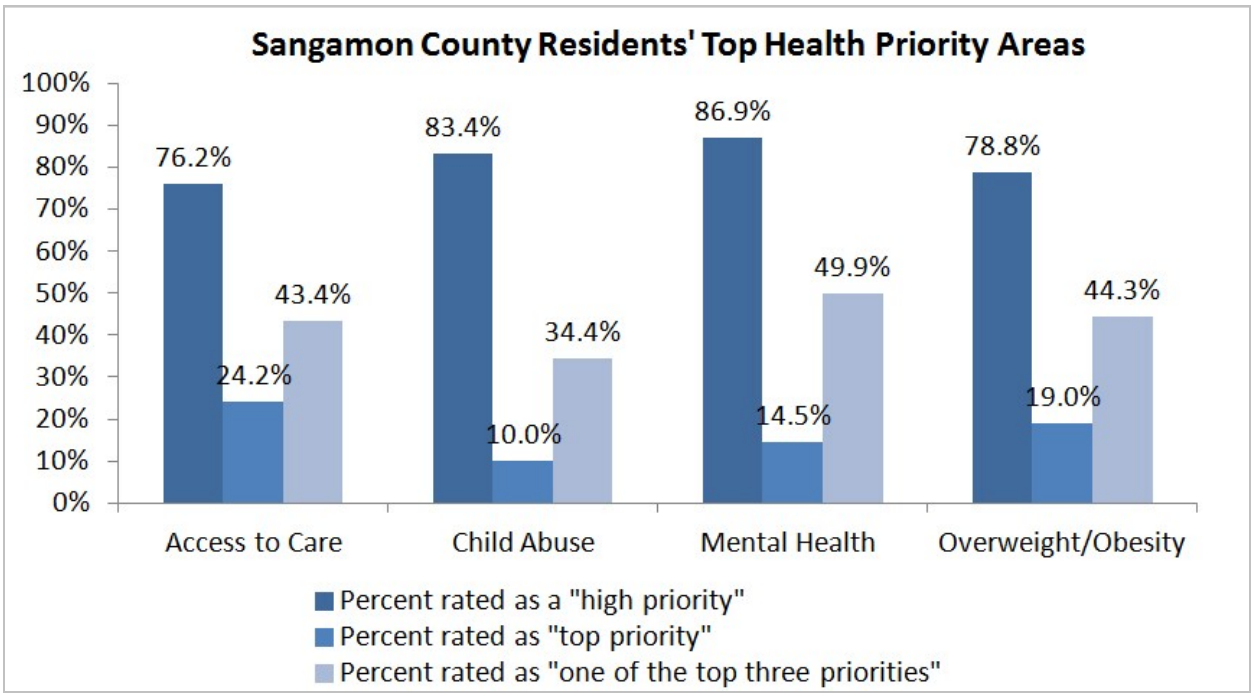
SIU School of Medicine organized five public forums from Oct. 1-Oct. 9, 2014. Staff from University of Illinois at Springfield (UIS) served as moderators for the forums, and staff and students from the UIS Survey Research Department provided technical support, recording all comments and then transcribing using both automated transcription software and individual researchers.

Three forums were held in Springfield. Two were within zip codes 62702 and 62703, which represent areas of the city with poor health and socioeconomic indicators and larger minority populations. An additional forum took place in Springfield zip code 62704, which has less severe health and socioeconomic indicators. Two forums targeted rural areas of the county. One took place in Riverton, northeast of Springfield (which also has low socioeconomic indicators) and another in Auburn in the southern part of the county. This was the first time such community forums were ever attempted to discuss broad community health issues. The forums were promoted through press releases, ads in community newspapers, flyers, radio, and contacts with community education and social service organizations. Although overall attendance at the forums was small, significant insights were gained from community members who participated.

Congruent to the community forums, an online community survey was conducted by the UIS Survey Research office from Sept. 22-Oct. 20. Hard copies of the survey were also distributed to organizations participating on the Community Advisory Committee, through the health department's Women, Infant, Children (WIC) program, and other community organizations. Hard copies were also distributed at the five community forums held from Oct. 1-Oct. 9.

The University of Illinois at Springfield's Survey Research office analyzed results of five community forums and the community survey, which was completed by 781 individuals. (Appendix B.)





The Community Survey results in ranked order were:

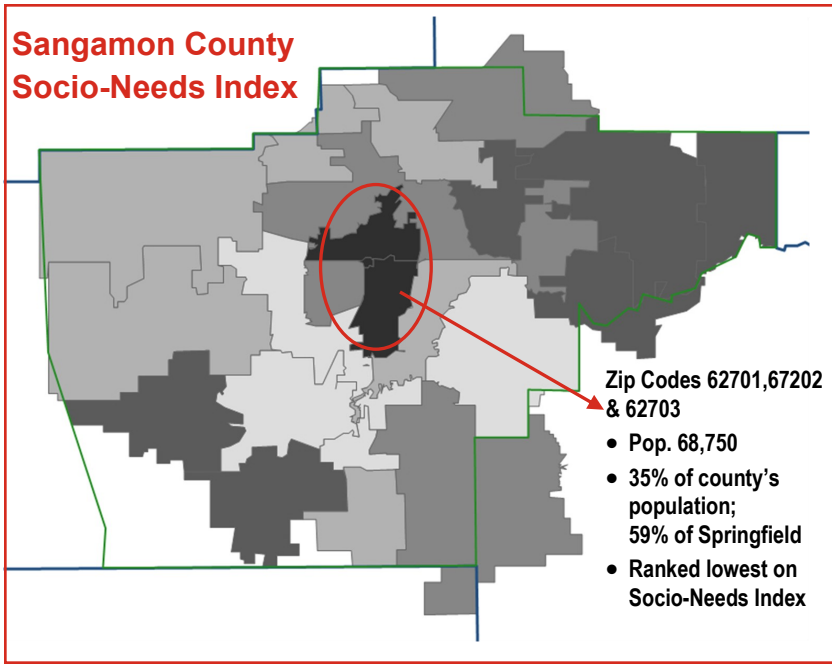
1. **Mental Health**
2. **Child Abuse**
3. **Overweight/Obesity**
4. **Access to Care**
5. **Heart disease**
6. **Diabetes**
7. **Dental Care**
8. **Food Insecurity**
9. **Asthma**

Memorial and St. John's: Selection of a Joint Priority

As previously stated, Memorial and St. John's agreed from the outset of the joint CHNA that at the end of the process they would select one joint priority and work on a way to address that issue together. Assumptions included:

- The hospitals would focus on areas of greatest need in the community (likely residents living zip codes 62701, 62702 and 62703).
- They would take a narrower, deeper dive into the issue rather than a broader, but shallower, community-wide approach
- They would consider the targeted initiative a pilot project that might be replicated elsewhere in the community, if successful.
- They would avoid issues of competitive marketing between the hospitals.
- The new initiative would be collaborative and they would invite other stakeholders to participate.
- The project must demonstrate measurable outcomes.

Sangamon County Socio-Needs Index



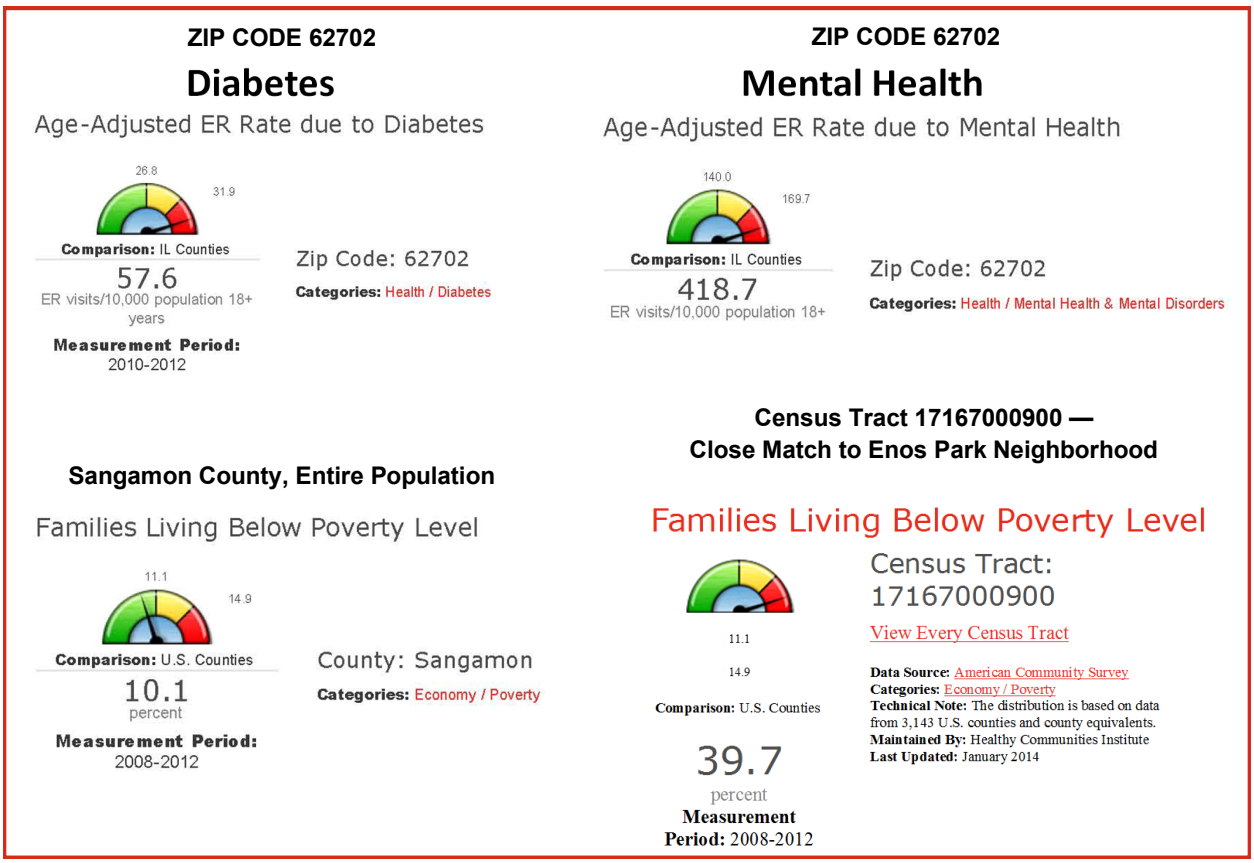
The Sangamon County Socio-Needs Index is a measure of socio-economic need that correlates with poor health outcomes.

Source: Healthy Communities Institute, retrieved from http://www.choosememorial.org/MHS-Community-Need-Assessment

On Dec. 3, 2014, MMC and SJH representatives reviewed input provided by the CHNA Community Advisory Committee, comments from five community forums and results of the community survey. Input from Memorial's Internal Advisory Committee was also reviewed (process described on page 28).

Throughout the entire community health need assessment process, Access to Care was consistently identified as one of the top priorities.

The two hospitals decided to jointly address Access to Care and selected the Enos Park neighborhood, which is adjacent to both hospital campuses. Enos Park is in zip code 62702, which has demonstrated need in the areas of health, with high usage of the emergency departments for ambulatory sensitive conditions. The zip code also has significant poor indicators in areas of social determinants of health. Census Tract 171670900, which closely matches the neighborhood's borders, has numerous indicators that demonstrate need. Just a few of the many indicators are included below.



Graphics are from Healthy Communities Institute, Community Dashboard. www.choosememorial.org/healthy communities, Memorial Health System website. Retrieved January 2015 from http://www.choosememorial.org/MHS-Community-Need-Assessment/default.

In considering the feasibility aspect of the CHNA Defined Criteria, of great importance is a key Enos Park asset – a well organized and active neighborhood association. The Enos Park Neighborhood Improvement Association (EPNIA) has been active for years in neighborhood improvement initiatives. It has reduced crime in the area through partnership with community policing programs. It buys blighted properties for restoration or demolition. It strongly supports McClernand Elementary School within its neighborhood, which has a high percentage of children from low-income families. EPNIA has installed new street lighting, improved neighborhood parks, and is working on numerous other initiatives. The neighborhood has an active and committed core of people that want to make a difference. EPNIA will be a key partner in working in this neighborhood.

Building Collaboration for the Enos Park Access to Care Project

On Dec. 11, 2014, Memorial and St. John's met with EPNIA representatives and leaders of several social service providers within the neighborhood and explained their wish to partner with the neighborhood to address issues of access to care. To that end, they asked for assistance to identify participants for three community focus groups to take place in January. EPNIA welcomed this new partnership and agreed to work with the hospitals. On Jan. 13, 2015, the hospitals completed a presentation at EPNIA's monthly meeting on the access to care project they were implementing in the neighborhood.

Memorial and SJH contracted with University of Illinois at Springfield to conduct four focus groups in January 2015 within the neighborhood to identify how the residents define the concept of "access to care" and what issues they faced. Groups consisted of existing social service providers within the neighborhood, senior residents, and young adults. Another focus group consisted of young homeless mothers who are part of M.E.R.C.Y. Communities program. (See Appendix C.)

Outcomes of the focus groups identified a variety of issues, many of which might be addressed through a community health worker (CHW) program in the neighborhood. Additional issues showed that the social service providers are not aware of available community resources or how to refer their clients to those resources.

The hospitals convened an Enos Park Community Advisory Committee to share the results of the focus groups. Those invited included representatives from EPNIA, social service providers in the neighborhood, seniors, young parents, school representatives, community policing officers and others. Although all could not attend the first meeting, everyone attending agreed to continue serving on the Advisory Committee. The hospitals shared their overall plan for addressing the issues raised in the focus groups and received the endorsement of the Enos Park Advisory Committee for those plans.

The hospitals are collaborating Tracey Smith, DNP, PHCNS-BC, MS, Director of Family & Community Medicine, Medical Student Education and Community Outreach Co-Director, Population Health for Southern Illinois University School of Medicine. Ms. Smith is helping us create a community health worker program model for this neighborhood. The CHW will be employed through the SIU Center for Family Medicine, a federally qualified health center, with salary and program expenses funded by both hospitals.

The hospitals are additionally increasing access to mental health services by jointly funding a fulltime behavioral health consultant for the elementary school in the Enos Park neighborhood. This is a component of the MOSAIC collaborative in Springfield, an initiative led by Mental Health Centers of Central Illinois to develop a system of providing mental health services and supports when they are needed and where they are needed, including a school-based setting. This initiative will collaborate with the CHW program.

The CHW program and behavioral health consultant in McClernand Elementary School will begin in the fall of 2015.

Memorial Medical Center Internal Advisory Committee and Final Priority Selection

As part of the CHNA process, Memorial convened an Internal Advisory Committee to identify possible areas for a collaborative initiative with St. John's Hospital and to give input into selection of MMC's other priorities.

> **Charter:** The Memorial Medical Center CHNA Internal Advisory Committee exists to review the top priorities identified in the Sangamon County community health need assessment. This committee will provide input from a clinical and operational perspective. Using the MHS Defined Criteria, the committee will recommend final priorities for MMC to address in its FY2016 CHNA implementation plan.

MMC CHNA Internal Advisory Committee

- Mitch Johnson, MBA, FACHE, Sr. Vice President and Chief Strategy Officer
- Kevin England, FACHE, Vice President, Business Development
- Linda Jones, DNS, RN, AOCN, FACHE, Vice President, Operations
- Jan Gambach, President, Mental Health Centers of Central Illinois, and System Administrator, Behavioral Health, Memorial Health System
- Jay Roszhart, MHA, Administrator, Clinical Integration and Care Coordination
- Robert Ellison, MHA, System Director, Business Development & Planning
- Paula Harwood, RN-BC, CCRP, BSN, Manager, Cardiopulmonary Rehabilitation and Heart Failure
- Kimberly Paskiewicz, MPH, RD, LDN, Director, Weight Loss & Wellness Center
- Kathy Levin, RD, LDN, CDE, Diabetes Program Coordinator
- Paula Gramley, BA, Community Benefit Program Manager

This Internal Advisory Committee first met on Nov. 20, 2014, and, after reviewing CHNA data and outcomes of the community survey, gave initial recommendations for the best options to address a joint initiative with HSHS St. John's Hospital (with subsequent selection of Access to Care for that project, as mentioned earlier in this report).

On Jan. 14, 2015, Memorial reconvened the MMC Internal Advisory Committee. The group did an overview of the other priorities that had been included in the community survey. They reviewed data indicators, including disparities, community survey outcomes, and discussed where the hospital might be able to make the biggest impact. They then used the Defined Criteria to force-rank the nine priorities, with the top results being Access to Care, Mental Health and Obesity.

Memorial Medical Center's Final 2015 CHNA Priorities

Priority 1: Access to Care

Although Sangamon County has one of the highest health care provider rates in Illinois, and the number of uninsured residents has decrease with the Affordable Care Act, access to care remains a problem. Access is defined in broad terms, and may include access to physicians or other health services or barriers that prevent people from getting the care they need.

In previous need assessments, access to care has been identified as a community priority by Memorial Medical Center, Springfield Urban League Head Start, the Sangamon County Medical Society and the 2013 Sangamon County Citizen's Survey. The Citizen's Survey, conducted by the UIS Survey Research Department, found that:

- 11.3% of residents did not have health coverage
- One in four uninsured people were under age 31
- 37.8% earned less than $15,000 a year
- 19.1% of African Americans were uninsured vs. 9.2% of Whites
- 13.8% did not have a primary care physician
- 20.9% of residents were economically insecure about their family's health care. At least once in the past 12 months they did not have enough money to pay for health care or medicines for someone in their family.

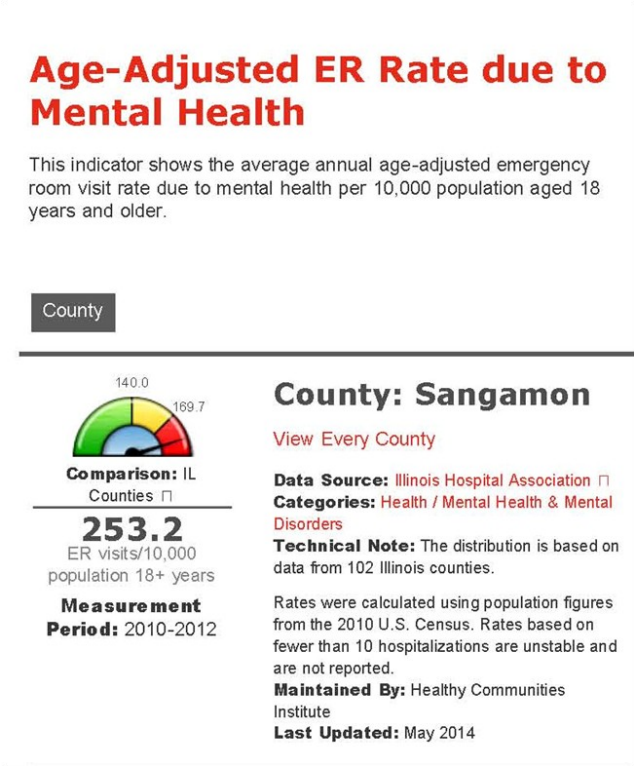
Additional indicators include:

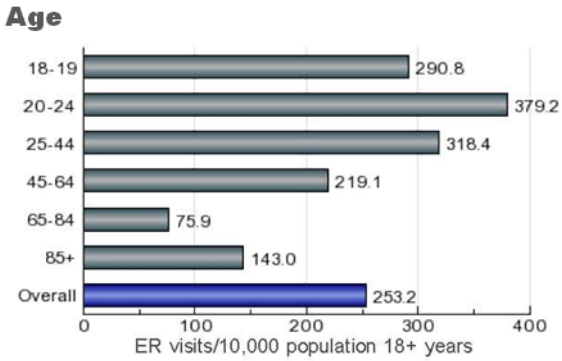
- According to Gilead Outreach and Referral Center 2012 Report, based on 2007 U.S. Census Bureau data, 15.9% of residents under age 65 were uninsured.
- Sangamon County as eight census tracts designated by the U.S. Department of Health and Human Services' Health Resources & Services Administration as Medically Underserved Areas and Health Manpower Professional Shortage Areas.

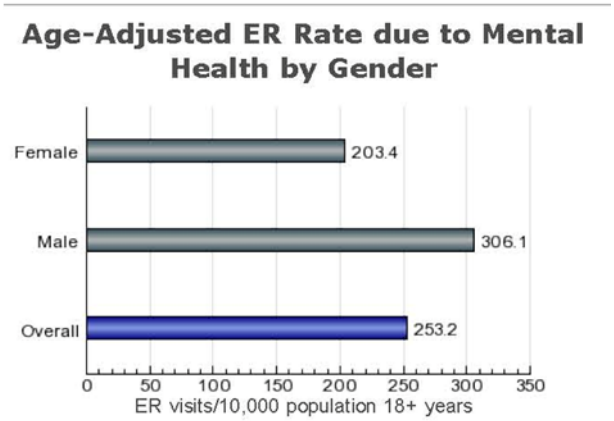
The community survey completed for this Sangamon County 2015 Community Health Need Assessment identified access to care as the fourth highest priority out of nine issues presented (page 25).

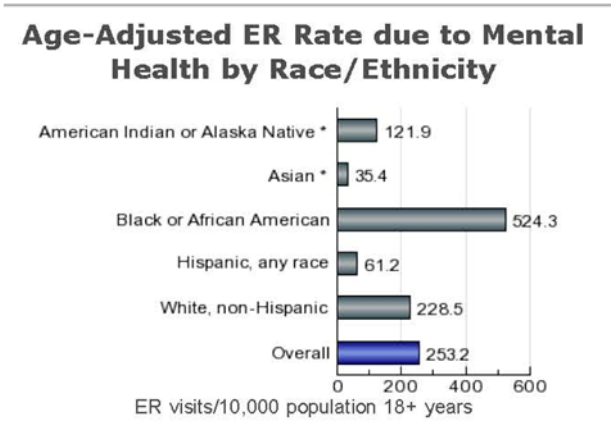
Priority 2: Mental Health

Numerous indicators as well as the community survey and community forums conducted for this community health need assessment demonstrate that mental health is a pressing need in Sangamon County. It was the number one priority on the community survey. Significant funding cuts for mental health over the past decade by the state of Illinois have created a lack of available services.









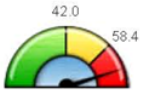
* Value may be statistically unstable and should be interpreted with caution.

Graphics are from Healthy Communities Institute, Community Dashboard. www.choosememorial.org/healthy communities, Memorial Health System website. Retrieved September 2014 from http://www.choosememorial.org/MHS-Community-Need-Assessment/default.

Age-Adjusted Hospitalization Rate due to Pediatric Mental Health

This indicator shows the average annual age-adjusted hospitalization rate due to mental health per 10,000 population under 18 years.

County | Time Period



Comparison: IL Counties ⊓

76.3
hospitalizations/10,000 population under 18 years

Measurement Period: 2010-2012

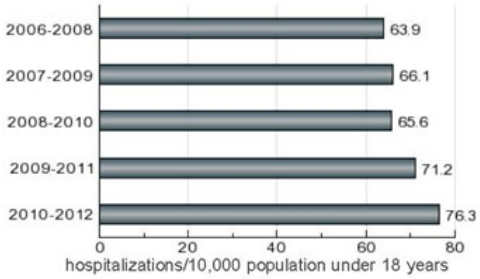
County: Sangamon

View Every County

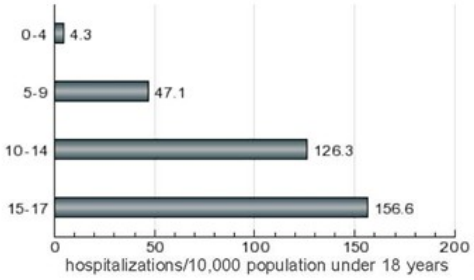
Data Source: Illinois Hospital Association ⊓
Categories: Health / Mental Health & Mental Disorders
Technical Note: The distribution is based on data from 92 Illinois counties.

Indicator includes all primary ICD9 primary DX codes 290-319. Rates were calculated using population figures from the 2000 U.S. Census. Rates based on fewer than 5 hospitalizations are unstable and are not reported.
Maintained By: Healthy Communities Institute
Last Updated: May 2014

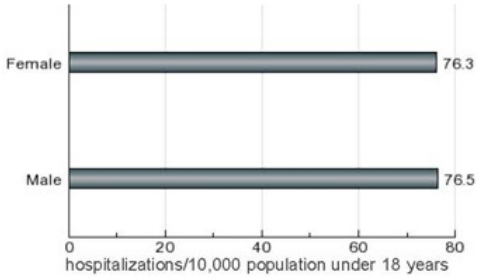
Time Series



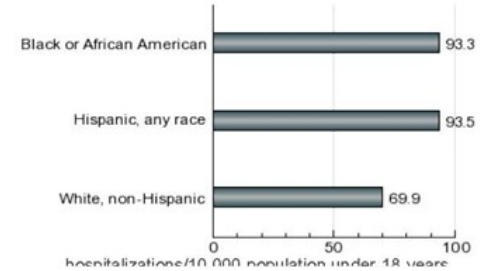
Hospitalization Rate due to Pediatric Mental Health by Age



Age-Adjusted Hospitalization Rate due to Pediatric Mental Health by Gender



Age-Adjusted Hospitalization Rate due to Pediatric Mental Health by Race/Ethnicity

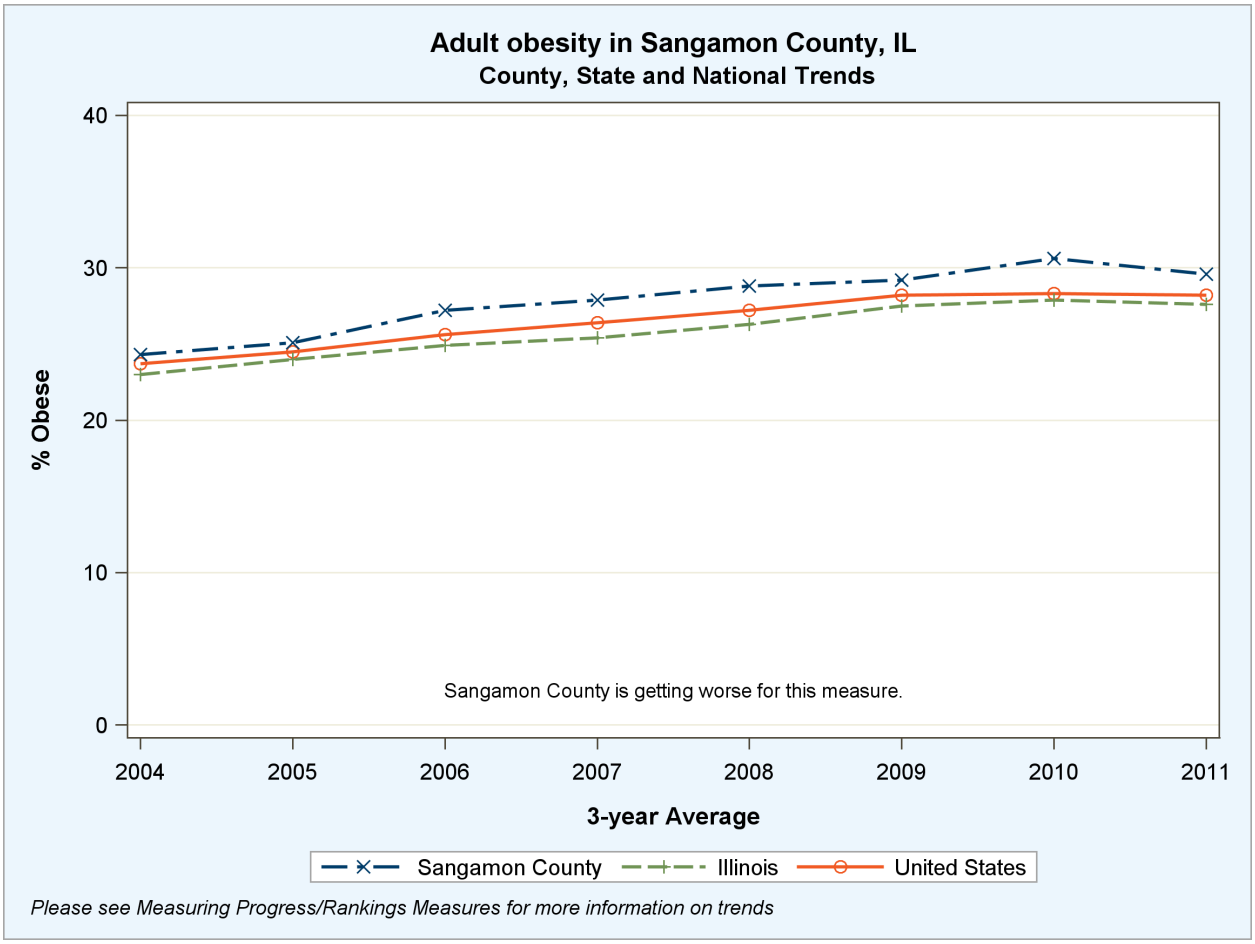


Priority 3: Obesity

Overweight/Obesity was the third highest-ranked priority of the CHNA community survey. It was also a major topic of discussion at the five community forums held in Sangamon County. Obesity has been identified as a priority by previous need assessments, including by Memorial Medical Center, HSHS St. John's Hospital, SIU School of Medicine and genH Kids Coalition, a local collaborative that addresses childhood obesity and healthy nutrition issues.

The Springfield Collaborative for Active Child Health (SIU School of Medicine, Springfield School District 186, Springfield Urban League/Head Start, and the Illinois Department of Public Health are the partners) has programs in eight elementary schools in Dist. 186 (Ridgely, Fairview, Enos, McClernand, Dubois, Iles, Lindsay and Butler).

- In the spring of 2014, the combined overweight and obesity rates of first and fourth graders in these eight schools was 33%.



Graphic is from County Health Rankings and Roadmaps, http://www.countyhealthrankings.org/. Retrieved spring 2015 from http://www.countyhealthrankings.org/app/illinois/2015/rankings/sangamon/county/outcomes/overall/snapshot.

Priorities Not Selected by Memorial Medical Center

Child Abuse – Considering feasibility, this issue is not a core competency for our hospital to address. Memorial will participate on community initiatives to address this issue, but is not positioned to lead such an initiative.

Heart/Cardiovascular Disease – Memorial is already committed to addressing cardiovascular issues, both within its patient population and in the community at large. Data shows that cardiovascular indicators for Sangamon County are gradually improving over time. Memorial will continue to address cardiovascular issues, but it was felt that a focus on obesity might be a way to address a significant contributing factor.

Diabetes is a significant issue in Sangamon County and impacts many people. But, like cardiovascular disease, it was determined that selecting obesity as a priority rather than diabetes would be a way to address a significant contributing factor.

Dental Care did not rank high in feasibility for Memorial, either in expertise or resources. The community does have a Federally Qualified Health Center that offers dental services.

Food Insecurity did not rank as high a priority for the hospital to address as the other issues. It was felt that it would be more feasible to address this through a broader community collaborative.

Asthma, although an important issue, did not rank as high using the defined criteria as did the other selected priorities

Final Priorities Selected by CHNA Collaborative Partners

In addition to the final priorities selected by Memorial Medical Center, these other CHNA priorities will also be addressed.

HSHS St. John's Hospital

- Access to Care
- Pediatric Mental Health
- Pediatric Asthma
- Pediatric Obesity

Sangamon County Department of Public Health IPLAN Priorities

- Child Abuse
- Access to Care
- Pediatric Asthma
- The Board of Health also established two Strategic Initiatives:
    - Infant Mortality/Maternal Health Issues
    - Sexually Transmitted Infections/Chlamydia and Gonorrhea.

Memorial Health System Internal Advisory Committee

On Jan. 30, 2015, the four hospitals of Memorial Health System (Memorial Medical Center, Abraham Lincoln Memorial Hospital, Taylorville Memorial Hospital and Passavant Area Hospital) met to review the results of each hospital's CHNA process. The purpose of the meeting was to identify whether there were any shared priorities among the hospitals.

Even though the CHNAs were completed in four different counties with different community advisory groups, mental health and obesity were final priorities in Sangamon, Logan, Christian and Morgan counties. There was discussion about various ways the four hospitals might address the priorities as a health system.

Because additional input was needed from content experts from all Memorial Health System affiliates, MHS convened an Obesity Task Force and Mental Health Task Force.

MHS Obesity Task Force

The MHS Obesity Task Force met on March 24, 2015, and included representatives from all four hospitals as well as Memorial Physician Services, Mental Health Centers of Central Illinois and Memorial Home Services.

> **Charter:** Obesity has been selected by all four Memorial Health System hospitals as a priority during the 2015 community health need assessments. The Memorial Health System Obesity Task Force Group will offer perspective on community obesity issues being addressed by their affiliate organizations. They will identify opportunities to address gaps in services, both as a health system and as individual affiliates, for the communities they serve.

Abraham Lincoln Memorial Hospital	Todd Morning, DPT, Manager, ALMH Rehab Angie Stoltzenburg, MBA, Manager, ALMH Marketing & Community Partnerships
Taylorville Memorial Hospital	Janelle Cornell, RD, Registered Dietitian Kyra Havera, PT, Physical Therapist
Passavant Area Hospital	Karen Sibert, Community Nutrition Educator
Memorial Physician Services	Gerald Suchomski, MD, MPS Family Medical Center, Chatham Barbara Gold, MPS Quality and Safety Manager
Mental Health Centers of Central Illinois	Cindy Butler, Administrator, Clinical Operations
Memorial Home Services	Chris King, Clinical Informatics Manager for Home Health
Memorial Medical Center	Kim Paskiewicz, MPH, RD, LDN, Director, Weight Loss & Wellness Center Kathy Levin, RD, LDN, CDE, Diabetes Program Coordinator Mitch Johnson, Sr. Vice President and Chief Strategy Officer Paula Gramley, Community Benefit Program Manager

Following assessment of assets and gaps within Memorial Health System to address obesity within each community, and exploration of various opportunities to impact obesity for people living in Sangamon, Christian, Logan and Morgan counties, the decision was made to expand Memorial Medical Center's Weight Loss and Wellness Center program to the rural MHS affiliate hospitals. This program is based on the nationally recognized, evidence-based model of Geisinger Health System. Memorial's program includes a medical (non-surgical) weight loss program; accredited bariatric surgery program; diabetes services; outpatient nutrition services; and fitness. It provides physicians a comprehensive resource to refer their patients to for individualized counseling and education. There is no other program offering this specialized approach in central Illinois. All four MHS hospital's 2016 Implementation Strategies reflect this joint priority.

MHS Mental Health Task Force

The MHS Mental Health Task Force met on April 13, 2015, and included representatives from all four hospitals as well as Memorial Physician Services, Mental Health Centers of Central Illinois and Memorial Home Services.

> **Charter:** Mental Health has been selected by all four Memorial Health System hospitals as a priority during the 2015 community health need assessments. The Memorial Health System Mental Health Task Force Group will offer perspective on community obesity issues being addressed by their affiliate organizations. They will identify opportunities to address gaps in services, both as a health system and as individual affiliates, for the communities they serve.

Abraham Lincoln Memorial Hospital	Ted Clark, MD, Medical Director, ALMH ED Tara Morris, RN, Manager, ALMH ED
Taylorville Memorial Hospital	Amy Graham, RN, Senior Life Solutions Program
Passavant Area Hospital	Pam Bickhaus, Office Manager Tracey Stucker, LCSW
Memorial Physician Services	Gerald Suchomski, MD, MPS Family Medical Center Chatham Barbara Gold. MPS Quality and Safety Manager
Mental Health Centers of Central Illinois	Jan Gambach, President, MHCCI, and System Administrator, Behavioral Health, MHS Melissa Stalets, Director of Quality and Program Evaluation
Memorial Home Services	Chris King, -Clinical Informatics Manager for Home Health
SIU School of Medicine / MPS	David Resch, MD
Memorial Medical Center	Mitch Johnson, Sr. Vice President and Chief Strategy Officer Paula Gramley, Community Benefit Program Manager

The Task Force discussed a wide variety of mental health issues affecting people living in Sangamon, Christian, Logan and Morgan counties. Community assets and gaps for mental health services were not identical in each county. One program that could benefit all counties is Mental Health First Aid. This national evidence-based program gives people the skills to help someone who is developing a mental

health problem or experiencing a mental health crisis. Evidence shows that it builds mental health literacy by helping the public identify, understand, and respond to signs of mental illness. All four MHS hospital's 2016 Implementation Strategies reflect this joint priority.

Sharing CHNA Results with the Community

A presentation of the overall outcomes of the Sangamon County CHNA survey and community forums was presented to the Citizens Club of Springfield on Dec. 19, 2014. The Citizens Club is an engaged group of community leaders who meet monthly to discuss a wide range of issues affecting Springfield and Sangamon County. At this meeting, the community received an overview of the entire CHNA process. UIS Survey Research presented results of the community survey. Memorial and St. John's announced that their collaborative priority would be Access to Care, with a particular focus on the Enos Park neighborhood.

The CHNA Core Team will do a final presentation to the Citizen's Club on Oct. 9, 2015. Memorial Medical Center and HSHS St. John's Hospital will announce each hospital's final priorities and strategies to address the priorities. The Sangamon County Department of Public Health will also announce the final results of its IPLAN process. Both hospitals will also make full reports of the CHNA process and their implementation strategies widely available to the public by posting on their respective hospital websites.

Both hospitals are also engaged with working on the Enos Park Neighborhood Access to Care Collaborative, and ongoing communications are taking place with stakeholders and residents in that neighborhood.

FY2016 Community Health Need Assessment Implementation Strategy

Following completion of its 2015 CHNA, Memorial Medical Center submitted its FY2016 implementation strategy to the Memorial Medical Center Board, which approved it on Sept. 9, 2015 (Appendix D). The implementation strategy goals and measures will be updated annually in FY2017 and FY2018.

APPENDICES

Appendix A

Review of Available Sangamon County Databases and Need Assessments

May 2014

Completed by St. John's Hospital, Sangamon County Department of Public Health and Memorial Medical Center

1. Sangamon County Citizen's Survey

Data Source: Sangamon County Citizen's Survey:
http://cspl.uis.edu/surveyresearchoffice/documents/final_full.pdf

Agency: Written and prepared by the Center for State Policy and Leadership at University of Illinois Springfield

Date Data/Report was Completed: 2013

Organizations Involved:

- Dr. Ashley Kirzinger, Survey Research Office (chair)
- John Allen, Citizens Club
- Lynn Arrindell, Hinshaw & Culbertson LLP
- Dr. Gordon Brown, Citizens Club
- Dr. Beverly Bunch, UIS
- Heather Burton, United Way of Central Illinois
- Josh Collins, Greater Springfield Chamber of Commerce
- Dr. Barbara Ferrara, UIS
- Larry Johnson, IL National Guard & Militia Historical Society
- Sarah Mackey, Habitat for Humanity of Sangamon County
- Norm Sims, Springfield-Sangamon County Regional Planning
- Commission
- Dr. David Steward, SIU
- Dr. John Transue, UIS
- Kenley Wade, Citizens Clubs

Main Committee

- Community Foundation for the Land of Lincoln,
- United Way of Central Illinois,
- Springfield-Sangamon County Regional Planning Commission.
- The Citizens Club of Springfield

Purpose of the Data or Assessment: The project's purpose is to establish benchmarks and evaluate changes in residents' assessments of the quality of life in Sangamon County. The periodic survey will provide local leaders, community organizations, and citizens with longitudinal insight into issues facing local residents.

Methodology: The 2013 survey was conducted by interviewers at the Survey Research Office, a unit within the Center for State Policy & Leadership at the University of Illinois Springfield. The survey is

representative of Sangamon County, Illinois and the data was weighted for probability sampling and to match 2012 population estimates as provided by the U.S. Census Bureau. The survey was conducted from March 7th to April 9th 2013.

Sources of Information: The sample for this year's survey includes 524 completed interviews (618 partial interviews). The landline component included 391 responses with a 12.1% response rate and 22.8% cooperation rate. The cell phone component included 133 responses with a 10.3% response rate and 19.6% cooperation rate. The margin of error for the survey is plus or minus 4.2%.

Key Findings or Priorities:

- Sangamon County is rated highly as a place to raise children
- Education programs are a priority for the area
- Despite downward trends, crime is still a concern among Sangamon County residents
- Growing downtown Springfield is important to all Sangamon County residents
- At-risk population groups in Sangamon County: One in five respondents reported that at least once in the past 12 months they were unable to afford food or healthcare.

Additional Community Information:

- Education
- Environment
- Public Safety
- Economy
- Infrastructure
- Health
- Culture and Recreation
- Government and Civic Participation

Outcomes:

- Highlights positive and negative indicators for the region.
- Serves as the benchmark for comparison as changes are tracked in Sangamon County over the next ten years.

Next Survey Period: Will be updated every two years.

2. County Health Rankings and Roadmaps

Data Source: County Health Rankings and Roadmaps www.countyhealthrankings.org

Agency: Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

Date Data/Report was Completed: 2014

Organizations Involved: Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

Purpose of the Data or Assessment:

- Provide a revealing snapshot of how health is influenced by where we live, learn, work and play.
- They provide a starting point for change in communities.
- Roadmaps provide guidance and tools to understand the data, and strategies that communities can use to move from education to action.
- Help communities bring people together from all walks of life to look at the many factors that influence health, focus on strategies that we know work, learn from each other, and make changes that will have a lasting impact on health.

Methodology: The health rankings are compiled using county-level measures from a variety of national data sources. These measures are standardized and combined using scientifically-informed weights. Counties are ranked by state, providing two overall ranks:

1. Health outcomes: how healthy a county is now
2. Health factors: how healthy a county will be in the future

Sources of Information: The health rankings are compiled using county-level measures from a variety of national data sources.

Key Findings or Priorities:

- Health outcomes: length and quality of life
- Health factors: how healthy a county will be in the future
    - Health behaviors
    - Clinical care
    - Social and economic factors
    - Physical environment

Additional Community Information: County Health Rankings suggests that to impact Sangamon County's ranking, consideration might be given to the following issues:

- Adult smoking
- Adult obesity
- Sexually transmitted diseases
- Violent crime

Outcomes: 81/102 in Health Outcomes; 22/102 in Health Factors

Next Survey Period: Annual

3. Voices for Children: Illinois Kids Count

Data Source Voices for Children: Illinois Kids Count www.voices4kids.org

Agency: Voices for Illinois Children

Date Data/Report was Completed: 2014

Organizations Involved:

Purpose of the Data or Assessment: To examine the quality of life facing children and families throughout the state. The county-level and statewide statistics demonstrate trends, illustrate needs, and support policy proposals

Methodology: N/A

Sources of Information:

- U.S. Census Bureau,
- Small Area Health Insurance Estimates
- Illinois Department of Healthcare and Family Services
- Illinois Department of Public Health
- American Community Survey, 2005–2007 and 2010–2012
- Illinois Department of Children and Family Services.
- Criminal Justice Information Authority; based on data from Illinois State Police

Key Findings or Priorities:

- Access to Care
- Infant mortality
- Child poverty rates
- Child poverty population
- Child abuse and neglect rates
- Substantiated cases of abuse and neglect
- Substitute care
- Teen births
- Crimes against children

Outcomes: Key community-level findings in the areas of:

- Child Poverty
- Family Income
- Medical Assistance
- Pre-School
- Low-Income Student Enrollment
- High School Graduation Rates
- Substitute Care
- Child Abuse and Neglect
- Child Population

Next Survey Period: Annually

4. Food Atlas

Data Source: http://www.ers.usda.gov/data-products/food-access-research-atlas.aspx#.U34puXa96uQ

Agency: Unites States Department of Agriculture

Date Data/Report was Completed: Ongoing – Last updated April 16, 2014

Organizations Involved: USDA

Purpose of the Data or Assessment: To identify and define which areas are considered food deserts as defined by the following criteria:

- Accessibility to sources of healthy food, as measured by distance to a store or by the number of stores in an area.
- Individual-level resources that may affect accessibility, such as family income or vehicle availability.
- Neighborhood-level indicators of resources, such as the average income of the neighborhood and the availability of public transportation.

Methodology: In the new Food Access Research Atlas, food access indicators for census tracts using ½-mile and 1-mile demarcations to the nearest supermarket for urban areas, 10-mile and 20-mile demarcations to the nearest supermarket for rural areas, and vehicle availability for all tracts are estimated and mapped. Users of the Atlas can view census tracts by food access indicators using these different measures, including the original food desert measure, to see how the map changes as the distance demarcation or inclusion of vehicle access changes.

Key Findings or Priorities in order of frequency:

- Accessibility to sources of healthy food, as measured by distance to a store or by the number of stores in an area.
- Individual-level resources that may affect accessibility, such as family income or vehicle availability.
- Neighborhood-level indicators of resources, such as the average income of the neighborhood and the availability of public transportation.

Additional Community Information:

Outcomes: n/a

Next Survey Period: Ongoing

5. State Health Improvement Plan (SHIP)

Data Source: State Health Improvement Plan (SHIP) www.idph.state.il.us/ship/

Agency: Illinois Department of Public Health

Date Data/Report was Completed: 2007 and 2010

Organizations Involved: Team of public, private and voluntary sector stake holders appointed by the Director of the Illinois Department of Public Health – 55 members

Purpose of the Data or Assessment: Identify high-impact strategies and desired health and system outcomes ate are of concern to and amenable to, action by this broadly defined public health system.

Methodology: Reviewed findings from four assessments and gathered public input.

Sources of Information: Statewide Themes and Strengths Assessment, State Health Profile, Public Health System Assessment and Force of Change Assessment

Key Findings or Priorities:
There are five public health system strategic issues in the SHIP Plan:
1) Improve Access to Health Services
2) Enhance Data and Health Information Technology
3) Address Health Disparities and Social Determinants of Health
4) Measure, Manage, Improve, and Sustain the Public Health System
5) Assure a Sufficient Workforce and Human Resources.

There are also nine priority health concerns addressed:
1) Alcohol and Tobacco
2) Use of Illegal Drugs/Misuse of Legal Drugs
3) Mental Health
4) Natural and Built Environment
5) Obesity: Nutrition and Physical Activity
6) Oral Health
7) Unintentional Injury
8) Violence
9) Patient Safety and Quality.

Additional Community Information: Statewide Plan

Outcomes: SHIP Implementation Plan and Coordination Council, "Aligning Illinois for Health Improvement and Equity" – Implementation Plan for the Illinois State Health Improvement Plan 2010-2015

Next Survey Period: Required to be updated every four years, Public Act 93-0975

6. Greater Springfield Q5 Competitive Assessment

Data Source: Q5 Competitive Assessment www.gscc.org

Agency: Greater Springfield Chamber of Commerce, Quantum Group Partnership

Date Data/Report was Completed: 4/17/14, Second Phase Q5 Recommendations, "2014 Springfield by the Numbers" – a numerical profile of the Greater Springfield Illinois Region

Organizations Involved: Greater Springfield Chamber of Commerce and the Springfield Sangamon County Regional Planning Commission

Purpose of the Data or Assessment: Economic Development Strategy

Methodology: Stakeholder Input (October 2010) Competitive Assessment (December 2010) This report assesses the region's trends and conditions in terms of People (demographic, social, and workforce characteristics.) Prosperity (realities of the economy), and Place (quality of life and infrastructure.) This report compares Springfield metro to the state, nation and three peer regions – Bloomington-Normal IL, Rochester, MN and Topeka, KS.

Sources of Information: Various

Key Findings or Priorities: Three priority goals: 1) Economic Diversification; 2) Workforce Sustainability; 3) Community Attachment and Inclusion.

Additional Community Information: "SangStat Regional Indicators Pilot Project" prepared by the Springfield-Sangamon County Regional Planning Commission mostly 2010 data

Outcomes: n/a

Next Survey Period: Unsure

7. Coordinated Access to Community Health (CATCH)

Data Source: Coordinated Access to Community Health - **CATCH**

Agency: Sangamon County Medical Society/CATCH www.scmsdocs.org/catch.htm

Date Data/Report was Completed: 5/21/14

Organizations Involved: CATCH only

Purpose of the Data or Assessment: Our CHNA team request for data and general impressions of CATCH clients/members

Methodology: Hand tally of Electronic Medical Records (EMR)

Sources of Information: Electronic medical record

Key Findings or Priorities in order of frequency:

1. 789.09 Abdominal Pain
2. 786.50 Chest Pain
3. 786.50 Shortness of Breath
4. 250.00 Diabetes uncomp Type II
5. 305.1 Non-dependent tobacco use
6. 311 Depressive Disorders
7. 300 Anxieties
8. 070.70 Unspec Hep C w/o coma
9. 493.90 Asthma unspec
10. 278.01 Morbid Obesity
11. 724.5 Backache unspec
12. 272.4 OTH unspec Hyperlipidemia

780.79 Malaise & Fatigue

Additional Community Information: Status of CATCH Members since implementation of the Affordable Care Act, ACA, Medicaid Expansion and Marketplace

Total CATCH enrollment is 1,948 (this number is since the beginning of the program May 2011). Current enrollment is 1662.

Out of the original 1948 enrolled in CATCH:

- 155 have received Medicaid
- 133 Pending Medicaid
- 12 are Deceased
- 9 have now received Medicare
- 12 have been terminated
- 11 have moved out of County
- 1 received Veterans Benefits
- 34 have appointments with CATCH to enroll in Medicaid
- For all others, voicemails have been left; letters sent trying to get them to make appointments for Medicaid enrollment.

Outcomes: n/a

Next Survey Period: upon request

8. Sangamon County Department of Community Resources Need Assessment & Action Plan

Data Source: Needs Assessment and Community Action Plan 2014

Agency: Sangamon County Department of Community Resources (SCDCR)
www.co.sangamon.il.us/CR/resource.asp

Date Data/Report was Completed: 2013

Organizations Involved: Sangamon County Department of Community Resources

Purpose of the Data or Assessment: SCDCR strives to improve the quality of life of residents with low incomes in Sangamon County. The goal is self-sufficiency of customers and referrals to community partners.

Methodology: Annual strategic planning and surveys of customers, community partners and the County Board completed every three years.

Sources of Information: n/a

Key Findings or Priorities:

1. Food assistance was identified as a need. A weekend (healthy) food box program will be designed for children whose families are food insecure in 2014. It will also cover the week between Christmas and New Year's.
2. Dental and prescription drug assistance is needed.

Additional Community Information: Financial education and scholarships for GED and college programs are intended to help self-sufficiency.

Outcomes: n/a

Next Survey Period: 2014

9. Central Counties Health Centers Federally Qualified Health Clinic

Data Source: http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&bid=059700&state=IL

See attached map of patient residence by zip code.

2010	2011	2012	2010 - 2012 Trend %Change
Total Patients			
Total Patients	17,204	16,707	17,119	-0.50%
Age (% of total patients)			
Children (< 18 years old)	40.40%	38.90%	36.00%	-10.90%
Adult (18 - 64)	57.30%	58.70%	61.40%	7.10%
Geriatric (age 65 and over)	2.20%	2.40%	2.50%	14.70%

Racial and/or Ethnic Minority	49.20%	48.90%	48.30%	-1.70%
Hispanic/Latino Ethnicity	2.50%	2.50%	2.60%	2.40%
Black/African American 1	43.90%	43.60%	43.00%	-2.10%
Asian 1	1.80%	2.00%	2.20%	18.40%
American Indian/Alaska Native 1	0.10%	0.10%	0.10%	0.60%
Native Hawaiian / Other Pacific Islander 1	0.10%	0.00%	0.00%	-19.50%
More than one race 1	0.90%	0.80%	0.60%	-28.60%
Language (% known)				
Best Served in another language	0.60%	1.20%	1.10%	93.90%
Patient Characteristics				
	2010	**2011**	**2012**	
Income Status (% of patients with known income)				
Patients at or below 200% of poverty	96.10%	95.70%	95.90%	-0.10%
Patients at or below 100% of poverty	74.40%	74.60%	75.80%	1.90%
Insurance Status (% of total patients)				
Uninsured	32.90%	36.00%	38.90%	18.10%
Children Uninsured (age 0-19 years)	6.00%	6.30%	6.30%	4.70%
Medicaid/CHIP 2	62.00%	59.30%	56.30%	-9.20%
Medicare	4.50%	4.00%	3.80%	-15.60%
Other Third Party	0.50%	0.70%	1.00%	87.60%
Special Populations				
Homeless	1,230	1,216	1,240	0.80%
Agricultural Worker	0	26	21	-
Public Housing	-	-	-	-
School Based	0	0	0	
Veterans	98	109	137	39.80%
Services				
Services (# of patients)	**2010**	**2011**	**2012**	**2010 - 2012 Trend %Change**
Medical	13,217	13,174	13,985	5.80%
Dental	6,666	5,773	5,409	-18.90%
Mental Health	0	0	-	
Substance Abuse	0	0	-	
Vision	0	0	-	
Enabling	0	0	-	
Clinical Data				
	2010	**2011**	**2012**	**2010 - 2012**

				Trend %Change
Patients				
Medical Conditions (% of patients with medical conditions)				
Hypertension 3	26.10%	28.30%	29.70%	13.70%
Diabetes 4	9.00%	9.90%	10.10%	12.30%
Asthma	4.70%	4.60%	10.10%	113.70%
HIV	0.20%	0.10%	0.20%	-5.50%
Prenatal				
Prenatal Patients	323	256	246	-23.80%
Prenatal patients who delivered	146	141	126	-13.70%
	2010	**2011**	**2012**	**2010 - 2012 Trend %Change**
Access to Prenatal Care (First Prenatal Visit in 1st Trimester)	73.70%	64.50%	76.80%	4.30%
Low Birth Weight	10.30%	8.50%	12.70%	23.60%
Cervical Cancer Screening	61.40%	52.90%	45.70%	-25.60%
Adolescent Weight Screening and Follow Up	-	90.00%	91.40%	
Adult Weight Screening and Follow Up	-	57.10%	78.60%	
Tobacco Use Screening	-	95.70%	95.70%	
Tobacco Cessation Counseling for Tobacco Users	-	40.00%	62.90%	
Colorectal Cancer Screening	-	-	28.60%	
Childhood Immunization 5	91.40%	78.60%	47.10%	-48.40%
Asthma Treatment (Appropriate Treatment Plan)	-	81.40%	72.90%	
Cholesterol Treatment (Lipid Therapy for Coronary Artery Disease Patients)	-	-	82.90%	
Heart Attack/Stroke Treatment (Aspirin Therapy for Ischemic Vascular Disease Patients)	-	-	87.10%	
Blood Pressure Control (Hypertensive Patients with Blood Pressure < 140/90)	64.30%	68.60%	68.60%	6.70%
Diabetes Control (diabetic patients with HbA1c <= 9%)	52.90%	71.40%	70.00%	32.40%
Cost Data				
	2010	**2011**	**2012**	**2010 - 2012 Trend**

				%Change
Cost Data				
Health Center Service Grant Expenditures	$1,981,982	$1,991,638	$2,047,670	3.30%
Total Cost	$6,786,766	$7,321,017	$7,704,271	13.50%
Total Cost Per Patient	$394.49	$438.20	$450.04	14.10%

10. Southern Illinois University Center for Family Medicine Federally Qualified Health Clinic

Data Source: http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&bid=05E00466&state=IL
SIU Center for Family Medicine became an FQHC in 2012. See attached map of patient residence by zip code.

2010	2011	2012	2010 - 2012 Trend %Change
Total Patients			
Total Patients	-	-	11,159
Age (% of total patients)			
Children (< 18 years old)	-	-	25.50%
Adult (18 - 64)	-	-	64.90%
Geriatric (age 65 and over)	-	-	9.60%
Racial and/or Ethnic Minority	-	-	26.20%
Hispanic/Latino Ethnicity	-	-	1.60%
Black/African American 1	-	-	24.00%
Asian 1	-	-	0.60%
American Indian/Alaska Native 1	-	-	0.10%
Native Hawaiian / Other Pacific Islander 1	-	-	0.10%
More than one race 1	-	-	0.10%
Language (% known)			
Best Served in another language	-	-	27.60%
Patient Characteristics			
	2010	**2011**	**2012**
Income Status (% of patients with known income)			
Patients at or below 200% of poverty	-	-	91.50%
Patients at or below 100% of poverty	-	-	71.30%
Insurance Status (% of total patients)			
Uninsured	-	-	4.70%

Children Uninsured (age 0-19 years)	-	-	1.50%	
Medicaid/CHIP 2	-	-	40.90%	
Medicare	-	-	14.90%	
Other Third Party	-	-	39.50%	
Special Populations				
Homeless	-	-	191	
Agricultural Worker	-	-	0	
Public Housing	-	-	-	-
School Based	-	-	0	
Veterans	-	-	0	
Services				
Services (# of patients)	**2010**	**2011**	**2012**	**2010 - 2012 Trend %Change**
Medical	-	-	11,159	
Dental	-	-	0	
Mental Health	-	-	387	
Substance Abuse	-	-	0	
Vision	-	-	0	
Enabling	-	-	-	-
Clinical Data				
	2010	**2011**	**2012**	**2010 - 2012 Trend %Change**
Patients				
Medical Conditions (% of patients with medical conditions)				
Hypertension 3	-	-	24.00%	
Diabetes 4	-	-	11.30%	
Asthma	-	-	6.80%	
HIV	-	-	0.00%	
Prenatal				
Prenatal Patients	-	-	265	
Prenatal patients who delivered	-	-	167	
	2010	**2011**	**2012**	**2010 - 2012 Trend %Change**
Access to Prenatal Care (First Prenatal Visit in 1st Trimester)	-	-	67.90%	
Low Birth Weight	-	-	8.40%	
Cervical Cancer Screening	-	-	64.30%	

Adolescent Weight Screening and Follow Up	-	-	31.40%	
Adult Weight Screening and Follow Up	-	-	48.60%	
Tobacco Use Screening	-	-	18.30%	
Tobacco Cessation Counseling for Tobacco Users	-	-	49.40%	
Colorectal Cancer Screening	-	-	44.30%	
Childhood Immunization 5	-	-	14.40%	
Asthma Treatment (Appropriate Treatment Plan)	-	-	25.10%	
Cholesterol Treatment (Lipid Therapy for Coronary Artery Disease Patients)	-	-	77.10%	
Heart Attack/Stroke Treatment (Aspirin Therapy for Ischemic Vascular Disease Patients)	-	-	35.60%	
Blood Pressure Control (Hypertensive Patients with Blood Pressure < 140/90)	-	-	65.30%	
Diabetes Control (diabetic patients with HbA1c <= 9%)	-	-	81.40%	
Cost Data				
	2010	**2011**	**2012**	**2010 - 2012 Trend %Change**
Cost Data				
Health Center Service Grant Expenditures	-	-	$209,416	
Total Cost	-	-	$5,824,028	
Total Cost Per Patient	-	-	$521.91	

11. UIS Center for State Policy and Research 2013 Annual Report

Data Source: UIS Center for State Policy and Research 2013 Annual Report

Agency: University of Illinois at Springfield

Date Data/Report was Completed: Spring 2014

Organizations Involved: UIS

Purpose of the Data or Assessment: The mission for the Center for State Policy and Research is to inform public decisions; educate and engage citizens in public affairs; improve leadership and service.

Methodology: Various methods of research, survey and analysis are employed to measure the impact of various programs and survey community members.

Sources of Information: Varies

Key Findings or Priorities: Just a few of the projects worked on in the past year include:

1. Preliminary analysis of results for the MOSAIC project for Mental Health Centers of Central Illinois to address child mental health issues shows favorable impact on those involved.
2. The Illinois Tobacco Quitline is a cost-effective program; nearly one-third of those surveyed had stopped smoking.
3. The Continuum of Learning is refocusing on what works for educational improvement, with emphasis on less advantaged children.
4. The Citizens Survey highlighted that a number of county residents regularly face food and healthcare insecurity.

Additional Community Information:

Outcomes:

Next Survey Period: Annual report 2014

12. Springfield Urban League Head Start/Early Head Start Community Assessment 2012-2013

Data Source: Springfield Urban League

Agency: Springfield Urban League

Date Data/Report was Completed: 2013

Organizations Involved: Springfield Urban League

Purpose of the Data or Assessment: In accordance with the Head Start Performance Standards, the 2012-2013 Community Assessment identifies and offers significant changes and trends regarding the current strengths, needs and challenges faced by the communities in Sangamon County and Morgan County.

Methodology: Querying various agencies in the communities that serve the targeted populations, referring to local census data, researching for pertinent information on-line, and analyzing aggregate

Head Start/Early Head Start Family Assessment results, parent surveys, and early childhood developmental assessment results.

Sources of Information: Parent surveys; US Census statistics; Voices for Illinois Children; Sangamon County Department of Public Health; mental health providers

Key Findings or Priorities: The assessment provides a great deal of detailed information on families in Sangamon and Morgan counties, the issues facing families whose children qualify for Head Start, and available services in the community. Issues include:

1. Dental services were identified as the greatest need for Head Start children.
2. Access to primary care; few PCPs who will accept these children; and use of hospital EDs (partly due to families missing appointments and being dropped by a PCP.
3. Sangamon County Dept. of Public Health has identified an increase in asthma among low-income African Americans, as well as increases in obesity and diabetes.
4. Second-hand smoke affects many Head Start children.
5. Teen births.
6. Mental health issues, with contributing factors being families facing reduced incomes and a decrease in available programs for assistance. Domestic violence and high levels of stress in Head Start families are increasing. The mental health section of the assessment provides additional overviews of related issues.
7. The number of children with disabilities/special needs continues to increase.
8. Available, affordable, quality child care is an issue
9. Literacy for both adults and children
10. Unemployment and poverty rates, particularly for African American families
11. Positive male involvement for children; need for support services for men
12. Child support payments
13. Abuse/neglect of children is increasing and is more severe
14. Domestic violence
15. Stable and affordable housing
16. Homelessness
17. Substance abuse
18. Transportation

Additional Community Information: The assessment report also provides a summary of available services in Sangamon and Morgan counties.

Next Survey Period: 2014-2015

13. Sangamon County Schools

Data Source: Sangamon County Schools

Agency: Regional Office of Education www.roe51.org

Date Data/Report was Completed: annually

Organizations Involved: Schools in Sangamon County

Purpose of the Data or Assessment: To determine the professional development needs of teachers and staff in Sangamon County Schools.

Methodology: Survey Monkey

Sources of Information: Teachers and Employees of Schools

Key Findings or Priorities: Unknown

Additional Community Information: n/a

Outcomes: n/a

Next Survey Period: annually

14. School Report Card

See attached one-page overview.

Data Source: School Report Card http://webprod.isbe.net/ereportcard/publicsite/getSearchCriteria.aspx

Agency: Illinois State Board of Education

Date Data/Report was Completed: 2012-2013 school year

Organizations Involved: Illinois State Board of Education; local school districts; local schools.

Purpose of the Data or Assessment: The school report card is a document that is produced for each regular public school in compliance with Section 10-17a of the Illinois School Code. With the passage of the federal No Child Left Behind law in 2001, report cards are also released for districts and the state.

Methodology: N/A

Sources of Information:

Key Findings or Priorities: See attached one-page overview for Springfield School District 186.

Additional Community Information: Financial education and scholarships for GED and college programs are intended to help self-sufficiency.

Outcomes: Individual school and district 'health'.

Next Survey Period: 2013-2014

Appendix B

SANGAMON COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT

Analysis of Public Input from Community Forums and Survey

Conducted by UIS Survey Research Office

UNIVERSITY OF ILLINOIS SPRINGFIELD

SURVEY RESEARCH OFFICE

October 31, 2014

Introduction

This report was completed by the UIS Survey Research Office as part of the Sangamon County Community Health Needs Assessment conducted by Memorial Medical Center, St. John's Hospital, and the Sangamon County Department of Public Health in collaboration with SIU School of Medicine's Office of Community Health and Service. This report provides the findings from the five community health forums as well as the results from the public survey, which allowed members of the Sangamon County community to provide input on the health priority areas in the region. This report was written by SRO Director Dr. Ashley Kirzinger with assistance from Tondalaya Reece (UIS Survey Research Office) and Mary Hart (Community Planning Fellow).

If you have any questions about this report, please contact the UIS Survey Research Office at (217) 206-6591 or sro@uis.edu.

Executive Summary

The Survey Research Office was asked by Memorial Medical Center, St. John's Hospital, the Sangamon County Department of Public Health, and SIU School of Medicine's Office of Community Health and Service to collect, record, and analyze public input for the 2014 Sangamon County Community Health Needs Assessment. The data that is included in this report is from two different but connected sources. First, it includes the survey responses completed by Sangamon County residents. The survey was available to residents online, at public forums, and at various locations throughout the community. In addition, public input from the five community health forums was recorded, transcribed, and coded in order to identify reoccurring themes as well as report on any additional health priority areas not previously identified. The following report includes detailed information on both of these data sources.

Overall, Sangamon County residents have a variety of health concerns ranging from specific illnesses affecting neighbors and family members to the absence of nutrition in the public school educational programs to the lack of access to proper healthcare and resources. Yet, when asked to identify the top health priority areas in Sangamon County, four priority areas are rated most important by the majority of Sangamon County residents. The four health priority areas are: Access to Care, Child Abuse, Mental Health, and Overweight/Obesity.

Access to Care

One-fourth of survey respondents report that access to care is the "top priority" in Sangamon County. In fact, less than 5 percent of Sangamon County residents report that it is not a priority. The lack of access to care was also a reoccurring theme in the community forums. Regardless of the location, forum participants reiterated the idea that the community does not benefit from having great hospitals and resources, if there are certain populations who lack access to these resources.

- At Lanphier High School (October 9, 2014), one the respondents said, "the hospitals have a lot of people who control a lot of resources…but when we talk about that access to care, we also need to talk about controlling resources or to be looking at how fair you are going to be with the resources. Not how my special interest groups are going to get taken care of (*participant*, Lanphier High School, October 9).
- One of the issues that you brought up was access to health care, and my concern is transportation for those who may be the elderly, disabled the low-income individuals. We have to major hospitals here will a major clinic, and some other facilities but if people can't get to those facilities to be taken care of, like you said it would be of no use. So my concern is what are the hospitals, what are the clinics doing, or is there something that can be done to provide transportation on a need bases to those individuals may need transportation (*participant*, Union Baptist Church, October 2).
- I've grown up in Riverton my whole life so I mean you're seeing, you know the people that I've grown up with that were, you know people that were through school through the village at work here they are getting to point where they are getting hard to get around. They still love their community they don't want to move to a nursing home they want to stay home as long as they can. There just doesn't seem to be a lot of assistance locally where we could afford to do it (*participant*, Riverton Village Hall, October 1).

It is important to note that at the community forum at Union Baptist Church, a community member

spoke of “institutional racism” and how it affects access to care.

- There was one that was left off and it is the one that most of us do like talk about a whole lot but I want to use the word and its racism. When I use that word I use it in the context specifically of racism that exists at an institutional systemic level not individual prejudice, but the kind that that is embedded in all of our organizations. Its of our history and I think when we think of the health of the community and racism is a better topic to look at because there are ways to address that at an institutional level that in turn set the stage for creating a really totally healthy community (*participant*, Union Baptist Church, October 2).

Child Abuse

Child Abuse ranked highly on the community survey with 83.4 percent reporting that it is a high priority and 10 percent reporting that it is the top health priority area in Sangamon County. This priority area was especially important to women and African American respondents. The topic was not widely discussed at the community forums, yet it was mentioned at the community forum at Lanphier High School on October 9th.

- There was a study done on 17,000 women who were seeking medical care for almost all the things that were on here; heart disease, alcoholism, cancer, variety of illnesses and what they had in common they discovered many of them were also they are to be in a weight loss program. There was a high incidence of obesity. One of the common denominators was child abuse. Out of the 17,000 women and they started learning from them about sexual abuse. These people had a variety of health issues later in life. They'd never disclosed they never talk to anybody about these issues before and till they went into this study they were not aware of the long-lasting issues that they would then encounter as a result of the abuse. And we also know that obesity is also linked to child abuse (*participant*, Lanphier High School, October 9).

Mental Health

Eighty-seven percent of survey respondents report that mental health is a high priority in the area with 14.5 percent of respondents reporting that it was the “top priority.” This subject was also frequently mentioned in the open-ended survey responses as well as the community forums. Individuals frequently mentioned how other illness were correlated with mental health issues like diabetes and obesity.

- One of the concerns that I think, is, not, adequately addressed by the whole country, is, is the issues of mental health, and primarily because, there are mental health services, but, as a society, we need to be more, aware of the magnitude of what these problems are when we hear about, people being shot and college campuses being shot at army posts and whatever, it doesn’t surprise me that much because, there is a lot more mental health problems that are out there, but the public doesn’t know about them, and I would really like to see something more to be done, including trying to make it more acceptable for people to come and, admit that they have mental health problems (*participant*, Washington Park Botanical Gardens, October 6).
- Our mental wellness because it seems like going off with what [redacted] was just talking about looking at these health needs you know access to care, dental care, food insecurity leads to a lot of stress in our families. That's you know it in and it were 81st in the whole state so it's all levels in our community, right? It's not just the kids and it's everybody. So I'm just wondering about our mental state you know how hopeful we are or how much stress we have. You had on there about affordable housing and when you're spending 50% of your income and more on

your house, no matter what income you are, you put a lot of stress on yourself. So, I just thought that was a big need for our children and for our adults is looking at that mental wellness and your mental ability and you know. Not mental health but how we determine what mental health means. Your well-being and how you feel about your life. That's what I was thinking about (*participant*, Lanphier High School, October 9).

Overweight and Obesity

Nineteen percent of Sangamon County residents report that overweight/obesity is the top healthy priority area in the region. When this topic was discussed at the community forums, most of the discussion traced back educating children about healthy nutrition. It is important to note that participants discussed both education in the schools and in the homes.

- I'm struck as I said in this high school by the signs that I see on the walls, Pepsi, I look back at the vending machines and I see high calorie, high sugar snacks, I see Mountain Dew and I think this is a real problem in our schools and I'm not particularly criticizing Lanphier high school. It's everywhere I'm on the board at the high school where my children used to go to school. We have a full-time fry cook! I think that's just inexcusable. I think that we need to take a serious look at what we're putting in our bodies and what power modeling for our children and begin to change our eating habits and how that would help our over hell, overall health and well-being. And know we talk about women with depression and issues related to child abuse. All of that is kind of tied up in self-esteem and I think that if we assist as society could try to get a handle on our own personal health that would help, that would help tremendously (*participant*, Lanphier High School, October 9).
- For many reasons children aren't eating it or aren't eating all of it. So, providing a nutritious meal and having it there for them is definitely one step that needs to be taken. But, we have to change the culture of the students' acceptance and their liking towards different types of foods. That goes beyond the school , you can't teach just in school. If they don't eat here, they go home after school and grab a bag of food and off they go. We're not accomplishing goals by simply regulating the food you have to eat your lunch here. It's just one component of what has to happen. It is more about culture I think (*participant*, Lanphier High School, October 9).
- Interest in full disclosure I'm a pediatrician in the area, so I definitely have a focus on the pediatric population. But I definitely see a rising in pediatric obesity, and I do think we definitely need to focus on the kids getting them the healthy, healthy foods, but also focusing on activity in the community as a whole. I don't have a one quick and easy answer for how to fix that but I definitely think it's something we need to focus on because kids are obviously our future. And the problems they are developing now in childhood are just gonna follow them later on into adulthood and result in increased mortality and morbidity (*participant*, Washington Park Botanical Gardens, October 6).

Survey Results

As part of the community health needs assessment, a survey was available (online and printed copies) to members of the public. Copies of the survey were available at specific locations throughout Sangamon County as well as at the community health forums. The link to the online survey was widely distributed via media and the partnering organizations.

Overall, 781 individuals completed the survey. Fifty-five of the surveys were completed at the community focus groups, 137 printed surveys were returned to the SRO, and 589 individuals completed the survey online. The survey was available to Sangamon County community members from September 22 to October 20, 2014.

Table 1 presents the demographic characteristics of both samples (community forum participants, community survey participants) compared to the most recent population estimates according the 2012 American Community Survey. As you can see in the table, a higher percentage of females participated in the community survey compared to overall population estimates. Three-fourths of the responses in the community survey are from female respondents while they only represent 52 percent of the Sangamon County population. In addition, we find that a higher percent of those who participated in the survey (forum participants and community participants) reported having advanced degrees compared to population estimates. For example almost three-fourths of individuals who attended the forums and completed a survey reported having an advanced degree as did 45.7 percent of those who completed a survey outside of the forum. This compares to only 11.6 percent of Sangamon County's population that has an advanced degree (see figure 1).

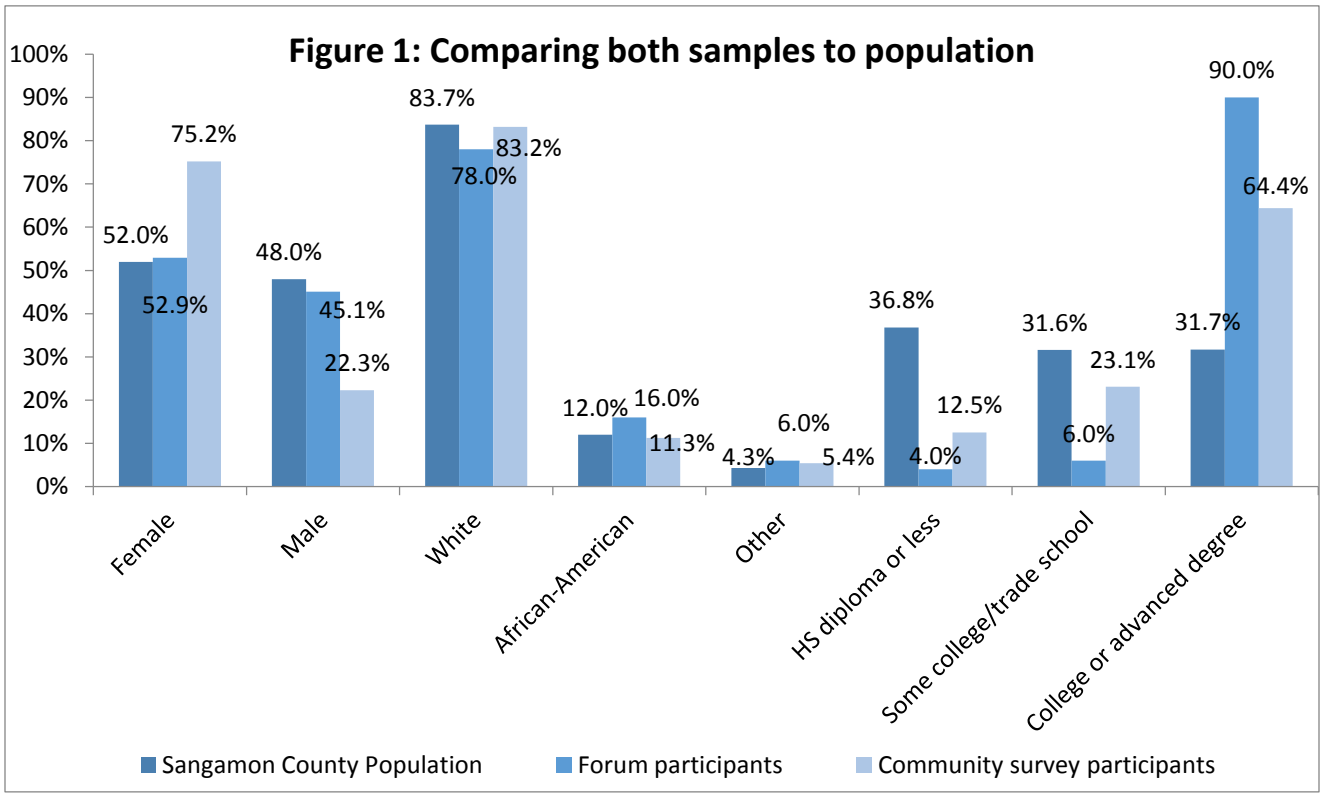


Table 1. Demographic characteristics of focus group participants and community participants compared to population

	Sangamon County Population (2012 ACS estimates)	Focus group participants *N*=55	Community participants (online and paper surveys) *N=726*
Gender			
Female	52.0%	52.9%	75.2%
Male	48.0%	45.1%	22.3%
Race			
White	83.7%	78.0%	83.2%
African-American	12.0%	16.0%	11.3%
Asian	1.6%	6.0%	0.9%
Other	2.7%	0.0%	4.6%
Ethnicity			
Hispanic/Latino(a)	1.8%	2.2%	2.7%
Non-Hispanic/Latino(a)	98.2%	97.8%	97.3%
Age			
18-24 years old	6.0%	8.0%	4.8%
25-34 years old	12.8%	16.0%	18.4%
35-44 years old	12.8%	8.0%	18.9%
45- 54 years old	15.2%	14.0%	26.4%
55-64 years old	13.3%	26.0%	23.2%
65 and older	13.7%	28.0%	8.3%
Education			
Less than high school diploma	8.2%	0.0%	4.0%
HS diploma	28.6%	4.0%	8.5%
Some college/trade school	31.6%	6.0%	23.1%
College degree	20.1%	16.0%	18.7%
Advanced degree	11.6%	74.0%	45.7%
Disability Status			
Have a disability	-	6.1%	8.4%
Do not have a disability	-	93.9%	91.6%
Income			
Less than $20,000	-	14.0%	10.4%
$20,000-$40,000	-	12.0%	16.4%
$40,001-$60,000	-	24.0%	18.4%
$60,001-$80,000	-	12.0%	13.7%
$80,001-$100,000	-	8.0%	8.4%
More than $100,000	-	16.0%	14.0%
Retired	-	10.0%	3.4%
Prefer not to say	-	4.0%	15.2%

The first section of the survey asks participants to rate each of the nine health priority areas as either "a high priority," "a low priority," or "not a priority at all." As seen in table 2 below, the top four health priority areas are mental health, child abuse, overweight/obesity, and access to care. For each of these health priority areas, more than three-fourths of respondents reported these were "high priority areas."

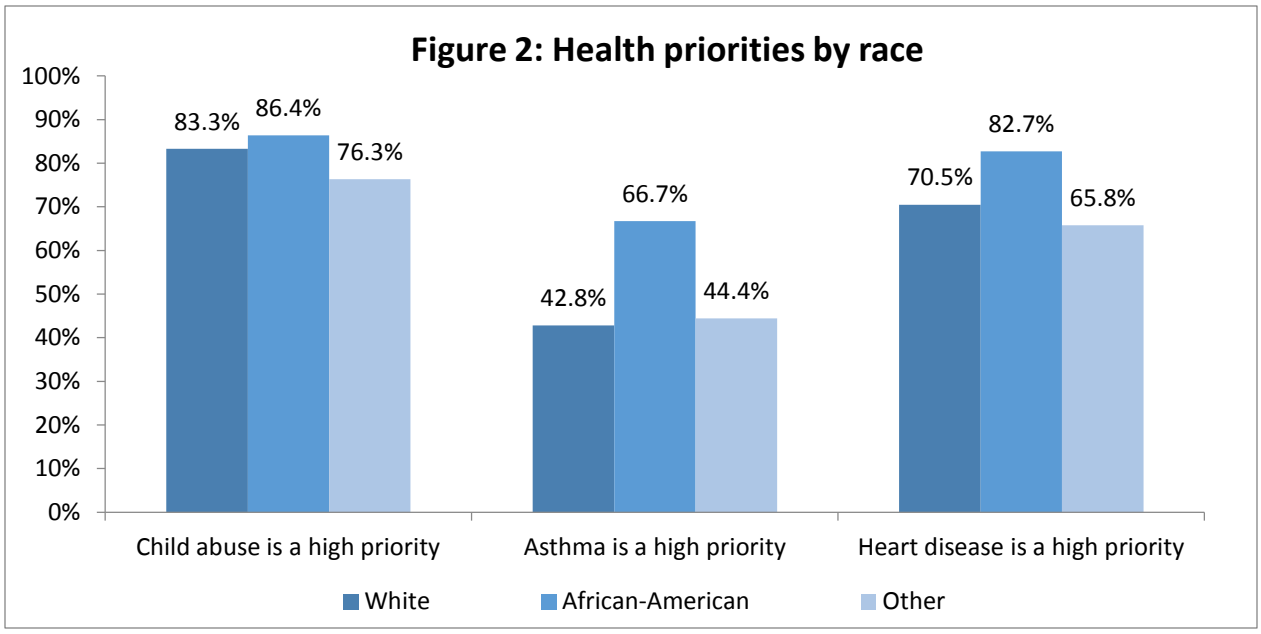
Table 2. Rating of health priority areas

	High priority	Low priority	Not a priority at all
Mental Health	86.9%	10.5%	2.7%
Child Abuse	83.4%	13.5%	3.1%
Overweight/Obesity	78.8%	18.2%	3.1%
Access to Care	76.2%	19.6%	4.2%
Heart Disease	71.9%	25.6%	2.6%
Diabetes	71.6%	25.6%	2.7%
Dental Care	62.1%	34.3%	3.6%
Food Insecurity	58.4%	31.9%	9.7%
Asthma	46.3%	48.5%	5.2%

When we examine whether demographic groups rated health priority areas differently, we only find a few significant differences (chi-squares in which significance is $p<.05$).

First, women are more likely than men to report that mental health and child abuse are a high priority. Eighty-six percent of women compared to 73.3 percent of men report that child abuse is a high priority. In addition, 91.3 percent of women compared to 74.8 percent of men report that mental health is a high priority. Overall, women rate the majority of all of the health priorities higher than the male respondents (the only exception is heart disease).

In addition, African-American respondents are more likely to report that asthma, child abuse, and heart disease are high priorities than either White respondents or respondents who do not identify as either White or African-American (see figure 2 below).



The second section of the survey asked respondents to identify the top three health priorities in the area. Table 3 presents the percentage of individuals who rated each of the health priorities as the top priority as well as the percentage of individuals who rated it in the top three priorities. The top four priorities are the same ones presented in the section above: access to care, overweight/obesity, mental health, and child abuse.

Table 3.The top health priority in the area

	Top priority	One of the top three priorities
Access to Care	24.2%	43.4%
Overweight/Obesity	19.0%	44.3%
Mental Health	14.5%	49.9%
Child Abuse	10.0%	34.4%
Heart Disease	6.4%	22.9%
Food Insecurity	4.9%	22.2%
Dental Care	3.7%	16.9%
Diabetes	2.4%	19.0%
Asthma	0.6%	4.9%

Finally, respondents were asked to report whether they thought any of the nine priority areas identified by the advisory group were **not** a health priority in Sangamon County. Overall, 147 individuals reported that they did not think food insecurity was a priority area and 115 individuals reported that asthma was not a priority area. Less than five percent of the sample (39 individuals) reported thinking that mental health was not a priority area in the area.

FROM THE SURVEYS

The 2014 Community Health Need Assessment Advisory Committee has identified the following nine community health needs as possible priorities for Sangamon County. For the following health needs, please identify whether you think it is a high priority, a low priority, or not a priority at all for Sangamon County?

Access to Care

	Percent of forum participants (*n*)	Percent of community participants (*n*)	Total percent(*n)*
High priority	83.7% (41)	75.7% (520)	76.2% (561)
Low priority	14.3% (7)	19.9% (137)	19.6% (144)
Not a priority at all	2.0% (1)	4.4% (30)	4.2% (31)

Asthma

	Percent of forum participants (*n*)	Percent of community participants (*n*)	Total percent(*n)*
High priority	50.0% (24)	46.1% (315)	46.3% (339)
Low priority	47.9% (23)	48.5% (332)	48.5% (355)
Not a priority at all	2.1% (1)	5.4% (37)	5.2% (38)

Child Abuse

	Percent of forum participants (*n*)	Percent of community participants (*n*)	Total percent(*n)*
High priority	85.4% (41)	83.3% (579)	83.4% (620)
Low priority	10.4% (5)	13.7% (95)	13.5% (100)
Not a priority at all	4.2% (2)	3.0% (21)	3.1% (23)

Dental Care

	Percent of forum participants (*n*)	Percent of community participants (*n*)	Total percent(*n)*
High priority	68.6% (35)	61.6% (427)	62.1% (462)
Low priority	29.4% (15)	34.6% (240)	34.3% (255)
Not a priority at all	2.0% (1)	3.8% (26)	3.6% (27)

Diabetes

	Percent of forum participants (*n*)	Percent of community participants (*n*)	Total percent(*n)*
High priority	77.1% (37)	71.3% (491)	71.6% (528)
Low priority	20.8% (10)	26.0% (179)	25.6% (189)
Not a priority at all	2.1% (1)	2.8% (19)	2.7% (20)

Food Insecurity

	Percent of forum participants (*n*)	Percent of community participants (*n*)	Total percent(*n)*
High priority	74.0% (37)	57.2% (391)	58.4% (428)
Low priority	20.0% (10)	32.8% (224)	31.9% (234)
Not a priority at all	6.0% (3)	10.0% (68)	9.7% (71)

Heart Disease

	Percent of forum participants (*n*)	Percent of community participants (*n*)	Total percent(*n)*
High priority	83.7% (41)	71.0% (490)	71.9% (531)
Low priority	16.3% (8)	26.2% (181)	25.6% (189)
Not a priority at all	0.0% (0)	2.8% (19)	2.6% (19)

Mental Health

	Percent of forum participants (*n*)	Percent of community participants (*n*)	Total percent(*n)*
High priority	88.0% (44)	86.8% (604)	86.9% (648)
Low priority	10.0% (5)	10.5% (73)	10.5% (78)
Not a priority at all	2.0% (1)	2.7% (19)	2.7% (20)

Overweight/ Obesity

	Percent of forum participants (*n*)	Percent of community participants (*n*)	Total percent(*n)*
High priority	82.0% (41)	78.5% (549)	78.8% (590)
Low priority	16.0% (8)	18.3% (128)	18.2% (136)
Not a priority at all	2.0% (1)	3.1% (22)	3.1% (23)

Listed below are the nine health needs, please identify the top three priorities in the region by drawing a line from the health need to the priority ranking. Please select only one health need for each priority ranking.

Forum participants

	Highest priority	Second Highest Priority	Third Highest Priority	Did not list as a top 3 priority
Access	35.5%	10.9%	1.8%	61.8%
Asthma	0%	1.8%	1.8%	96.4%
Child Abuse	3.6%	12.7%	5.5%	78.2%
Dental Care	1.8%	0.0%	14.5%	83.6%
Diabetes	1.8%	5.5%	5.5%	87.3%
Food Insecurity	3.6%	10.9%	18.2%	67.3%
Heart Disease	9.1%	7.3%	5.5%	78.2%
Mental Health	3.6%	10.9%	18.2%	67.3%
Overweight/ Obesity	25.5%	14.5%	3.6%	56.4%

Community participants

	Highest priority	Second Highest Priority	Third Highest Priority	Did not list as a top 3 priority
Access	24.1%	9.5%	10.2%	56.2%
Asthma	0.7%	2.5%	1.8%	95.0%
Child Abuse	10.5%	12.8%	12.1%	64.6%
Dental Care	3.9%	5.8%	7.3%	83.1%
Diabetes	2.5%	9.2%	7.7%	80.6%

Food Insecurity	5.0%	7.4%	9.0%	78.7%
Heart Disease	6.2%	7.4%	9.4%	77.0%
Mental Health	15.3%	19.0%	16.9%	48.8%
Overweight/ Obesity	18.5%	13.4%	12.5%	55.6%

Total

	Highest priority	Second Highest Priority	Third Highest Priority	Did not list as a top 3 priority
Access	24.2%	9.6%	9.6%	56.6%
Asthma	0.6%	2.4%	1.8%	95.1%
Child Abuse	10.0%	12.8%	11.7%	65.6%
Dental Care	3.7%	5.4%	7.8%	83.1%
Diabetes	2.4%	9.0%	7.6%	81.0%
Food Insecurity	4.9%	7.7%	9.6%	77.8%
Heart Disease	6.4%	7.4%	9.1%	77.1%
Mental Health	14.5%	18.4%	17.0%	50.1%
Overweight/ Obesity	19.0%	13.4%	11.9%	55.7%

Please select all, if any, of the following health needs that you do not think are priority in Sangamon County.

	Forum participants	Community participants	Total
Access	1	89	90
Asthma	4	111	115
Child Abuse	3	47	50
Dental Care	5	78	83
Diabetes	1	50	51
Food Insecurity	5	142	147
Heart Disease	2	38	40
Mental Health	2	37	39
Overweight/ Obesity	3	69	72

Appendix C

SANGAMON COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT
Analysis of Public Input from Enos Park Focus Groups
Conducted by UIS Survey Research Office

UNIVERSITY OF ILLINOIS SPRINGFIELD
SURVEY RESEARCH OFFICE

Draft Report submitted on February 18, 2015

Project Methodology

The Survey Research Office was contacted by Memorial Medical Center, St. John's Hospital, the Sangamon County Department of Public Health, and SIU School of Medicine's Office of Community Health and Service to collect, record, and analyze public input for the 2015 Sangamon County Community Health Needs Assessment. Based, in part, on the results of that report (issued on December 2, 2014), Memorial Medical Center and HSHS St. John's Hospital chose "Access to Care among Enos Park Residents" as their joint collaborative for the 2015 Community Health Needs Assessment.

The topic of Access to Care is broad and has many different dimensions. The goal of this step in the process is to identify the obstacles that prevent people and their families in the Enos Park neighborhood from getting the health care services they need, and obstacles that prevent them from being healthy.

In an effort to answer these questions, the SRO conducted four focus groups in Enos Park. The CHNA Core Group developed a list of topics to be discussed at the focus groups; however, the final scripts were developed solely by the SRO staff. The topics discussed at the focus groups include the following:

- Points of access to health care
- Trust of medical community
- Transportation
- Health literacy
- Health insurance
- Prescription medication
- Other needed services

The forty-three participants were involved in one of the four focus groups. They were recruited using a variety of methods. The following details the specific methodology for each of the focus groups.

Focus Group of Enos Park Stakeholders (Jan. 20, 2015)

A list of possible stakeholders who currently serve Enos Park residents and/or provide services in close proximity to the Enos Park neighborhood was provided by Memorial Medical Center and HSHS St. John's Hospital. These individuals were contacted via mail (December 30, 2014) with follow up phone calls beginning on January 6, 2015. Lunch was provided. Sixteen individuals participated in this focus group representing the following agencies: Enos Park Neighborhood Improvement Association, Family Service Center- Compass Program, Inner City Mission, Kumler Outreach Ministries, McClernand Elementary School, M.E.R.C.Y Communities, Mental Health Centers of Central Illinois, Mini O'Beirne Crisis Nursery, Ronald McDonald House, Community Support Network, Springfield Housing Authroity, SIU School of Medicine. This focus group was held at Kumler Outreach Ministries.

Focus Group of Enos Park Older Adults (Jan. 22, 2015)

Possible participants for this focus group were developed using two methodologies. First, Enos Park Neighborhood Improvement Association provided a list of names of individuals who live in Enos Park and are 55 or older. Second, a listed sample was generated by SRO using telephone numbers located within the geographic parameters of Enos Park Neighborhood (U.S. Census Tracts, Sangamon County IL8 and IL9). Individuals were called by trained interviewers in the SRO and asked screening information including age of individual and whether they still currently live in Enos Park. Fifteen individuals participated in this focus group and received $50 financial incentive and breakfast for their participation. The focus group was held at Kumler Methodist Church.

Focus Group of Enos Park Younger Adults/Young Parents (Jan. 24, 2015)

Possible participants for this focus group were developed using two methodologies. First, Enos Park Neighborhood Improvement Association provided a list of names of individuals who live in Enos Park and are 40 years old or younger or have young children. Second, a listed sample was generated by SRO using telephone numbers located within the geographic parameters of Enos Park Neighborhood (U.S. Census Tracts, Sangamon County IL8 and IL9). Individuals were called by trained interviewers in the SRO and asked screening information including age of individual and whether they still currently live in Enos Park. Seven individuals participated in this focus group and received $50 financial incentive and lunch for their participation. Childcare was also provided by UIS for these individuals. The focus group was held at Third Presbyterian Church.

Focus Group of Enos Park MERCY Communities (Feb. 3, 2015)

This focus group consisted of families who are connected to M.E.R.C.Y Communities, a not-for-profit organization dedicated to addressing the crisis of family homelessness. This organization provides housing in Enos Park neighborhood for several families. Five individuals living in M.E.R.C.Y Communities Enos Park residences were recruited by the organization to attend this focus group. Individuals received $50 financial incentives for their participation. The focus group was held at M.E.R.C.Y Communities, located in Enos Park and childcare was also provided by M.E.R.C.Y Communities for these individuals.

Summary of Findings

Executive Summary

The summary report is categorized into the topics suggested by the CHNA Core Group. Yet, there are some key findings that are covered in almost all of the topics. First, Enos Park residents have limited knowledge of how to successfully access the current health care system. While stakeholders mentioned a vast network of support services that are available in Enos Park, the majority of residents were unaware of these services. In addition, for many, their only point of access to health care is through the hospitals' Emergency Departments. These visits are typically for acute health problems and therefore, have an added level of stress on individuals who are unaware of health care systems. Even among individuals who have primary care providers, there is almost no relationship between the individual and the provider. This leads to mistrust, confusion, and dissatisfaction among individuals. This lack of knowledge spreads also to oral health services, mental health services, and vision services. Second, transportation issues loom large for senior adults. Finally, the majority of the individuals who participated in these focus groups are eligible for Medicaid/Medicare. Yet, the stigma surrounding these programs as well as the confusion surrounding the benefits of these programs leaves resources untapped by vulnerable population.

Points of access to health care

There are only a few points of access to health care for the Enos Park Neighborhood residents. Individuals either access health care through a social service agency, through a primary care provider, or through the hospitals' emergency rooms or an urgent care facility like *Prompt Care* or *Priority Care*.

Social service agencies serve as liaisons between the patients and care providers and assist individuals with access to transportation, understanding insurance and prescriptions, and providing basic health needs (like food, clothing, etc.) Several of the social service agencies that assist Enos Park residents also provide health services, like blood pressure testing or dental services, however, these types of services are limited. One of the more interesting findings regarding social service agencies is that there is not a lot of communication and collaboration among the agencies. Most of the agencies are not completely aware of the services provided by other agencies and very rarely do the agencies work together on issues. One of the rare exceptions is an event held at Kumler Methodist Church in which more than 20 social service agencies participate. Yet, this type of collaboration is rare. Interestingly, the social service agencies are also not aware of United Way's 2-1-1 service.[1] In fact, this was common among all focus group participants.

The lack of primary care providers seems to mainly affect younger adults in Enos Park. Some of the individuals report that they do not have a primary care provider located in Springfield, because they were not sure how to access one or understood the importance of maintaining a primary care provider.

[1] 211 is an easy to remember telephone number assigned by the Federal Communications Commission to streamline access to health and human services. 211 is available on a 24-hour basis to connect residents to a wide variety of human services or social services across the state. If someone needs information or referral services but has little or no prior knowledge or experience, dialing 211 is much simpler than other option. Once the person dials 211, a professional Information and Referral specialist will then either refer or connect that caller to the correct agency based on the services needed. Callers to 211 can get LIVE assistance with needs such as: food, shelter, counseling, income supports, employment, healthcare, services for specialized populations such as the elderly and persons with disabilities and much more. All calls are free, anonymous and confidential.

Individuals covered under Medicaid also reported that while they were assigned a primary care provider, they have difficulty making appointments with these individuals and therefore, are more likely to go to the emergency room.

Emergency room or urgent care facilities are the primary point of access for individuals under the age of 40. This is the result of two factors: education and cost/convenience. As many individuals involved in the stakeholder meeting mentioned, individuals do not know how to properly access health care and their only knowledge is through the emergency room. In addition, many of the younger adults who had children reported that it was cheaper for them to receive care for their children at the emergency room rather than their primary care provider (lower co-pay). This type of system incentivizes the emergency room as the primary care provider.

Possible solutions:

- Encourage more collaboration among social service agencies currently providing services to Enos Park residents.
- Increase awareness and visibility of the 2-1-1 service.
- Develop strategies to educate individuals on the importance of maintaining a primary care provider and work with primary care providers on being more available to Enos Park residents.

Trust of medical community

The trust of the medical community is broken into two sections: trust of doctors and trust of hospitals.

For the most part, individuals report that they trust their doctors. A lot of the participants reported that "trust is earned, not given," but that they had positive relationships with their doctors. One of the participants added the following to the conversation:

> "I'd say with limited resources, doctors could spend a little more time with each patient instead of just trying to shuffle them through, and maybe focus a little more on the quality of care that they're giving instead of the quantity, of care, the number of patients that they can see in a day's time, maybe, instead of feeling so rushed and having waiting rooms full of people waiting a long time, either extend their office hours and staff them a little bit better, or just make the appointment time slots a little bit longer to give each patient the time that they really need. I think if they spend more time in the office with each patient more information would be able to come out – there again you would be able to build may be more trust between you and the patient."

According to the participants, the most distrust occurs between health care providers and low-income families. Individuals repeatedly spoke about how they felt like "second class citizens" and that they felt like they had to wait longer than individuals who had private insurance. For example, one individual reported that she is not taking her bipolar medication because she does not trust her doctor. "I'm bipolar but I'm not on medicine because I don't trust my doctor, or I don't want to go there, or something."

Individuals frequently spoke about the lack of trust between individuals and the hospitals, mainly around the issue of emergency room staff. They reported that when they go to the emergency room, there is a stigma around individuals with Medicaid.

Possible solutions:

- Training for hospital staff on how to effectively communicate with low-income families.
- Increase the time that primary care providers spend with low-income families in order to develop a trusting relationship between the entities.

Transportation

Transportation issues were a key aspect of the focus group with individuals 55 and older. This includes both public transportation availability as well as the courtesy vans.

When it comes to the public transportation system, understanding the system and hours of operation are the main issues facing individuals who use this for access to health care providers. As a stakeholder point out, "even if you did want to use the public transportation system, if you use the map system they have set up to assist you… it does not have all of the stops. So, like the bus stop at Memorial does not show up anywhere on the map even if you look for it. So, no bus stop in most people's minds." So individuals are unaware that there are bus stops at Memorial Medical Center and HSHS St. John's Hospital. In addition, individuals are concerned about the hours that these buses operate. Repeatedly, individuals pointed out that SMTD does not provide enough nighttime and weekend public transportation to/from the hospitals. Therefore, individuals reported that it was a lot easier to ride in an ambulance to the emergency room than to find money for a cab.

The cost of obtaining transportation to primary care providers and hospitals for the older population was a reoccurring theme. Individuals reported that while SMTD has courtesy vans for older individuals and those with a disability, it costs $2.50 per trip. This totals to $5 per trip to the doctor and a lot of senior adults do not have the resources to expend that amount to go to the doctor-especially if they are not sick. Individuals who were involved in social service agencies did not have transportation issues as organizations like M.E.R.C.Y Communities provides transportation.

Possible solutions:

- Travel vouchers to pay for cab services to/from doctors and emergency rooms.
- Increasing public transportation hours for stops at hospitals and urgent care facilities.

Health literacy, health insurance, prescription medication

Health literacy was so closely intertwined with discussions of health insurance and prescription medication, that for the purpose of this report, we combined them. Understanding both health insurance and prescription compliance was a big concern among both older adults and the younger population. If individuals have health insurance (whether it is private, work-provided, Medicare, or Medicaid) individuals do not understand their health insurance benefits. The main issues focus around current benefits and billing/payment issues (including co-pays).

Unfortunately, a lot of the discussion surrounding health insurance dealt with common myths or misunderstandings surrounding both Medicare or Medicaid. Younger individuals are confused about the enrollment process and a large number of them were assigned a plan because they did not choose their own plan during open enrollment. This led to dissatisfaction with the system because individuals were forced to go see different doctors or pay an increased co-pay for their visit. This also extends to prescription coverage. One of the social service agency representations reported that while their agency helps individuals cover expensive medications, a lot of the individuals who ask for assistance are already covered under their insurance plan. Individuals (both young and older) have serious literacy issues surrounding what is covered with their current health insurance coverage.

In addition, there is confusion about the process when individuals receive billings or payment statements from hospitals. Most importantly, they do not know who to contact at the hospital about the billing issue. Secondly, they are unsure if it is a "bill" to them, or something that is covered by their insurance plan.

This problem is not specific to Memorial Medical Center and HSHS St. John's Hospital, nor specific to Springfield, Illinois. There are serious educational, socioeconomic, and cultural barriers to overcome in order to improve the medical literacy of the population.

Possible solutions:

- Patient advocates to help individuals understand both their health insurance as well to be compliant with their prescription medications.
- Hospital-led community workshops to help address some of the main questions surrounding health insurance programs.
- Combine resources with *Enroll America*'s Health Insurance Literacy Resource Hub on how to properly communicate with individuals during the enrollment period.

Other needed services

Utility assistance programs- Individuals frequently mentioned that the prohibitive cost of utilities in the Enos Park residents. This includes the weatherization of older homes to protect from harsh climates.
Mental health services- As with the community survey, the lack of mental health services for both children and the elderly is a growing concern.
Nutrition education- There are several social service agencies that are currently working on improving the nutritional education of Enos Park residents. These efforts could be benefited by increasingly collaboration and more financial support.

Appendix D

Memorial Medical Center
Community Health Need Assessment Implementation Strategy
FY2016 October 1, 2015 – September 30, 2016

Introduction

Memorial Health System is a not-for-profit healthcare organization located in central Illinois. It includes four hospitals: Memorial Medical Center in Sangamon County, Abraham Lincoln Memorial Hospital in Logan County; Taylorville Memorial Hospital in Christian County and Passavant Area Hospital in Morgan County. Memorial Health System also includes Mental Health Centers of Central Illinois, Memorial Physician Services and Memorial Home Services.

Community health need assessments (CHNAs) were completed in 2015 in each of the counties where the hospitals are located. These needs assessments meet the federal health reform's Section 9007 of the Patient Protection and Affordable Care Act of March 2010 and requirements of the IRS 990 Schedule H report. Memorial Health System hospital also completed need assessments in 2012.

Memorial Medical Center – Sangamon County, Illinois

Memorial Medical Center (MMC), a nonprofit tertiary care hospital with 500 licensed beds, is located in the state capitol of Springfield, Ill. MMC is a teaching hospital for Southern Illinois University School of Medicine, which is adjacent to the hospital campus. MMC is a level 1 trauma center and major regional healthcare provider for central and southern Illinois, which is largely rural. Although MMC serves patients from a wide range of counties, the majority of MMC's community outreach efforts are focused on Sangamon County, where the medical center is located. Its primary service area includes Sangamon County (pop. 198,997). Sangamon County has eight federally designated medically underserved areas (MUAs). The population of Sangamon County is 83.4% white, 12.2% black and 4.4% other. The median household income is $55,449. Persons age 65 and older make up 15% of Sangamon County's population, which is higher than the state average of 13.5%. A total of 14.2% of all county residents live below the federal poverty level, including 21.8% of all children and 6.3% of seniors. In FY2014, 1.8 percent of the patients served at MMC received uninsured/underinsured charity care assistance; 16.4percent of patients were on Medicaid; and 29.9 percent were covered by Medicare.

Sangamon County Identification of Priority Health Needs

Memorial Medical Center conducted a Sangamon County Community Health Need Assessment in 2015 in collaboration with HSHS St. John's Hospital, a 439 bed not-for-profit hospital and Sangamon County Department of Public Health. The Health Department used the process to meet its IPLAN requirements (Illinois Project for Local Assessment of Needs). Southern Illinois University School of Medicine's Department of Community Health and Service and the University of Illinois' Survey Research Department assisted throughout the assessment process.

From the inception of the CHNA planning process the two hospitals agreed that they would select one joint priority and work together to address that issue. The two hospitals and health department also

agreed that each entity would make final selection of other priorities for their organizations based on their capacity to address the issue.

Resources for the CHNA included Sangamon County data available through Healthy Communities Institute, which provides more than 100 health and social determinants measures specific to Sangamon County. Memorial Health System pays for that data, which are available to the community at large (www.choosememorial.org/healthycommunities). Additional secondary data was gathered from other existing community assessments and documents. Primary data was gathered through a Community Advisory Committee made up of representatives that serve low income, minority and vulnerable populations. Additionally a series of five public forums and a written community survey gathered community input. (Complete explanation of the CHNA process is available on Memorial Medical Center's website.)

Defined Criteria

To help evaluate the highest priority issues, the following Defined Criteria were established:

1. Institute of Medicine Triple Aim Impact:
    - Improve the Care of Individuals
    - Improve the Health of Populations
    - Reduce Waste, Variation and Cost
2. Magnitude of the Issue – How wide an issue is this in the community?
3. Seriousness of the Issue – How related is the issue to the mortality (deaths) of those affected?
4. Feasibility – Considering available resources to address the issue, how likely are we to make a significant impact on the issue?

Twelve high priority issues were presented to the CHNA Community Advisory Committee:

1. Access to Care
2. Asthma
3. Cardiovascular Disease
4. Child Abuse
5. Dental Care
6. Diabetes
7. Food Insecurity
8. Infant Mortality/Mother-Infant Issues
9. Mental Health
10. Overweight/Obesity
11. Sexually Transmitted Diseases: Chlamydia and Gonorrhea
12. Violent Crime

Using the Defined Criteria, the Committee selected nine priorities to be included in the community forums and community survey. The items not ranking as high and left off of the survey were Infant Mortality/Mother-Infant Issues, Sexually Transmitted Diseases and Violent Crime.

The University of Illinois at Springfield's Survey Research office analyzed results of five community forums and community survey, which was completed by 781 individuals. The survey results in ranked order were:

1. Mental Health
2. Child Abuse
3. Overweight/Obesity
4. Access to Care
5. Heart disease
6. Diabetes
7. Dental Care
8. Food Insecurity
9. Asthma

Priorities Not Selected by Memorial Medical Center

Memorial presented the nine priorities from the community survey to an Internal Advisory Committee. This group used the Defined Criteria to help select final priorities. Those not selected were:

1. Child Abuse – Considering feasibility, this issue is not a core competency for our hospital to address. Memorial will participate on community initiatives to address this issue, but is not positioned to lead such an initiative.
2. Heart/Cardiovascular Disease – Memorial is already very involved in addressing cardiovascular issues, both within its patient population in the community at large. Data shows that cardiovascular indicators for Sangamon County are gradually improving over time. Memorial will continue to address cardiovascular issues, but it was felt that a focus on obesity might be a way to address a significant contributing factor.
3. Diabetes is a significant issue in Sangamon County and impacts many people. But, like cardiovascular disease, it was determined that selecting obesity as a priority than diabetes would be a way to address a significant contributing factor.
4. Dental Care did not rank high in feasibility for Memorial, either in expertise or resources. The community does have a Federally Qualified Health Center that offers dental services.
5. Food Insecurity did not rank as high a priority for the hospital to address as the other issues. It was felt that it would be more feasible to address this through a broader community collaborative.
6. Asthma, although an important issue, did not rank as high using the defined criteria as did the other selected priorities

Memorial Medical Center's Final Selected Priorities

Following review of input from the Community Advisory Committee, community forums, the community survey, and Memorial's Internal Advisory Team, Memorial Medical Center selected three priorities to address in its implementation strategy over the next three years, from FY2016-FY2018. These priorities are:

1. Access to Care – This is a joint priority with HSHS St. John's Hospital, and the two hospitals are developing a joint initiative to address access to care in vulnerable neighborhood.
2. Mental Health [In addition to goals specific to MMC, the four Memorial Health System Hospitals have a collaborative program to address this priority.]
3. Obesity [In addition to goals specific to MMC, the four Memorial Health System Hospitals have a collaborative program to address this priority.]

FY2016 IMPLEMENTATION STRATEGY

PRIORITY 1:	ACCESS TO CARE
Reasons for priority selection	Memorial Medical Center's 2015 community health need assessment identified access to care as a top priority through its community survey, community forums, advisory groups and data collection.

Goal 1: Improve access to health care in Springfield's Enos Park neighborhood	
Target Population	Residents of Enos Park Neighborhood
Objective	Create a community health worker program to help Enos Park neighborhood residents increase access to health care, in collaboration with HSHS St. John's Hospital and SIU Center for Family Medicine federally qualified health center.

Strategy Selected: Increasing access to care was one of the priorities of the community health need assessment. Research into neighborhood-specific data show that health outcomes and social determinants of health for people living in the Enos Park area of Springfield are an issue. Additional focus groups held for Enos Park residents and social service providers highlighted areas of need, including issues that may be addressed by a community health worker program to work with individuals living in Enos Park.

Commitment of Resources: Memorial Medical Center commits to joint funding of this project with HSHS St. John's Hospital as well as administrative leadership for the steering committee.

Collaborative Partners: HSHS St. John's Hospital, SIU School of Medicine's Center for Family Medicine federally qualified health center, Enos Park Neighborhood Improvement Association, Central Counties Health Centers FQHC, Mental Health Centers of Central Illinois, MOSAIC, McClernand Elementary School, and a range of community social service agencies, community police officers and local residents.

Activity	Timeline	Anticipated Results
1. Develop the organizational structure for the Enos Park Access Project.	Oct. 2015 Dec. 2015 Aug. 2016	• Finalize memorandum of understanding, mission statement and expectations for the project steering committee. • Set measurable objectives for the program. • Produce an annual impact statement.
2. Develop the Community Health Worker Program	Aug. 2015 Sept. 2015 Dec. 2015 Feb. 2016	• Identify hiring agency and budget, develop job description, office location, and hire CHW coordinator • Identify training requirements. • Gather hospital data on ED utilization and admissions; establish baseline measures • Begin identifying and seeing clients
3. Create Enos Park Access Advisory Council	Nov. 2015 Dec. 2015 Jan. 2016	• Identify council membership, including residents, social service providers, community police officers and others • Draft charter for the council • Create organizational structure. • Identify meeting schedule and location and hold meetings

4. Create Enos Park Providers Alliance	Nov. 2015 Dec. 2015 Jan. 2016	• Identify alliance membership of social service providers in the neighborhood • Draft charter for the council • Create organizational structure. • Identify meeting schedule and location and hold meetings
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Program builds meaningful connections between community residents and service providers located within Enos Park; measured by surveys of Advisory Council, Providers Alliance and number of new clients due to increased visibility. • Program identifies Enos Park residents who will participate in CHW program and increases their access to medical, mental health and other services; measures to be determined during the first quarter of the program. • Program collaborates with the MOSAIC mental health project's social worker at McClernand Elementary School in Enos Park; measured at least by referrals between the two programs.	
Long term indicators & source	• Increase the number of enrolled Enos Park residents who have a medical home, measured by patient medical records. • Enrolled residents will decrease their use of hospital emergency departments for non-emergent care and decrease hospitalizations for ambulatory sensitive conditions, measured by hospital electronic health records. • Improve health outcomes and quality of life for enrolled program participants; measure to be determined.	

Goal 2: Increase access to children's mental health services through the MOSAIC Mental Health Initiative in Enos Park	
Target Population	Children attending McClernand Elementary school and/or living in the Enos Park neighborhood and their families.
Objective	To increase access to mental health screening, intervention and educational services through provision of these services at McClernand Elementary School, homes, and other sites in the Enos Park Neighborhood. [NOTE: Memorial Medical Center has additional objectives for the community-wide MOSAIC project under the Mental Health Priority]
Strategy Selected: The Children's MOSAIC Project is a community collaborative transforming the landscape of children's mental health care by moving services out of the clinic and into the community. Under this transformed system of care, children are identified earlier and are quickly engaged in appropriate services and supports in schools, primary care offices, and a target neighborhood. Behavioral health integration into schools and primary care practices has been shown to be effective in early identification and treatment of children at risk. **Commitment of Resources**: Memorial Medical Center and HSHS St. John's Hospital will help expand and secure the MOSAIC program by providing financial support for screening and engagement activities and for a behavioral health consultant (BHC) at McClernand Elementary School. The BHC will provide early identification and intervention at the school and work with the Community Health Worker to provide	

other community identification and intervention to improve behavioral health access.

Collaborative Partners: Memorial and St. John's will collaborate with Mental Health Centers of Central Illinois, School District 186 and in particular McClernand Elementary School, SIU School of Medicine, area primary care providers, area social service providers, Enos Park Neighborhood Improvement Association, United Way of Central Illinois, the Community Foundation for the Land of Lincoln and the University of Illinois Springfield.

Activity	Timeline	Anticipated Results
1. Add one new school clinician to increase number of sites within Springfield Public Schools.	9/30/16	Increased number of school sites with MOSAIC services in Springfield Public Schools.
2. Provide screening of children at McClernand Elementary School.	9/30/16	Increased number of children receiving a social/emotional screen.
3. Provide behavioral health consultant to serve McClernand Elementary School and Enos Park neighborhood.	9/30/16	Increased number of children receiving mental health intervention in school and community settings.
4. Provide education on healthy social/emotional development and parenting.	9/30/16	Increased number of parents/caregivers receiving education on healthy social/emotional development and parenting.

MEASURES: What will we measure to know the program is making a difference?

Short term indicators & source	• Number of children receiving social/emotional screening. • Percentage of children receiving elevated screens. • Number of parent/caregivers receiving education on social/emotional development and parenting. • Source: MOSAIC records, Electronic Health Record, school records.
Long term indicators & source	• Number of children and/or families receiving intervention. • Source: MOSAIC records and measures from University of Illinois at Springfield's Survey Research Department

Goal 3: Support education of physicians through financial and in-kind support of Southern Illinois University School of Medicine

Target Population	People living in central and southern Illinois
Objective	Increase access to health care services in central and southern Illinois by providing ongoing support for SIU School of Medicine for the education of new physicians (nearly half select primary care for their residencies).

Strategy Selected: Educating new physicians is vital to maintaining access to care for people living in central and southern Illinois. Memorial Medical Center serves as a teaching hospital for SIU School of Medicine and provides significant financial and in-kind support for the education and graduation of new physicians, many of whom enter primary care practices. Healthy People 2020 Access to Health Services (AHS) objectives:

- AHS-3: Increase the proportion of persons with a usual primary care provider
- AHS-4: Increase the number of practicing primary care providers

Commitment of Resources: Memorial commits a grant for academic support, in-kind support by providing office, clinic and classroom space, and staff to support the work necessary to be a teaching hospital.

Collaborative Partners: Southern Illinois University School of Medicine

Activity	Timeline	Anticipated Results
1. Provide financial support for training of new physicians	Oct. 2015-Sept. 2016	SIU School of Medicine has operating support for educating new physicians
2. Employ medical residents and fellows to facilitate completion of residencies and fellowships.	Oct. 2015-Sept. 2016	Medical students complete and graduate medical school
3. Provide state-of-the art clinical simulation and surgical skills laboratories as well as classroom space.	Oct. 2015-Sept. 2016	Students receive hands-on experiential education in simulation laboratories that offer top quality education in medical procedures they may encounter as physicians.
4. Provide physical facilities for faculty offices, clinics and classrooms.	Oct. 2015-Sept. 2016	SIU School of Medicine has necessary space for programs and staff.

MEASURES: What will we measure to know the program is making a difference?

Short term indicators & source	• Number of medical students on MMC campus, measured by MMC/SIU records. • Number of medical residencies supported by MMC, measured by MMC/SIU records. • Number of residents and fellows who complete their residencies or fellowships, measured by MMC/SIU records. • Number of student who receive education in the clinical simulation and surgical skills labs, measured by MMC/SIU records. • Square footage of office, clinic and classroom space provided by MMC, measured by MMC records.
Long term indicators & source	• Number of medical students on MMC campus • Number of medical residencies supported by MMC • Number of residents and fellows who complete their residencies or fellowships • Number of student who receive education in the clinical simulation and surgical skills labs

Goal 4: Support Southern Illinois University School of Medicine's Center for Family and Community Medicine Federally Qualified Health Center (FQHC).

Target Population	**Underserved and uninsured residents of Sangamon County.**
Objective	**Increase convenient access to primary care health services for target population.**

Strategy Selected: The Affordable Care Act (ACA) is shifting the healthcare industry focus to primary and preventative care and on expanding coverage to millions of people through Medicaid expansion and enrollment through private health care exchanges. Part of the Medicaid expansion now allows coverage to individuals and families making up to 133% of the federal poverty level of income. A primary objective of the ACA is to increase convenient access to care for patients through FQHCs and other clinics. These

facilities can become the patient's medical home, and will in turn reduce the strain on hospital emergency rooms and decrease health care costs.

Commitment of Resources: Memorial Medical Center will provide financial support of The SIU Family and Community Medicine FQHC including the expansion of its existing clinic facility by 30,315 sq. ft. The current facility features 33 exam rooms and two procedure rooms with a staff of 43 licensed professionals (including 23 FCM physician and midlevel providers, pharmacy, dietary and mental health providers) who support the administration of the FQHC's 30 residents. It is estimated the FQHC will reach 50,000 visits this year, serving a total of 19,000 patients. SIU FCM is also actively working with Mental Health Centers of Central Illinois to integrate behavioral health into primary care, an integral component of health care. The Residency Program has a strong desire to remain at this location given its FQHC designation. This expansion will position the FQHC to serve a growing number of underserved and underserved patients.

Collaborative Partners: SIU Center for Family Medicine

Activity	Timeline	Anticipated Results
1. Provide financial support for operation of FQHC.	Oct. 2015	FQHC providing access to underserved and uninsured residents of Sangamon County.
2. Initiate construction of 30,315 sq. ft., $16,259,000 clinic expansion.	April 2016	Facility expansion project initiated.
3. Recruit additional FQHC health care providers.	Sept. 2016	Execution of plan to expand FQHC provider capacity under way.

MEASURES: What will we measure to know the program is making a difference?

Short term indicators & source	• Number of physician and mid-level providers at end of FY2016 = 23. • Number of individual patients served in FY2016 = 19,000. • Number of patient visits in FY2016 = 50,000. • Facility construction on-time and on-budget.
Long term indicators & source	• Number of physician and mid-level providers at end of FY2018 = 31. • Number of individual patients served in FY2018 = 22,000. • Number of patient visits in FY2018 = 70,000. • Facility expansion project completed on-time and on-budget.

Goal 5: Support Kumler Outreach Ministries pharmaceutical assistance program

Target Population	Low-income insured or uninsured people without access to prescription medications, or who cannot afford the co-pay for the medication.
Objective	Increase access to necessary prescription medications regardless for people who cannot afford to pay for prescription medications

Strategy Selected: Access to necessary pharmaceutical medications is important to treat diagnosed conditions. People who cannot afford their prescription medication experience adverse health outcomes, may rely on receiving care through repeated visits to hospital emergency departments and may experience preventable hospitalizations for conditions that could have been treated with the proper medications. Support for Kumler Outreach Ministries' program helps this program provide prescription medication for people who otherwise would not be able to obtain required medications.

Commitment of Resources: $24,000 in support for FY16

Collaborative Partners: Kumler Outreach Ministries

Activity	Timeline	Anticipated Results
1. Provide monthly funding of $2000 for 12 months	Oct. 2015-Sept. 2016	Financial support will help Kumler assist at least 750 clients in FY16.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	Assist 750 people; measured by report from Kumler	
Long term indicators & source	Program assists those in need to receive necessary prescription medications, as measured by Kumler	

PRIORITY 2:	**MENTAL HEALTH**
Reasons for priority selection	Mental Health was identified by the community as the top priority in the community health need assessment. Community data shows very high rates of emergency department utilization and hospitalization for both adult and pediatric populations. Healthy People 2020 goals for Mental Health & Mental Disorders (MHMD) • MDHD-6 Increase the proportion of children with mental health problems who receive treatment • MDHD-9 Increase the proportion of adults with mental health disorders who receive treatment • MDHD-10 Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders

Goal 1: MOSAIC Project	
Target Population	Children in Sangamon County
Objective	To increase the number of child-serving sites with the capacity to conduct social/emotional screening and to provide mental health services on-site in order to identify children in distress and to increase access to intervention. The screening and early intervention efforts are provided in Springfield Public Schools physician practices and the community.

Strategy Selected: The Children's MOSAIC Project is a community collaborative transforming the landscape of children's mental health care by moving services out of the clinic and into the community. Under this transformed system of care, children are identified earlier and are quickly engaged in appropriate services and supports in schools, primary care offices, and in the community. Behavioral health integration into schools and primary care practices has been shown to be effective in early identification and treatment of children at risk.

Commitment of Resources: In addition to the expansion of the MOSAIC project at McClernand Elementary School within the Enos Park Access to Care initiative in collaboration with St. John's Hospital, (listed under Access to Care priority), Memorial Medical Center will help expand and secure the MOSAIC program by providing financial support for the project coordinator, expansion of behavioral health consultants into new schools and primary care physician practices, and to provide training to the primary care physicians and behavioral health consultants on behavioral health integrated care.

Collaborative Partners: Memorial will collaborate with Mental Health Centers of Central Illinois, SIU School of Medicine, local school districts, area primary care physicians, area social service providers, United Way of Central Illinois, the Community Foundation of the Land of Lincoln and the University of Illinois Springfield		
Activity	**Timeline**	**Anticipated Results**
1. Support the MOSAIC project coordinator position until sustainable or other funding is secured.	Through 9/30/16	Plan to fully sustain position with more permanent funding will be developed.
2. Add one new school clinician to increase number of sites within Springfield Public Schools.	9/30/16	Increased number of school sites with MOSAIC services in Springfield Public Schools.
3. Sustain current MOSAIC school based clinicians until sustainable or other funding is secured.	Through 9/30/16	Plan to fully sustain position with more permanent funding will be developed.
4. Add one new clinician to primary care sites.	9/30/16	Increased number of behavioral health consultants within primary care sites.
5. Provide training in the integrated care model to new clinicians based in primary care practices.	9/30/16	Increased number of clinicians trained in the integrated care model.
6. Provide screening of children at the additional schools and physician offices.	9/30/16	Increased number of children receiving a social/ emotional screen.
7. Provide ongoing program evaluation of MOSAIC's impact.	9/30/16	Completion of annual report of MOSAIC results to the community.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Number of sites providing social/emotional screens and on-site intervention. • Number of primary care clinicians trained in the integrated health model. • Number of children receiving social/emotional screening. • Source: MOSAIC records, Electronic Health Record, school records.	
Long term indicators & source	• Number of children receiving on-site intervention. • Source: MOSAIC records	

Goal 2: Implement Mental Health First Aid training in Sangamon, Logan, Morgan and Christian counties	
Target Population	**Community at large**
Objective	Step in early to stop the trajectory of issues that lead to mental health issues and the need for psychiatric intervention by providing community education to improve mental health literacy, early identification, peer intervention, and referral of community members to available resources if needed.

Strategy Selected: Mental Health First Aid (MHFA) is an evidence-based program that offers a five-day intensive training session to community members to become certified MHFA trainers. These certified trainers in turn go out in the community to provide an eight-hour education session to community members such as teachers, police, first responders, churches, youth leaders and others to teach them how to identify mental health issues, how to refer people to resources, and encourage community support of those struggling with issues that may contribute to mental illness. The Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency that leads public health efforts to advance the behavioral health of the nation, endorses MHFA and recently established grant funding for MHFA as part of the President's initiative to increase access to mental health services. MHFA is on the National Registry of Evidence Based Practices (NREPP). All interventions on the registry have been independently assessed and rated for quality of research and readiness for dissemination. MHFA has been shown to increase understanding of mental health disorders, knowledge of available resources, and confidence in and likelihood to help and individual in distress,

Commitment of Resources: Memorial Medical Center will commit funding to bring a trainer from the national program to Springfield to train up to 30 local community members. Memorial will provide the conference center, promotion of the event, required materials and provide funding for an ongoing program coordinator and tracking of results.

Collaborative Partners: Memorial will collaborate with Mental Health Centers of Central Illinois, Abraham Lincoln Memorial Hospital, Passavant Area Hospital, Taylorville Memorial Hospital, SIU School of Medicine, local school districts, area social service providers and the University of Illinois Springfield.

Activity	Timeline	Anticipated Results
1. Reserve date and facility for Mental Health First Aid program.	12/2015	Date for Mental Health First Aid instructor training identified. Trainer and facility reserved.
2. Provide promotional materials to partners for potential individuals to become certified MHFA trainers.	By 6/2016	Partners will be aware of opportunity to receive MHFA instructor training.
3.. Hold MHFA instructor training	By 9/2016	Complete training of up to 30 individuals in central Illinois to become certified MHFA instructors.
4. Promote the program to communities in Sangamon, Logan, Morgan and Christian counties and begin to schedule communication education events.	9/2016	Local school districts and community organizations will be aware of the availability of MHFA training events for the community by certified MHFA trainers.
5. Hold at minimum 1 MHFA community trainings by certified MHFA instructors in each of the communities.	9/2016	Increase number of individuals in each community trained as mental health first aiders.

MEASURES: What will we measure to know the program is making a difference?

Short term indicators & source	• Number of individuals becoming certified trainers from MHS sponsored certification training • Number of MHS sponsored community training events • Number of community members trained as mental health first aiders • Source: MHFA data collection tool

Long term indicators & source	• Among instructors and first aiders, increases in: mental health literacy, awareness of available resources, and confidence in assisting individuals in distress • Source: Survey of community members trained as instructors and first aiders.

Goal 3: Increase access to psychiatric care by increasing the number of inpatient psychiatric beds at Memorial Medical Center		
Target Population	Adults with Mental Health & Mental Disorders (MHMD) in Sangamon, Christian, Logan and Morgan Counties.	
Objective	Expand access to acute mental health treatment by increasing the inpatient psychiatric beds capacity in the community by at least 4 beds.	
Strategy Selected: A shortage of adult inpatient psychiatric beds exists in the community. Patients in psychiatric crisis are being held in area emergency rooms and jails for extended periods of time waiting for a bed to become available for treatment. **Commitment of Resources**: Space, construction, staffing and programming costs. **Collaborative partners:** Memorial Medical Center will partner with SIU School of Medicine Department of Psychiatry and Memorial Physician Services Vine Street Clinic to expand the current inpatient psychiatric bed capacity.		
Activity	**Timeline**	**Anticipated Results**
1. Complete preliminary space planning and incorporate into approved capital and operating budgets.	Oct. 2015	Preliminary space planning completed, incorporated into approved budget, timeline established.
2. Initiate construction of inpatient psychiatric beds.	Sept. 2016	Construction milestones achieved.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	Increased bed capacity construction milestones achieved. Source: MMC Facilities Planning Data	
Long term indicators & source	Increased numbers of inpatient acute psychiatric patients receive service in 12 months after expansion vs. 12 months before expansion. Source: MMC Census Data	

PRIORITY 3:	**OBESITY**
Reasons for priority selection	Memorial Medical Center's 2015 community health need assessment identified obesity as a top priority through its community survey, community forums, advisory groups and data collection.

Goal 1: Expand access to the Memorial Weight Loss and Wellness Center program (MWLWC)	
Target Population	Adults who are overweight who live in Sangamon, Logan, Christian and Morgan Counties

Objective	Expand access to the Memorial Weight Loss and Wellness Center by developing strategy to implement the program at Abraham Lincoln Memorial Hospital (Logan County); Passavant Area Hospital (Morgan County) and Taylorville Memorial Hospital (Christian County)

Strategy Selected:

Healthy People 2020 goals highlight the need for increased intervention by physicians with patients in the areas of nutrition and weight status (NWS).

- NWS-6.1: Increase the proportion of physician office visits made by patients with a diagnosis of cardiovascular disease, diabetes, or hyperlipidemia that include counseling or education related to diet and nutrition. (Baseline: 20.8 percent of physician visits in 2007; Target = 22.9 percent/10 percent improvement)
- NWS-6.2: Increase the proportion of physician office visits made by adult patients who are obese that include counseling or education related to weight reduction, nutrition or physical activity. (Baseline: 28.9 percent of physician visits in 2007; Target = 31.8 percent/10 percent improvement)

Memorial's Weight Loss and Wellness Center is based on the nationally recognized, evidence-based model of Geisinger Health System. Memorial's program includes a medical (non-surgical) weight loss program; accredited bariatric surgery program; diabetes services; outpatient nutrition services; and fitness. It provides physicians a comprehensive resource to refer their patients to for individualized counseling and education. There is no other program offering this specialized approach in central Illinois.

Commitment of Resources: Memorial Medical Center will provide leadership and staff for assessing expansion of the program, develop the business plan, create implementation strategies, train staff, and provide resources and promotional support.

Collaborative Partners: Abraham Lincoln Memorial Hospital, Passavant Area Hospital, Taylorville Memorial Hospital, Memorial Physician Services, Springfield Clinic, SIU School of Medicine, Springfield YMCA, Mental Health Centers of Central Illinois

Activity	Timeline	Anticipated Results
1. MWLWC will collaborate with ALMH to establish staffing and space requirements for program expansion to ALMH and complete staff training and implementation of protocols and processes.	Sept 2016	• Staffing and space will be secured for implementation of MWLWC at ALMH. • ALMH staff will be trained to implement MWLWC programming at affiliate location.
2. MWLWC will collaborate with ALMH to implement communication and marketing plan and launch program	Sept 2016	• Referring physicians in the Lincoln area will refer patients to the MWLWC at ALMH • Increase awareness of the new service to residents of Logan County. • ALMH will begin seeing MWLWC patients at ALMH.
3. MWLWC will collaborate with Passavant to determine staffing, space and physician involvement for program expansion to Passavant and complete staff training and	Sept 2016	Staffing, space and physician involvement will be secured for implementation of MWLWC at Passavant. Passavant staff will be trained to implement MWLWC programming at affiliate location.

implementation of protocols and processes.		
4. MWLWC will collaborate with Passavant to develop communication and marketing plan	Sept 2016	• Increase awareness of referring physicians and community members in Morgan County about the new MWLWC services at Passavant. • Target FY17 for program launch.
5. MWLWC will collaborate with TMH to complete a feasibility study for MWLWC at TMH	Sept 2016	• Decision will be made whether MHS will develop MWLWC at TMH.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• MWLWC program development and implementation at ALMH. • MWLWC program development at Passavant. • Decision of MWLWC at TMH made.	
Long term indicators & source	• Medical weight loss patients who complete at least 6 months of programming, on average, will achieve 5% weight loss. • Bariatric surgical patients will achieve, on average, 45% excess weight loss at one year post-op. • MWLWC at ALMH will achieve 40 physician referrals in year 2 (FY17) and 50 in year 3 (FY18). • MWLWC at Passavant will achieve 40 physician referrals in year 3 (FY18).	

Goal 2: At Memorial Medical Center, add a pediatric component to Memorial's Weight Loss and Wellness Center.	
Target Population	Children and adolescents ages 2-18
Objective	Expand the success of the Weight Loss and Wellness Center to address the needs of pediatric patients.

Strategy Selected: Healthy People 2020 goals highlight the need for physicians to address the nutrition and weight status (NWS) issues of pediatric patients.

- NWS-6.3: Increase the proportion of physician visits made by all children or adult patients that include counseling about nutrition or diet.
- NWS-10.4: Reduce the proportion of children and adolescents aged 2 to 19 years who are considered obese. (Baseline: 16.1 percent were considered obese in 2005-2008; Target = 9.4 percent, a 10 percent improvement)

Memorial's Weight Loss and Wellness Center is based on the nationally recognized, evidence-based model of Geisinger Health System. Memorial's program includes a medical (non-surgical) weight loss program; accredited bariatric surgery program; diabetes services; outpatient nutrition services; and fitness. It provides physicians a comprehensive resource to refer their patients to for individualized counseling and education. Since its inception in 2013, the program has focused on adults. There is no pediatric program offering this comprehensive approach in central Illinois, and physicians and community members are requesting the addition of this service.

Commitment of Resources: Memorial Medical Center will provide leadership, staff, and financial support for assessing expansion of the program, developing the business plan, the facility for the program and training of staff.

Collaborative Partners: Springfield Clinic, Memorial Physician Services, SIU School of Medicine, Springfield YMCA, Mental Health Centers of Central Illinois		
Activity	**Timeline**	**Anticipated Results**
1. MWLWC will establish staffing, space and physician involvement, protocols and processes for pediatric program development	Sept 2016	• Staffing, space and physician involvement will be secured for pediatric programming. • Standard pediatric program protocols and processes will be implemented
2. MWLWC will develop program materials and communication plan and launch the pediatric program	Sept 2016	• Referring physicians and community members in the MMC service area will have knowledge of the new pediatric services offered under MWLWC. • Begin seeing pediatric patients at MWLWC.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	Program implemented and begins seeing pediatric patients.	
Long term indicators & source	Program will serve 100 families by the end of FY18.	

Goal 3: Memorial Medical Center and YMCA of Springfield will collaborate to establish the Center for Disease Control's National Diabetes Prevention Program in Springfield.	
Target Population	Residents of Springfield and Sangamon County
Objective	Memorial Weight Loss and Wellness Center's Diabetes Services and the Springfield YMCA will partner to attain a CDC-recognized Diabetes Prevention Program through the process identified by the American Association of Diabetes Educators (AADE).

Strategy Selected: The CDC-led National Diabetes Prevention Program is an evidence-based lifestyle change program for preventing type 2 diabetes. The year-long program helps participants make real lifestyle changes such as eating healthier, including physical activity into their daily lives, and improving problem-solving and coping skills. This proven program can help people with prediabetes and/or at risk for type 2 diabetes make achievable and realistic lifestyle changes and cut their risk of developing type 2 diabetes by 58 percent.

Commitment of Resources: MMC's AADE-certified Diabetes Services program will lead the initiative and have staff complete required training. A $23,500 grant from Memorial Medical Center Foundation is helping with expenses for creation of the program and the application process.

Collaborative Partners: YMCA of Springfield, IL

Activity	**Timeline**	**Anticipated Results**
1. YMCA to determine 1-2 appropriate staff for training. YMCA and MMC meet to determine roles in the partnership. Appropriate staff complete AADE Lifestyle Coach Training.	Aug.-Nov. 2015	• Partnership roles identified. • Appropriate staff members receive training.
2. Memorial/YMCA will submit application for CDC Pending Status. Initial cohort groups will start the program.	Jan.-Sept. 2016	• Application submitted • Cohorts formed, program starts to be offered.

3. Memorial/YMCA will collect data for submission as a CDC Recognized National Diabetes Prevention Program.	Jan. 2016-Dec. 2017	• Data collected.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Staff are trained and program begun (precertification status).	
Long term indicators & source	• CDC-certified program is established and implemented. • Program participants demonstrate documented lifestyle changes.	

Goal 4: Support YMCA Healthier Communities Initiative		
Target Population	Residents of Springfield and Sangamon County	
Objective	Support YMCA of Springfield's efforts to create a community coalition to address obesity by enhancing the role of policy, systems and environmental changes to ensure that healthy living options are within reach of the people who live in the Springfield-area community.	
Strategy Selected: In 224 communities across the nation, YMCAs are working with other community leaders to form community coalitions focused on an intentional effort to ensure that healthy living is within reach of the people who live in those communities. To date, communities participating in this type of initiative have influenced more than 35,900 community-level changes that have impacted up to 65 million people across the nation. The Springfield YMCA is working to establish such a coalition in our community. **Commitment of Resources**: MMC will commit up to $50,000 in FY2016, will participate on the coalition task force and support program initiatives. **Collaborative Partners:** To be determined		
Activity	**Timeline**	**Anticipated Results**
1. Establish Springfield Community Coalition	March 2016	• Recruit 6-8 community coalition members • Initial meeting of coalition members to identify priority issues that will address areas of need in the Springfield area community
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Initial meeting of coalition and identifying areas of need in the Springfield area community, measured by Springfield YMCA.	
Long term indicators & source	• Begin policy and systems change at the community-level that directly impact the ability of community residents to lead a healthy lifestyle; measured by Community Coalition, Springfield YMCA.	

Goal 5: Support Girls on the Run of Central Illinois	
Target Population	Girls in grades 3-8 and their families
Objective	The goal of the program is to unleash confidence through accomplishment while establishing a lifetime appreciation of health and fitness.
Strategy Selected: Girls on the Run is a transformational physical activity based positive youth development program (PA-PYD) for girls in 3rd-8th grade. We teach life skills through dynamic,	

interactive lessons and running games. The program culminates with the girls being physically and emotionally prepared to complete a celebratory 5k running event.

Commitment of Resources: Memorial Medical Center provides $12,500 in cash and in-kind support for Girls on the Run. This includes program support, scholarships for low-income girls, coverage at race-day events by SportsCare professionals, and printing of program materials.

Collaborative Partnerships: Memorial Health System's three affiliate hospitals also support Girls on the Run, along with 45 schools, the Springfield YMCA, YMCA of Christian County, Springfield Park District and HeathLink

Activity	Timeline	Anticipated Results
1. Offer program to at least 1,000 girls in central Illinois during the 2015-2016 school year. [NOTE: Ensure the target is one you will hit.]	Oct. 2015-Sept. 2016	1,000 girls will participate in the 2015-16 school year program.
2. Encourage community health and physical fitness through family member participation in the end-of-season 5k event.	Oct. 2015-Sept. 2016	A total of 600 community members and families of the program girls will complete either the fall or spring the 5k events.

MEASURES: What will we measure to know the program is making a difference?

Short term indicators & source	As a result of the Girls on the Run program season and 5k race event, 75% or more of GOTR participants and their families will report that the program positively impacted their attitude toward exercise. Measurement: GOTR survey of participants and their families.
Long term indicators & source	Continued growth of the program and reaching new schools/communities due to the demand for positive and physically active programming for girls. Expected increase in the number of schools and participants served will be 10% over the next 3-4 years. Measurement: GOTR program records

Goal 6: Support genH Kids community garden and programming at MacArthur Park Apartments Outreach Center & Community Garden

Target Population	Low-income children and families in the MacArthur Park apartment complex in Springfield, IL
Objective	The goal of the MacArthur Park Apartments Outreach Center & Community Garden is to enrich the lives of the children and families that live at MacArthur Park Apartments through increasing access to fresh fruits and vegetables as well as by providing a safe after-school program for the children that will provide tutoring, access to books, healthy snacks, gardening lessons, and cooking classes.

Strategy Selected/Commitments: GenH Kids is increasing access to fresh foods through community gardens in several neighborhoods. This initiative provides additional year-round outreach and education to children and families on healthy eating, cooking and exercise to help them adopt healthier lifestyles.

Commitment of Resources: Memorial Medical Center has committed $5,000 to this project for the coming year.

Collaborative Partners: Sangamon County Medical Society Alliance, HyVee grocery store, St. John's Hospital, MacArthur Boulevard Association, St. John's Lutheran Church, Central Illinois Food Bank and Sedesco.

Activity	Timeline	Anticipated Results
1. Grow and distribute fresh produce	April-Sept. 2016	Distribute fresh produce to 20 low-income families
2. Offer at least 40 after-school programs to 12 children/session	Oct. 2015-Sept. 2016	Complete 480 contacts with children, providing every child with healthy snacks, exercise, tutoring, and learning about good nutrition and growing healthy foods.

MEASURES: What will we measure to know the program is making a difference?

Short term indicators & source	Engage 20 families in the 2016 garden project and increase amount of food distributed over the 2015 program. Results will be measured by genH.
Long term indicators & source	Children and families living in the apartment complex will demonstrate knowledge of healthy food choices and preparation of fresh produce for meals. This will be measured by pre- and –post evaluations conducted by genH.

Approved by the MMC Board of Directors 9-9-15
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