2018

Sangamon County—Illinois
Community Health Needs Assessment

Memorial
MEDICAL CENTER

CONTENTS

This report was completed in September 2018 and posted online at
ChooseMemorial.org/Community-Health-Needs-Assessment

Memorial MEDICAL CENTER

Executive Summary

In 2018, Memorial Medical Center (MMC) completed a community health needs assessment (CHNA) for Sangamon County, Ill., as required of nonprofit hospitals by the Affordable Care Act of 2010. The hospital completed previous needs assessments in 2012 and 2015.

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

1. Institute of Medicine Triple Aim Impact
2. Magnitude of the Issue
3. Seriousness of the Issue
4. Feasibility to Address the Issue

Memorial Medical Center collaborated with HSHS St. John's Hospital and the Sangamon County Department of Public Health to complete the 2018 CHNA. Community health needs were prioritized based on reviews of secondary community data as well as primary data gathered during the assessment. Social determinants of health were included in all data reviews. The University of Illinois at Springfield's Survey Research Department conducted a community survey. A Community Advisory Committee, comprised of 13 representatives from community organizations, helped to identify the issues to include in the community survey. Following the survey they helped to prioritize final community priorities. MMC then convened an Internal Advisory Committee, which approved the final priorities recommended by the Community Advisory Committee and selected by MMC. These are:

1. Access to Care
2. Mental Health
3. Substance Abuse
4. Mother/Infant Health

The Memorial Medical Center Board approved the 2018 community health needs assessment report and final priorities on Sept. 12, 2018. This report is available online at ChooseMemorial.org/HealthyCommunities or by contacting the MMC community benefit department at 217–788–7014 or by email at Gramley.Paula@mhsil.com.

An implementation strategy is being developed to address the identified needs, which MMC will implement in FY2019–FY2021. The strategy will be posted at the same website in December 2018.

Introduction to Memorial Health System

Memorial HEALTH SYSTEM

mission

our mission:
to improve the health of the people and communities we serve.

vision

our vision:
to be a national leader for excellence in patient care.

Memorial Health System of Springfield, one of the leading healthcare organizations in Illinois, is a community-based, not-for-profit corporation dedicated to patient care, education and research. 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 Memorial Behavioral Health, Memorial Physician Services and Memorial Home Services. Our more than 7,100 staff members, partnering physicians and hundreds of volunteers are dedicated to improving the health of the communities we have served since 1897. In fiscal year 2017, our hospitals served more than 43,000 inpatients and nearly 573,000 outpatients.

Community health needs assessments (CHNAs) were completed in 2018 in each of the counties where the hospitals are located. These needs assessments meet the requirements of federal health reform's Section 9007 of the Patient Protection and Affordable Care Act of March 2010 as well as requirements of the IRS 990 Schedule H report. Memorial Health System hospitals also completed needs assessments in 2012 and 2015.

Leadership of Community Benefit and Community Health Needs Assessment

An appointed board committee made up of board members, community representatives and senior leadership approves and oversees all aspects of Memorial Health System's community benefit programs and community health needs assessments. Community benefit and outcomes of the hospital community health needs 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 required to "achieve 100 percent of approved Community Benefit targets." The MHS Board's Community Benefit Committee oversight includes:

- MHS charity care policies
- Tri-annual community health needs assessment processes for the four MHS hospitals
- Annual review and approval of CHNA implementation strategies for the four MHS hospitals
- Annual review of measures of success in meeting the goals of the CHNA implementation strategies

Introduction to Memorial Medical Center

Memorial Medical Center is a 500-bed acute care, nonprofit hospital in the state capital of Springfield, Ill., that offers comprehensive inpatient and outpatient services. It employs more than 4,425 people. 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. In 2016, Memorial earned its third consecutive Magnet® Hospital Designation by the American Nurses Credentialing Center. The hospital is accredited by The Joint Commission and is a member of the American Hospital Association, the Illinois Hospital Association and Vizient.

Our hospital's featured services include the Southern Illinois Level 1 Trauma Center, Memorial Heart & Vascular Services, Memorial Rehab Services, Family Maternity Suites, Regional Cancer Center, Regional Burn Center, Orthopedic Services, Memorial Weight Loss & Wellness Center, Memorial Behavioral Health and Memorial Transplant Services. MMC is a Joint Commission-designated Comprehensive Stroke Center and maintains a TeleStroke network with other hospitals in the region whereby patients presenting with stroke symptoms can be diagnosed and triaged at their local hospital.

MMC maintains a 24-hour Emergency Department that is a Level 1 Trauma Center. The Emergency Department has traditionally served as a safety net healthcare 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 four 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. Patient financial assistance is provided as needed.

In FY2017, Memorial Medical Center provided the following care to the community:

- Patient Discharges: 24,784
- Births: 1,564
- Surgical Procedures: 19,927
- Outpatient Visits: 412,165

As a nonprofit community hospital, Memorial Medical Center provides millions of dollars in community support each year, both for its patients and in support of community partnerships. For the past three years, MMC's community benefits have totaled $309.1 million. (FY18 totals were not available at the time this report was completed.)

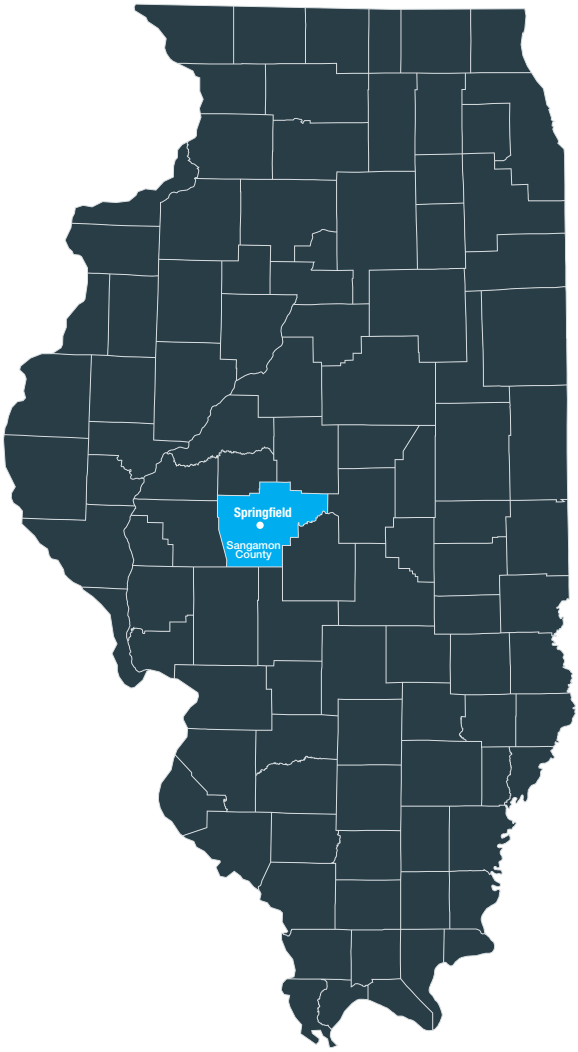
MEMORIAL MEDICAL CENTER COMMUNITY BENEFIT

	FY2015	FY2016	FY2017
Patient Financial Assistance	$4.3 million	$3.9 million	$5.7 million
Unpaid Medicaid	$36 million	$48.1 million	$46.8 million
Other Community Programs	$45.6 million	$59 million	$59.7 million
TOTAL COMMUNITY BENEFIT	$85.9 million	$111 million	$112.2 million

Recent Awards and Recognitions

- American Hospital Association NOVA Award: In 2018, Memorial Medical Center received the NOVA Award from the American Hospital Association for its collaboration with HSHS St. John's Hospital and SIU Medicine's Center for Family Medicine, a federally qualified health center, to create a community health worker program in a neighborhood with identified health and socioeconomic issues. The Enos Park Access to Care Collaborative was a direct outcome of the joint 2015 community health needs assessment and impacted the health and wellness of more than 300 people in the first 30 months of the program.
- Hospital Federation: In 2017, Memorial Health System was one of two winners of the Excellence Awards in the category of Quality & Safety and Patient-Centered Care. Memorial received the Honorable Mention award at the 41st World Hospital Congress in Taipei, Taiwan.
- American Hospital Association: 2016 winner of the McKesson Quest for Quality Prize, awarded annually to one hospital in the United States.
- Illinois Health and Hospital Association: 2017 Quality Excellence Achievement Award, Community Partnership Category; 2016 IHA Quality Excellence Achievement Award, Urban Hospital Category; 2016 IHA Quality Excellence Achievement Award, Palliative Care Category; 2014 IHA Quality Excellence Achievement Award, Urban Hospital Category
- World Hospital Congress: 2015 Top Quality Project
- Women's Choice Award: One of America's Best Hospitals for Cancer Care in 2015

Introduction to Sangamon County, Illinois



Memorial Medical Center 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, making MMC a significant resource for healthcare services.

However, 54 percent of MMC's patients reside in Sangamon County. Also, the majority of MMC's community outreach efforts are focused on Sangamon County, where MMC is located. Sangamon County (population 197,499) comprises 868 square miles in central Illinois. It is primarily a rural area that includes the city of Springfield (population 117,000), which is the county's largest city as well as the state capital of Illinois and the county seat. Sangamon County has eight federally designated medically underserved areas (MUAs). Healthcare and state and local government are the major employers in the county. Small business, industry 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.

Besides Springfield, there are three other cities in Sangamon County: Auburn (pop. 4,300); Leland Grove (pop. 1,600); and Virden (pop. 3,430). There are also 23 villages throughout the county.

Higher Education

Southern Illinois University School of Medicine is located in Springfield. MMC serves as a major teaching hospital for SIU Medicine, which has more than 300 medical students studying

in Springfield during their second through fourth years of medical school, as well as more than 300 residents and fellows participating in 23 different specialty programs. Springfield is also home to two universities: University of Illinois at Springfield and Robert Morris University, as well as Lincoln Land Community College, a junior college.

Healthcare Resources

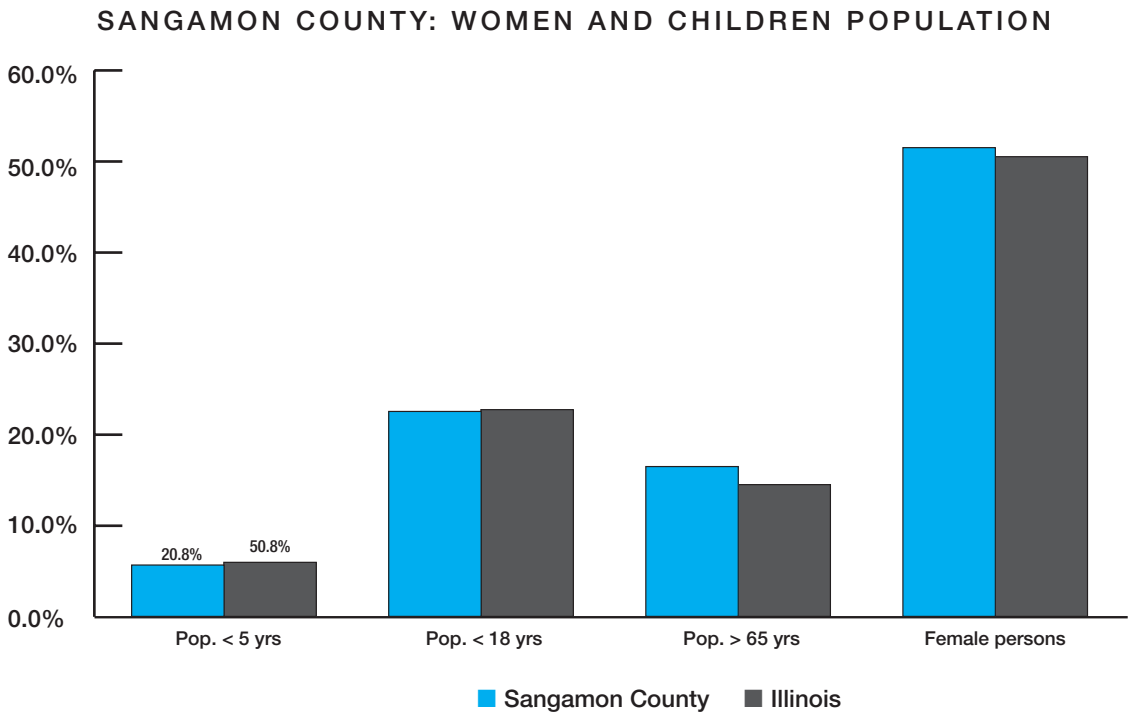
Thousands of patients from central and southern Illinois come to Springfield annually for quality specialty care and surgery that is not available in their rural communities. In addition to Memorial Medical Center, other Sangamon County healthcare resources include:

- HSHS St. John's Hospital, a 430-bed nonprofit hospital affiliated with Hospital Sisters Health System
- Sangamon County Department of Public Health (the tenth-largest public health department in Illinois, with approximately 95 employees)
- 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 Medicine (240 teaching physicians with SIU School of Medicine and more than 300 other providers including nurses, licensed clinical social workers, midwives, dietitians and audiologists)
- Memorial Physician Services (an affiliate of Memorial Health System with a primary care network of more than 130 physicians, physician assistants and 30 advanced practice nurses, with nine branch clinics)
- Memorial Home Services (an affiliate of Memorial Health System providing home health and hospice services)
- Memorial Behavioral Health (an affiliate of Memorial Health System providing crisis intervention, psychiatric and medical services, outpatient therapy, case management, employment services, residential care and psychiatric response teams for hospital emergency departments; is a member of the National Suicide Prevention Lifeline network)
- HSHS Medical Group (a multi-specialty physician group affiliate of Hospital Sisters Health System)

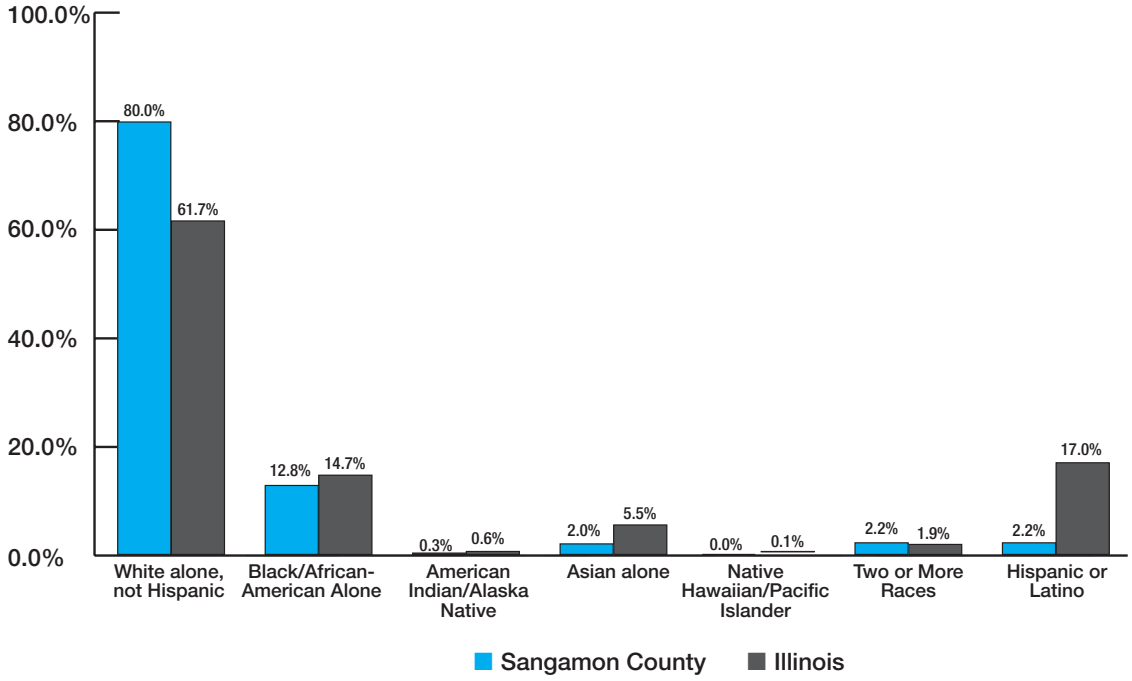
- Prairie Cardiovascular (32-physician group)
- Vibra Hospital of Springfield (50-bed, long-term, acute-care facility)
- Orthopedic Center of Central Illinois (orthopedic surgeons and physiatrists)
- Lincoln Prairie Behavioral Health Center (providing psychiatric treatment to children and adolescents)

Sangamon County Residents

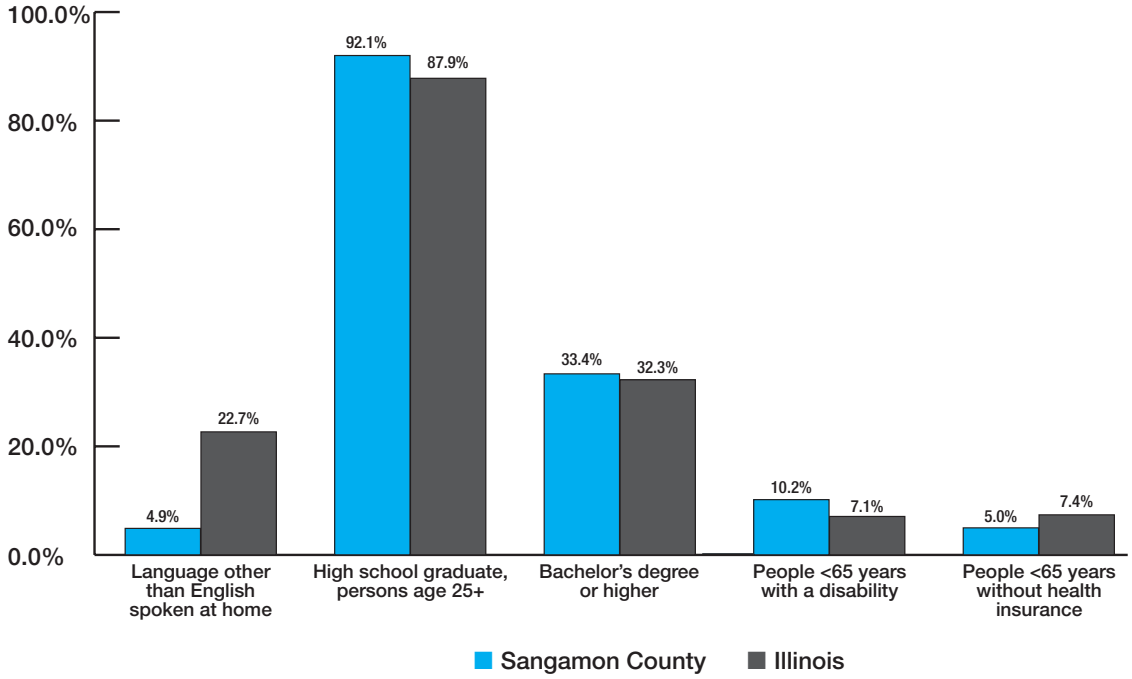
The following statistics, from the U.S. Census Bureau's Quick Facts, came from the Healthy Communities Institute. *Retrieved March 2, 2017 from www.ChooseMemorial.org/Community-Health-Needs-Assessment/HCI?hcn=Demographics.*
Source: U.S. Census Bureau
Quick Facts, (V2016), revised Sept. 15, 2017.



SANGAMON COUNTY: RACE AND HISPANIC ORIGIN



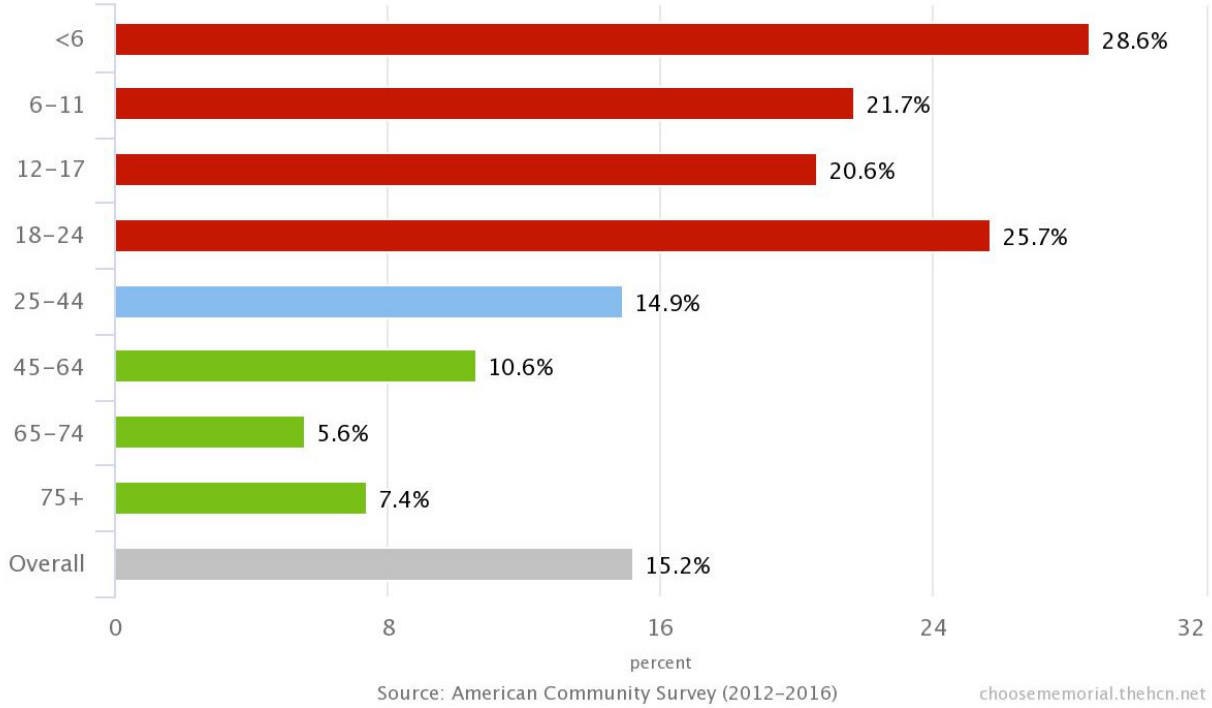
SANGAMON COUNTY: LANGUAGE, EDUCATION, DISABILITY, HEALTH INSURANCE



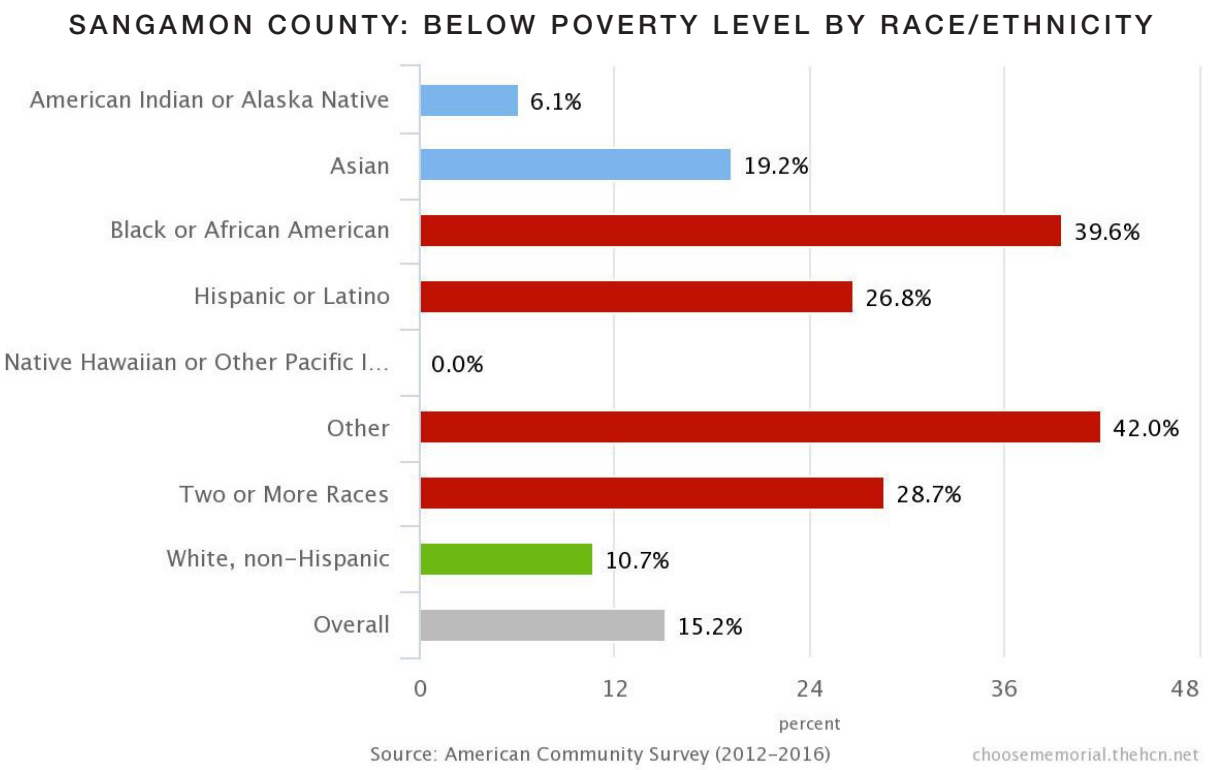
SANGAMON COUNTY: INCOME & POVERTY

	Sangamon County	Illinois
Median household income, 2012-2016	$56,742	$59,196
Persons in poverty, percent	15.2%	14.0%

SANGAMON COUNTY: BELOW POVERTY LEVEL BY AGE



GREEN = Significantly better than the overall value
RED = Significantly worse than the overall value
BLUE = Not significantly different than the overall value (or no confidence intervals available)



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

According to reports from two Springfield-based federally qualified health centers, SIU Center for Family Medicine and Central Counties Health Centers, hypertension, asthma and diabetes are primary and chronic diseases affecting their patients. Low-birth-weight babies are also an issue. Mental health is an issue community-wide that is particularly prevalent in this population, as is emergency department utilization for alcohol and drug use. Access to dental care continues to be an issue for this population as well.

Areas of Sangamon County with High Socioeconomic Need

The SocioNeeds Index, created by Conduent Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes. All zip codes, counties and county equivalents in the United States are given an Index Value from 0 (low need) to 100 (high need). To help find the areas of highest need in Sangamon County, the selected locations are ranked from 1 (low need) to 5 (high need) based on their Index Value.

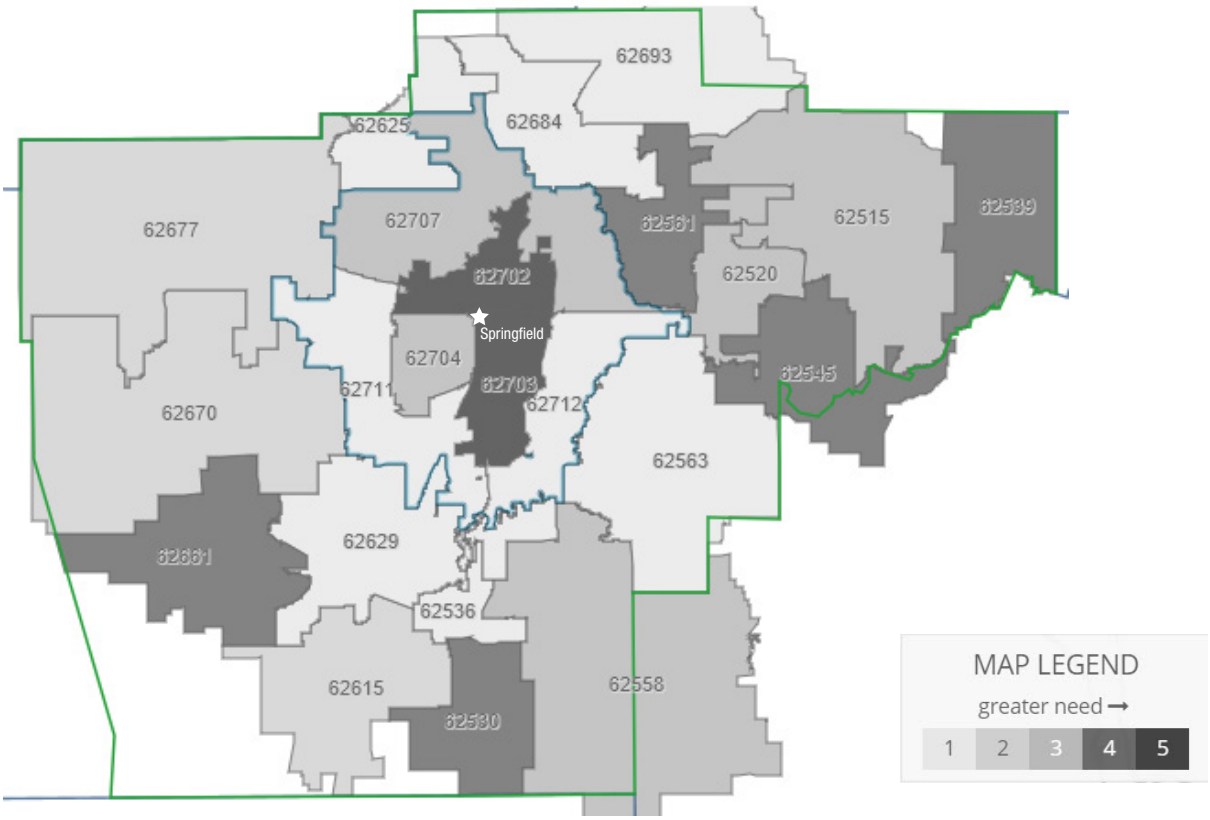
In Sangamon County, the zip codes estimated with the highest socioeconomic need are the Springfield zip codes 62701, 62703 and 62702 in the north and east sides of the city. Residents living in these areas of the community are at greater risk of being hospitalized for preventable illness or premature death. The zip code with the lowest socioeconomic indicators and reduced risk of preventable hospitalizations or premature death is 62711.

Sangamon County Zip Codes Ranked by SocioNeeds

Source: Healthy Communities Institute. Retrieved September 2018 from https://www.ChooseMemorial.org/Community-Health-Needs-Assessment/Community-Snapshot.

Zip Code	Index	Rank
62703	90.9	5
62701	83.6	5
62702	80.7	5
62661	54.8	4
62561	53.3	4
62545	48.4	4
62539	47.5	4
62530	41.7	4
62515	36.5	3
62707	33.4	3
62704	31.8	3
62558	29.7	3

Zip Code	Index	Rank
62520	25.9	3
62615	17.6	2
62677	16.3	2
62670	13	2
62629	8.8	1
62536	8.2	1
62563	7.1	1
62693	7.1	1
62712	7.1	1
62684	6.8	1
62625	4.3	1
62711	3.5	1


62693
62625
62684
62677
62707
62561
62515
62589
62702
62520
Springfield
62704
62545
62711
62703
62712
62670
62563
62629
62681
62536
62615
62530
62558
MAP LEGEND
greater need →
1
2
3
4
5

Evaluation of Progress since the 2015 Community Health Needs Assessment

Priority Topics of 2015 Community Health Needs Assessment

Memorial Medical Center, HSHS St. John's Hospital and the Sangamon County Department of Public Health collaborated on the 2015 community health needs assessment conducted in Sangamon County. Each organization selected priorities to address during the next three years. Priorities selected by Memorial Medical Center were:

- Access to Care
- Mental Health
- Obesity

The implementation strategy developed for FY2016 was updated annually in FY2017 and FY2018, and approved by the Community Benefit Committee of the Memorial Health System board as well as the hospital board. The MHS Community Benefit Committee also annually reviewed the outcomes of each MHS hospital's CHNA implementation strategy toward meeting the strategic plan goal to achieve 100 percent of approved Community Benefit targets. Complete implementation strategy outcomes for FY2016-FY2018 are available online at ChooseMemorial.org/HealthyCommunities.

Access to Care

The 2015 priority of access to care was also selected by HSHS St. John's Hospital. Both hospitals collaborated with the Center for Family Medicine, a federally qualified health center that is part of Southern Illinois University School of Medicine, to create a new place-based community health worker model. The Enos Park Access to Care Collaborative serves a neighborhood adjacent to both hospitals and the FQHC. Since the program started in late 2015, more than 300 residents benefited from improved access to care in the program's first 30 months. Impact includes 100% of clients have medical homes; 93% visited their primary care provider in the past year; 28% increase in hospital outpatient utilization; 69% increase in employment; 53% increase in income; 31% increase in food access; and 74% increase in housing safety. The program also demonstrated a 22% decrease in unnecessary emergency department visits; 36% reduction in inpatient hospital charges; 0% parolee recidivism; 11% reduction in neighborhood crime; and 28% reduction in homelessness. The American Hospital Association recognized the Enos Park Access to Care Collaborative with a 2018 NOVA Award for its work to improve community health status by looking beyond physical ailments to address economic and social barriers to care. Impact statements from years one and two of the program are in Appendices p. 65. (The third-year impact statement had not been completed at the time of this report.)

To further address access to care, Memorial Medical Center completed building a $16-million, 30,315-square-foot expansion to the SIU Center for Family Medicine FQHC, greatly increasing the size of the facility. This allowed the FQHC to add medical providers and increased its ability to care for more low-income, underserved patients.

Memorial also offers significant financial support to Southern Illinois University School of Medicine, in addition to serving as a teaching hospital. This financial support makes it possible for this state university to continue educating the next generation of healthcare providers, increasing access to care in central and southern Illinois.

Mental Health

To address the priority of mental health, the four MHS hospitals (Memorial Medical Center, Abraham Lincoln Memorial Hospital, Passavant Area Hospital and Taylorville Memorial Hospital) brought national trainers from the Mental Health First Aid of the National Council for Behavioral Health to Springfield, Ill. MHS paid for all week-long training costs for 27 individuals from Sangamon, Logan, Morgan and Christian counties to be certified Mental Health First Aid trainers. Those receiving certification included staff from mental health agencies, public health, hospitals, school districts and social service agencies. MHS also paid to have the national trainers return to offer a three-day certification program for Youth Mental Health First Aid. By the end of the third quarter of FY2018, these trainers had offered Mental Health First Aid courses to 1,227 people in central Illinois. The program is offered to participants free with the exception of the cost of the workbook.

Memorial Medical Center also provided three years of funding for the Children's MOSAIC Project, an initiative of Memorial Behavioral Health to provide thousands of social/emotional screenings to children in Springfield Public School District 186. This helps to identify children sooner and reduces barriers to receiving appropriate intervention. Behavioral health clinicians embedded in the schools offer services to children within the school setting. During school years 2015-2018, 525 children with highly elevated screens received MOSAIC counseling and behavioral health services at 11 Springfield schools.

Obesity

Obesity was addressed through the expansion of the Memorial Weight Loss & Wellness Center to rural populations served by Abraham Lincoln Memorial Hospital and Passavant Area Hospital, as well as the addition of a new pediatric component to the program in Springfield. Memorial is also collaborating with the Springfield YMCA to implement the Center for Disease Control's Diabetes Prevention Program. Significant support was also provided for Girls on the Run of Central Illinois, which is reaching more than 1000 girls annually; the Springfield YMCA's Healthier Communities Initiative, reaching low-income and at-risk youth; and to a new community garden in a low-income neighborhood.

Two of the 2015 priorities, access to care and mental health, have again been identified as priorities in the 2018 CHNA, and the implementation strategy for FY2019-FY2021 will build upon work begun in FY2016-FY2018.

Community Feedback Regarding the 2015 CHNA and Implementation Strategy

Memorial Medical Center made the 2015 CHNA report available on its website at ChooseMemorial.org/HealthyCommunities. In collaboration with HSHS St. John's Hospital and the Sangamon County Department of Public Health, the 2015 CHNA outcomes and selected priorities of each organization were presented to the Springfield Citizen's Club in December 2015. Another presentation was given in November 2016 to share the first-year impact statement of the Enos Park Access to Care Collaborative, as well as updates on other programs addressing CHNA priorities. Updates on programs were also provided several times by local media.

The collaborative CHNA process received broad approval from community members, hospital board members and the media. No direct written feedback was received, other than several articles in the newspaper commending the collaboration. The programs have received good verbal feedback from the community, although several people expressed the hope that future initiatives would target more at-risk areas of the community.

2018 Sangamon County Community Health Needs Assessment

Methodology

During the 2015 Sangamon County Community Health Needs Assessment, Memorial Medical Center collaborated with HSHS St. John's Hospital, a regional medical center and children's hospital, and the Sangamon County Department of Public Health. The collaborative process in 2015 was beneficial to both hospitals and the health department, and received positive feedback from the larger community.

In December 2016, Memorial Medical Center (MMC) and HSHS St. John's Hospital (HSHS SJH) met to develop the following timeline for the 2018 CHNA process, including participation from Sangamon County Department of Public Health (SCDPH).

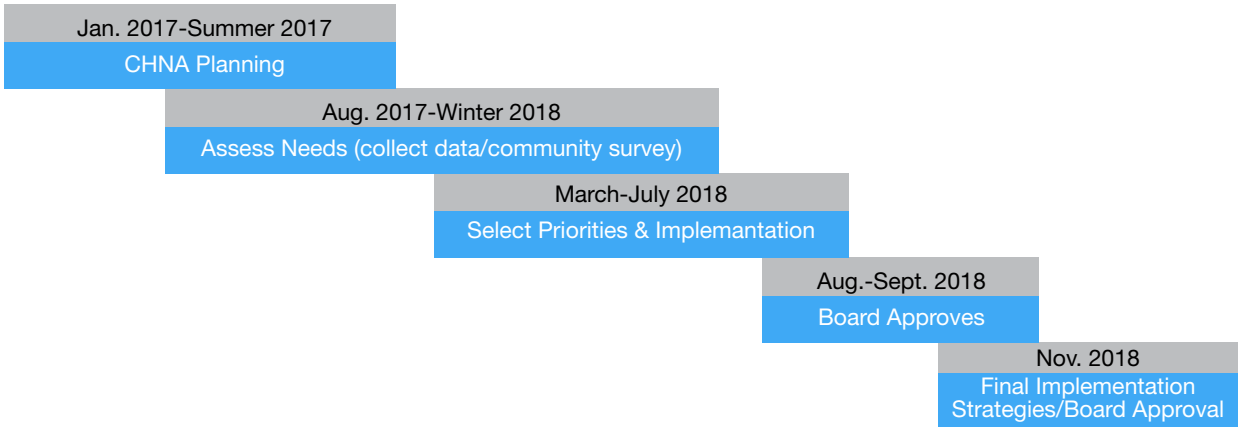
TIMELINE FOR THE 2018 SANGAMON COUNTY COMMUNITY HEALTH NEED ASSESSMENT

Timeline	Activity	Outcomes
Jan. 2017	▪ MMC, SJH and SCDPH meet	▪ Discuss CHNA agreement/ parameters; Core Team
Feb.–April 2017	▪ Finalize CHNA timeline, process and other major participants (UIS Survey Research)	▪ Secure agreements with UIS ▪ Finalize contract with UIS Survey Research
Feb.–May 2017	▪ Investigate and collect other available data sources for Sangamon County ▪ ID whom to invite to participate in Community Advisory Council	▪ MMC, SJH, SCDPH identify data resources in addition to Healthy Communities on MMC website ▪ Set dates for Community Advisory Committee; issue first invitation and "save the meeting date" notices
June 2017	▪ Complete analysis of existing secondary data assessment	▪ Complete report summarizing significant findings of other needs assessments
July–Aug. 2017	▪ Complete deep review of Healthy Communities Institute data for Sangamon County ▪ Analyze and identify significant issues ▪ Narrow priority list ▪ Begin work on CHNA community survey	▪ ID significant health issues for Sangamon County ▪ Narrow down priorities to present to Community Advisory Committee ▪ ID detailed plan for completing the CHNA community survey, including preparation and communication plan
Oct. 2017	▪ Convene first Community Advisory Committee to review CHNA process, mid- to late-October ▪ Obtain primary data/input from Community Advisory Committee on health needs	▪ Obtain Committee understanding/ support of the CHNA process ▪ Gain input from members to further understand priority health issues

Nov.–Dec. 2017	▪ Convene second Community Advisory Committee in early November; obtain primary data ▪ Finalize survey questions	▪ Get Advisory Committee input into health priorities to include in the community survey; obtain their support to help promote the survey ▪ With UIS, finalize survey tool ▪ Using the communication plan, begin promotion of upcoming community survey
Jan. 2018	▪ Conduct community survey ▪ UIS analysis	▪ Obtain outcomes from survey ▪ Core Team reviews
Feb.–March 2018	▪ Convene Community Advisory Committee to share outcomes of community survey ▪ MMC, SJH and SCDPH identify final priorities	▪ Hospitals and health department will identify priorities ▪ Determine joint priority/collaborative
April–May 2018	▪ With UIS, conduct focus groups around key priorities	▪ Increase understanding of issues and identify implementation strategies
June 2018	▪ SJH presents to HSHS SJH board the 2018 CHNA report on process/ outcomes/priorities	▪ HSHS SJH board approves
Sept. 2018	▪ MMC presents to MHS Community Benefit Committee and MHS board the 2018 CHNA report on process/ outcomes/priorities	▪ MHS board approves
Oct. 2018	▪ SJH finalizes CHNA implementation strategy for FY2019-2021	▪ HSHS SJH board approves ▪ Post information on HSHS SJH website
Nov. 2018	▪ MMC finalizes CHNA implementation strategy for FY2019-2021	▪ MHS Board approves ▪ Post information on MHS website
Dec. 2018	▪ Public announcement of Sangamon County Community Health Needs Assessment outcomes	▪ Make information widely available to the public
Feb. 2019	▪ SCDPH completes IPLAN report for Sangamon County	▪ Submit to Illinois Department of Public Health for approval

Memorial Health System Hospitals 2018 CHNA Timeline

In addition to the timeline established for the Sangamon County CHNA, the following overall timeline was established for the four Memorial Health System hospitals to complete the 2018 CHNA process in their respective communities.



Sangamon County Community Health Needs Assessment Core Team Members

MEMORIAL MEDICAL CENTER

- Kevin England, senior vice president, Business Development
- Michael Curtis, administrator, Business Development and Strategic Planning
- Mitch Johnson, senior vice president and chief strategy officer (through Dec. 31, 2017)
- Paula Gramley, MHS Community Benefit Program manager

HSHS ST. JOHN'S HOSPITAL

- Kim Luz, Divisional Director of Community Outreach
- Megan Williams, Community Outreach Facilitator

SANGAMON COUNTY DEPARTMENT OF PUBLIC HEALTH

- Jim Stone, Director of Public Health
- Gail O'Neill, Assistant Director of Public Health

The first meeting of the Core Team for the 2018 CHNA process took place on Jan. 11, 2017. The group agreed to the proposed timeline and the Intention to Collaborate.

Memorial Medical Center, HSHS St. Johns Hospital and Sangamon County Department of Public Health Intention to Collaborate on a Community Health Needs Assessment

To be completed in 2018.

Memorial Medical Center, HSHS St. John's Hospital and Sangamon County Department of Public Health will collaborate on a community health needs assessment to be completed in each hospital's FY2018 (6/30/2018 for SJH and 09/30/2018 for MMC). The health department will complete and submit its IPLAN to the Illinois Department of Public Health by February 2019.

- The overall CHNA process will assist both hospitals in meeting the requirements of the Affordable Care Act and Internal Revenue Service and help the health department accomplish its IPLAN process.
- The geographic area for this joint CHNA will be Sangamon County.
- Each hospital may have additional CHNA responsibilities with other hospitals/counties within their respective health systems, as well as the health department completing an IPLAN for another county. These processes will be separate from this CHNA.
- MMC, SJH and SCDPH will identify and agree upon pre-established criteria to use when evaluating the needs and opportunities that arise from the CHNA process.
- MMC, SJH and SCDPH will review the priorities from the 2015 CHNA and IPLAN and their implementation strategies. 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 on a community advisory committee. Included in the advisory committee will be representatives from the broader community, particularly from organizations that serve vulnerable and at-risk populations, as well as representatives from rural portions of Sangamon County.
- A community survey will be conducted and, depending upon the need for additional information, focus groups will be identified to gain additional insight into particular topics. The University of Illinois Survey Research Department will be contracted to complete the survey and focus groups.
- MMC and SJH will consider selecting one priority need to address jointly. The implementation strategy would include measurable outcomes for community health improvement. Additional community partners would be included in this program.

Review of Secondary Data Sources and Analysis

Numerous secondary data sources were consulted. These included:

1. The most significant source of secondary data consulted was Conduent Healthy Communities Institute data on Memorial Health System website: health & socioeconomic indicators specific to Sangamon County ChooseMemorial.org/HealthyCommunities
2. County Health Rankings and Roadmaps (http://www.countyhealthrankings.org/app/illinois/2018/rankings/sangamon/county/outcomes/overall/snapshot)
3. Sangamon Success and Continuum of Learning: local goals and recommendations to help less-advantaged children achieve success (https://www.continuumoflearning.org/sangamon-success/)
4. Sangamon County 2015 and 2017 Citizens Survey (http://springfieldunitedway.org/our-work/sangamon-county-citizen-survey/#.W3hd3SRKiDg and http://www.cfll.org/Portals/0/PDFs/2017%20Sangamon%20County%20Citizen%20Survey%20Report.pdf)
5. Sangamon County Department of Community Resources Needs Assessment and Action Plan (https://co.sangamon.il.us/Portals/0/Departments/Community%20Resources/Docs/2017%20Community%20Needs%20Assessment%20Report.pdf)
6. Springfield Urban League Head Start/Early Head Start Community Assessment 2014-15 (obtained from Urban League)
7. Central Counties Federally Qualified Health Clinic 2015 report made to HRSA (https://bphc.hrsa.gov/uds/datacenter.aspx?q=d&bid=059700&state=IL&year=2015)
8. SIU Center for Family Medicine Federally Qualified Health Clinic 2015 report made to HRSA (https://bphc.hrsa.gov/uds/datacenter.aspx?q=d&bid=059700&state=IL&year=2015)
9. CDC/Robert Woods Johnson 500 Cities Project – Springfield Measures (ftp://ftp.cdc.gov/pub/MAPBOOKS/IL_Springfield_MB_508tag.pdf)
10. State Health Improvement Plan (SHIP) (http://www.idph.state.il.us/ship/icc/ship.htm)
11. UIS Center for State Policy and Research 2017 Annual Report (https://www.uis.edu/cspl/)
12. Sangamon County Schools, Regional Office of Education (https://www.roe51.org/)
13. United Way of Central Illinois priority funding areas (http://springfieldunitedway.org/)
14. Voices for Illinois Children: Kids Count Report (http://www.voices4kids.org/)
15. Food Atlas (https://www.ers.usda.gov/foodatlas/)
16. School Report Card, Illinois State Board of Education (https://www.illinoisreportcard.com/)
17. Interview: Linda Jones, Vice President of Operations, Memorial Medical Center – cancer incidence and mortality
18. Sangamon County Coroner's Office, infant mortality data from July 2012-May 2016
19. Sangamon County Adult Emergency Department Usage for Mental Health Conditions by ICD 9 and ICD 10 codes, Jan. 2014-March 2017. Data drawn from Illinois COMPdata by Memorial Health System.

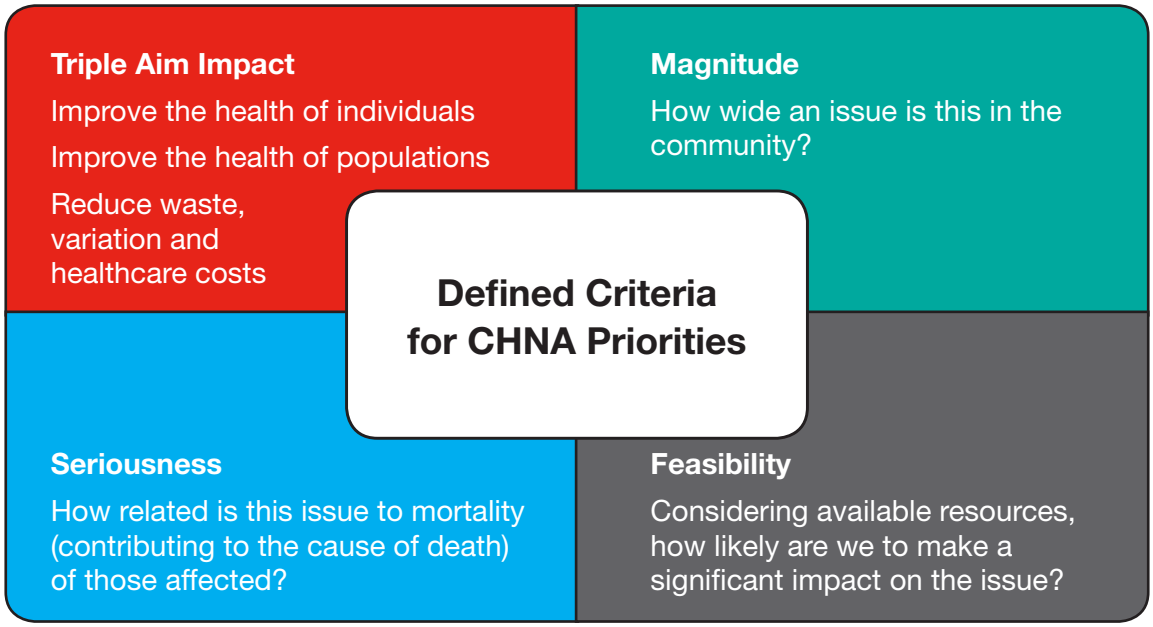
Conduent Healthy Communities Institute Data

The most significant source of secondary data was collected and analyzed through ChooseMemorial.org/HealthyCommunities, a web-based community health data platform developed by Conduent Healthy Communities Institute (HCI) and sponsored by Memorial Health System. The site brings non-biased data and reporting tools to one accessible, user-friendly location. The site includes a comprehensive dashboard of more than 100 community indicators covering more than 20 topics in the areas of health, determinants of health and quality of life. That data is primarily derived from state and national public secondary data sources. Specific Sangamon County indicators are compared to other communities, state-wide data, national measures and Healthy People 2020. Many indicators also track change over time or identify disparities.

During the 2018 CHNA, HCI's data scoring tool for Sangamon County indicators was used to summarize and compare multiple indicators across the community dashboard and to rank these indicators based on highest need. Comparison scores ranged from 0 (best) to 3 (worst). These indicators were grouped into various topic areas. In June and July 2017, members of the CHNA Core Team carefully reviewed all indicators ranked 1.5 or higher, and also noted disparities in specific indicators and changes over time to identify community health needs. Additional information is in Appendices p. 74.

Criteria for Determining Need

The following criteria were successfully used during the 2015 CHNA process for determining significant need, and were used again during the 2018 CHNA.



The Core Team reviewed the HCI Data Scoring Tool and discussed each need that scored 1.5 or higher, and also included a review of any disparities noted for those issues. They then discussed all the issues on the basis of Triple Aim, magnitude, seriousness and feasibility. They identified 12 categories of need to investigate further.

1. **Maternal, Fetal, Infant Health**
   - Prenatal care
   - Infant death
   - Teen pregnancy
   - Mothers who smoke
2. **Public Safety**
   - Violent crime
   - Child abuse
3. **Cancer ***
   - Lung cancer
4. **Mental Health, Mental Disorders**
   - Substance abuse
   - Depression in seniors
   - Access to mental healthcare
   - Suicide rates
5. **Respiratory Disease**
   - Adult asthma
   - Childhood asthma
6. **Infectious Disease**
   - Gonorrhea / Chlamydia rates
7. **Diabetes**
8. **Exercise, Nutrition, Weight**
   - Overweight / Obese adults
   - Childhood obesity
   - Food access / Insecurity
9. **Environment**
   - Housing
10. **Substance Abuse**
    - All substances
    - Smoking
    - Death rate for drug poisoning
    - Alcoholism and related deaths
    - Opioid abuse
11. **Heart Disease, Stroke**
    - High blood pressure
    - Stroke
    - Cardiovascular disease disparities
12. **Other Issues**
    - Employment
    - Access to care
    - Dental access

**Sangamon County had numerous cancer indicators that were concerning, but it was difficult to narrow down which indicators were the most significant. Linda S. Jones, DNS, RN, AOCN, FACHE, vice president of Operations at Memorial Medical Center, was consulted as a key informant for additional analysis. Dr. Jones has experience with cancer research and oversight of MMC's Regional Cancer Center. On the basis of the specific types of cancer incidence and the actual number of people impacted in this rural area, as well as the opportunity to conduct a community intervention to impact a particular type of cancer, lung cancer was selected as a priority need.*

Social Determinants of Health

The Sangamon County CHNA Core Team included consideration of social determinants of health throughout the CHNA process, using the following information from the Kaiser Family Foundation to consider the many issues contributing to health outcomes.

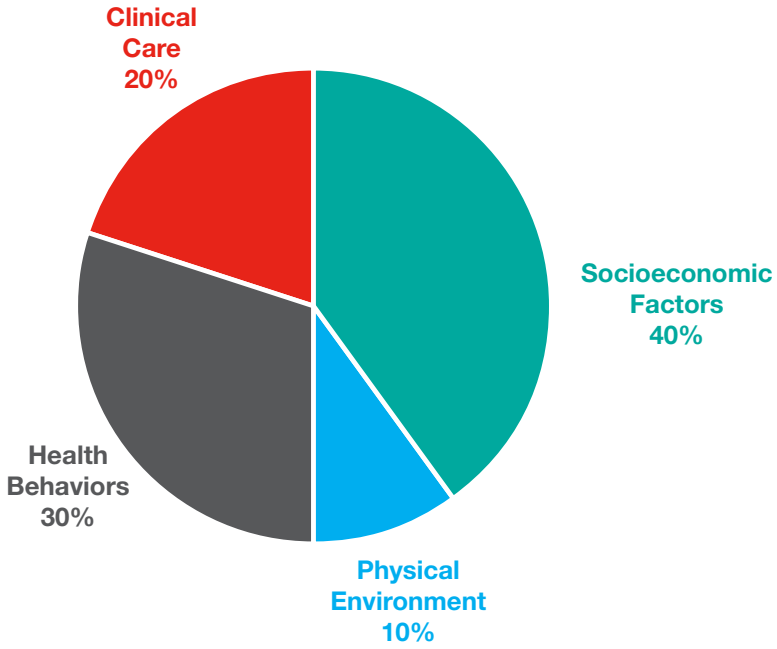
Economic Stability	Neighborhood & Physical Environment	Education	Food	Community & Social Context	Healthcare System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Resulting in Health Outcomes:
Mortality, Morbidity, Life Expectancy, Healthcare Expenditures, Health Status, Functional Limitations

Source: Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity by Harry J. Heiman and Samantha Artiga. Oct. 13, 2015. www.issuelab.org/resources/22899/22899.pdf

The following information from County Health Rankings was used when considering the impacts of clinical care vs. other social determinant factors.

WHAT IMPACTS INDIVIDUAL AND COMMUNITY HEALTH



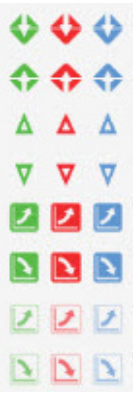
Major Sangamon County Contributing Social Determinants Factors

Several resources for Sangamon County secondary data, including County Health Rankings, local needs assessments and surveys and Healthy Community's Institute Data Scoring Tool, highlighted three significant social determinant factors that impact overall community health and quality of life in this county. These are:

1. Number of families with single heads-of-households: 41.2%
2. Number of children who live in poverty: 23.5%
3. Low high school graduation rates: 84.9%

The number of single-parent families and people living in poverty varies widely across different areas of the county. For example, county-wide data when compared to zip code 62703 (which has the highest identified socio-needs areas) clearly show the disparity. (High school graduation rates are not reflected for zip code 62703, as they are only available at the county level.)

KEY



The current value is lower than the previously measured value.

The current value is higher than the previously measured value.

The current value is higher than the previously measured value.

The current value is lower than the previously measured value.

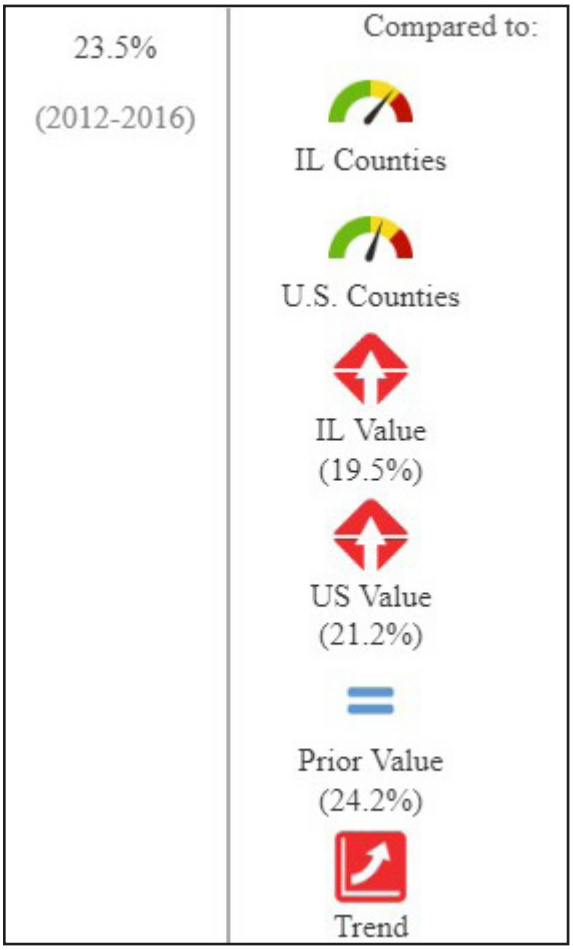
There has been a significant increase over time.

There has been a significant decrease over time.

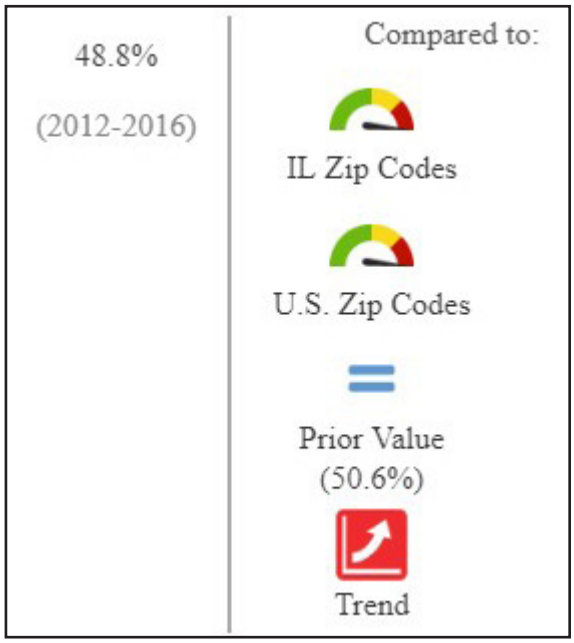
There has been a non-significant increase over time.

There has been a non-significant decrease over time.

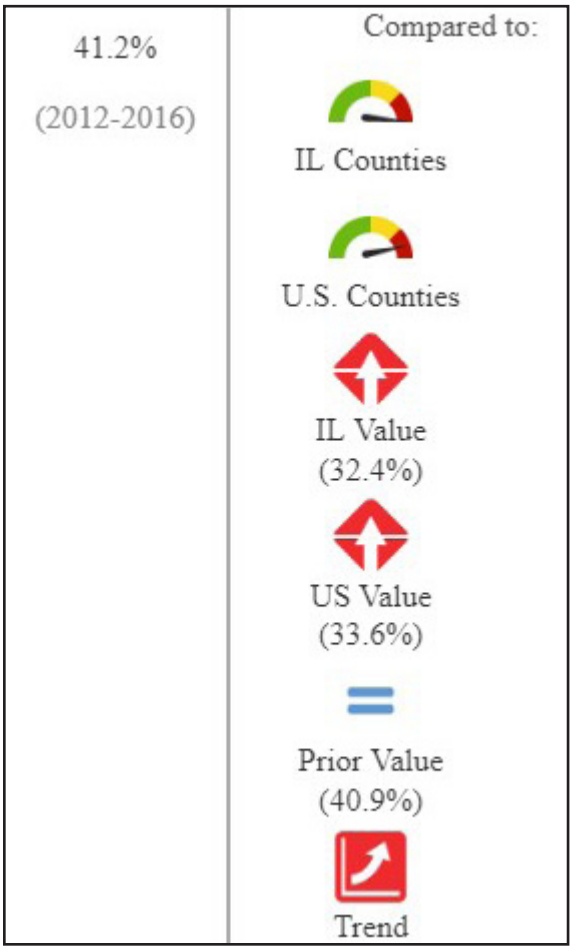
SANGAMON COUNTY: CHILDREN LIVING BELOW POVERTY LEVEL



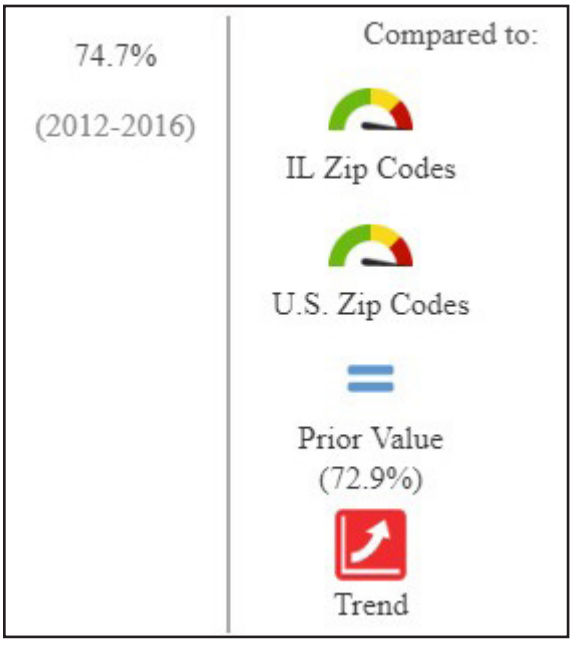
ZIP CODE 62703: CHILDREN LIVING BELOW POVERTY LEVEL



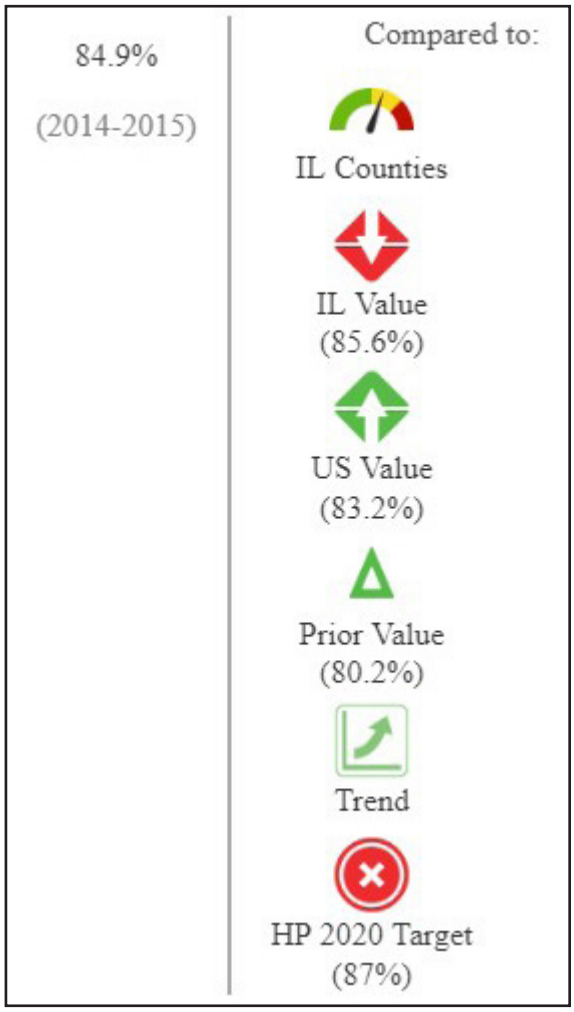
SANGAMON COUNTY: SINGLE-PARENT HOUSEHOLDS



ZIP CODE 62703: SINGLE-PARENT HOUSEHOLDS



SANGAMON COUNTY: HIGH SCHOOL GRADUATION



Primary Data Collection and Analysis

Community Advisory Committee

Primary data was gathered by convening a Community Advisory Committee made up of representatives from organizations that serve low-income, minority and at-risk populations in Sangamon County.

CHARTER: The Advisory Committee of the Sangamon County 2018 Community Health Needs Assessment exists to help Memorial Medical Center, HSHS St. John's Hospital and the 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.

Thirteen organizations participated on the Community Advisory Committee.

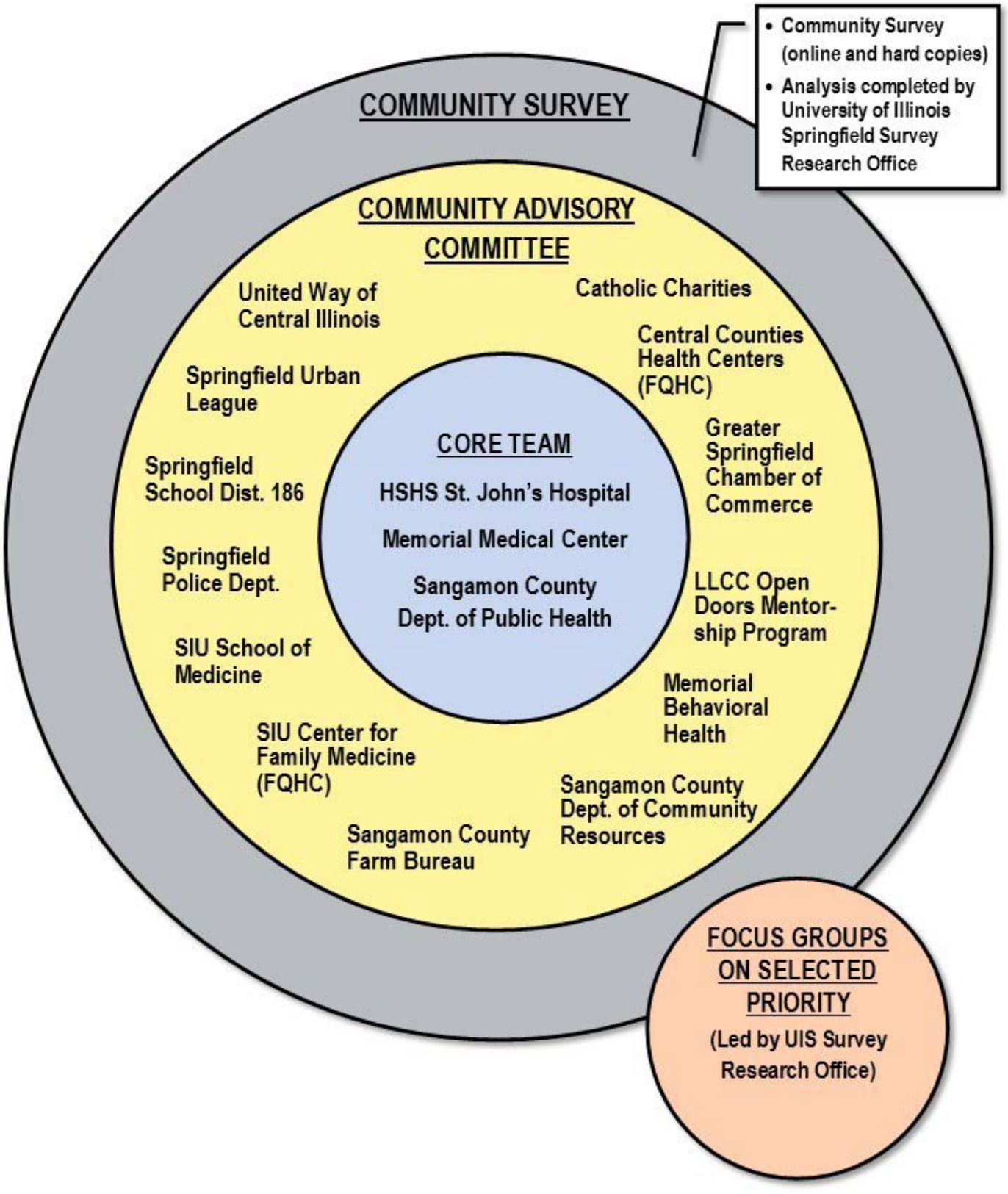
Organization	Organization Description	Organization Serves
Catholic Charities Dioceses of Springfield	Mission: To extend to all the healing and empowering presence of Jesus. Through our competent and compassionate ministries, we will support the dignity and sanctity of human life at all stages of development and growth; value families and the sacredness of marriage, and work to strengthen them; and provide hope and help to those in need.	Low-income and underserved populations
Central Counties Health Center (a federally qualified health center)	CCHC is a community health center which provides the underserved access to primary medical care, general dentistry, healthcare 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, nondiscriminatory and accessible primary medical and dental care that meets the personalized needs of underserved people in central Illinois.	Underserved and low-income residents
Greater Springfield Chamber of Commerce	Mission: To enhance our members' success and advance our economy.	Serves businesses/employers throughout Sangamon County

Lincoln Land Community College Open Door Mentorship	The mission of Lincoln Land Community College is to provide district residents with quality educational programs and services that are accessible, affordable and responsive to individual and community needs.	The Open Door Mentorship, in collaboration with the Chamber of Commerce, serves African-American male students at LLCC. It helps to improve the persistence, retention and completion of education for African-American male students.
Memorial Behavioral Health	Memorial Behavioral Health is a not-for-profit organization providing high-quality, comprehensive behavioral health and rehabilitation services. An affiliate of Memorial Health System, MBH is one of the largest providers of behavioral health services in central Illinois. Services include crisis intervention, psychiatric and medical services, screenings and assessments, outpatient case management, psychiatric crisis intervention, homeless persons' advocacy and counseling and other services. Mission: To improve the health of the people and communities we serve.	MBH serves children, adolescents and adults needing behavioral health services.
Sangamon County Department of Community Resources	SCCR is a community action agency which strives to improve the quality of life for people with low incomes in Sangamon County through department programs, services and referrals that promote stability and/or self-determination. Programs include LIHEAP and weatherization, which serve Sangamon County residents at or below 150 percent of the Federal Poverty Level (FPL), as well as many Community Services Block Grant programs which serve residents at or below 125 percent of the FPL.	Low-income residents of Sangamon County
Sangamon County Farm Bureau	Advocating the voice of agriculture through education and grassroots legislation. We serve all of Sangamon County.	Rural Sangamon County communities

SIU Center for Family Medicine (federally qualified health center)	SIU Center for Family Medicine is a federally qualified health center with a mission to improve the health of our community by serving all patients and particularly targeting those who are most vulnerable. We provide the full scope of primary care and partner with resources in the community to address the social determinants of health. We are also a hub of learning - training tomorrow's health-care work force.	Underserved and low-income residents
SIU School of Medicine Department of Equity, Diversity and Inclusion	SIU School of Medicine exists to: (1) improve the healthcare education, delivery of healthcare and the health of people of western, central and southern Illinois, and (2) advance the discipline of medicine. We do that by educating physicians, physician assistants and scientists by researching the causes and cures of disease and by caring for people and communities through systems of care that meet the Triple Aim +1: Health-care and healthcare education that's more effective, efficient, equitable and enjoyable.	Addresses issues of racism, diversity and inclusion for SIU students and faculty as well as the community at large
Springfield Police Department	The SPD serves the 117,000 citizens of Springfield, ensuring that the community is a safe place for individuals to live and raise their families.	All residents of Springfield
Springfield School Dist. 186	Mission Statement: The District, in collaboration with families and community, shall develop in all students the knowledge, understanding, skills and attitudes to empower them to be responsible life-long learners and 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 Inc.	The Springfield Urban League Inc. is a nonprofit, nonpartisan, civil rights and community-based movement that serves over 9,000 people annually. Primarily working with low-income individuals and youth, we work to close equality gaps for people at all economic levels and stages of life, and afford citizens an opportunity to socially tithe as volunteers. The mission of the Springfield Urban League is to empower those who struggle to secure economic self-reliance, parity, power and civil rights. Our vision is to serve as the stakeholder that fosters pathways to education, economic empowerment and self-sufficiency.	Low-income residents and minority youth
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 and specific programs providing food, shelter, healthcare and victim services. Mission: Mobilizing resources to meet community needs.	Supports health and human service programs that provide food, shelter, healthcare and victim services.

Sangamon County 2018 Community Health Needs Assessment



The CHNA Core Team met three times with the Community Advisory Committee, twice prior to the Sangamon County Community Survey, to identify issues to include on the community survey.

Meeting one: Oct. 24, 2017 – The first meeting introduced the purpose of the CHNA and the process that would take place. Memorial Medical Center, HSHS St. John's Hospital and the Sangamon County Department of Public Health provided an overview of outcomes of the 2015 CHNA and implementation strategies for each hospital and the health department's IPLAN. During this meeting, social determinants of health were discussed. The committee received an overview of the many sources of secondary data consulted, and were introduced to the 12 identified categories of need. The committee was asked to provide input on community need based on their experience and the persons served by their organizations. The committee was also asked whether there were any significant priorities they were aware of that should be considered in addition to those already identified; no further significant issues were noted.

Meeting two: Nov. 17, 2017 – During the second meeting of the Community Advisory Committee, the 12 categories of need that were presented during the first meeting were broken down to 17 specific issues. Data was shared on each individual issue, including Sangamon County incidence rates, emergency department and hospitalization data, trends over time and disparities.

1. Access to care
2. Asthma
3. Child abuse
4. Diabetes
5. Dental care
6. Education/High school graduation rates/Employment
7. Food access/Insecurity
8. Heart disease and stroke disparities
9. Housing
10. Lung cancer
11. Maternal/Fetal/Infant health
12. Mental health
13. Obesity/Overweight
14. Sexually transmitted diseases (chlamydia and gonorrhea)
15. Substance abuse—Alcohol
16. Substance abuse—Drugs, including opioids
17. Violent crime

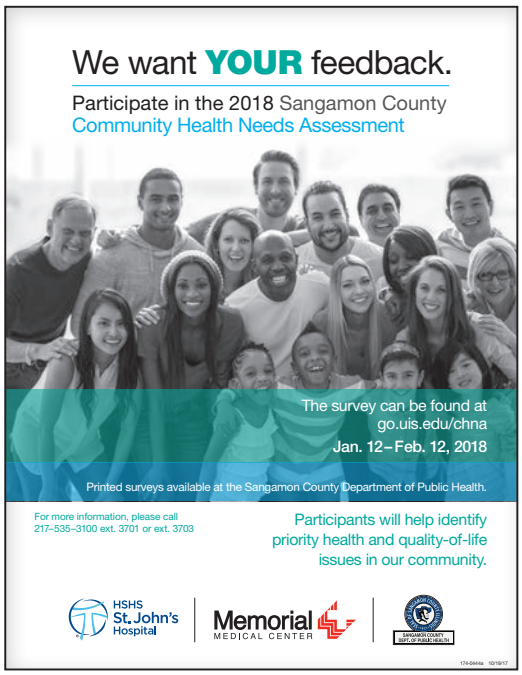
Discussion took place on each of the issues, with the committee sharing specific information on how these issues impact their clients and the community. The committee was then asked to complete a forced ranking of the 17 needs to identify the top eight issues to include on the upcoming community survey. Because two issues tied, nine final priorities were identified to include on the Sangamon County Community Survey to start in January 2018. These nine issues in alphabetical order were:

- Asthma
- Child abuse
- Education
- Food access
- Housing
- Mental health
- Mother/Infant health
- Substance abuse – Drugs
- Violent crime

The Sangamon County Community Survey – Jan. 12–Feb. 12, 2018

Memorial Medical Center and HSHS St. John's Hospital contracted with the University of Illinois at Springfield Survey Research Department to conduct the Sangamon County Community Health Needs Assessment Survey. The survey took place online. Because everyone does not have computer access, paper copies of the survey were made available to various community organizations and were also available at the Sangamon County Department of Public Health.

The communications teams from Memorial Medical Center and HSHS St. John's Hospital worked together to create a communication plan and promote the survey. The survey was promoted through press releases to all media outlets throughout the county, as well as email and personal contacts with a wide range of community and social service organizations.



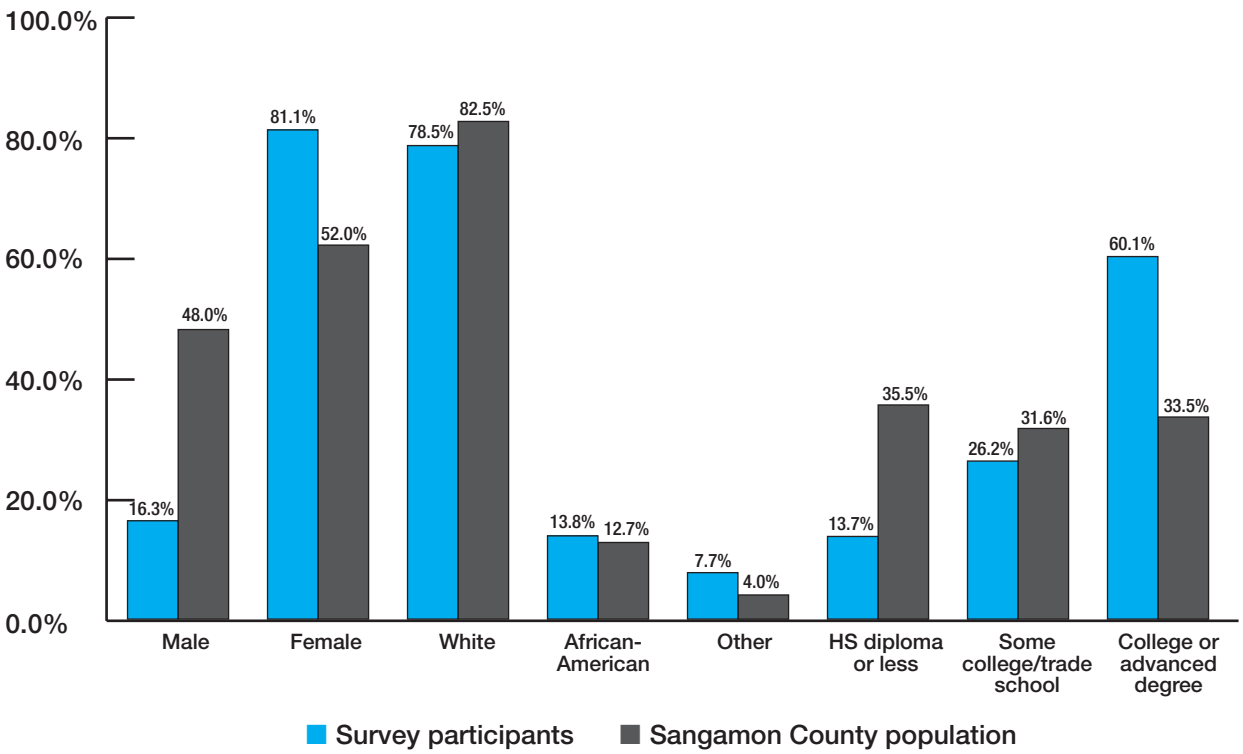
The local State Journal-Register newspaper had a feature story on the survey, as well as an editorial commending the two hospitals and health department for collaborating to improve community health. Interviews were conducted by local television and radio stations, as well as public service announcements on the radio. Promotion was also included on hospital social media outreach, as well as internal communications for employees of the hospitals and health department.

Survey Results

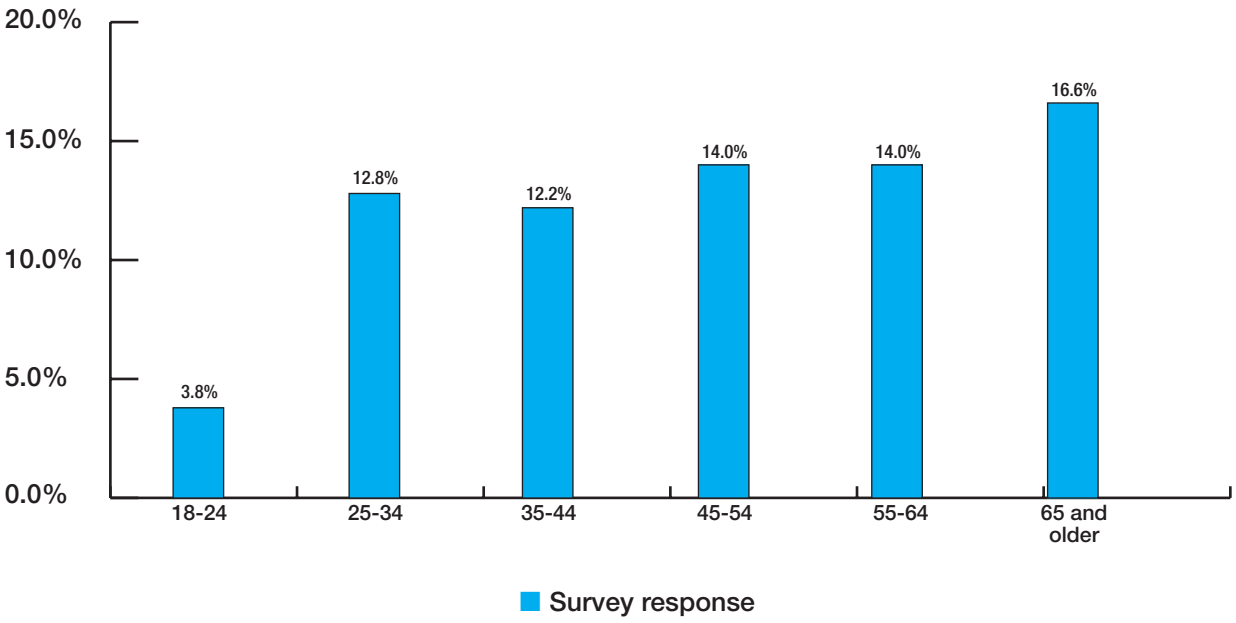
A total of 1,079 individuals completed the survey: 936 surveys were submitted online and 143 respondents returned printed surveys. This was an increase of 298 participants over the 781 surveys completed in the 2015 CHNA. An additional 80 surveys were incomplete and could not be counted in the 2018 survey total.

Surveys were submitted from throughout the county. The city of Springfield had 640 completed surveys; of note, 266 were submitted from zip codes 62701, 62702 and 62703, which are the areas of Sangamon County ranked with highest need on the socio-needs index. There were 292 surveys submitted by residents living outside of Springfield. An additional 277 people did not indicate their zip code, and 10 listed a zip code outside of Sangamon County. See Appendices p. 85 for a copy of the survey and the topline report from UIS Survey Research.

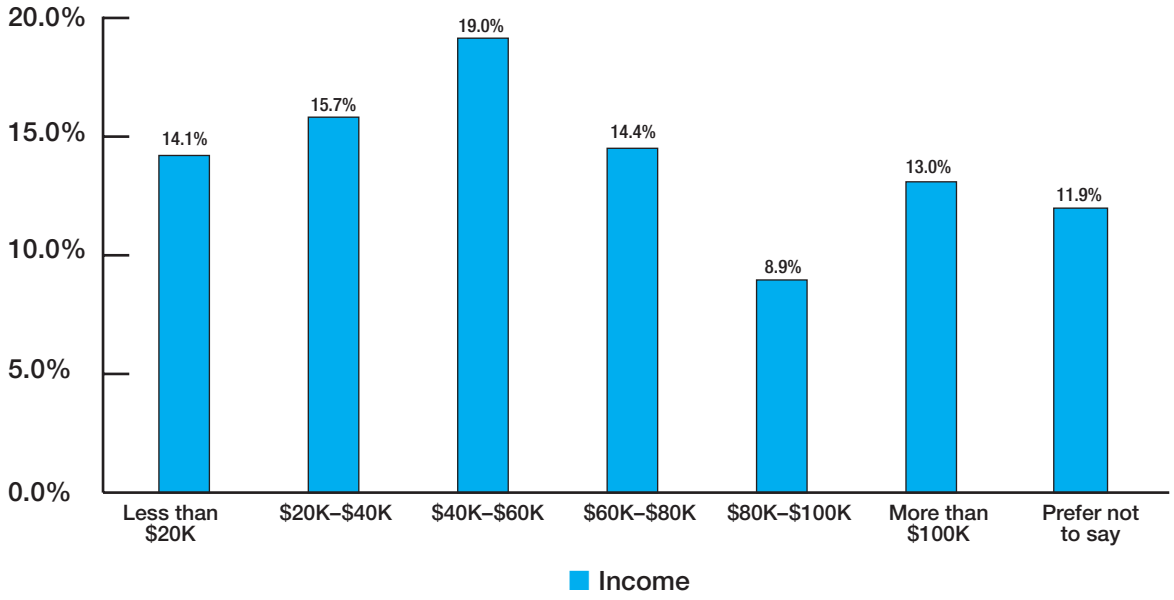
SURVEY RESPONDENTS VS. COUNTY POPULATION



AGES OF PARTICIPANTS

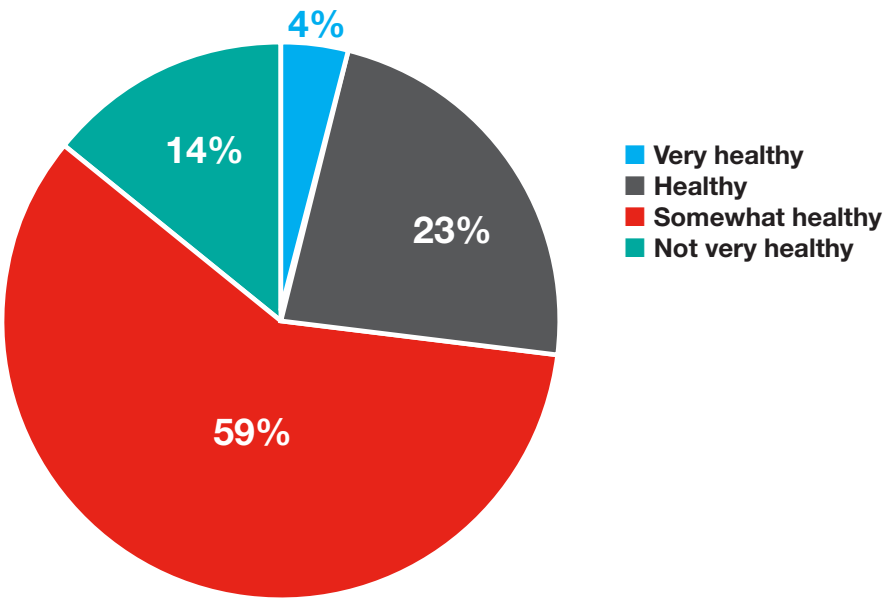


INCOME



Note: Median family income for Sangamon County is $56,167.

HOW WOULD YOU RATE THE HEALTH OF SANGAMON COUNTY?



Note: There were not significant demographic differences in how people responded to this question.

OVERALL PRIORITY RANKING – ALL RESPONDENTS

Top Health Priorities	Percentage Ranking in Top 5
Substance abuse/Drugs	80.2%
Mental health	78.4%
Housing	58.2%
Violent crimes	54.4%
Education	52.4%
Food access	45.9%
Child abuse	36.2%
Mother/Infant health	32.5%
Asthma	11.3%

OVERALL PRIORITY RANKING — WHITE AND AFRICAN-AMERICAN RESPONDENTS

Top 5 Choice	White Respondents
Substance abuse/Drugs	91.3%
Mental health	91.2%
Housing	62.4%
Violent crime	57.5%
Education	53.2%
Food access	51.7%
Child abuse	39.2%
Mother/Infant health	35.4%
Asthma	11.4%

Top 5 Choice	African-American Respondents
Housing	79.3%
Violent crime	67.6%
Education	67.6%
Substance abuse/Drugs	64.9%
Mental health	55.0%
Food access	54.1%
Mother/Infant health	41.4%
Child abuse	39.6%
Asthma	20.7%

WHAT IS THE ONE THING YOU WOULD DO TO MAKE THE HEALTH OF SANGAMON COUNTY BETTER?

Note: The number one answer, “Access to Care,” was additionally identified hundreds of times in the written comments as a need across all areas.

Top 5 Choice	White Respondents
Access to care	28.8% (207)
Increase/Improve education	17.0% (122)
Promote preventive care/Exercise	13.1% (94)
Improve mental health services	12.0% (86)
Address poverty/Homelessness	4.9% (21)
Increase access to healthy food	4.5% (32)
Increase drug prevention/Substance abuse treatment	3.9% (28)
Address violence/Crime	1.3% (9)
Decrease obesity	0.8% (6)
Improve dental access	0.7% (5)
Other	13.1% (94)

Highlights from the Survey Comments

The survey tool allowed participants to provide input on the issues they selected as priorities. Thousands of comments were received on the nine priority topics. Below are some summary comments for each issue.

1. Substance Abuse: 80.2% selected as a top-five issue

- Very serious issue. Cuts across socioeconomic lines. Contributes to crime, child abuse, poor health, education issues, mental health, housing, homelessness, unemployment, accidents, DUIs, suicide and early deaths. It is a drain on available community resources. Affects everyone, either directly or indirectly.
- Drug use is rampant. Alcohol is the socially-acceptable drug of choice; binge drinking. Marijuana use is common; self-medicating. Substance abuse is reaching grade school.
- Opioid issues are a key concern; no local programs/policies. Many noted the healthcare system has been cited with contributing to the epidemic. Heroin is very common in community. Emergency departments treat many for drug and alcohol overdoses. Need detox/crisis center here instead of jail.
- Lack of rehab programs; long waiting periods; expensive. Limited treatment options for low-income. Lack of innovative thought and political will among local leaders to address the issues.

2. Mental Health: 76.4% selected as a top-five issue

- Mental illness is very common but is hidden and has many stigmas. Community and professionals need more training on interacting with mental health issues.
- Access is an issue; shortage of resources. Funding cuts have reduced services; long waits for appointments. Many fall through the cracks. It leads to additional issues (unemployment, substance abuse, child abuse, homelessness, crime, poor health). Often falls on law enforcement to deal with issues; many end up in jail.
- Services are free/reduced to those in poverty, but lower-middle/middle class cannot afford treatment; insurance may pay for medication but not counseling. Some cannot get help until they have lost their financial stability.
- Patients not compliant with medications. Also need treatment besides pharmaceuticals.
- Mental illness is a HEALTH problem. Patients with mental illness cost more for hospitals to care for; drives usage of emergency departments; increases length of stay.

3. Housing: 58.2% selected as a top-five issue

- Homelessness is a growing issue; affects women and children as well as men. It leads to poor health and affects usage of emergency departments.
- Affordable housing in safe neighborhoods is not available. Wages are not enough for rent/home ownership.
- Home maintenance is an issue; dilapidated housing can lead to drugs and violent crime; people then move from neighborhood. Building codes need to be enforced. Landlords need to be responsible. Poor maintenance leads to mold/asthma, which affects school attendance; lead exposure affects ability to learn. Renters also need to be responsible.
- Meet basic human needs. Housing is crucial to individual and community stability. Clean, safe and fairly permanent housing secures a base for people to address virtually all aspects of physical and mental health.
- Housing is issue for those with mental illness. Pair housing and mental health services.

4. Violent Crime: 54.4 2% selected as a top-five issue

- Widespread perception that crime is increasing; numerous comments on the frequency of news stories about shootings, assaults and break-ins.
- Many noted gang activity, tied to drug activity, and Springfield's location between St. Louis and Chicago.
- Some said areas that used to be considered safe now have seniors who are afraid in their own homes. Some neighborhoods do not have people out walking or children playing.
- One of the most frequent comments regarded the interconnectedness of crime with drug abuse, mental illness, education, homelessness and other issues, and that crime was a symptom of these issues. "It means the community is sick." Also, crime takes large toll on victims.
- Crime rates affect the future. When the community is unsafe, people will not choose to live here. "A reverberating effect on the quality of life in this area."

5. Education: 52.4% selected as a top-five issue

- Some respondents addressed this for school education; others addressed it as a need for awareness of health issues and community resources.
- Issues: poor funding, lack of parental involvement, bullying, violence and substance abuse in schools. Early childhood programs and mentoring programs are needed. School may be a child's only source of physical, mental and emotional care.

- Poor education affects lifelong future income and lifelong health. Low literacy impacts understanding of health and making good choices; this can lead to poor health status.
- Communities with great schools thrive. People must have education to obtain employment and be responsible for themselves and their families.
- Continuing education is too expensive for many. Student loan debt can last decades. Rural areas are impacted by lack of public transportation and high-speed internet.

6. Food Access: 45.9% selected as a top-five issue

- Access is a big issue, as well as ability to afford food. Food deserts exist in many areas of the county, not just city. Many families (some middle class) cannot afford to put enough food on the table and basic nutritional needs are not met. Some (including elderly) must choose between rent, food and medications.
- Need affordable healthy, fresh food. Many do not know how to select or prepare healthy food. Particular problem for those with diabetes.
- Many children don't eat except at school or through summer meal programs.
- Poor nutrition is the root of many other issues. You cannot learn, or heal, if you're hungry. Must meet basic needs first.
- Food banks need more funding and need to offer healthy food, including low-sodium food. Transportation is an issue.
- There are plenty of hungry people in our community. No one should go hungry.

7. Child Abuse: 36.2% selected as a top-five issue

- Problem is widespread in the county and likely underreported. Some children have no one protecting them. Abuse may be an underlying cause to children's other health issues and low school attendance.
- DCFS resources limited; not enough monitoring. Courts return children to parents.
- Lifelong impacts on health, both mental and physical, which also affects the health and resources of the community. ACES and trauma were both mentioned.
- Child abuse is systemic and often a culmination of other issues: substance abuse, poverty, hunger, family stress, single-parent families, uninvolved parents. There can be abuse at all socioeconomic levels. Can become generational.
- Many noted that children may not meet definition of abuse, but are definitely neglected.
- Our children are our future.

8. Mother/Infant Health: 32.5% selected as a top-five issue

- A healthy start to life is crucial for later health and welfare. “Children who are cared for by mentally and physically healthy mothers have much better outcomes on every measure.” Children who begin life with issues that could have been prevented face lifelong health issues that impact the community.
- Need better prenatal care and postpartum follow up in the home (check on mental health, breastfeeding, support system). Services cut due to poor reimbursement. “We have mothers who are having babies who aren’t even equipped to bring a baby home.”
- Issues: High infant mortality. Low birth weight babies. High number of single mothers. Many young, low-income mothers don’t seek prenatal care. Homelessness. Drug use during pregnancy. Infant nutrition. High infant mortality. Teen sex education is needed. No paid maternity leave.
- “It’s not easy being a mom, even when you have two parents, a home and job. Disadvantaged infants and moms need support.” Investing in mothers impacts the community.

9. Asthma: 11.3% selected as a top-five issue

- Numerous responders indicated they know people with asthma.
- Frequently not diagnosed; often treated in emergency department but with no follow-up with doctors for regular treatment plan, medications, etc.
- Many are unable to pay for medications.
- Parents and schools lack education on the causes of asthma, treatment plans or emergency care.
- Poor housing (mold, etc.) was frequently cited as an issue.
- Additional issues include central Illinois air quality (agriculture and pollen), as well as burning being permitted in rural areas of the county.
- Impacts school attendance and ability to work. Some cannot leave the home and must keep windows closed.

Determining Significant Health Needs in Sangamon County

The Sangamon County Community Advisory Committee convened for its final meeting on March 20, 2018. The committee received a detailed review of the outcomes of the community survey as listed above.

Committee members engaged in discussion on the following topics for each of the nine issues from the community survey.

- Assets—What community resources are available to address these issues?
- Gaps—Are there gaps in services or resources to address these issues?
- Are there any populations disproportionately affected by disparities in these issues?
- Are there inequities in available resources?
- Do any of these issues seem especially appropriate for a collaborative approach?

Identified Available Community Resources/Gaps

1. Substance Abuse/Drugs

COMMUNITY ASSETS/RESOURCES	GAPS
• Gateway Foundation • Triangle Center • Federally Qualified Health Centers: SIU Center for Family Medicine and Central Counties Health Centers • New Medication-Assisted Treatment Clinics are starting at both FQHCs; available to anyone, including low-income and uninsured individuals • Behavioral health services integrated with primary care practices • Alcoholics Anonymous • Local Substance Abuse Court • Stakeholders: MMC and HSHS SJH Emergency Departments, law enforcement, citizens of the community • Helping Hands Homeless Shelter • Salvation Army	• There are no crisis detox services in Sangamon County; burden falls on hospitals or law enforcement/ jail. Sometimes those needing detox are transported many miles to another community for services (Decatur, Bloomington, Peoria). • Shortage of treatment centers once detox is complete. Eligibility is based on income. • Substance abuse and addiction affects all socioeconomic classes. But services are not equally available for all. • Shortage of resources to deal with opioid addiction/ mental health. • Community is unsure of resources available to treat substance abuse in a rehabilitation environment. • Need additional physician education to limit inappropriate prescriptions • Healthcare workers working specifically in inpatient units at hospitals need training to deal with alcoholism and substance abuse with empathy to facilitate holistic care for patients and their families. • Collaboration is lacking between hospitals and treatment centers, AA and NA to connect inpatients with substance abuse/alcoholism issues with help post-discharge. • Issue affects all socioeconomic groups.

2. Mental Health

COMMUNITY ASSETS/RESOURCES	GAPS
• Community health worker (CHW) programs have helped vulnerable people increase access to mental health services. • New Homeless Outreach Team is being implemented by Springfield Police Department • Mental Health First Aid training for community members is offered by Memorial. • MOSAIC collaborative is led by Memorial Behavioral Health to increase screenings of children and early access to mental health services; now in 11 Springfield Dist. 186 public schools. • Memorial Behavioral Health offers a wide range of mental health services, including PATH Homeless Outreach. • SIU Medicine Psychiatric program • Emergency Dept. Psychiatric Response Teams, led by Memorial Behavioral Health • Mental Health Court at Sangamon County States Attorney • New mobile crisis outreach collaboration between Springfield Police, SIU Medicine and Memorial Behavioral Health • Trauma Informed Care training for community • Both FQHCs provide some mental health/ behavioral health services regardless of income level or insurance. • Various counseling services are offered by the faith community. • In spring 2018, University of Illinois at Springfield will offer mental health services through the UIS Human Development Counselor program; student interns will offer their services free by appointment at Pure Haven, Family Resource Center, MERCY Community and Contact Ministries.	• Insured individuals who have coverage for mental health services often face very high out-of-pocket deductibles that prevent them from seeking care. • We have a very high number of single-parent homes, which increases the chances that children face Adverse Childhood Experiences (ACEs), leading to mentalhealth issues. • Homelessness and mental health go hand-in-hand, and the issues are often connected. • Need more mental health providers. • Need to address mental health and reduce stigma. • Need more CHW programs.

3. Housing

COMMUNITY ASSETS/RESOURCES	GAPS
• Enos Park Access to Care Collaborative/CHW program is addressing housing needs in Enos Park neighborhood. • Calvary Missionary Baptist Church builds homes through the Nehemiah Homes Affordable Housing Project. • Springfield Housing Authority • SIU Community Health Roundtable looks at the issue of safe housing for children. • Sangamon County Community Resources has a certified healthy homes evaluator on staff. • City of Springfield Community Relations • Homeless PATH at Memorial Behavioral Health • Springfield Police Department's new Homeless Outreach Team (HOT) • Salvation Army • SIU Medical Legal Partnership assists with legal housing issues. • HUD	• Young homeless males are an issue in the community. • There is also a lack of housing available for homeless women who do not have any children. • The community lacks education about housing issues or how people can access housing. • There is a lack of affordable, safe housing – many rentals that are available for lower-income residents are in poor or unsafe condition.

4. Violent Crimes

COMMUNITY ASSETS/RESOURCES	GAPS
• New hot-spotting mobile crisis unit with police and mental health providers • New police Homeless Outreach Team • CHW program in Enos Park has improved relationships with police and residents: 9-1-1 calls and crime rates have decreased; parolee recidivism is low when working with CHW. • Focused Deterrence Project, Springfield Police • Restorative justice program in Springfield District 186 - work out problems and solutions to keep kids in school. • Violent Crime Reduction Program • Resources: Springfield Police Department, Sangamon County Sheriff's Department, Illinois State Police • Boys & Girls Club • Sojourn Shelter for abused women • The Outlet mentoring program for fatherless youth ages 8-22	• Services are not available to assist ex-offenders with return into community. • Jobs for kids in summer. Many adults take jobs kids once filled. • Widespread community perception that some neighborhoods are unsafe. • Need to address root causes of crime. • Need to focus on prevention rather than intervention. • Need greater investment in youth programs. • People often do not report crime due to lack of trust in law enforcement and the system; this is an urban myth that needs to be addressed.

5. Education

COMMUNITY ASSETS/RESOURCES	GAPS
• MOSAIC program offers mental health screening and early intervention in schools. • YMCA • Lincoln Land Community College - Open Door Program offers mentoring for African-American male students. • Faith Coalition for the Common Good • Greater Springfield Chamber of Commerce • The Outlet mentoring program for fatherless youth ages 8-22 • Springfield Urban League's Freedom School summer program • 21st Century after-school program/tutoring • Compass Program • Boys & Girls Club • Big Brothers/Big Sisters • United Way-funded education initiatives	• District 186 in the city of Springfield has been impacted by "urban flight" and majority of households are low-income ("white flight"). • Constructive summer activities/hangouts needed for school-age kids. • We need a multi-sector collaboration for education for low-income families around social determinants of health and life skills. • Need collaboration around anti-violence in schools. • Uncertainty of State of Illinois school funding.

6. Food Access

COMMUNITY ASSETS/RESOURCES	GAPS
• Illinois Community Coalition Services • Compass backpack program to feed kids on weekends • WIC prenatal food for moms, infant formula, breastfeeding support and food for children • Gen H Kids program and community gardens • Catholic Charities mobile food truck • Central Illinois Foodbank (increased focus on healthy foods over the past several years) • Both FQHCs partner with Foodbank to provide access to healthy foods free on a regular basis • Loami Food Pantry • Kumler Outreach Ministries Food Pantry • Partnerships between schools and Central Illinois Foodbank to provide fresh produce at Washington Middle School, Matheny Withrow Elementary and Harvard Park Elementary • Clara's Cupboard • Meals on Wheels/Senior Services • SNAP • St. John's Breadline • Boys & Girls Club	• Lack of a coordinated food insecurity coalition. • Lack of resources in rural portions of county.

7. Child Abuse

COMMUNITY ASSETS/RESOURCES	GAPS
• Mini O'Beirne Crisis Nursery • Sojourn Women's Center • Safe Families host families • University of Illinois at Springfield training program for DCFS and investigators • DCFS • Child Advocacy Center • Prevent Child Abuse Illinois • Memorial Behavioral Health – SASS • ED at HSHS St. John's • SIU Pediatrics	• Need better training for early identification and intervention – teachers and school. • Adults need to act as first responders: counselors, staff at day cares, preschools and anywhere a child frequents should be trained to recognize and report abuse.

8. Mother/Infant Health

COMMUNITY ASSETS/RESOURCES	GAPS
• Nurse Family Partnership at SIU Medicine • Elizabeth Ann Seton program • Parents as Partners program in public high schools – assisting teen parents in learning about proper child care and providing assistance • Baby brain development program at SIU • Home visit programs – health department • MOSAIC Moms • HSHS SJH Beyond the NICU program • Baby Talk • Ounce of Prevention • WIC at health department • Physicians: primary care, OB and pediatricians	• Infant mortality in first year of life due to accidental asphyxiation • An early healthy start for infants is crucial • Baby boxes/supplies for newborns • High number of single moms and children living in poverty • More mother/parent education • Children need early access to words, books

9. Asthma

COMMUNITY ASSETS/RESOURCES	GAPS
• Brandon Court – HSHS St. John's Hospital asthma home assessment project • SIU Population Science • SIU Community Health Roundtable • Both FQHCs offer access to affordable prescription medications for their patients	• Lack of standardized treatment across hospitals, physician practices • Poor housing contributes to asthma occurrences

Inequities/People Disproportionately Affected

- Single-parent families and low-income families are disproportionately affected by these issues.
- However, many of these issues are struggles across class lines.
- Sometimes services are available for low-income individuals, but middle-class individuals who struggle have to meet high deductibles before their insurance will assist, and they cannot afford care for mental health or substance abuse issues. Food access and affordable housing increasingly are issues for the middle class as well.
- Urban flight is a problem that has left many low-income families and individuals living within Springfield city limits.
- Children affected by ACES (Adverse Childhood Experiences) and trauma are affected by these issues.
- Young homeless males lack services, support or housing. The SNAP food assistance for a young man on his own is only $18 a month. They have difficulty feeding themselves.

Issues Appropriate for Collaborative Approach

- A food coalition could address hunger in the Springfield area.
- Substandard housing, including community resources to teach people how to have better housing and to keep properties livable, could be addressed.
- Crime – Due to media reports, people perceive that crime is worse throughout the city than it really is. Statistics show crime is decreasing. However, perception impacts people's view and lives. Education of the community and the media is needed.
- Mental health issues are the root cause of many problems discussed during the needs assessments. The community must continue to be educated on mental health issues. A collaborative approach to preventing school shootings could be explored, as well as the intersection between mental health and substance abuse.
- A community opioid coalition has been founded. Sangamon County Public Health will continue to lead that initiative.

Additional Priority: Access to Care

The Community Advisory Committee additionally discussed the topic of Access to Care, which was one of the original high priorities that the committee did not select for inclusion on the community survey. However, the community itself identified Access to Care as the most important single thing that could be done to improve the health of Sangamon County (28.8 percent of respondents). Issues of Access to Care were additionally identified hundreds more times in written comments throughout the survey.

Access to Care and the need to address social determinants of health were also raised throughout the March 20 meeting by the Community Advisory Committee.

Enos Park Access to Care Collaborative

The Committee then engaged in discussion of outcomes of a collaborative Access to Care initiative that came out of the 2015 CHNA: the Enos Park Access to Care Collaborative. This program is a collaboration between Memorial Medical Center, HSHS St. John's Hospital and the SIU Center for Family Medicine federally qualified health center. This program has placed community health workers within a vulnerable neighborhood and has had measured success in addressing both health and social determinants factors, including:

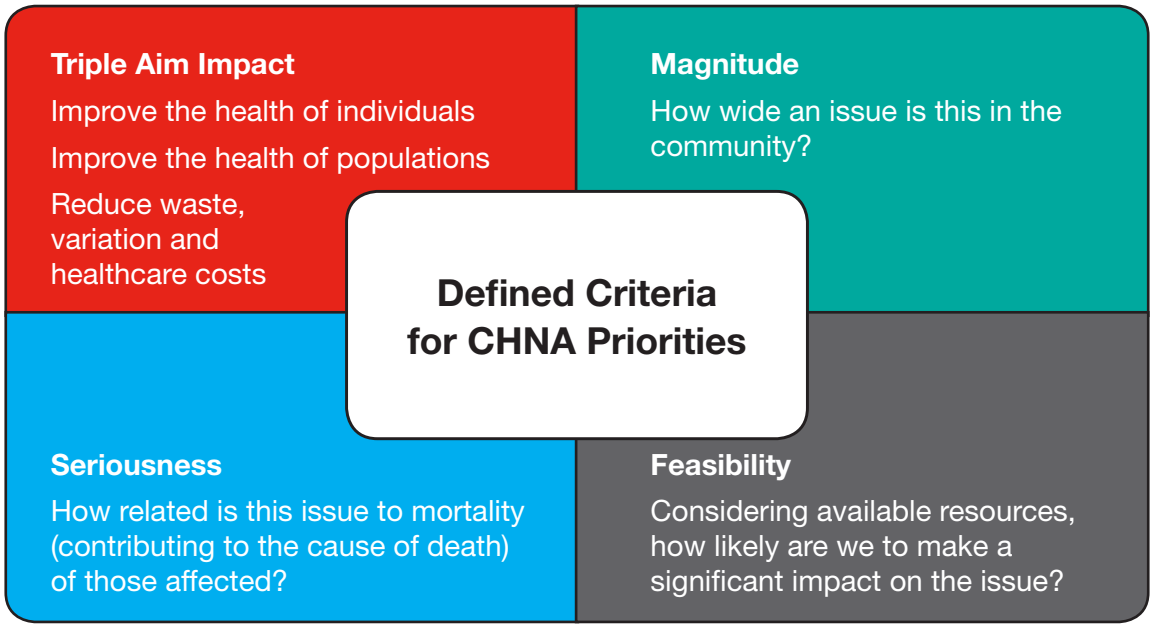
INCREASES	DECREASES
• Increased access to doctors, mental health, dental care and prescription medications; 100% of clients have a medical home • 93% visited their primary care provider annually • 81% show rate to all healthcare appointments • 28% increase in outpatient hospital utilization • 69% employment • 53% income • 31% food access • 74% housing safety	• 22% reduction in unnecessary emergency department visits • 36% reduction in inpatient hospital charges • 0% parolee recidivism • 11% reduction in neighborhood crime • 28% reduction in homelessness

The Community Advisory Committee made a strong recommendation that the hospitals continue and expand the community health worker program.

Community Advisory Committee Final Priority Recommendations

Using the Defined Criteria, the Community Advisory Committee recommended the following as the top priorities for Sangamon County:

1. **Access to Care—particularly community health workers**
2. **Mental Health**
3. **Substance Abuse**
4. **Mother/Infant Health (particularly infant mortality)**



Memorial Medical Center Internal Advisory Committee

Memorial Medical Center convened an Internal Advisory Committee on March 27, 2018.

INTERNAL ADVISORY COMMITTEE MEMBERS

1. Kevin England, senior vice president, Business Development
2. Raj Govindaiah, MD, senior vice president and chief medical officer
3. Jan Gambach, president, Memorial Behavioral Health
4. Linda Jones, DNS, RN, vice president, Operations
5. Todd Roberts, vice president, Quality & Safety and chief quality officer
6. Jay Roszhart, vice president, Ambulatory Networks and Clinical Integration
7. Kristi Olson-Sitki, MSN, RN, Magnet coordinator
8. Tamar Kutz, administrator, Ambulatory Operations
9. Henry Hurwitz, director, Memorial Health Partners

The purpose of this committee was to provide input from a clinical and operational perspective, and recommend final priorities. The Committee reviewed the CHNA process to date, including secondary and primary data, the role of the Community Advisory Committee, the outcomes of the Sangamon County Community Survey and the final priority recommendations of the Community Advisory Committee.

The Internal Advisory Committee looked at significant data relating to the priorities selected by the Community Advisory Committee and discussed their observations from a clinical and operational perspective. This group ultimately agreed with the final recommended priorities of the Community Advisory Committee and recommended that these be adopted as the priorities for Memorial Medical Center for CHNA implementation strategy for FY2019–FY2021.

Memorial Medical Center's Final Prioritized Significant Health Needs for Sangamon County

1. Access to Care

As mentioned above, issues of Access to Care cross a broad range of issues and contributing social determinants factors. Both the Community Advisory Committee and the MMC Internal Advisory Committee recommended that Memorial Medical Center continue to prioritize Access to Care as a significant health issue.

HSHS St. John's Hospital and SIU Center for Family Medicine federally qualified health center have agreed to continue their collaboration started in 2015 with the Enos Park Access to Care Collaborative and expand the program to an additional low-income neighborhood that has significant social determinants of health issues, with a third possible neighborhood identified.

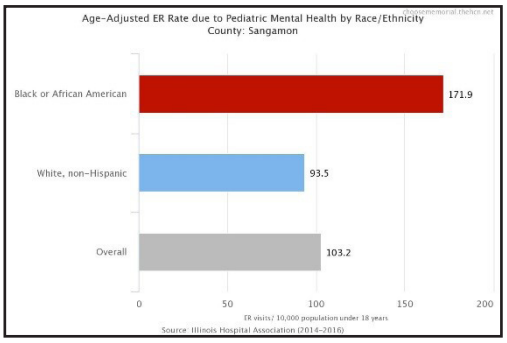
2. Mental Health

The community survey and the Community Advisory Committee both highlighted mental health as a very significant issue in Sangamon County, and the MMC Internal Advisory Committee agreed. Below are a few of the statistics that demonstrate the need to continue addressing community mental health issues.

Age-Adjusted ER Rate due to Pediatric Mental Health: Sangamon

103.2
ER visits per 10,000 population under 18 years
(2014-2016)

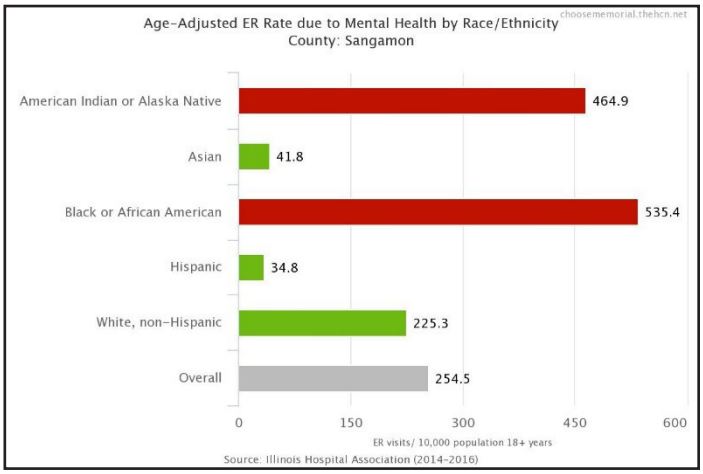
Compared to:
IL Counties
IL Value (67.2)



Age-Adjusted ER Rate due to Mental Health: Sangamon

254.5
ER visits per 10,000 population 18+ years
(2014-2016)

Compared to:
IL Counties
IL Value (167.3)



Age-Adjusted ER Rate due to Mental Health: Sangamon

254.5
ER visits per 10,000 population 18+ years
(2014-2016)

Compared to:
IL Counties
IL Value (167.3)

Age-Adjusted Hospitalization Rate due to Pediatric Mental Health: Sangamon

73.1
Hospitalizations per 10,000 population under 18 years

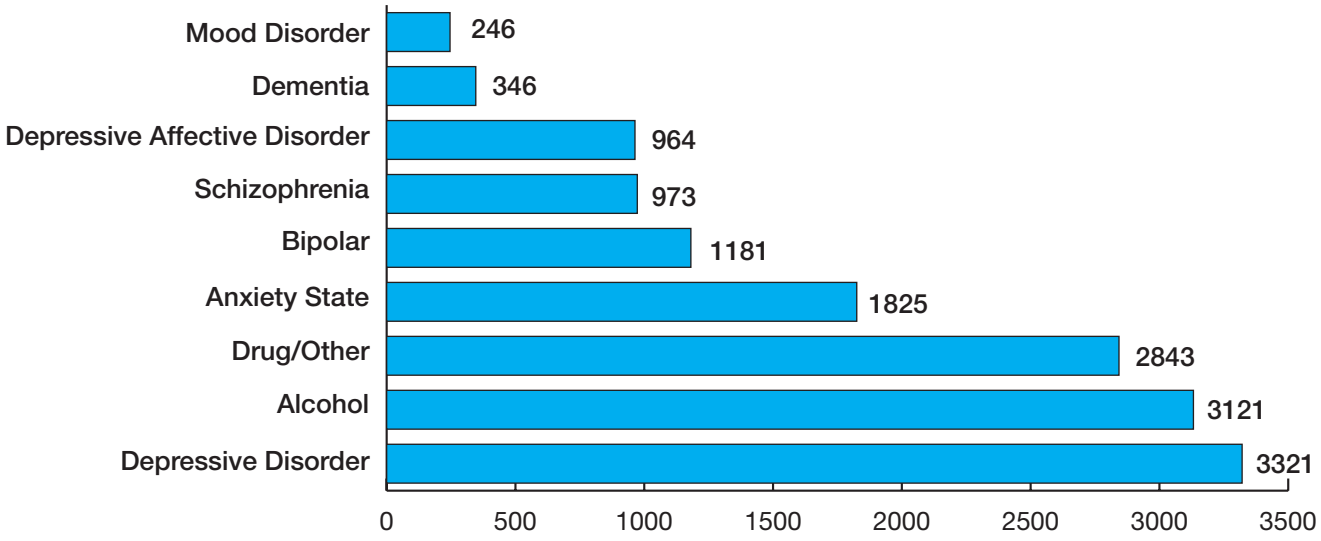
Compared to:
IL Counties
IL Value (50.9)

Source: Healthy Communities Institute. Retrieved March 16, 2018. Retrieved from Choosememorial.org/Community-Health-Needs-Assessment/HCI?hcn= CommunityDashboard HCI?hcn=Community Dashboard

CAUSES OF MENTAL HEALTH EMERGENCY DEPARTMENT VISITS: SANGAMON COUNTY MENTAL HEALTH ED USAGE 2014-Q1 2017

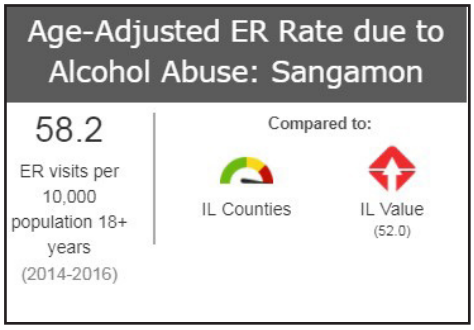
Total: 14,831 visits

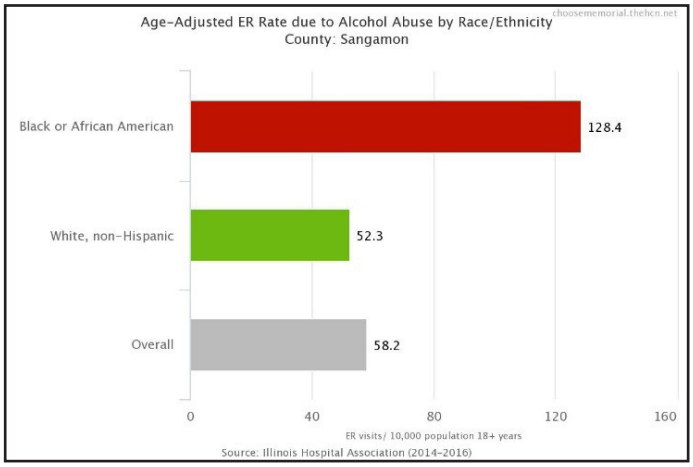
Source: Illinois COMPdata 9/27/2017

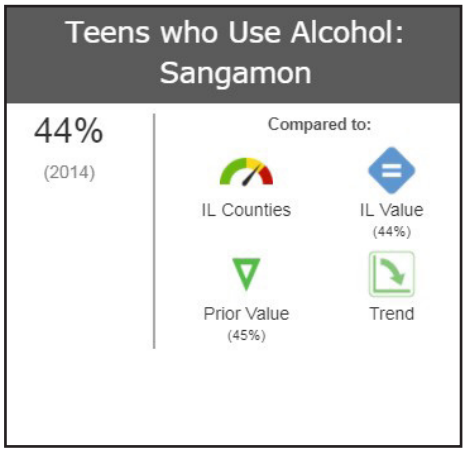


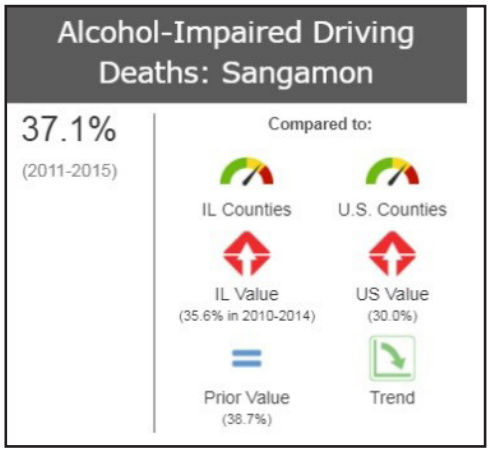
3. Substance Abuse

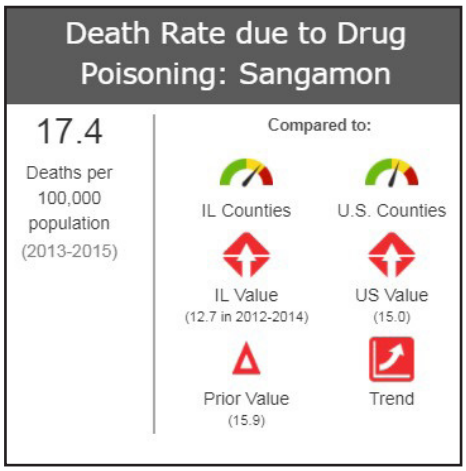
Because substance abuse rated so highly on the community survey and was a significant concern of the Community Advisory, as well as a concern for the MMC Internal Advisory Committee, MMC has selected it as a final priority to address in FY2019-FY2021. The Community Advisory Committee noted that this issue affects the entire community, regardless of socioeconomic backgrounds. Below are some community data demonstrating the significance of the issue.

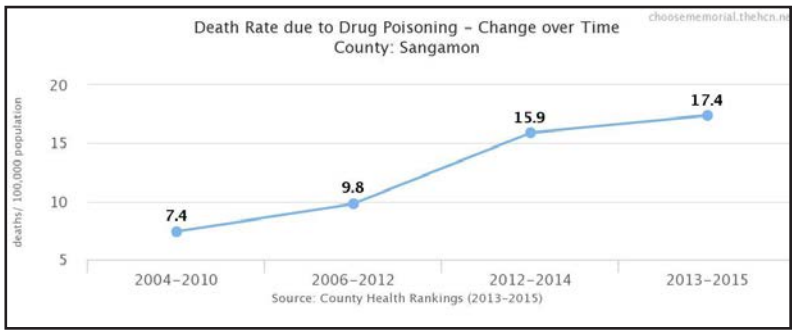








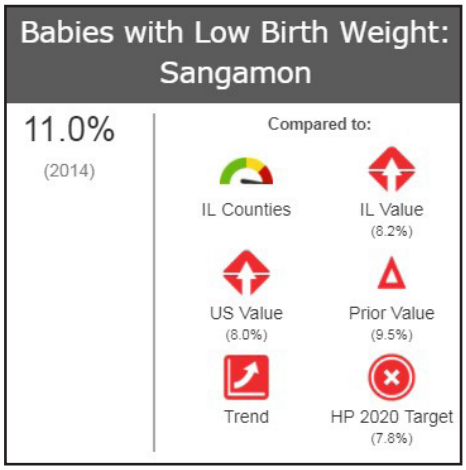


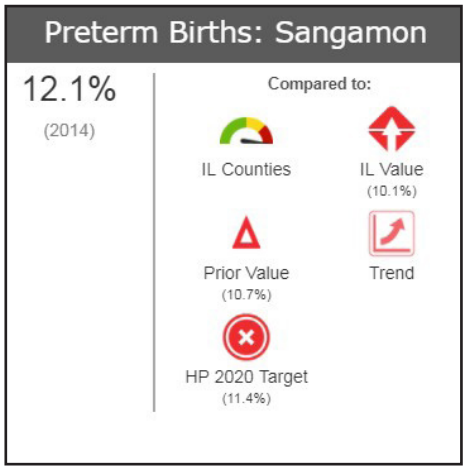


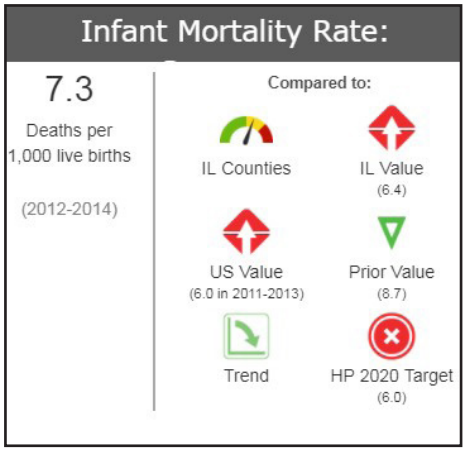
Source: Healthy Communities Institute. Retrieved March 16, 2018. Retrieved from [Choosememorial.org/Community-Health-Needs-Assessment/HCI?hcn= CommunityDashboard HCI?hcn=Community Dashboard]

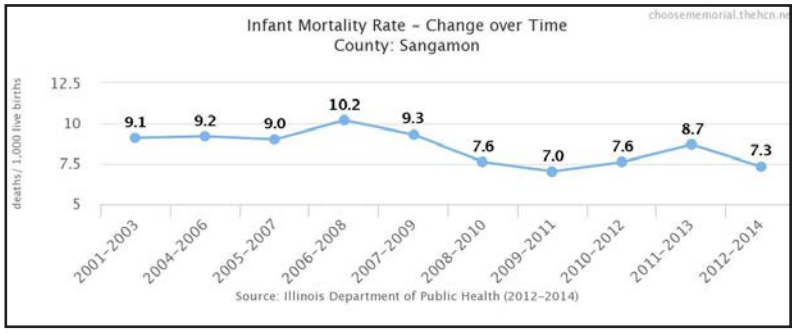
4. Mother/Infant Health

Sangamon County has long had challenges with low birth weight and preterm births, as well as a higher than average infant mortality rate. Research on the causes of infant mortality showed that the primary cause is accidental asphyxiation, which is something the Community Advisory Committee thought should be addressed in collaboration with other community partners. Following are some data that documents these issues.









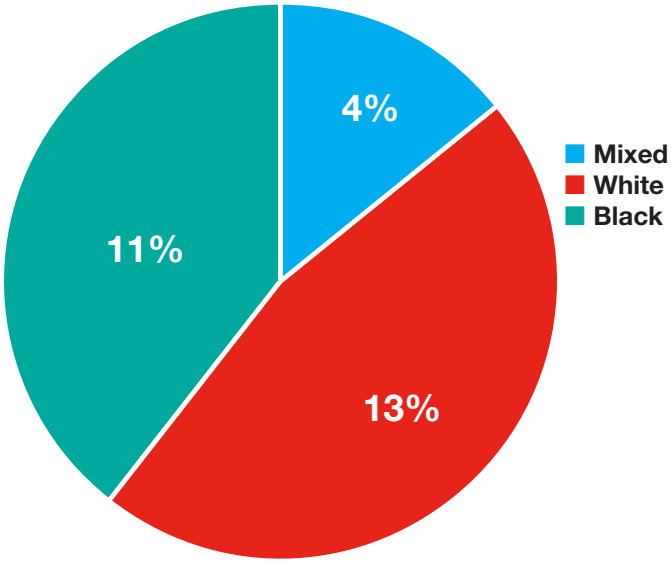
Source: Healthy Communities Institute. Retrieved March 16, 2018. Retrieved from [Choosememorial.org/Community-Health-Needs-Assessment/HCI?hcn= CommunityDashboard HCI?hcn=Community Dashboard]

SANGAMON COUNTY INFANT MORTALITY

July 2012-May 2016, Information from Sangamon County Coroner's Office

27 total deaths; 16 were accidental asphyxiation

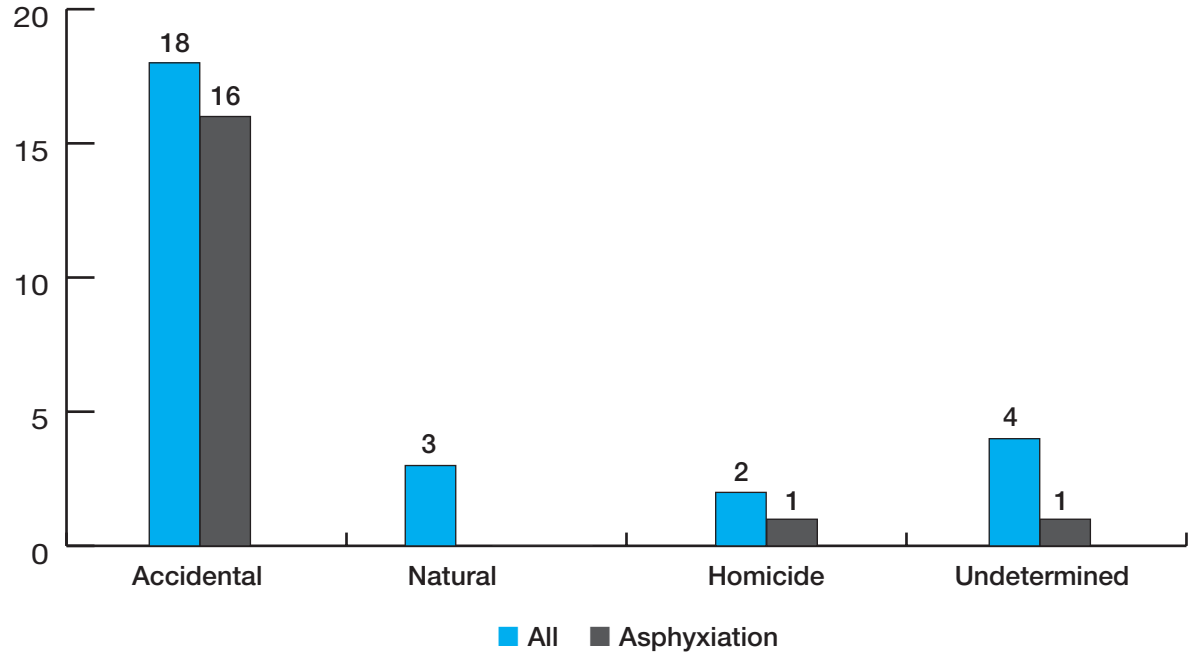
- 11 caused by co-sleeping (father, mother, father and mother, father and siblings) in recliners, on couches, on air mattress, in adult beds with bedding
- In five cases, it's noted that the child was sleeping on the floor, an air mattress, pack-and-play or crib with adult pillows and blankets
- Coroner notes that although not substantiated by lab tests, use of alcohol, marijuana or other sedatives by adults contributed to many of these deaths



SANGAMON COUNTY INFANT MORTALITY

July 2012-May 2016

27 total deaths, ages 2 hrs. to 1 yr.



Non-Prioritized Significant Health Needs

The Sangamon County Community Advisory Committee and Community Health Needs Assessment identified nine significant community health needs. Memorial Medical Center selected the four final priorities identified above to address in FY19-FY21. The priorities that were not selected follow.

Housing—Housing is not a core competency of the hospital, and there are a number of other organizations already addressing this issue in the community. The Community Advisory Committee did not recommend that the hospitals select this as a final priority.

Violent Crime—The hospital does not have the expertise to address this issue directly or the resources to lead an initiative, although it does work with both individuals and organizations on issues of individual and public safety.

Education—The Community Advisory Committee recommended that the hospitals focus on other initiatives which are a higher priority.

Food Access—This issue is being addressed through numerous other agencies and community resources.

Child Abuse—Issues of child abuse are dealt with on an individual basis in the hospital emergency department, Memorial Physician Services and Memorial Behavioral Health. However, the hospital does not have the expertise to address this issue on a community-wide basis.

Asthma—This issue was not a high priority in the community survey or for the Community Advisory Committee. Memorial chose to address other, higher-priority issues.

New Community Health Needs Assessment Implementation Strategy

Memorial Medical Center is developing a new CHNA implementation strategy that it will implement in FY2019–FY2021. This strategy will be approved by the MMC Board in November 2018 and will be posted to its website. Because the strategy will be approved after this CHNA Report is completed and posted to our website, the completed implementation strategy is not included in this document. However, it will be available on the website by Nov. 30, 2018, at ChooseMemorial.org/HealthyCommunities. Below is a summary of the initial direction being explored for the implementation strategy.

Preliminary FY19 Implementation Strategy

Access to Care

- Collaborate with HSHS St. John's Hospital and SIU Center for Family Medicine FQHC, continuing support of a community health worker program in at-risk neighborhoods.
  - Continue CHW work in Enos Park.
  - Expand the CHW program to the Pillsbury Mills neighborhood directly east of Enos Park.
  - Establish relationship with one additional neighborhood and explore feasibility of program expansion in that neighborhood.
- Continue to support the education of physicians and programs of SIU Medicine.
- Increase access to exercise and health improvement opportunities pending construction of the new downtown Springfield YMCA.

Mental Health

- Continue to offer Mental Health First Aid training.
- Continue to support Memorial Behavioral Health's MOSAIC program.
  - Expand program to a local high school.
- Fund a mental health professional from MBH to form a co-responder model to crisis calls with SIU Medicine and the Springfield Police Department.
- Support Girls on the Run of Central Illinois, which encourages positive emotional development for girls in grades 3 through 8.

Substance Abuse

- MHS will develop a system-wide initiative to combat opioid abuse.
- MHS will engage in a system-wide initiative to expand access to substance abuse treatment.

Mother/Infant Health

- Continue to support for the Nurse Family Partnership, in collaboration with SIU Medicine, HSHS St. John's Hospital and Land of Lincoln Community Foundation.
- With HSHS St. John's Hospital and Sangamon County Department of Public Health, explore the issues affecting infant mortality, particularly accidental asphyxiation.

Expansion of Access to Health Collaborative

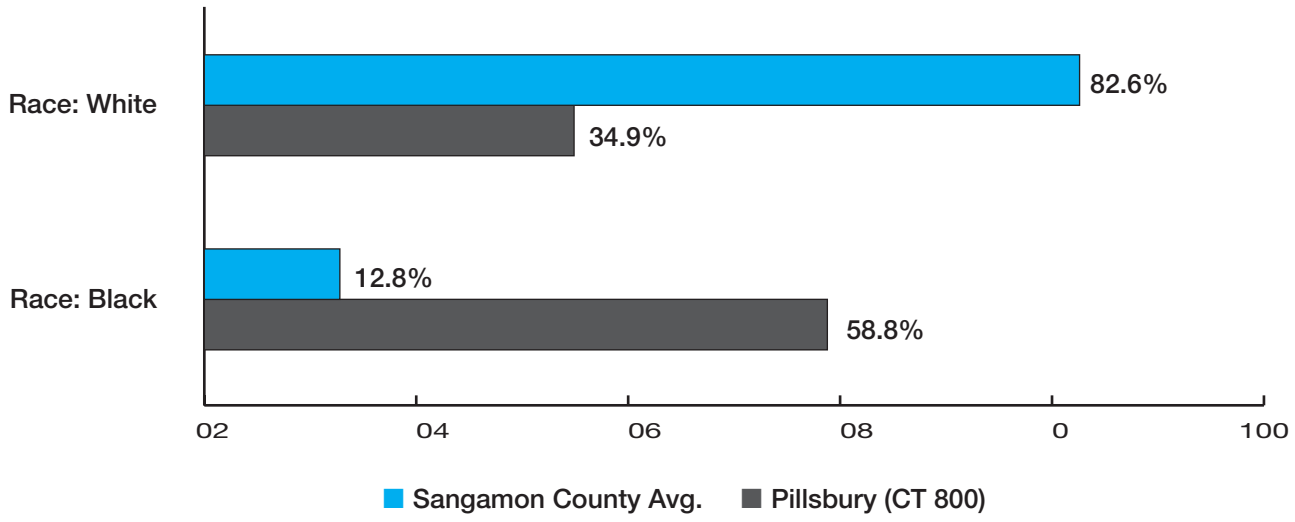
Memorial Medical Center and HSHS St. John's Hospital have agreed to collaborate again on the issue of Access to Care with SIU Center for Family Medicine FQHC, continuing support of the community health worker program in Enos Park and expanding to additional neighborhoods. The program expansion for FY19-FY21 will be called the Access to Health Collaborative rather than the Enos Park Access to Care Collaborative. Two neighborhoods in Springfield were identified and initial discussion began with their neighborhood associations.

Following a meeting with its neighborhood association on May 2, 2018, Pillsbury Mills agreed to partner in the Access to Health Collaborative. An additional neighborhood has entered discussions to be part of the program but arrangements were tentative at the time this report was completed.

Pillsbury Mills lies in census tract 1716700800. Located directly east of the Enos Park neighborhood, Pillsbury Mills faces some significant social determinants of health issues and a lack of neighborhood resources.

Name	Census Tract	Approximate Boundaries	Pop. 2010 Census
Pillsbury Mills (directly east of Enos Park)	17167000800	**10th-19th (E/W)** **North Grand to Carpenter (N/S)** NOTE: census tract extends south to Clearlake	**2,075**

SANGAMON COUNTY AVERAGES VS. CENSUS TRACTS 800 (PILLSBURY MILLS NEIGHBORHOOD)



Census Tract: 17167000800 Pillsbury Neighborhood

Single-Parent Households

88.4%
(2012-2016)

IL Census Tracts | U.S. Census Tracts | Sangamon, IL County Value (41.2%) | Prior Value (83.9%) | Trend

Children Living Below Poverty Level

69.6%
(2012-2016)

IL Census Tracts | U.S. Census Tracts | Sangamon, IL County Value (23.5%) | Prior Value (71.8%) | Trend

People Living Below Poverty Level

54.7%
(2012-2016)

IL Census Tracts | U.S. Census Tracts | Sangamon, IL County Value (15.2%) | Prior Value (48.8%) | Trend

Median Household Income

$20,500
(2012-2016)

IL Census Tracts | U.S. Census Tracts | Sangamon, IL County Value ($56,742) | Prior Value ($25,197) | Trend

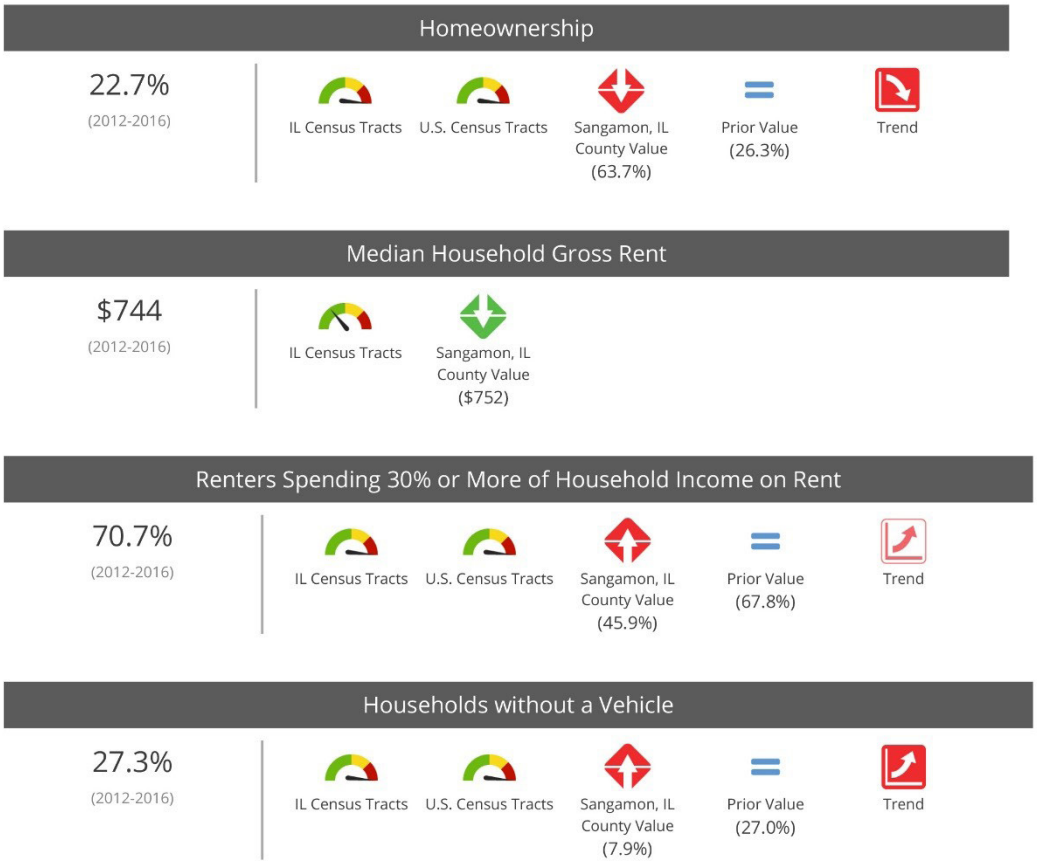
People 25+ with a High School Degree or Higher

72.3%
(2012-2016)

IL Census Tracts | U.S. Census Tracts | Sangamon, IL County Value (92.2%) | Prior Value (66.7%) | Trend

Generated by choosememorial.thehcn.net on May 2, 2018.

Census Tract: 17167000800 Pillsbury Neighborhood



Generated by choosememorial.thehcn.net on May 2, 2018.

Focus Groups in Pillsbury Mills Neighborhood

Memorial and HSHS St. John's Hospital contracted with UIS Survey Research to conduct 3 focus groups for the Pillsbury Mills neighborhood. Four focus groups took place in June 2018 involving 45 participants. These included focus groups for seniors, stakeholder organizations in the neighborhood, and younger parents. The focus groups identified a number of issues that could be impacted through implementation of a neighborhood community health worker program. A report on focus groups outcomes is included in Appendices p. 109.

Sharing Community Health Needs Assessment Outcomes with the Community

This CHNA report, following approval by the Memorial Health System Board, will be posted online at ChooseMemorial.org/HealthyCommunities by Sept. 30, 2018, prior to the completion of FY2018. The CHNA FY2019 implementation strategy for Memorial Medical Center, following board approval, will also be available at this website by Nov. 30, 2018.

On Dec. 21, 2018, the Springfield Citizens Club will host a public meeting. Memorial Medical Center, HSHS St. John's Hospital and the Sangamon County Department of Public Health will share the final outcomes of the 2018 Sangamon County Community Health Needs Assessment, final priorities for each organization and their implementation strategies for the coming three years. The media will be invited to cover this meeting.

Additionally, the Communications department of Memorial Health System will issue press releases and share information on social media regarding the final CHNA priorities and Memorial Medical Center's implementation strategy.

The MHS Board's Community Benefit Committee will receive annual updates on progress in meeting the measures of the CHNA implementation strategy, and will subsequently approve implementation strategies to address Access to Care, Mental Health, Substance Abuse, and Mother/Infant Health for FY2020 and FY2021. Implementation strategies and outcomes will be updated annually on the website. Information will also be included in the MHS annual report's community benefit report.

Questions about the Sangamon County 2018 Community Health Needs Assessment or implementation strategies may be directed to:

Paula Gramley, Community Benefit Program manager, Memorial Health System
Gramley.Paula@mhsil.com | 217–788–7014

2018 Sangamon County Community Health Needs Assessment

Appendices

Attachments

- Enos Park Access to Care Impact Statements (2016 and 2017)
- Conduent Healthy Communities Institute Data Scoring Tool: Sangamon County, Illinois
- Sangamon County 2018 Community Health Needs Assessment Community Survey Report from UIS Survey Research Department
- 2018 Pillsbury Mills Neighborhood Focus Groups Report from UIS Survey Research Department

Enos Park Access to Care Collaborative, Springfield, IL

Year One Impact Statement (Oct. 2015-Sept. 2016)

The Problem: The 2015 Sangamon County Community Health Need Assessment conducted by HSHS St. John's Hospital, Memorial Medical Center, and Sangamon County Public Health Department involved a community survey, community forums, advisory groups and other data collection activities. Access to care was one of the identified top priorities. The two hospitals decided to address this as a joint collaborative and invited the participation of Southern Illinois University School of Medicine's Center for Family Medicine (a federally qualified health center).

Goal: To improve access to health care in Springfield's Enos Park neighborhood, a vulnerable, low-income neighborhood.

Population: Approximately 2,300 residents living in the Enos Park neighborhood.

Objective: Create a Community Health Worker (CHW) program to increase access to health care for residents through a collaborative of MMC, HSHS, and SIU CFM.

Strategy: Implementation of a Community Health Worker program to work with individuals living in the Enos Park Neighborhood to address access and health using a holistic approach. Funding for the program is split between the two hospitals.

Outcomes: In October 2015, the collaborative team began the journey of implementing the project by hiring Dr. Tracey Smith, Director of Population Health Integration and Community Health with SIU Center for Family Medicine, as the project director, and hiring the first Community Health Worker. By the end of September 2016 the Enos Park Access to Care Collaborative had organized a Steering Committee (meets monthly); a Community Advisory Group (made up of neighborhood residents, meets monthly), and a Provider Alliance Group (local social service agencies, meets quarterly). By April 2016, two additional part-time CHWs joined the team.

Measurements set for the project include: resident enrollment, primary care provider engagement, emergency room utilization decrease, and community outreach. The goals were met for each quarter of the project's first year. Additional support totaling $2,000 was received from Friends of Memorial and the MidWest Dairy Council to fund community outreach projects.

The Access to Care Collaborative focuses on connection with the Enos Park residents individually and the Enos Park neighborhood as a whole, including service providers to the Enos Park neighborhood.

Residents: 455 People Reached

(The program impacted a total of 455 individuals. Some were assisted more than once through various services.)

- 111 clients enrolled with Community Health Workers
  - Spent 41,070 minutes (685 hours with these 111 clients)
- 19 youth (aged 9 to 14) through Bike Club
- 27 youth (aged 9 to 14) through Summer Enrichment Program
- 560 people through community outreach activities (i.e. Trunk 'R Treat, McClernand School Health Fair, National Night Out, etc.)
- 12 families (28 people) through the Memorial Behavioral Health's MOSAIC Program
- Reached a diverse population:
  - Gender: 58% Male, 42% Female
  - Age: average age is 34
  - Race: 36% black
- Reached Special Populations:
  - 26 people who were parolees
  - 15 people who were homeless

Increased Self-Sufficiency Measures

- Employment by 50%
- Income by 200%
- Food and nutrition by 50%
- Health care coverage by 50%
- Life skills by 40%
- Mobility by 100%
- Community Involvement by 67%
- Physical Health by 25%

Increased Access to Health Care Services

- 100% selected a primary care medical home (increase of 51%)
  - 409 primary care provider appointments made
  - 96% of our patients saw a primary care provider at least once in the past year
  - 83% show rate (national avg. 60-80%)
- 100% health insurance enrollment (increase of 56%)
- 38% reduction in unnecessary emergency department visits
- 19 patients attended 40 dental appointments, resulting in more than 40 cavities addressed and completion of seven full dental extractions
- 44 received mental health services

Addressed Other Needs

- Worked with patients 121 times to address housing needs, resulting in a 150% improvement in the safety of their housing (housing rental, advocacy, rent, utilities, etc.)
- Made 151 social service agency referrals
- Connected 10 patients to veteran services
- Provided transportation to clients 983 times
- Accompanied clients to 290 physician visits
- Partnered with more than 40 other community agencies
- CHWs educated 15 students (medical, social work, other CHWs) on provision of this kind of care and social determinants of health
- Worked with patients to gain disposable income of $50,800 since February through disability or reinstatement of benefits

Neighborhood Connections

- 11 meetings held with community residents leading to 27 different activities being held including:
  - Summer Bike Club
  - Summer Enrichment Program
  - McClernand Elementary School Parent Group
  - Northside Children's Library Friend Program
  - Mature Club
  - Central Illinois Food Bank fresh food distribution
  - SIU School of Medicine's Medical Students' Day of Service
  - SIU School of Medicine's New Medical Student Experience (*A Journey Through Your Patient's Health*)
  - Simmons Cancer Institute Colorectal Cancer Screening
  - MMC/YMCA Pre-diabetes Screening at Hildebrandt Housing site
- 5 meetings held with Provider Alliance Group leading to:
  - Trainings on insurance enrollment, medical legal partnerships, and social security enrollment

Discoveries

The Good	The Challenging
• New Collaborative Partners: ○ Enos Park Neighborhood Improvement Association ○ Springfield Police Dept. Neighborhood Police Officers ○ Memorial Behavioral Health MOSAIC program ○ Third Presbyterian Church ○ McClernand Elementary School ○ Central Counties Health Center (FQHC) ○ HSHS St. John's Caregiver Interfaith Volunteer Services ○ Numerous social service agencies	• The overall need is great!
• New model for housing	• Data access is complicated.
• Effect on recidivism (parolees returning to prison) ○ 19% vs. 56.7% nationally	• Developing a data base is complex.
• Reduction in neighborhood crime ○ 89% reduction in police calls to housing units we help manage ○ Police report 13% overall reduction in calls to Enos Park since the program began (from 1,260 to 1,092 calls)	• Transient nature of the neighborhood's super utilizers (people who frequently use hospital emergency departments as their primary source of health care services)
• System changes ○ Development of a different clinic to address needs of clients ○ Ability to work with local agencies to address policy changes	• Lack of housing, employment and parolee support programs

First-Year Impacts

Three major areas were impacted during the first year: Enos Park residents; the overall Springfield health care system; and community health workers themselves.

Enos Park Residents: Nearly 20% of residents in Enos Park were impacted by obtaining increased access to care, including access to dental services, primary care, and mental health services.

Springfield Health Care System: One of the major challenges with utilizing community health workers is there are very limited opportunities to bill Medicaid or insurance companies for the services CHWs provide, making these programs very expensive to operate. The clients themselves are not charged for the services. Building a sustainable program is difficult.

A new clinic model at SIU Center for Family Medicine was developed that established a strong team approach between mental health specialists, primary care provider, pharmacists, and medical-legal partners. This clinic has a 100% show rate and high level of billing by both the primary care provider and mental health specialists. The program is in the early stages of becoming an income-generating clinic that provides comprehensive care while helping its patients decrease their use of hospital emergency departments.

Community Health Workers: The Enos Park Community Health Workers have participated in more than 150 hours of training and are helping to develop a new workforce in the Springfield area. Because of the work started by this program, a grant from the United Way of Central Illinois is funding a similar CHW project in the Brandon Court neighborhood on Springfield's east side, in collaboration with Central Counties Health Center. This has led to the employment of three more CHWs.

Summary and Future

Year two will see expansion of current programs plus a larger emphasis on increased billing and outreach to super utilizers who depend upon emergency departments rather than seeing their primary care physicians for health care services. Dr. Smith and the Springfield Police Department are exploring new models of collaboration with our community health workers to assist residents that both of them serve. We are excited to continue to identify ways to work with local agencies, engage Enos Park residents, build new relationships, and disseminate results of this program.

For additional information, please contact:

Tracey Smith, DNP, PHCNS-BC, MS,
Director of Population Health
Integration and Community Health
SIU School of Medicine
217-545-2200
tsmith@siumed.edu

Kimberly Luz, MS, CHES, Divisional
Director of Community Outreach,
HSHS Central Illinois Division
217-544-6464, ext. 50343
Kim.Luz@hshs.org

Paula Gramley, Community
Benefit Program Manager
Memorial Health System
217-788-7014
gramley.paula@mhsil.com

Enos Park Access to Care Collaborative, Springfield, IL
Year Two Impact Statement (Oct. 2016-Sept. 2017)

The Problem: The 2015 Sangamon County Community Health needs assessment conducted by HSHS St. John's Hospital, Memorial Medical Center, and Sangamon County Department of Public Health involved a community survey, community forums, advisory groups and other data collection activities. Access to care was one of the identified top priorities. The two hospitals decided to address this as a joint collaborative and invited the participation of Southern Illinois University School of Medicine's Center for Family Medicine (a federally qualified health center).

Goal: To improve access to health care in Springfield's Enos Park neighborhood, a vulnerable, low-income neighborhood.

Population: Approximately 2300 residents living in the Enos Park neighborhood.

Objective: Create a Community Health Worker (CHW) program to increase access to health care for residents through a collaboration with MMC, HSHS, and SIU FCM.

Strategy: Implementation of a Community Health Worker program to work with the individuals living in the Enos Park Neighborhood to address access and health using a holistic approach. Funding for the program is split between the two hospitals.

Outcomes: In October 2015, the collaborative team began the journey of implementing the project by hiring Dr. Tracey Smith, Director of Population Health Integration and Community Health with SIU Center for Family Medicine, as the project director, and hiring the first Community Health Worker. By the end of September 2016 the Enos Park Access to Care Collaborative had organized a Steering Committee (meets monthly); a Community Advisory Group (made up of neighborhood residents, meets monthly), and a Provider Alliance Group (local social service agencies, meets quarterly). By April 2016, two additional part-time CHWs joined the team.

Measurements set for the project include: resident enrollment, primary care provider engagement, emergency room utilization decrease, and community outreach. The goals were met for each quarter of the project's first and second year. Additional support totaling $7800 was received from Friends of Memorial and the MidWest Dairy Council to fund community outreach projects among others.

The Access to Care Collaborative focuses on connection with the Enos Park residents individually and the Enos Park neighborhood as a whole, including service providers to the Enos Park neighborhood.

Residents: 640 People Reached in Year 2 (455 were impacted in Year 1)

(Some were assisted more than once through various services.)

- 300 clients enrolled with Community Health Workers since Oct 2015
  - 136 new clients enrolled in year 2
  - 164 clients enrolled since inception have graduated from the program
  - 67 children enrolled since inception
  - 116 clients active at the end of year 2
  - Spent 143,830 minutes since inception with clients (2,397 hours); 102,760 of these minutes occurred in year 2
- 43 youth (aged 9 to 14) through Bike Club and Summer Enrichment Program
- 504 people through community outreach activities (i.e. Trunk 'R Treat, National Night Out, etc.)
- 8 families through the Memorial Behavioral Health's MOSAIC Program
- 39 parolees
- 33 individuals who were homeless
- 7 veterans

Increased Self-Sufficiency Measures in Year 2

- Employment by 64%
- Income by 52%
- Food and nutrition by 31%
- Health care coverage by 8%
- Life skills by 8%
- Mobility by 14%
- Community Involvement by 7%

Increased Access in Year 2

- 100% selected a primary care home
  - 599 primary care provider appointments made
  - Accompanied clients to:
    - 237 specialty appointments
    - 253 physician visits
  - 93% of our patients saw a primary care provider at least once in the past year
  - 81% show rate (national avg. 60-80%)
- 100% health insurance enrollment
- 22% reduction in unnecessary emergency department visits
- 46 dental appointments, resulting in more than 22 cavities addressed and completion of three full dental extractions
- 172 mental health service visits received and Community Health Workers accompanied clients to 103 of these visits

Addressed Other Needs in Year 2

- Worked with patients 209 times to address housing needs, resulting in a 74% improvement in the safety of their housing (housing rental, advocacy, rent, utilities, etc.)
- Made 479 social service agency referrals in year 2 and accompanied clients to 238 referrals
- Provided transportation to patients 2,891 times
- Partnered with more than 40 other community agencies
- Accompanied clients 124 times to the food pantry
- CHWs educated 22 students (medical, social work, other CHWs) on provision of this kind of care and social determinants of health

- Worked with patients to gain disposable income of $251,606 through disability or reinstatement of benefits or employment
- Assisted 30 people to obtain an ID
- 34% of the time when a patient calls before going to the emergency department an emergency department visit was avoided

Neighborhood Connections in Year 2

- 38 client referrals from other agencies
- 10 meetings held with community residents leading to 18 plus different activities being held including:
  - Summer in The Park Program (16 community sponsors- 9 weeks in length and free)
    - Garden Club
    - Construction Club
    - Bicycle Club
    - Read 5 Club
    - Boy Scout Club
    - Art Club
  - Food Bank Fresh Food Distribution
  - SIU School of Medicine Medical Students' Day of Service
  - 94 radon kits places, 49 collects, 7 initial elevations, 3 needing mitigated
  - SIU School of Medicine's New Medical Student Experience (*A Journey through Your Patient's Health*)
  - Christmas Pajama Party at neighborhood library
  - Purpose Built Communities Meeting
  - Truck N Treat
  - Delivery of food to shut ins at Hildebrandt High Rise
  - Presents for Clients
  - Thanksgiving Meals Delivery
  - Baby Shower for client at Kumler Church
  - Meal train participation for community member who was ill
  - Sewing Club
  - Club for Seniors
- 17 meetings held with Provider Alliance Group or its members leading to:
  - Trainings on Mental Health First Aide (3 separate trainings) and Trauma Informed Care (1 training) offered
  - Kumler Church to develop new programs (Sewing, Seniors, Recycling) (3 meetings) and Cleaning Classes for Hildebrandt High Rise (2 meetings)
  - Community Garden meetings with SIU and HSHS (3 meetings)
  - Illinois Emergency Management Agency to develop radon program in Enos Park (4 meetings)
  - Meetings with Community Connection Point (1 meeting)

Discoveries

The Good
Expanding Partnerships ➢ Enos Park Neighborhood Improvement Association ➢ Springfield Police Dept. Neighborhood Police Officers ➢ Memorial Behavioral Health MOSAIC program

➢ Third Presbyterian Church ➢ McClernand Elementary School ➢ Central Counties Health Center (FQHC) ➢ Numerous community and social service agencies
Effect on recidivism (parolees returning to prison) ➢ 0% post release in year 2 (average period of time out of prison currently is 6 months)- average for the demographics we serve is a 25.6% recidivism rate at one year post release
Reduction in neighborhood calls to police ➢ During Year 1, the police experienced a reduction in in calls from the Enos Park neighborhood, which continued in Year 2. Overall from Oct. 2015-Sept. 2017 there has been a 22% reduction in calls to the Springfield Police Department from this neighborhood.

The Challenging
The overall need is great!
Data access is complicated.
Developing a data base is complex.
Transient nature of the neighborhood's super utilizers (people who frequently use hospital emergency departments as their primary source of health care services)
Lack of housing, employment and parolee support programs

Second-Year Impacts

Three major areas were impacted during since inception of the program: Enos Park residents; the overall Springfield health care system; and Community Health Workers themselves.

Enos Park Residents: Nearly 38% of residents in Enos Park were impacted by obtaining increased access to care, including access to dental services, primary care, and mental health services.

Springfield Health Care System: One of the major challenges with utilizing community health workers is there are very limited opportunities to bill Medicaid or insurance companies for the services CHWs provide, making these programs very expensive to operate. The clients themselves are not charged for the services. Building a sustainable program is difficult.

A new clinic model at SIU Center for Family Medicine was developed that established a strong team approach between mental health specialists, primary care provider, pharmacists, and medical-legal partners. This clinic has a greater than 90% show rate and high level of billing by both the primary care provider and mental health specialists. The clinic has expanded from 2x/month to 6x/month due to the demand and acceptance of this clinic model by clients.

SIU has implemented a new documentation in the electronic health record to capture elements around providing care facilitation services. The Springfield Police Department has implemented a new pilot of

having a behavioral health consultant from SIU FCM ride along (3 hours/week) to follow up on clients with mental health concerns and has demonstrated a 89% reduction in repeat 9-1-1 calls by those being visited (still in pilot). Also Helping Hands Homeless Shelter has contracted with SIU Center for Family Medicine to increase mental health access for their clients (10 hours/month) based upon the relationship built through work with them on the Enos project.

Community Health Workers: The Enos Park Community Health Workers have participated in more than 250 hours of training.

Dr. Smith presented 14 times including locally (4), regionally (6), and nationally (4) on the project. The Enos Park Project was covered also in 3 interviews and highlighted in 6 articles during Year 2 of implementation.

Summary and Future

Year three will see expansion of current programs plus a larger emphasis on increased billing and outreach to super utilizers who depend upon emergency departments rather than seeing their primary care physicians for health care services. We are excited to continue to identify ways to work with local agencies, engage Enos Park residents, build new relationships, and disseminate results of this program.

For additional information, please contact:

Tracey Smith, DNP, PHCNS-BC, MS,
Director of Population Health
Integration and Community Health
SIU School of Medicine
217-545-2200
tsmith@siumed.edu

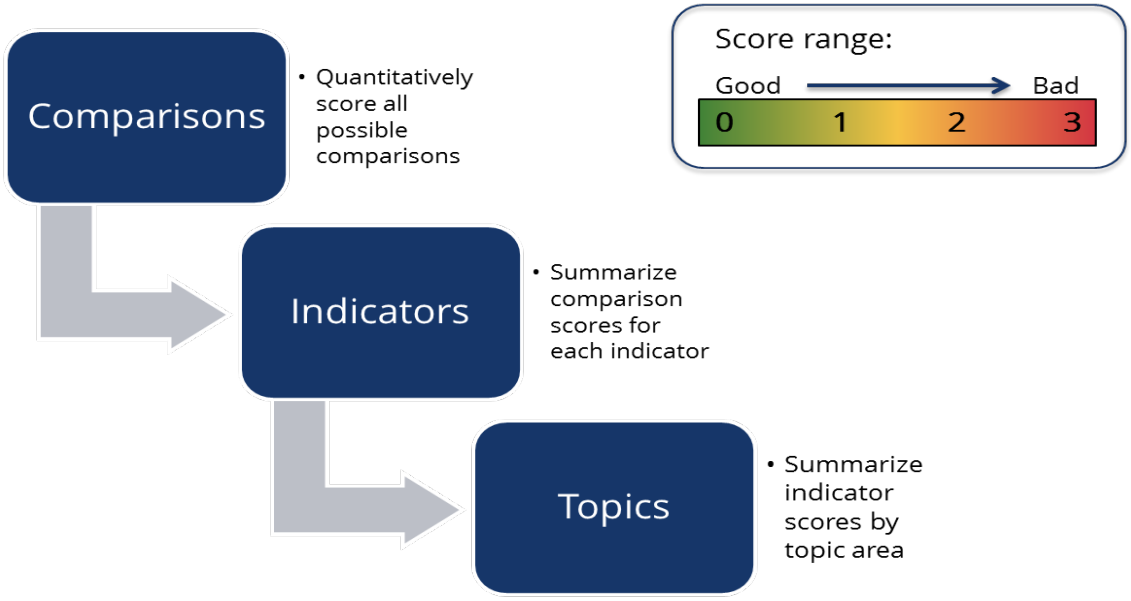
Kimberly Luz, MS, CHES, Divisional
Director of Community Outreach,
HSHS Central Illinois Division
217-544-6464, ext. 50343
Kim.Luz@hshs.org

Paula Gramley, Community Benefit
Program Manager
Memorial Health System
217-788-7014
gramley.paula@mhsil.com

Healthy Communities Institute Data Scoring Tool - Methodology

Scoring Method

Data Scoring is done in three stages:



For each indicator, your county is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time.

Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

HCI Platform County Distribution Gauge

Comparison to Values: State, National, and Targets

Your county is compared to the state value, the national value, and target values. Targets values include the nation-wide Healthy People 2020 (HP2020) goals as well as locally set goals. Healthy People 2020 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

HCI Platform Compare to State or National Value

HCI Platform Compare to Healthy People 2020 Target

Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated and the indicator is excluded from the data scoring results.

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.

SOURCE: Conduent Healthy Communities Institute (2017). Data Scoring Tool. Memorial Health System, Springfield, IL. Retrieved June 20, 2017. www.choosememorial.org/healthycommunities

County: Sangamon
Memorial Health System
Total indicators: 165
Tuesday 20th of June 2017 08:17:18 AM

Indicator	County Distribution State	County Distribution US	Value State	Value US	Target HP2020	Target Local	Trend	Score	Precision
Single-Parent Households	3	3	3	3	1.5		3	2.83	High
Children Living Below Poverty Level	3	2	3	3	1.5		3	2.67	High
Asthma: Medicare Population	3	3	3	3	1.5		2	2.61	High
Babies with Low Birth Weight	3	1.5	3	3	3		2	2.53	High
Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	2	2	3	3	3		2	2.44	High
All Cancer Incidence Rate	3	3	2	3	1.5		2	2.44	High
Breast Cancer Incidence Rate	3	3	2	3	1.5		2	2.44	High
Substantiated Child Abuse Rate	2	1.5	3	3	1.5		3	2.42	Medium
Chlamydia Incidence Rate	3	3	3	3	1.5		1	2.39	High
Gonorrhea Incidence Rate	3	3	3	3	1.5		1	2.39	High
Cervical Cancer Incidence Rate	1.5	2	3	3	3		2	2.36	High
Lung and Bronchus Cancer Incidence Rate	2	2	3	3	1.5		2	2.28	High
Age-Adjusted Death Rate due to Suicide	1.5	1	3	2	3		3	2.25	High
Death Rate due to Drug Poisoning	2	2	1.5	3	1.5		3	2.25	Medium
Preterm Births	3	1.5	3	2	2		2	2.25	High
Ischemic Heart Disease: Medicare Population	2	3	3	3	1.5		1	2.22	High
Hospitalization Rate due to Hip Fractures Among Males 65+	3	1.5	3	1.5	3		1.5	2.17	Medium
Pedestrian Death Rate	3	1.5	3	1.5	3		1.5	2.17	Medium
Infant Mortality Rate	2	1.5	3	1.5	3		2	2.11	Medium
Age-Adjusted Death Rate due to Cancer	2	2	2	3	3		1	2.06	High
Age-Adjusted Death Rate due to Lung Cancer	1	2	3	3	3		1	2.06	High
Age-Adjusted Death Rate due to Unintentional Injuries	2	1	3	3	3		1	2.06	High
Hospitalization Rate due to Hip Fractures Among Females 65+	3	1.5	3	1.5	2		1.5	2.06	Medium
Workers who Walk to Work	1	2	3	3	3		1	2.06	High
Adults who Smoke	3	1.5	1.5	1.5	3		2	2.03	Medium
Age-Adjusted ER Rate due to Adult Asthma	3	1.5	3	1.5	1.5		1.5	2.00	Low
Age-Adjusted ER Rate due to Alcohol Abuse	3	1.5	3	1.5	1.5		1.5	2.00	Low
Age-Adjusted ER Rate due to Asthma	3	1.5	3	1.5	1.5		1.5	2.00	Low
Age-Adjusted ER Rate due to Diabetes	3	1.5	3	1.5	1.5		1.5	2.00	Low
Age-Adjusted ER Rate due to Long-Term Complications of Diabetes	3	1.5	3	1.5	1.5		1.5	2.00	Low
Age-Adjusted ER Rate due to Mental Health	3	1.5	3	1.5	1.5		1.5	2.00	Low
Age-Adjusted ER Rate due to Pediatric Mental Health	3	1.5	3	1.5	1.5		1.5	2.00	Low
Age-Adjusted Hospitalization Rate due to Asthma	3	1.5	3	1.5	1.5		1.5	2.00	Low
Age-Adjusted Hospitalization Rate due to Hypertension	3	1.5	3	1.5	1.5		1.5	2.00	Low
Age-Adjusted Hospitalization Rate due to Pediatric Mental Health	3	1.5	3	1.5	1.5		1.5	2.00	Low
Age-Adjusted Hospitalization Rate due to Short-Term Complications of Dia	3	1.5	3	1.5	1.5		1.5	2.00	Low
Children with Low Access to a Grocery Store	3	3	1.5	1.5	1.5		1.5	2.00	Low
People Living Below Poverty Level	2	1	2	2	1.5		3	2.00	High
People with Low Access to a Grocery Store	3	3	1.5	1.5	1.5		1.5	2.00	Low
Age-Adjusted Death Rate due to Influenza and Pneumonia	1	2	2	3	1.5		2	1.94	High
Food Insecurity Rate	3	1	3	1	1.5		2	1.94	High
Oral Cavity and Pharynx Cancer Incidence Rate	1	2	2	3	1.5		2	1.94	High
Farmers Market Density	2	2	1.5	3	1.5		1.5	1.92	Medium
Mothers who Smoked During Pregnancy	2	1.5	3	3	3		0	1.92	High
Fast Food Restaurant Density	3	3	1.5	1.5	1.5		1	1.89	Medium
Age-Adjusted Death Rate due to Colorectal Cancer	2	2	2	3	3		0	1.83	High
Age-Adjusted ER Rate due to Bacterial Pneumonia	2	1.5	3	1.5	1.5		1.5	1.83	Low
Age-Adjusted ER Rate due to Dental Problems	2	1.5	3	1.5	1.5		1.5	1.83	Low
Age-Adjusted ER Rate due to Heart Failure	2	1.5	3	1.5	1.5		1.5	1.83	Low
Age-Adjusted ER Rate due to Kidney and Urinary Infections	2	1.5	3	1.5	1.5		1.5	1.83	Low
Age-Adjusted ER Rate due to Short-Term Complications of Diabetes	2	1.5	3	1.5	1.5		1.5	1.83	Low
Age-Adjusted ER Rate due to Uncontrolled Diabetes	2	1.5	3	1.5	1.5		1.5	1.83	Low
Age-Adjusted ER Rate due to Urinary Tract Infections	2	1.5	3	1.5	1.5		1.5	1.83	Low
Colorectal Cancer Incidence Rate	2	2	2	3	3		0	1.83	High
Depression: Medicare Population	3	2	3	2	1.5		0	1.83	High
Families Living Below Poverty Level	2	1	2	1	1.5		3	1.83	High
People 65+ with Low Access to a Grocery Store	3	2	1.5	1.5	1.5		1.5	1.83	Low
Workers who Drive Alone to Work	1	2	3	2	1.5		1.5	1.83	High
Alcohol-Impaired Driving Deaths	2	2	1.5	3	1.5		1	1.81	Medium
Mothers who Received Early Prenatal Care	3	1.5	1.5	2	1		1.5	1.78	Medium
Adults with Current Asthma	3	1.5	1.5	1.5	1.5		1.5	1.75	Low
Age-Adjusted Hospitalization Rate due to Pediatric Asthma	1.5	1.5	3	1.5	1.5		1.5	1.75	Low
Grocery Store Density	3	2	1.5	1.5	1.5		1	1.72	Medium
Life Expectancy for Males	2	2	2	2	1.5		1	1.72	High
Adults with Diabetes	2	1.5	1.5	1.5	1.5		2	1.69	Low
Self-Reported General Health Assessment: Very Good or Excellent	2	1.5	1.5	1.5	1.5		2	1.69	Low
Student-to-Teacher Ratio	2	2	1	1.5	1.5		2	1.69	Medium
Age-Adjusted ER Rate due to COPD	1	1.5	3	1.5	1.5		1.5	1.67	Low
Age-Adjusted ER Rate due to Dehydration	1	1.5	3	1.5	1.5		1.5	1.67	Low
Age-Adjusted ER Rate due to Hypertension	2	1.5	2	1.5	1.5		1.5	1.67	Low
Age-Adjusted ER Rate due to Pediatric Asthma	3	1.5	1	1.5	1.5		1.5	1.67	Low

SOURCE: Conduent Healthy Communities Institute (2017). Data Scoring Tool. Memorial Health System, Springfield, IL. Retrieved June 20, 2017. www.choosememorial.org/healthycommunities

County: Sangamon
Memorial Health System
Total indicators: 165
Tuesday 20th of June 2017 08:17:18 AM

Indicator	County Distribution State	County Distribution US	Value State	Value US	Target HP2020	Target Local	Trend	Score	Precision
Age-Adjusted Hospitalization Rate due to Diabetes	3	1.5	1	1.5	1.5		1.5	1.67	Low
Age-Adjusted Hospitalization Rate due to Heart Failure	3	1.5	1	1.5	1.5		1.5	1.67	Low
Low-Income and Low Access to a Grocery Store	2	2	1.5	1.5	1.5		1.5	1.67	Low
Renters Spending 30% or More of Household Income on Rent	3	2	1	1	1.5		1.5	1.67	High
Adults who Visited a Dentist	1.5	1.5	1.5	1.5	1.5		2	1.61	Low
Age-Adjusted Death Rate due to Breast Cancer	2	2	1	2	2		1	1.61	High
Atrial Fibrillation: Medicare Population	1	2	1	2	1.5		2	1.61	High
PBT Released	1.5	1.5	1.5	1.5	1.5		2	1.61	Low
Recognized Carcinogens Released into Air	1.5	1.5	1.5	1.5	1.5		2	1.61	Low
Tuberculosis Cases	1.5	1.5	1.5	1.5	1.5		2	1.61	Low
Age-Adjusted Hospitalization Rate due to Hepatitis	1.5	1.5	2	1.5	1.5		1.5	1.58	Low
Students Eligible for the Free Lunch Program	1	2	0	1.5	1.5		3	1.58	Medium
COPD: Medicare Population	1	2	2	2	1.5		1	1.56	High
Workers Commuting by Public Transportation	0	0	3	3	3		1	1.56	High
Food Environment Index	2	1	1.5	1	1.5		2	1.53	Medium
Severe Housing Problems	3	1	1.5	0	1.5		2	1.53	Medium
Access to Exercise Opportunities	0	1	3	2	1.5		1.5	1.50	Medium
Age-Adjusted Hospitalization Rate due to Mental Health	3	1.5	0	1.5	1.5		1.5	1.50	Low
Alzheimer's Disease or Dementia: Medicare Population	2	2	1	1	1.5		1.5	1.50	High
Cancer: Medicare Population	2	3	1	2	1.5		0	1.50	High
Homeownership	2	1	1	0	1.5		3	1.50	High
Teen Births	2	1.5	3	0	1.5		1	1.47	Medium
Households without a Vehicle	3	2	0	0	1.5		2	1.44	High
Low-Income Preschool Obesity	1	1	1.5	1.5	1.5		2	1.44	Medium
Adult Fruit and Vegetable Consumption	1	1.5	1.5	1.5	1.5		1.5	1.42	Low
Age-Adjusted ER Rate due to Hepatitis	1.5	1.5	1	1.5	1.5		1.5	1.42	Low
High School Graduation	2	2	1.5	1	1		1	1.42	High
Violent Crime Rate	3	1.5	1.5	1.5	1.5		0	1.42	Low
Child Food Insecurity Rate	1	1	3	1	1.5		1	1.39	High
Deaths due to Motor Vehicle Collisions	1.5	1.5	1.5	1.5	1.5		1	1.39	Low
HIV Diagnosed Cases	1.5	1.5	1.5	1.5	1.5		1	1.39	Low
Life Expectancy for Females	1	1	2	2	1.5		1	1.39	High
Teens who Use Alcohol	2	1.5	1	1.5	1.5		1	1.39	Medium
Age-Adjusted Hospitalization Rate due to Adult Asthma	1	1.5	1	1.5	1.5		1.5	1.33	Low
Age-Adjusted Hospitalization Rate due to Alcohol Abuse	2	1.5	0	1.5	1.5		1.5	1.33	Low
Age-Adjusted Hospitalization Rate due to Bacterial Pneumonia	1	1.5	1	1.5	1.5		1.5	1.33	Low
Age-Adjusted Hospitalization Rate due to Dehydration	2	1.5	0	1.5	1.5		1.5	1.33	Low
Age-Adjusted Hospitalization Rate due to Long-Term Complications of Dia	2	1.5	0	1.5	1.5		1.5	1.33	Low
Households with Cash Public Assistance Income	2	2	1	0	1.5		1.5	1.33	High
Households with No Car and Low Access to a Grocery Store	1	1	1.5	1.5	1.5		1.5	1.33	Low
Insufficient Sleep	2	1	1	1	1.5		1.5	1.33	Medium
SNAP Certified Stores	1	1	1.5	1.5	1.5		1.5	1.33	Medium
Adults with Influenza Vaccination	0	1.5	1.5	1.5	3		1	1.31	Medium
Adults with Pneumonia Vaccination	1	1.5	1.5	1.5	1.5		1	1.31	Low
Food Insecure Children Likely Ineligible for Assistance	2	1.5	1	1	1.5		1	1.31	Medium
High Blood Pressure Prevalence	0	1.5	1.5	1.5	2		1.5	1.31	Low
Adults who Binge Drink	1	1.5	1.5	1.5	0		1.5	1.25	Medium
Adults with a Usual Source of Health Care	1	1.5	1.5	1.5	1		1	1.25	Medium
Age-Adjusted Hospitalization Rate due to Uncontrolled Diabetes	1.5	1.5	0	1.5	1.5		1.5	1.25	Low
Annual Particle Pollution	1.5	0	1.5	1.5	1.5		1.5	1.25	Low
Frequent Mental Distress	1	1	1.5	1	1.5		1.5	1.25	Medium
Frequent Physical Distress	1	1	1.5	1	1.5		1.5	1.25	Medium
Adults who are Obese	0	1.5	1.5	1.5	0		2	1.19	Medium
Age-Adjusted Death Rate due to Coronary Heart Disease	1	1	2	1	1		1	1.17	High
Age-Adjusted ER Rate due to Immunization-Preventable Pneumonia and I	1	1.5	0	1.5	1.5		1.5	1.17	Low
Age-Adjusted Hospitalization Rate due to COPD	1	1.5	0	1.5	1.5		1.5	1.17	Low
Age-Adjusted Hospitalization Rate due to Immunization-Preventable Pneu	1	1.5	0	1.5	1.5		1.5	1.17	Low
Age-Adjusted Hospitalization Rate due to Kidney and Urinary Infections	1	1.5	0	1.5	1.5		1.5	1.17	Low
Heart Failure: Medicare Population	1	2	1	2	1.5		0	1.17	High
Population with Optimally Fluoridated Water	0	1.5	0	1.5	3		1.5	1.17	Medium
Recreation and Fitness Facilities	1	0	1.5	1.5	1.5		1.5	1.17	Medium
Adults who are Overweight or Obese	0	1.5	1.5	1.5	1.5		1	1.14	Low
Annual Ozone Air Quality	1.5	0	1.5	1.5	1.5		1	1.14	Low
Drinking Water Violations	1	1	0	1.5	1.5		1.5	1.08	Medium
Diabetes: Medicare Population	1	1	1	1	1.5		1	1.06	High
Teens who Use Marijuana	1	1.5	0	1.5	1.5		1	1.06	Medium
Voter Turnout: General Election	0	1.5	1	1.5	1.5		1	1.06	Medium
Age-Adjusted Hospitalization Rate due to Urinary Tract Infections	0	1.5	0	1.5	1.5		1.5	1.00	Low
Chronic Kidney Disease: Medicare Population	0	1	0	0	1.5		3	1.00	High
Low-Income Persons who are SNAP Participants	0	0	1.5	1.5	1.5		1.5	1.00	Low
Prostate Cancer Incidence Rate	1	2	1	1	1.5		0	1.00	High

SOURCE: Conduent Healthy Communities Institute (2017). Data Scoring Tool. Memorial Health System, Springfield, IL. Retrieved June 20, 2017. www.choosememorial.org/healthycommunities

County: Sangamon
Memorial Health System
Total indicators: 165
Tuesday 20th of June 2017 08:17:18 AM

	County Distribution		Value		Target				
Indicator	State	US	State	US	HP2020	Local	Trend	Score	Precision
Unemployed Workers in Civilian Labor Force	0	1	1	1	1.5		1.5	1.00	High
Liquor Store Density	1	1	0	0	1.5		2	0.94	High
Rheumatoid Arthritis or Osteoarthritis: Medicare Population	0	1	0	1	1.5		2	0.94	High
Stroke: Medicare Population	1	1	0	0	1.5		2	0.94	High
Hypertension: Medicare Population	0	1	1	1	1.5		1	0.89	High
Osteoporosis: Medicare Population	1	2	0	0	1.5		1	0.89	High
Primary Care Provider Rate	0	0	1.5	1.5	1.5		1	0.89	Medium
Diabetic Monitoring: Medicare Population	1	1	1	1	1.5		0	0.83	High
People 25+ with a High School Degree or Higher	0	0	1	1	1.5		1	0.72	High
Age-Adjusted Death Rate due to Kidney Disease	0	1	0	2	1.5		0	0.67	High
Dentist Rate	0	0	1.5	1.5	1.5		0	0.67	Medium
Median Household Income	0	0	2	1	1.5		0	0.67	High
Non-Physician Primary Care Provider Rate	0	0	1.5	1.5	1.5		0	0.67	Medium
Teens who Smoke	0	1.5	0	1.5	1.5		0	0.67	Medium
Adults with Health Insurance	0	0	1	1.5	2		0	0.64	High
Children with Health Insurance	0	0	1	1.5	2		0	0.64	High
Solo Drivers with a Long Commute	0	0	1.5	0	1.5		1	0.64	Medium
Hyperlipidemia: Medicare Population	0	1	0	0	1.5		1	0.56	High
Per Capita Income	0	0	1	1	1.5		0	0.50	High
Age-Adjusted Death Rate due to Prostate Cancer	1.5	0	0	0	0		1	0.47	High
Mean Travel Time to Work	0	0	0	0	1.5		1	0.39	High
People 25+ with a Bachelor's Degree or Higher	0	0	1	0	1.5		0	0.33	High
People 65+ Living Below Poverty Level	1	0	0	0	1.5		0	0.33	High

Healthy Communities Institute Indicators for Sangamon County, June 2017
Topic Areas Showing Worst Scores & Trending Worse Over Time
Ranking of Scores by Topic ≥ 1.5 on 3 point scale
17 Topic Areas

Social Environment in Sangamon County

	County		Value		Target			
Indicator	State	US	State	US	HP2020	Trend	Score	Precision
Single-Parent Households	3	3	3	3	1.5	3	2.83	High
Children Living Below Poverty Level	3	2	3	3	1.5	3	2.67	High
Substantiated Child Abuse Rate	2	1.5	3	3	1.5	3	2.42	Medium
Voter Turnout: General Election	0	1.5	1	1.5	1.5	1	1.06	Medium

Maternal, Fetal & Infant Health in Sangamon County

	County		Value		Target			
Indicator	State	US	State	US	HP2020	Trend	Score	Precision
Babies with Low Birth Weight	3	1.5	3	3	3	2	2.53	High
Preterm Births	3	1.5	3	2	2	2	2.25	High
Infant Mortality Rate	2	1.5	3	1.5	3	2	2.11	Medium
Mothers who Smoked During Pregnancy	2	1.5	3	3	3	0	1.92	High
Mothers who Received Early Prenatal Care	3	1.5	1.5	2	1	1.5	1.78	Medium
Teen Births	2	1.5	3	0	1.5	1	1.47	Medium

Women's Health in Sangamon County

	County		Value		Target			
Indicator	State	US	State	US	HP2020	Trend	Score	Precision
Breast Cancer Incidence Rate	3	3	2	3	1.5	2	2.44	High
Cervical Cancer Incidence Rate	1.5	2	3	3	3	2	2.36	High
Age-Adjusted Death Rate Breast Cancer	2	2	1	2	2	1	1.61	High
Life Expectancy for Females	1	1	2	2	1.5	1	1.39	High

Prevention & Safety in Sangamon County

	County		Value		Target			
Indicator	State	US	State	US	HP2020	Trend	Score	Precision
Death Rate Drug Poisoning	2	2	1.5	3	1.5	3	2.25	Medium
Hosp. Rate Hip Fractures Among Males 65+	3	1.5	3	1.5	3	1.5	2.17	Medium
Pedestrian Death Rate	3	1.5	3	1.5	3	1.5	2.17	Medium
Age-Adj. Death Rate Unintentional Injuries	2	1	3	3	3	1	2.06	High
Hosp. Rate Hip Fractures Among Females 65+	3	1.5	3	1.5	2	1.5	2.06	Medium
Severe Housing Problems	3	1	1.5	0	1.5	2	1.53	Medium
Deaths Motor Vehicle Collisions	1.5	1.5	1.5	1.5	1.5	1	1.39	Low

Environmental & Occupational Health in Sangamon County

Indicator	County		Value		Target			
	State	US	State	US	HP2020	Trend	Score	Precision
Asthma: Medicare Population	3	3	3	3	1.5	2	2.61	High
Age-Adjusted ER Rate Adult Asthma	3	1.5	3	1.5	1.5	1.5	2	Low
Age-Adjusted ER Rate Asthma	3	1.5	3	1.5	1.5	1.5	2	Low
Age-Adjusted Hospitalization Rate Asthma	3	1.5	3	1.5	1.5	1.5	2	Low
Adults with Current Asthma	3	1.5	1.5	1.5	1.5	1.5	1.75	Low
Age-Adjusted Hosp. Rate Pediatric Asthma	1.5	1.5	3	1.5	1.5	1.5	1.75	Low
Age-Adjusted ER Rate Pediatric Asthma	3	1.5	1	1.5	1.5	1.5	1.67	Low
Age-Adjusted Hosp.Rate Adult Asthma	1	1.5	1	1.5	1.5	1.5	1.33	Low

Public Safety in Sangamon County

Indicator	County		Value		Target			
	State	US	State	US	HP2020	Trend	Score	Precision
Substantiated Child Abuse Rate	2	1.5	3	3	1.5	3	2.42	Medium
Pedestrian Death Rate	3	1.5	3	1.5	3	1.5	2.17	Medium
Alcohol-Impaired Driving Deaths	2	2	1.5	3	1.5	1	1.81	Medium
Violent Crime Rate	3	1.5	1.5	1.5	1.5	0	1.42	Low
Deaths Motor Vehicle Collisions	1.5	1.5	1.5	1.5	1.5	1	1.39	Low

Cancer in Sangamon County

Indicator	County		Value		Target			
	State	US	State	US	HP2020	Trend	Score	Precision
All Cancer Incidence Rate	3	3	2	3	1.5	2	2.44	High
Breast Cancer Incidence Rate	3	3	2	3	1.5	2	2.44	High
Cervical Cancer Incidence Rate	1.5	2	3	3	3	2	2.36	High
Lung and Bronchus Cancer Incidence Rate	2	2	3	3	1.5	2	2.28	High
Age-Adjusted Death Rate Cancer	2	2	2	3	3	1	2.06	High
Age-Adjusted Death Rate Lung Cancer	1	2	3	3	3	1	2.06	High
Oral Cavity & Pharynx Cancer Incidence Rate	1	2	2	3	1.5	2	1.94	High
Age-Adjusted Death Rate Colorectal Cancer	2	2	2	3	3	0	1.83	High
Colorectal Cancer Incidence Rate	2	2	2	3	3	0	1.83	High
Age-Adjusted Death Rate Breast Cancer	2	2	1	2	2	1	1.61	High
Cancer: Medicare Population	2	3	1	2	1.5	0	1.5	High
Prostate Cancer Incidence Rate	1	2	1	1	1.5	0	1	High
Age-Adjusted Death Rate Prostate Cancer	1.5	0	0	0	0	1	0.47	High

Mental Health & Mental Disorders in Sangamon County

Indicator	County		Value		Target			
	State	US	State	US	HP2020	Trend	Score	Precision
Age-Adjusted Death Rate Suicide	1.5	1	3	2	3	3	2.25	High
Age-Adjusted ER Rate Mental Health	3	1.5	3	1.5	1.5	1.5	2	Low
Age-Adj. ER Rate Pediatric Mental Health	3	1.5	3	1.5	1.5	1.5	2	Low
Age-Adj. Hosp. Rate Pediatric Mental Health	3	1.5	3	1.5	1.5	1.5	2	Low
Depression: Medicare Population	3	2	3	2	1.5	0	1.83	High
Age-Adj. Hospitalization Rate Mental Health	3	1.5	0	1.5	1.5	1.5	1.5	Low
Alzheimer's Disease or Dementia: Medicare Pop	2	2	1	1	1.5	1.5	1.5	High
Frequent Mental Distress	1	1	1.5	1	1.5	1.5	1.25	Medium

Mortality Data in Sangamon County

Indicator	County		Value		Target	Trend	Score	Precision
	State	US	State	US	HP2020			
Age-Adj. Death Rate Cerebrovascular (Stroke)	2	2	3	3	3	2	2.44	High
Age-Adjusted Death Rate Suicide	1.5	1	3	2	3	3	2.25	High
Death Rate Drug Poisoning	2	2	1.5	3	1.5	3	2.25	Medium
Pedestrian Death Rate	3	1.5	3	1.5	3	1.5	2.17	Medium
Infant Mortality Rate	2	1.5	3	1.5	3	2	2.11	Medium
Age-Adjusted Death Rate Cancer	2	2	2	3	3	1	2.06	High
Age-Adjusted Death Rate Lung Cancer	1	2	3	3	3	1	2.06	High
Age-Adj. Death Rate Unintentional Injuries	2	1	3	3	3	1	2.06	High
Age-Adj. Death Rate Influenza and Pneumonia	1	2	2	3	1.5	2	1.94	High
Age-Adjusted Death Rate Colorectal Cancer	2	2	2	3	3	0	1.83	High
Alcohol-Impaired Driving Deaths	2	2	1.5	3	1.5	1	1.81	Medium
Age-Adjusted Death Rate Breast Cancer	2	2	1	2	2	1	1.61	High
Deaths Motor Vehicle Collisions	1.5	1.5	1.5	1.5	1.5	1	1.39	Low
Age-Adj. Death Rate Coronary Heart Disease	1	1	2	1	1	1	1.17	High
Age-Adjusted Death Rate Kidney Disease	0	1	0	2	1.5	0	0.67	High
Age-Adjusted Death Rate Prostate Cancer	1.5	0	0	0	0	1	0.47	High

Respiratory Diseases in Sangamon County

Indicator	County		Value		Target	Trend	Score	Precision
	State	US	State	US	HP2020			
Asthma: Medicare Population	3	3	3	3	1.5	2	2.61	High
Lung and Bronchus Cancer Incidence Rate	2	2	3	3	1.5	2	2.28	High
Age-Adjusted Death Rate Lung Cancer	1	2	3	3	3	1	2.06	High
Age-Adjusted ER Rate Adult Asthma	3	1.5	3	1.5	1.5	1.5	2	Low
Age-Adjusted ER Rate Asthma	3	1.5	3	1.5	1.5	1.5	2	Low
Age-Adjusted Hospitalization Rate Asthma	3	1.5	3	1.5	1.5	1.5	2	Low
Age-Adjusted Death Rate Influenza and Pneumonia	1	2	2	3	1.5	2	1.94	High
Age-Adjusted ER Rate Bacterial Pneumonia	2	1.5	3	1.5	1.5	1.5	1.83	Low
Adults with Current Asthma	3	1.5	1.5	1.5	1.5	1.5	1.75	Low
Age-Adjusted Hospitalization Rate Pediatric Asthma	1.5	1.5	3	1.5	1.5	1.5	1.75	Low
Age-Adjusted ER Rate COPD	1	1.5	3	1.5	1.5	1.5	1.67	Low
Age-Adjusted ER Rate Pediatric Asthma	3	1.5	1	1.5	1.5	1.5	1.67	Low
Tuberculosis Cases	1.5	1.5	1.5	1.5	1.5	2	1.61	Low
COPD: Medicare Population	1	2	2	2	1.5	1	1.56	High
Age-Adjusted Hospitalization Rate Adult Asthma	1	1.5	1	1.5	1.5	1.5	1.33	Low
Age-Adj. Hospitalization Rate Bacterial Pneumonia	1	1.5	1	1.5	1.5	1.5	1.33	Low
Adults with Influenza Vaccination	0	1.5	1.5	1.5	3	1	1.31	Medium
Adults with Pneumonia Vaccination	1	1.5	1.5	1.5	1.5	1	1.31	Low
Age-Adj. ER Rate Immunization-Preventable Pneumonia and Influenza	1	1.5	0	1.5	1.5	1.5	1.17	Low
Age-Adjusted Hospitalization Rate COPD	1	1.5	0	1.5	1.5	1.5	1.17	Low
Age-Adj. Hosp. Rate Immunization-Preventable Pneumonia & Influenza	1	1.5	0	1.5	1.5	1.5	1.17	Low

Children's Health in Sangamon County

Indicator	County		Value		Target	Trend	Score	Precision
	State	US	State	US	HP2020			
Substantiated Child Abuse Rate	2	1.5	3	3	1.5	3	2.42	Medium
Age-Adjusted ER Rate Pediatric Mental Health	3	1.5	3	1.5	1.5	1.5	2	Low
Age-Adjusted Hosp. Rate Pediatric Mental Health	3	1.5	3	1.5	1.5	1.5	2	Low
Children with Low Access to a Grocery Store	3	3	1.5	1.5	1.5	1.5	2	Low
Age-Adjusted Hospitalization Rate Pediatric Asthma	1.5	1.5	3	1.5	1.5	1.5	1.75	Low
Age-Adjusted ER Rate Pediatric Asthma	3	1.5	1	1.5	1.5	1.5	1.67	Low
Low-Income Preschool Obesity	1	1	1.5	1.5	1.5	2	1.44	Medium
Child Food Insecurity Rate	1	1	3	1	1.5	1	1.39	High
Food Insecure Children Likely Ineligible for Assistance	2	1.5	1	1	1.5	1	1.31	Medium
Children with Health Insurance	0	0	1	1.5	2	0	0.64	High

Immunizations & Infectious Diseases in Sangamon County

Indicator	County		Value		Target	Trend	Score	Precision
	State	US	State	US	HP2020			
Chlamydia Incidence Rate	3	3	3	3	1.5	1	2.39	High
Gonorrhea Incidence Rate	3	3	3	3	1.5	1	2.39	High
Age-Adjusted Death Rate Influenza and Pneumonia	1	2	2	3	1.5	2	1.94	High
Age-Adjusted ER Rate Bacterial Pneumonia	2	1.5	3	1.5	1.5	1.5	1.83	Low
Tuberculosis Cases	1.5	1.5	1.5	1.5	1.5	2	1.61	Low
Age-Adjusted Hospitalization Rate Hepatitis	1.5	1.5	2	1.5	1.5	1.5	1.58	Low
Age-Adjusted ER Rate Hepatitis	1.5	1.5	1	1.5	1.5	1.5	1.42	Low
HIV Diagnosed Cases	1.5	1.5	1.5	1.5	1.5	1	1.39	Low
Age-Adjusted Hosp. Rate Bacterial Pneumonia	1	1.5	1	1.5	1.5	1.5	1.33	Low
Adults with Influenza Vaccination	0	1.5	1.5	1.5	3	1	1.31	Medium
Adults with Pneumonia Vaccination	1	1.5	1.5	1.5	1.5	1	1.31	Low
Age-Adj. ER Rate Immunization-Preventable Pneumonia and Influenza	1	1.5	0	1.5	1.5	1.5	1.17	Low
Age-Adj. Hospitalization Rate Immunization-Preventable Pneumonia and Influenza	1	1.5	0	1.5	1.5	1.5	1.17	Low

Diabetes in Sangamon County

Indicator	County		Value		Target	Trend	Score	Precision
	State	US	State	US	HP2020			
Age-Adjusted ER Rate Diabetes	3	1.5	3	1.5	1.5	1.5	2	Low
Age-Adj. ER Rate Long-Term Complications Diabetes	3	1.5	3	1.5	1.5	1.5	2	Low
Age-Adj. Hosp. Rate Short-Term Complications of Diabetes	3	1.5	3	1.5	1.5	1.5	2	Low
Age-Adj. ER Rate Short-Term Complications of Diabetes	2	1.5	3	1.5	1.5	1.5	1.83	Low
Age-Adjusted ER Rate Uncontrolled Diabetes	2	1.5	3	1.5	1.5	1.5	1.83	Low
Adults with Diabetes	2	1.5	1.5	1.5	1.5	2	1.69	Low
Age-Adjusted Hospitalization Rate Diabetes	3	1.5	1	1.5	1.5	1.5	1.67	Low
Age-Adj.Hosp. Rate Long-Term Complications of Diabetes	2	1.5	0	1.5	1.5	1.5	1.33	Low
Age-Adjusted Hosp. Rate Uncontrolled Diabetes	1.5	1.5	0	1.5	1.5	1.5	1.25	Low
Diabetes: Medicare Population	1	1	1	1	1.5	1	1.06	High
Diabetic Monitoring: Medicare Population	1	1	1	1	1.5	0	0.83	High

Exercise, Nutrition, & Weight in Sangamon County

Indicator	County		Value		Target	Trend	Score	Precision
	State	US	State	US	HP2020			
Workers who Walk to Work	1	2	3	3	3	1	2.06	High
Children with Low Access to a Grocery Store	3	3	1.5	1.5	1.5	1.5	2	Low
People with Low Access to a Grocery Store	3	3	1.5	1.5	1.5	1.5	2	Low
Food Insecurity Rate	3	1	3	1	1.5	2	1.94	High
Farmers Market Density	2	2	1.5	3	1.5	1.5	1.92	Medium
Fast Food Restaurant Density	3	3	1.5	1.5	1.5	1	1.89	Medium
People 65+ with Low Access to a Grocery Store	3	2	1.5	1.5	1.5	1.5	1.83	Low
Grocery Store Density	3	2	1.5	1.5	1.5	1	1.72	Medium
Low-Income and Low Access to a Grocery Store	2	2	1.5	1.5	1.5	1.5	1.67	Low
Food Environment Index	2	1	1.5	1	1.5	2	1.53	Medium
Access to Exercise Opportunities	0	1	3	2	1.5	1.5	1.5	Medium
Low-Income Preschool Obesity	1	1	1.5	1.5	1.5	2	1.44	Medium
Adult Fruit and Vegetable Consumption	1	1.5	1.5	1.5	1.5	1.5	1.42	Low
Child Food Insecurity Rate	1	1	3	1	1.5	1	1.39	High
Households with No Car & Low Access to Grocery Store	1	1	1.5	1.5	1.5	1.5	1.33	Low
SNAP Certified Stores	1	1	1.5	1.5	1.5	1.5	1.33	Medium
Food Insecure Children Likely Ineligible for Assistance	2	1.5	1	1	1.5	1	1.31	Medium
Adults who are Obese	0	1.5	1.5	1.5	0	2	1.19	Medium
Recreation and Fitness Facilities	1	0	1.5	1.5	1.5	1.5	1.17	Medium
Adults who are Overweight or Obese	0	1.5	1.5	1.5	1.5	1	1.14	Low
Low-Income Persons who are SNAP Participants	0	0	1.5	1.5	1.5	1.5	1	Low

Environment in Sangamon County

Indicator	County		Value		Target	Trend	Score	Precision
	State	US	State	US	HP2020			
Children with Low Access to a Grocery Store	3	3	1.5	1.5	1.5	1.5	2	Low
People with Low Access to a Grocery Store	3	3	1.5	1.5	1.5	1.5	2	Low
Farmers Market Density	2	2	1.5	3	1.5	1.5	1.92	Medium
Fast Food Restaurant Density	3	3	1.5	1.5	1.5	1	1.89	Medium
People 65+ with Low Access to a Grocery Store	3	2	1.5	1.5	1.5	1.5	1.83	Low
Grocery Store Density	3	2	1.5	1.5	1.5	1	1.72	Medium
Low-Income and Low Access to a Grocery Store	2	2	1.5	1.5	1.5	1.5	1.67	Low
PBT Released	1.5	1.5	1.5	1.5	1.5	2	1.61	Low
Recognized Carcinogens Released into Air	1.5	1.5	1.5	1.5	1.5	2	1.61	Low
Food Environment Index	2	1	1.5	1	1.5	2	1.53	Medium
Severe Housing Problems	3	1	1.5	0	1.5	2	1.53	Medium
Access to Exercise Opportunities	0	1	3	2	1.5	1.5	1.5	Medium
Households with No Car & Low Access to Grocery Store	1	1	1.5	1.5	1.5	1.5	1.33	Low
SNAP Certified Stores	1	1	1.5	1.5	1.5	1.5	1.33	Medium
Annual Particle Pollution	1.5	0	1.5	1.5	1.5	1.5	1.25	Low
Population with Optimally Fluoridated Water	0	1.5	0	1.5	3	1.5	1.17	Medium
Recreation and Fitness Facilities	1	0	1.5	1.5	1.5	1.5	1.17	Medium
Annual Ozone Air Quality	1.5	0	1.5	1.5	1.5	1	1.14	Low
Drinking Water Violations	1	1	0	1.5	1.5	1.5	1.08	Medium
Liquor Store Density	1	1	0	0	1.5	2	0.94	High

Substance Abuse in Sangamon County

Indicator	County		Value		Target	Trend	Score	Precision
	State	US	State	US	HP2020			
Death Rate Drug Poisoning	2	2	1.5	3	1.5	3	2.25	Medium
Adults who Smoke	3	1.5	1.5	1.5	3	2	2.03	Medium
Age-Adjusted ER Rate Alcohol Abuse	3	1.5	3	1.5	1.5	1.5	2	Low
Mothers who Smoked During Pregnancy	2	1.5	3	3	3	0	1.92	High
Alcohol-Impaired Driving Deaths	2	2	1.5	3	1.5	1	1.81	Medium
Teens who Use Alcohol	2	1.5	1	1.5	1.5	1	1.39	Medium
Age-Adjusted Hospitalization Rate Alcohol Abuse	2	1.5	0	1.5	1.5	1.5	1.33	Low
Adults who Binge Drink	1	1.5	1.5	1.5	0	1.5	1.25	Medium
Teens who Use Marijuana	1	1.5	0	1.5	1.5	1	1.06	Medium
Liquor Store Density	1	1	0	0	1.5	2	0.94	High
Teens who Smoke	0	1.5	0	1.5	1.5	0	0.67	Medium

Heart Disease & Stroke in Sangamon County

Indicator	County		Value		Target	Trend	Score	Precision
	State	US	State	US	HP2020			
Age-Adj. Death Rate Cerebrovascular (Stroke)	2	2	3	3	3	2	2.44	High
Ischemic Heart Disease: Medicare Population	2	3	3	3	1.5	1	2.22	High
Age-Adjusted Hospitalization Rate Hypertension	3	1.5	3	1.5	1.5	1.5	2	Low
Age-Adjusted ER Rate Heart Failure	2	1.5	3	1.5	1.5	1.5	1.83	Low
Age-Adjusted ER Rate Hypertension	2	1.5	2	1.5	1.5	1.5	1.67	Low
Age-Adjusted Hospitalization Rate Heart Failure	3	1.5	1	1.5	1.5	1.5	1.67	Low
Atrial Fibrillation: Medicare Population	1	2	1	2	1.5	2	1.61	High
High Blood Pressure Prevalence	0	1.5	1.5	1.5	2	1.5	1.31	Low
Age-Adjusted Death Rate Coronary Heart Disease	1	1	2	1	1	1	1.17	High
Heart Failure: Medicare Population	1	2	1	2	1.5	0	1.17	High
Stroke: Medicare Population	1	1	0	0	1.5	2	0.94	High
Hypertension: Medicare Population	0	1	1	1	1.5	1	0.89	High
Hyperlipidemia: Medicare Population	0	1	0	0	1.5	1	0.56	High

Survey Research Office
ILLINOIS SPRINGFIELD

Sangamon County 2018 Community Health Need Assessment Survey

Conducted by the University of Illinois Springfield Survey Research Office on behalf of HSHS St. John's Hospital, Memorial Medical Center and the Sangamon County Department of Public Health

Thank you very much for taking time out of your day to complete this survey. The data gathered through this survey will help HSHS St. John's Hospital, Memorial Medical Center and the Sangamon County Department of Public Health identify and address health and quality-of-life issues in your community.

This set of questions is for analysis purposes only.
This information will not be used to identify you as a participant. The information is important to ensure that we have responses from all members of your community.

In what year were you born? _____

Do you consider yourself….*Please check all that apply*.

- ◯ White
- ◯ Black or African American
- ◯ Asian
- ◯ Native Hawaiian or Pacific Islander
- ◯ American Indian or Alaska Native
- ◯ Other, please specify: _____

Do you consider yourself Hispanic or Latino/a?

◯ Yes ◯ No

What is your zip code? _____

What is your disability status?

◯ Do not have a disability ◯ Have a disability

How would you rate the health of Sangamon County?

◯ Very healthy ◯ Healthy ◯ Somewhat healthy ◯ Not very healthy

What do you think is/are the biggest health problem(s) in Sangamon County right now?

What is the ONE thing you would do to make the health of Sangamon County better?

With 1 being the most important, please choose and rank five of the following nine health problems or access issues in Sangamon County.

_____ Asthma

_____ Child Abuse

_____ Education

_____ Food Access

_____ Housing

_____ Mental Health

_____ Mother/Infant Health

_____ Substance Abuse – Drugs

_____ Violent Crime

Why did you choose these five community health problems or access issues?

Is there anything else you would like to say about the health of Sangamon County?

These last questions are for analysis purposes only and will not be used to identify you as a participant. The information is important to ensure that we have responses from all members of your community.

What is your gender?

- ⬭ Male ⬭ Female ⬭ Other, please, specify: _____
- ⬭ Prefer not to say

What is your highest level of education?

- ⬭ Less than high school
- ⬭ Some high school
- ⬭ High school diploma or equivalent
- ⬭ Trade or technical school beyond high school
- ⬭ Some college
- ⬭ 4 year college degree
- ⬭ More than 4 year degree

Please provide us with your household's income last year before taxes:

- ⬭ Less than $20,000 ⬭ $40,001-60,000 ⬭ $80,001- $100,000 ⬭ Retired
- ⬭ $20,000-40,000 ⬭ $60,001-80,000 ⬭ More than $100,000 ⬭ Prefer not to say

SANGAMON COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT

Analysis of Public Input from Community Survey

Conducted by UIS Survey Research Office

Survey Research Office
ILLINOIS SPRINGFIELD

March 12, 2018

NOTE: For purpose of inclusion of this report in the appendices of Memorial Medical Center's Sangamon County Community Health Needs Assessment report, the open comment survey responses were excluded due to the length of the report. A complete copy of the survey report that includes all 329 pages is available by contacting the Memorial Health System Community Benefit Department at 217/788-7014.

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 and Service. This report provides the findings from the results of 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 Visiting Research Manager Cindy Jones with the assistance from Tonda Reece, Elyssa Smith, and Kendall Smith (UIS Survey Research Office).

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, and the Sangamon County Department of Public Health to collect, record, and analyze public input for the 2018 Sangamon County Community Health Needs Assessment. This was done through survey responses completed by Sangamon County residents. The survey was available to residents online, while paper surveys were made available at various locations throughout the community. 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 concerns about access to healthy food to the impact drugs and violent crimes have on the community. The survey lists nine health problems or access issues in Sangamon County and asks respondents to choose and rank what they feel are the top health problems or access issues in the county. The nine choices are: asthma, child abuse, education, food access, housing, mental health, mother/infant health, substance abuse/drugs, and violent crime. The five priority areas ranked most important are Substance Abuse/Drugs, Mental Health, Violent Crime, Housing, and Education.

Substance Abuse/Drugs

Nearly two-thirds (62.1 percent) of survey respondents ranked substance abuse/drugs as their first or second priority in Sangamon County. In fact, 78.4 percent of Sangamon County residents chose substance abuse/drugs as one of their top five priorities. Not surprisingly, many of the open-ended comments referred to the nation's ongoing opioid battle. Said one respondent,

- A recent study showed that for nearly 45% of all substance abusers, the problem began with an addiction to prescription drugs and escalated from there. Substance abuse affects all areas of our society -- police, EMS, health care, schools, state agency resources-- everything. If those issues are pinpointing back to the healthcare system as a cause, we need to address that real problem.

However, other respondents point out that even though opioid addiction is getting all the attention now, alcoholism is still a major issue, while others say the county has always had a substance abuse problem.

- Alcohol is the drug of choice and dangerous binge drinking is socially acceptable. Alcoholism is rampant and drug abuse is growing. Our kids think nothing is wrong with them smoking marijuana very early and it seems like no one cares. They are self-medicating! Opioids have destroyed families. I personally know of multiple overdoses, a suicide and criminal behavior all due to opioids and I'm upper middle class white. It's everywhere and it's destroying our communities.

- Sangamon County has always had a drug and alcohol problem.

Mental Health

Just under sixty percent (59.2) of survey respondents report that mental health is a high priority (choosing it as a one or two) in the county with 34.5 percent of respondents reporting it as the "top priority." In many of the open-ended responses, many commented on the fact there is still a stigma with mental illness that prevents many from seeking care. Said one respondent, "Because it is overlooked and stigmatized, people don't want to admit the issue. You are also put in a class once you are diagnosed and it is impossible to get life insurance once diagnosed regardless of what the issue was, i.e. depression." Said another respondent

- I, and a lot of people I know, struggle with various mental health issues from seasonal depression to very serious issues. As common as this problem seems to be, it still seems to be taboo to discuss or admit that we struggle. There is also a need for more and better treatment options instead of primarily pharmaceuticals that seem to be the go-to solution but do not necessarily provide relief or wellness.

Other respondents commented on the lack of services for mental health care.

- Mental health is an ongoing issue. Without the facilities to care for those truly in need, they continue to battle themselves as well as society. Our law enforcement is expected to be trained to handle mental health issue as a counselor when in fact many times it becomes violent simply because the mental illness does not allow reasoning. This is a huge issue and without the entire community and the resources addressing the issues, it will continue to be an issue.

Many others commented on how untreated mental health can affect all parts of life and can lead to drug abuse, child abuse, homelessness, etc. As one respondents summed it up, "mental health is the cause of so many problems."

Violent crime

Over 37 percent of respondents rank violent crime as a high priority (either chosen as one or two). In fact, three out of every five respondents chose the issue as one of their top three priorities. Many commented on the crime they see regularly. "The amount of killings, gunshots and violence at the hands of people with guns has escalated in my community. It is not openly listed in the paper or otherwise announced, but it is happening." Another shared, "There are shooting and stabbings that occur frequently in the community. There was recently a stabbing at a high school basketball game at Lanphier."

Others shared ideas about what they feel is the cause of the crime.

- Springfield has one of the highest crime rates in the country, giving the community a black eye. There are way too many shootings, knifings, and attacks. Substance abuse and gang activity are rampant. We need to address factors that turn youth toward crime.
- Substance abuse, homelessness, and mental health lead to violent crimes. If the health issues had been treated then we wouldn't have as much crime.
- There is a huge violent crime problem in our communities predominantly in the east side which is mostly African American community. There need to be a way to help reduce crime and prevent in crime in youth. Springfield also has segregated communities.

Housing

Just under one third (30.3 percent) chose housing as a high priority issue, either ranking it as a one or two. The topic was mentioned many times in the open-ended responses. Many pointed out how essential housing is to overall health.

- Housing ,in all its formats, is crucial to individual and community stability. Clean, safe and 'fairly permanent' housing secures and promotes a base and launching pad for virtually all aspects of individual and group physical and mental health.
- Affordable housing is always important, as it is often the foundation of our basic needs. Living in a safe neighborhood, with nearby amenities can make a huge difference in the lives of those who are trying to survive or better themselves. If something feels unattainable, people will often give up their pursuit.
- Because so many of our families live in poor housing or are technically homeless those concerns become most important and then health issues may go to the wayside because of needing to address Maslow's hierarchy of needs.

Education

A little over a quarter (28.3 percent) ranked education as a high priority, choosing it as a one or two, while over fifty percent ranked it as one of their top three priorities. Several respondents who chose education as a high priority stated they did so because they see it as the heart of the community.

- In order to improve health outcomes, education is a priority that needs to be addressed in all facets of age to truly address social determinants.

- It is part of the economic cycle. You need an education (school is often a safe place for children where they are provided food/snacks or know they are looked after) that leads to employment and paychecks, etc. The education support is a key foundation to someone's overall health.
- It is not just about educating people for medical needs, it is teaching and mentoring and getting community involved in helping families in stress learn better coping mechanisms. It is old men and women giving of their time to teach younger people a better way of life. The instant smart phone/video gaming life is not educating people how to communicate. It isn't teaching them how to work for a goal and do your best. I wish schools would let kids learn in an environment conducive to how they learn. Instead of trying to mold a child into a one way works for all education system. We have complicated education system that isn't teaching a child how to learn and acquire different skills when they are young.

Child Abuse

Just under one third (31.8 percent) of respondents rank child abuse as a top health priority (a one or two) in Sangamon County. This priority area was especially important to women and African American respondents. Many of the respondents who addressed the issue in the open-ended questions spoke of both the immediate and long-term damage child abuse has on the health of a community.

- When Child Abuse is dealt with by a community, proper education and the health of the community improves. Children are a top priority.
- Because according to a report in 2017 there were over a million calls to the Illinois child abuse hotline in the last 4 years and it is estimated that child abuse is severely unreported and the actual numbers of children abused could be double what is reported. These abused children inevitably are brought to our hospitals and other health care facilities for examination and/or treatment, requiring the resources of our healthcare system. Because health care providers are mandatory reporters, the impact on our healthcare system goes beyond just treatment. As drug use and mental illness become more impactful health care issues, child abuse will, too.
- Because it has always been an issue that was under reported and I work in a field where I hear about abuse issues on a daily basis. Many of our more troubled schools are full of children with poor parental involvement and support.

Food access

While only 9.3 percent chose food access as their top priority, 45.7 percent of respondents rank it in their top three, and it was commented on many times in the open-ended responses.

- A large population of families in Sangamon County are in food desserts and ironically those areas have the greatest need and less accessibility to personal transportation. The number of children that qualify for free lunches is an indicator of food insecurity.
- Because I see a lot of people having to access food pantries, in small towns. Some people are on fixed incomes and don't have enough money to get by. So it makes it difficult for them to buy enough food to last them for the month.
- Even with SNAP many people don't have access to enough food, or they don't know how to select or prepare healthy foods. They make poor food choices for themselves and children.

Mother and infant health

Nearly 22 percent of respondents rank this topic as a high priority area (one or two), and just under a third chose it as top five priority area. Many who commented on this issue in the open-ended comments shared that they feel this area is so important because it provides the foundation of health for a child's life.

- As a healthcare worker in this particular area, we could have better prenatal care education/services and postpartum follow up. We have mothers who are having babies who aren't even equipped to bring a baby home. In regards to postpartum follow up , moms and babies would definitely benefit from at least one home visit within the first week for breastfeeding help and to check on mental health, support system, refer to appropriate community services.
- A healthy start to life is very important to the later health and welfare of the child. Dealing with maternal and infant (and child) health problems is costly and stresses the family and the community. If we wish to be a health community, we need to be sure that mothers and infants have appropriate health care.
- Access and cost is high for most people, and they are not supported by family members so some people do know have prenatal care. It is the simplest and best thing one can do for their baby.
- Assess the problems early on can eliminate several problems down the road. With the access to care that is available, infant mortality rates in this country should be much lower than they are.

Asthma

Just over a quarter of respondents rank this as a high priority (one or two), and it was commented on many times in the open-ended questions. Several wrote it in as the area they felt most impacted the health of Sangamon County, while many others commented on the poor air quality in the county and the fact that in the unincorporated areas of Springfield, it is legal for residents to burn leaves and trash. Shared one respondent,

> I have COPD and asthma. I cannot go outside most days. Sometimes it is so thick, it comes in through the furnace and smallest cracks. I live by Grandview, and they burn a lot!!!Go out towards Riverton on route 36 by the old mansion, and watch the thick black smoke.

Others shared this dilemma. In fact, when asked what the one thing that should be done to improve the health of residents of the county, one respondent wrote, “Ban burning, fireplaces as well. Wood smoke is toxic, plus it is a waste to burn it.” Some respondents discussed the prevalence of asthma in Springfield.

- According to the CDC, Springfield adults and children have a 2% per higher incidence of asthma than the national rate.
- Asthma is a huge problem in Sangamon County, because the city has 1) poor housing code rules and 2) poor enforcement of the rules the county actually has. When people live with low quality housing and the city has no accountability for landlords, asthma is going to be an ongoing problem.
- Because asthma stems from poor housing and we have an extreme problem with lack of affordable and adequate housing in Springfield as well has "hot spots" for asthma.

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, and the link to the online survey was widely distributed via media and the partnering organizations.

Overall, 1079 individuals completed the survey - 143 printed surveys were returned to the SRO, and 936 individuals completed the survey online. The survey was available to Sangamon County community members from January 11 to February 12, 2018.

Table one, on page ten, presents the demographic characteristics of the survey sample compared to the most recent population estimates according to the 2012 American Community Survey. As you can see in the table, a higher percentage of females participated in the community survey compared to the overall population estimates. Four out of every five of the responses in the community survey are from female respondents while females represent 52 percent of the Sangamon County population. In addition, we find that a higher percent of those who participated in the survey reported having advanced degrees compared to population estimate. For example, over one third (36.4 percent) of individuals who completed a survey reported having an advanced degree. This compared to only 12.7 percent of Sangamon County's population that has an advanced degree (see figure one).

Figure 1: Comparing survey sample to population

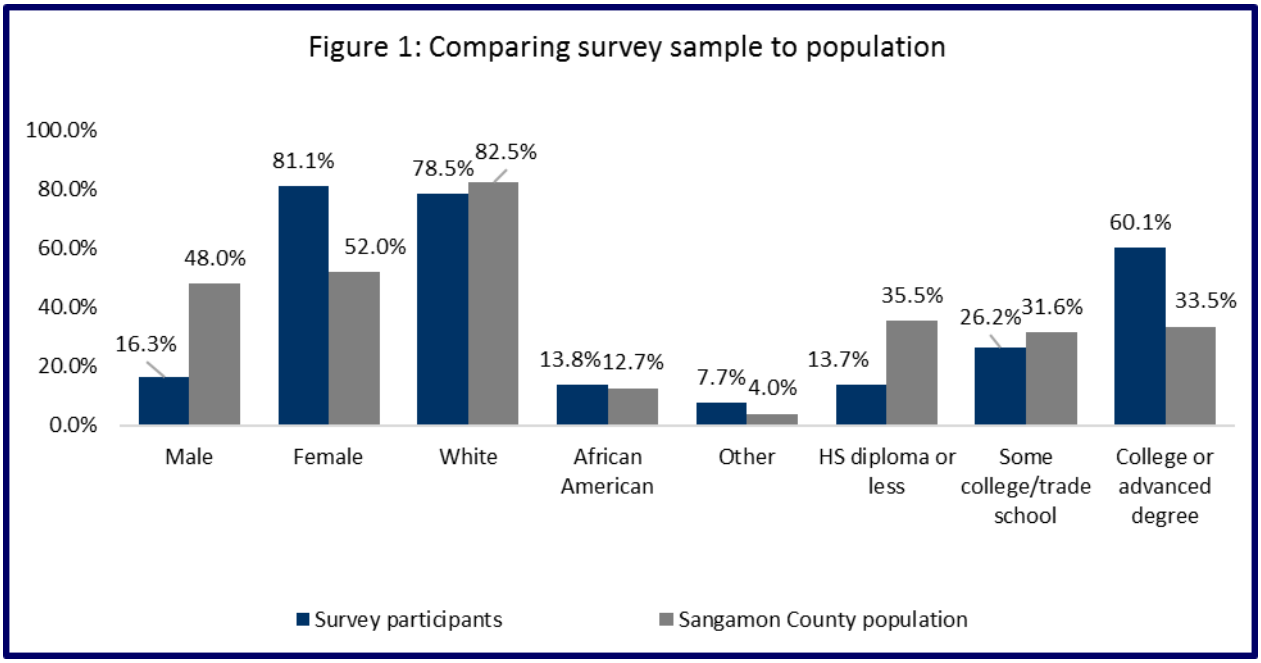


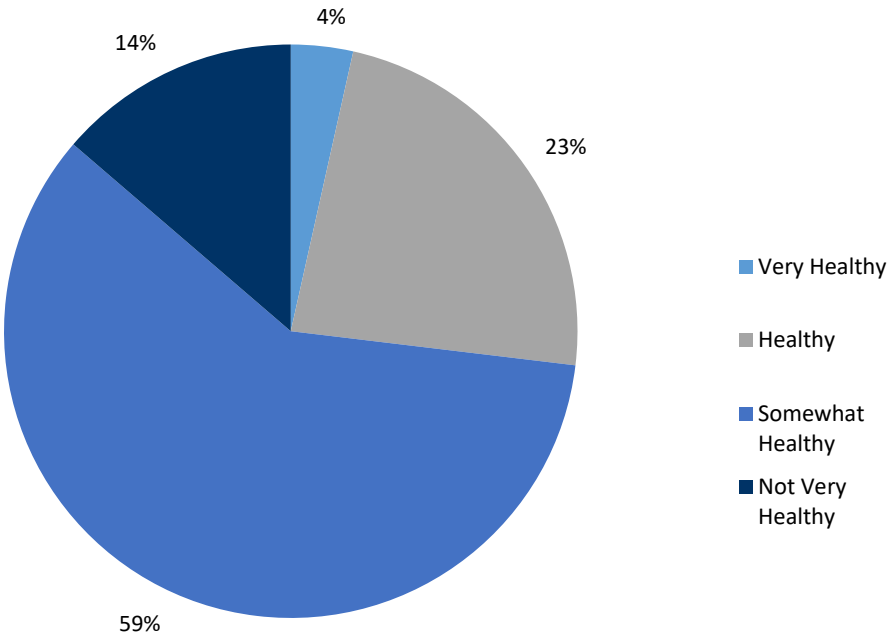
Table 1. Demographic characteristics of focus group participants and community participants compared to population

	Sangamon County Population (2016 ACS estimates)		Community participants (online and paper surveys) N=1079
Gender			
Female	52.0%		81.1%
Male	48.0%		16.3%
Race			
White	82.5%		78.5%
African-American	12.7%		13.8%
Asian	1.8%		1.5%
Other/Mixed Race	2.2%		6.2%
Ethnicity			
Hispanic/Latino(a)	2.1%		2.9%
Non-Hispanic/Latino(a)	97.9%		97.1%
Age			
18-24 years old	8.5%		3.8%
25-34 years old	12.8%		21.9%
35-44 years old	12.2%		20.8%
45-54 years old	14.0%		21.1%
55-64 years old	14.0%		24.7%
65 and older	16.6%		7.8%
Education			
Less that high school diploma	7.8%		3.0%
HS diploma	27.7%		10.7%
Some college/trade school	31.6%		26.2%
College degree	20.8%		23.7%
Advanced degree	12.7%		36.4%
Disability Status			
Have a disability	13.8%		7.4%
Do not have a disability	86.2%		92.6%
Income			
Less than $20,000	-		14.1%

$20,000-$40,000	-		15.7%
$40,001-$60,000	-		19.0%
$60,001-$80,000	-		14.4%
$80,001-$100,000	-		8.9%
More than $100,000	12.0%		13.0%
Retired			3.1%
Prefer not the say	-		11.9%

The first section of the survey asks respondents to rank the health of Sangamon County as very healthy, healthy, somewhat healthy, or not very healthy. As seen below in figure one, the majority (59 percent) chose somewhat healthy, while only four percent felt Sangamon County was very healthy. When we examine whether demographic groups rated this differently, there were no significant differences.

Figure 2: How would you rate the health of Sangamon County



Next, two open-ended questions were asked. The first question asked respondents what they felt was the biggest health problem in the county. The responses were coded into 16 options. Just over 18 percent of the respondents report substance as the biggest problem, while 16.2 percent report mental health, 14.9 percent report access to care and 10.3 percent report obesity.

The second open-ended question asked respondents the one thing they would do to improve the health of Sangamon County. The responses were coded into eleven options, with 28.8 percent of the respondents reporting they would improve access to care. This could include options such as making care more affordable, recruiting more physicians, offering transportation, or improving health insurance. Seventeen percent of the respondents stated they would improve education in the county, while 13.1 percent reported they would develop programs to promote preventative care and exercise.

Finally, participants were asked to choose and rank five of a list of nine health priority areas. As seen in table two below, the top five health priority areas are substance abuse/drugs, mental health, housing, violent crimes, and education. The data for these priority areas as well as the ranking for all nine are in table two.

Table 2. Percentage ranking as a top five health priority area

	Percentage ranking in top five	Median	Standard deviation
Substance abuse/drugs	80.2%	2.0	1.271
Mental Health	78.4%	2.0	1.348
Housing	58.2%	3.0	1.367
Violent crimes	54.4%	3.0	1.388
Education	52.4%	3.0	1.340
Food access	45.9%	4.0	1.305
Child abuse	36.2%	3.0	1.382
Mother/infant health	32.5%	4.0	1.309
Asthma	11.3%	4.0	1.434

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, as seen below in table three, African-American respondents are less likely to rank substance abuse/drugs or mental health as a top five choice, and more likely to choose housing, violent crime, and education as a top five choice, while nine out of ten white respondents chose substance abuse/drugs and mental health as top five health priority areas.

Table 3. Percentage of respondents ranking health priority areas in top five by white/African-American

	White respondents	African American respondents
Substance abuse/drugs	91.3%	64.9%
Mental Health	91.2%	55.0%
Housing	62.4%	79.3%
Violent crimes	57.5%	67.6%
Education	53.2%	67.6%
Food access	51.7%	54.1%
Child abuse	39.2%	39.6%
Mother/infant health	35.4%	41.4%
Asthma	11.4%	20.7%

Table 4. Percentage of respondents ranking health priority areas in top five by male/female

	Female	Male
Substance abuse/drugs	86.8%	87.8%
Mental Health	85.9%	88.5%
Housing	64.9%	65.6%
Violent crimes	59.0%	64.1%
Education	55.3%	67.6%
Food access	52.4%	48.9%
Child abuse	41.8%	26.7%
Mother/infant health	35.4%	36.6%
Asthma	12.6%	14.5%

Table four shows the responses broken down by male and females. While the percentages are similar, a few differences stand out. Women are more likely to rank food access and child abuse as high priorities. Almost 42 percent of women compared to 26.7 percent of men ranked child abuse as a top five priority. In addition, 52.4 percent of women compared to 48.9 percent of men ranked food access as a top five priority. Conversely, men were more likely to rank violent crime and education as high priorities. Over 64 percent of men compared to 59.0 percent of women ranked violent crime as a top five priority. In addition, 67.6 percent of men compared to 55.3 percent of women ranked education as a top five priority.

TOPLINE

Sangamon County Community Health Need Assessment Survey Topline (n=1079)

Demographic Section

Age?	
18-24	3.8% (30)
25-34	21.9% (175)
35-44	20.8% (166)
45-54	21.1% (168)
55-64	24.7% (197)
65 or older	7.8% (62)

Do you consider yourself Hispanic or Latino/a?	
Yes	2.9% (23)
No	97.1% (783)
Refused	273

Do you consider yourself…	
White	78.5% (633)
Black or African American	13.8% (111)
Asian	1.5% (12)
American Indian or Alaska Native	.6% (5)
Other/More than on race	5.6% (45)
Refused	273

What is your gender?	
Male	16.3% (131)
Female	81.1% (653)
Prefer not to say	2.6% (21)

Refused	**274**

What is your disability status?	
Do not have a disability	**92.6% (731)**
Have a disability	**7.4% (58)**
Refused	**290**

What is your highest level of education?	
Less than high school	**3.0% (24)**
High school diploma or equivalent	**10.7% (86)**
Trade or technical school beyond high school	**4.2% (34)**
Some college	**22.0% (177)**
4 year college degree	**23.7% (292)**
More than 4 year college degree	**36.4% (292)**
Refused	**276**

What is your zip code?	
56711	**.1% (1)**
60000	**.1% (1)**
61745	**.1% (1)**
62359	**.1% (1)**
62515	**(2)**
62520	**(5)**
62530	**(3)**
62536	**(4)**
62539	**.1% (1)**
62545	**.1% (1)**
62558	**(6)**

62561	**(12)**
62563	**(18)**
62615	**(11)**
62625	**(3)**
62629	**(45)**
62661	**(4)**
62670	**(9)**
62677	**(8)**
62684	**(13)**
62689	**(1)**
62693	**(6)**
62701	**(9)**
62702	**(138)**
62703	**(119)**
62704	**(220)**
62707	**(24)**
62708	**.1% (1)**
62711	**(76)**
62712	**(49)**
62769	**.1% (1)**
62781	**.1% (1)**
62794	**(2)**
62881	**(1)**
63702	**(2)**
63704	**(1)**
65703	**(1)**

72670	**(1)**	
Refused	**277+**	**802**

What is your household income last year before taxes?

Less than $20,000	**14.1% (113)**
$20,000-$40,000	**15.7% (126)**
$40,001-$60,000	**19.0% (152)**
$60,001-$80,000	**14.4% (115)**
$80,001-$100,000	**8.9% (71)**
More than $100,000	**13.0% (104)**
Retired	**3.1% (25)**
Prefer not to say	**11.9% (95)**
Refused	**278**

SURVEY

How would you rate the health of Sangamon County?

Very healthy	**3.5% (37)**
Healthy	23.4% (248)
Somewhat Healthy	59.4% (628)
Not very healthy	13.7% (145)
Refused	(21)

What do you think is/are the biggest health problem(s) in Sangamon County right now?

Poverty/Homelessness	6.9% (51)
Food access	2.8% (21)
Substance abuse	18.1% (134)
Access to care	14.9% (110)

Mental health	16.2% (120)
Education	4.1% (30)
Poor lifestyle choices	3.0% (22)
Asthma/air quality	1.2% (9)
Obesity	10.3% (76)
Influenza	9.9% (73)
Cancer	.9% (7)
Cardiovascular disease	2.2% (16)
Diabetes	1.1% (8)
Infectious diseases	3.2% (24)
Violence/crime	1.8% (13)
Other	3.4% (25)

What is the ONE thing you would do to make the health of Sangamon County better?	
Increase access to healthy food	**4.5% (32)**
Improve mental health services	12.0% (86)
Access to care	28.8% (207)
Promote preventative care and exercise	13.1% (94)
Address violence and crime	1.3% (9)
Increase/improve Education	17.0% (122)
Address poverty/homelessness	4.9% (21)
Decrease Obesity	.8% (6)
Improve Dental access	.7% (5)
Increase Drug prevention/substance abuse treatment	3.9% (28)
Other	13.1% (94)

Rank the top 5 health problems in Sangamon County with 1 being the most important.

Substance Abuse-Drugs

1	29.5% (255)
2	32.6% (282)
3	16.6% (144)
4	12.3% (106)
5	9.0% (78)
Total	865

Mental Health

1	34.5% (292)
2	24.7% (209)
3	19.1% (162)
4	10.3% (87)
5	11.3% (96)
Total	846

Housing

1	13.9% (87)
2	16.4% (103)
3	19.9% (125)
4	25.2% (158)
5	24.7% (155)
Total	628

Violent crime

1	18.9% (111)
2	18.4% (108)
3	23.2% (136)
4	19.9% (117)
5	19.6% (115)
Total	587

Education

1	14.5% (82)
2	13.8% (78)
3	24.4% (138)
4	24.8% (140)
5	22.5% (127)
Total	565

Asthma

1	12.3% (15)
2	13.9% (17)
3	12.3% (15)
4	22.1% (27)
5	39.3% (48)
Total	122

Child Abuse

1	15.9% (62)
2	15.9% (62)
3	18.7% (73)
4	27.1% (106)
5	22.5% (88)
Total	391

Food Access

1	9.3% (46)
2	15.8% (78)
3	20.6% (102)
4	25.5% (126)
5	28.9% (143)
Total	495

Mother/Infant Health

1	11.1% (39)
2	10.8% (38)
3	21.7% (76)
4	27.6% (97)
5	28.8% (101)
Total	351

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

Survey Research Office
ILLINOIS SPRINGFIELD

Report submitted on July 31, 2018

NOTE: For purpose of inclusion of this report in the appendices of Memorial Medical Center's Sangamon County Community Health Needs Assessment report, the focus group transcripts were excluded due to the length of the report. A complete copy of the survey report that includes all 50 pages is available by contacting the Memorial Health System Community Benefit Department at 217/788-7014.

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 FY 2018-2021 Sangamon County Community Health Needs Assessment. After conducting a survey of Sangamon County residents, the results were detailed in a report issued on March 12, 2018. Based, in part, on the results of an SRO survey and report (issued on March 12, 2018), Memorial Medical Center and HSHS St. John's Hospital chose "Access to Care among Pillsbury Mills Residents" as their joint collaborative for the 2018 Community Health Needs Assessment.

The topic of Access to Care is broad and has many different dimensions. Therefore, the purpose for holding focus groups is to identify the obstacles that prevent people and their families in the Pillsbury Mills neighborhood from getting the health care services they need, and obstacles that prevent them from being healthy. In an effort to identify the obstacles, 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-five 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 Pillsbury Mills Older Adults **(June 6, 2018)**

A list of possible participants for this focus group was developed by collaboration between hospital representatives and the Pillsbury Mills Neighborhood Improvement Association. Those with phone numbers were issued invitations via a phone call on May 31, 2018. The remainder received an invitation via USPS, mailed June 1, 2018. Thirteen individuals participated in this focus group and received $50 financial incentive and breakfast for their participation. The focus group was held at Triumph Community Outreach Ministries.

Focus Group of Pillsbury Mills Stakeholders **(June 8, 2018)**

A list of possible stakeholders who currently serve Pillsbury Mills residents and/or provide services in close proximity to the Pillsbury Mills neighborhood was provided by Memorial Medical Center and HSHS St. John's Hospital. These individuals were first contacted by hospital representatives and were also contacted by SRO via emails (June 1, 2018) with follow up phone calls beginning on June 4, 2018. Lunch was provided. Four individuals participated in this focus group representing the following agencies: Another Chance Services, Springfield Public School District 186, Sangamon County Department of Public Health, and Sangamon County Department of Community Resources. This focus group was held at the SIU Center for Family Medicine. It should be noted that stakeholders from The

Boys and Girls Club as well as the Springfield Police Department were not present at the meeting but were interviewed at a later date (June 26, 2018 and July 16, 2018, respectively).

Focus Group of Pillsbury Mills Adults/Parents **(June 26, 2018)**

This focus group consisted of individuals who reside in the Pillsbury Mills neighborhood. A list of eight possible participants for this focus group was developed by collaboration between hospital representatives and the Urban League. The eight individuals were phoned by SRO staff on May 31, 2018. From that list, one agreed to participate and volunteered to recruit more parents in the neighborhood. Four individuals living in the Pillsbury Mills neighborhood attended this focus group. Individuals received $50 financial incentives and snacks for their participation. The focus group was held at a participant's home located in Pillsbury Mills.

Focus Group of Pillsbury Mills Younger Adults/Parents **(June 28, 2018)**

Possible participants for this focus group were recruited by a neighborhood volunteer. Following the June 26 meeting, the neighborhood volunteer stated that she knew several more from the neighborhood who wanted to participate, so a fourth group was scheduled. Twelve individuals participated in this focus group and received $50 financial incentive and snacks for their participation. The focus group was held at Triumph Community Outreach Ministries.

Summary of Findings

Executive Summary

The summary report is based on the key findings from the four focus groups described above. While the older residents seemed to have a greater knowledge on how to navigate the health care system, they still have deficiencies in health literacy. However, the younger residents of Pillsbury Mills have a more limited knowledge on how to effectively navigate the current health care system. While many know the basic access points, they are unaware of how to advocate for themselves or their families. Because so many of the residents live in poverty, basic living needs are far more important than medical care. For individuals who have primary care providers, there is almost no relationship between them and the provider, nor an understanding of why this is important. It's reported many children in the neighborhood do not have access to basic medical and dental care. For some, their only point of access to health care is through the hospitals' Emergency Departments. There are almost no support services available in Pillsbury Mills. There are no schools, no parks, and a divide exists among the longtime residents of the neighborhood and the newer residents, the majority of which are renters. There is no sense of community, especially among the younger residents. The older residents seem fixated that the future of the neighborhood lies in ridding the neighborhood of the mill and its structures. Finally, transportation issues loom large for both the young and old in the neighborhood. Twenty-seven percent of the residents do not have their own vehicle. This limits access to medical care as well as access to many services such as WIC since the residents do not have money to take a cab or the bus to get to the health department.

Points of access to health care/Trust of medical community

There are only a few points of access to health care for the Pillsbury Mills residents. Most of the participants in the senior group were on Medicare and had a regular primary care provider. For participants in the other community groups, the emergency departments are the primary point of access. This is the result of two factors: lack of health literacy and the convenience of the ED. Many community participants reported that they avoid urgent care facilities due to cost, saying that when they go there they usually end up getting sent to the emergency department anyway. Said one participant, "I go to the emergency room for me. I don't have time for prompt care or none of that. The emergency room is quick, fast, and all of that... I've never been in prompt care." Added another, "I just go the emergency because they got everything there."

Additionally, many participants had little interest in developing a relationship with a PCP. A few mentioned that they have had trusted doctors at times, but maintaining a relationship with their doctor is not something for which they strive. A few who received services from SIU stated they grew tired of only having a doctor for a short time. Said one participant, "A lot of these doctors around here are nothing but students… I have been coming to see this doctor for six months, and all of a sudden, you graduated and gone." It's interesting to note that none of the participants singled out any medical provider in Springfield in either a positive or negative way, but rather seemed to speak of the medical community almost as one entity. A few expressed concern with disparity in treatment, stating that they feel their doctor does not listen and that they have limited medical care because they are Medicaid recipients. One shared that her son has had a health issue for eight years, yet their PCP does not listen to her concerns. Another expressed her frustration in trying to communicate with her doctor, "Especially, when you can't exactly get your point across. You have to have somebody else to speak for you. It's annoying." Because of this as well as the cost and lack of transportation, many of the community participants stated that they just don't go to the doctor.

Possible solutions:

- Increase medical literacy and basic medical to residents of the neighborhood.
- Develop strategies to educate individuals on the importance of maintaining a primary care provider and advocating for themselves and their families.

Support Services

Social service agencies are valuable partners to hospitals, serving as liaisons between the patients and medical care providers and assisting individuals with access to transportation, understanding insurance and prescriptions, and providing basic health needs (like food, clothing, etc.) And though there are some support services near Pillsbury Mills, there are few support services located in the neighborhood. Two churches exist in the neighborhood; Holy City Missionary Baptist Church and Triumph Church of God in Christ, which operates a community outreach. Another Chance Services also has its office in the Triumph Church.

The neighborhood has a reputation for crime and drug deals. The officer from the Springfield Police Department assigned to the area that includes Pillsbury Mills says he spends more time in that

neighborhood than others. When looking at a list of the calls for the area from the last three months, most are for disturbance calls - the majority of which came at night - followed by calls for a police welfare check. There were also many calls about suspicious persons or vehicles. While the neighborhood is quiet during the daytime, residents report that at night it becomes much more loud and raucous.

The neighborhood has no hub, no common space to draw the residents together. There are no schools and no parks in the neighborhood, and very little for kids to do. There are few businesses and many rental properties. The older residents blame the troubles of the neighborhood on the presence of the old Pillsbury Mill, and see its demolition as the solution to all of the neighborhood problems. Most of the younger residents are so impoverished they are just trying to meet their basic needs and don't concern themselves with community improvement. All of this creates a divide in the neighborhood and accentuates the residents' differences. However, it provides a great opportunity for the hospitals to collaborate with various services in the city to help the neighborhood develop a sense of community.

Possible solutions:

- Encourage more collaboration among social service agencies currently providing services to Pillsbury Mills residents.
- Collaborate with District 186 to promote education in the neighborhood.
- Collaborate with Springfield Park District to create a common space to increase a sense of community.
- Embed an office and community health worker into the neighborhood to serve as a hub.

Transportation

Transportation issues were one feature that both the younger and older residents shared. While the public transportation system in Springfield has improved, the routes and hours of operation are still limited. Moreover, many of the residents shared they cannot always afford the bus fare. It costs $1.25 per ride per person, which would be $2.50 round trip. The cost would increase if the residents also needed to transport their kids. And though SMTD offers reduced rates for older individuals and those with a disability, there is still a charge.

Transportation issues are doubly complicated for Pillsbury Mills residents because, as mentioned, support services are not located within the neighborhood. Stated one stakeholder:

> There are a lot of programs out there, but the challenge is that they have to get to them. These programs are not located where people in the neighborhood can really get there. It costs money to ride the bus. If they can depend upon someone well they might show up or they might not show up, and those are just some of the issues that I observe in terms of access to care. The care is out there, but how do we get the information there and how do we get the care we need in the neighborhood or how do we provide transportation to get them the care.

Another added, "And for the doctor's appointment, now, with the Managed Care, they do allow for you to call for a ride for doctor's appointment. They do allow transportation, but for WIC, there is no transportation for WIC appointments." So while support many support services for low income families exist in Springfield, many of the residents of Pillsbury Mills still do not have access. Some of the

community participants reported they were aware their insurance policies cover transportation. One respondent stated that she used her medical card to get a ride to the health department. However, many report they have to catch rides with others to get to appointments while a few stated they walk.

Possible solutions:

- Providing travel vouchers to pay for cab services to/from doctors, emergency rooms, and health department.
- Increasing public transportation hours and stops in the neighborhood.

Health insurance, health literacy, and prescription medication

Health literacy is closely intertwined with discussions of health insurance and prescription medication. Much of the discussion surrounding health insurance dealt with confusion surrounding changes in Medicaid and the fact that it is up to the recipient to choose a policy. Many of the participants shared they did not understand this process and as a result they and their children had ended up on different policies or a policy that covers few services for this area. One participant shared his experience, "With Medicaid, it all depends on who you are with because they have all of these different insurances now. You got Alliance and all of this other stuff going on. I got about fifty packets at home. It's getting a little confusing around here."

Issues with prescription medications seemed to be particularly prevalent, especially with co-pays and lack of coverage for needed medication. Reported one participant, "When you need your medication, you can't get it. It's really annoying. It has to come out of your pocket like $139. It has to come out of your pocket because you can't get it." Several shared that they now have co-pays that they did not have before. Stated one mother, "I went to go get my son's medicine, and I had to pay a copay. I don't understand that because he has a medical card." Another participant shared a story about how the changes had affected her family's ability to get timely prescriptions:

> When the doctor prescribes specific medicine, they know that you have a medical card. They know all of this, but the access is hard. When you go to the prescription place to pick it up, that's the problem because it didn't cover it because the dosage is too small or they don't do this for people…They have to go get authorization. Well, it could be Friday at 4:00, for example. It happened to my son. He is really sick, and they gave him a superpower antibiotic. But you have to wait an hour because it is sent electronically. I go get it, and he couldn't have it…It was a holiday on Monday. The doctor wanted [him to have it before] a three day weekend, but it was like 87 dollars, and that's what I have a medical card for. So, they had to wait till Tuesday to get authorization to lower the dosage and bam, they paid for it. It was that simple.

Possible solutions:

- Embed an office and community health worker into the neighborhood to help with increasing medical literacy.
- Create patient advocate positions to help individuals understand both their health insurance as well as how to be compliant with their prescription medications.
- Develop hospital-led community workshops to help address some of the main questions surrounding health insurance programs.

Other needed services

Dental- In the stakeholder group, many expressed concerns for the children in the neighborhood, especially the young. Because many residents are transient, they move to the neighborhood with no idea of where to seek services. And because they often lack transportation, they have no way to get the County Health Department to sign up for WIC, get their kids immunized, or find dental care.

Mental health services- As with basic medical and dental care, the lack of mental health services, especially for children, is an issue. However, Memorial Behavioral Health is very close to the neighborhood and some of the adults stated they do receive services there, though there is always a wait.

Nutrition education and access to healthy food- There are some food pantries around Pillsbury Mills that provides access to healthier food. With no grocery stores nearby, the area is considered a food dessert. The neighborhood, particularly the youth, could benefit by increasing collaboration and financial support to aid with this.