Community Health Implementation Plan

Sangamon County Illinois 2025-27

Springfield Memorial Hospital

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EXECUTIVE SUMMARY

Every three years, Springfield Memorial Hospital (SMH) conducts a Community Health Needs Assessment (CHNA) and Community Health Implementation plan (CHIP) for its service area as required of nonprofit hospitals by the Affordable Care Act of 2010. As an affiliate of Memorial Health (MH), SMH worked with four other affiliate hospitals on the overall timeline and process for the CHNA and the CHIP but completed its final reports independently from those hospitals in collaboration with local community partners. Springfield Memorial Hospital collaborated with the Sangamon County Department of Public Health to complete the 2024 CHNA. The completed 2024 CHNA Report is publicly available online at https://memorial.health/about-us/community-health/community-health-needs-assessment/.

Based on the findings of the 2024 CHNA, the following priorities were selected for Springfield Memorial Hospital to address: **mental health, chronic diseases, homelessness and substance use**.

This plan has been developed to address the priorities identified in the 2024 CHNA. Springfield Memorial Hospital has chosen 18 strategies for the FY25-27 reporting period. In addition, four regional strategies have been selected to address the shared priority of mental health with the other Memorial Health affiliate hospitals including Decatur Memorial Hospital, Jacksonville Memorial Hospital, Lincoln Memorial Hospital and Taylorville Memorial Hospital. The Springfield Memorial Hospital Board of Directors also approved this plan on Nov. 14, 2024. The Memorial Health Community Benefit Committee reviewed and approved these strategies on Nov. 18, 2024.

INTRODUCTION

MEMORIAL HEALTH

Memorial Health (MH) of Springfield, one of the leading healthcare organizations in Illinois, is a community-based, nonprofit organization dedicated to our mission to improve lives and strengthen communities through better health. Our highly skilled team has a passion for providing great patient care and a great experience for every patient, every time. Memorial Health includes five hospitals: Springfield Memorial Hospital in Sangamon County, Decatur Memorial Hospital in Macon County, Jacksonville Memorial Hospital in Morgan County, Lincoln Memorial Hospital in Logan County and Taylorville Memorial Hospital in Christian County.

Memorial Health also includes primary care, home care and behavioral health services. Our more than 9,000 colleagues, partnering physicians and hundreds of volunteers are dedicated to improving the health of the communities we have served since the late nineteenth century. The Memorial Health Board of Directors Community Benefit Committee is made up of board members, community health leaders, community representatives and senior leadership who approve and oversee all aspects of the MH community benefit programs, CHNAs and Community Health Implementation Plan (CHIPs).

Memorial Health

Our Mission

Why we exist:

To improve lives and build stronger communities through better health

Our Vision

What we aspire to be:

To be the health partner of choice

Strategy 3 of the FY22–25 MH Strategic Plan is to "build diverse community partnerships for better health" by building trusting relationships with those who have been marginalized, partnering to improve targeted community health inequities and outcomes and partnering to support economic development and growth of our communities. These objectives and strategy are most closely aligned with the MH goal of being a Great Partner, where we grow and sustain partnerships that improve health. CHNAs are available for each of the counties where our hospitals are located— Christian, Logan, Morgan, Macon and Sangamon counties. These assessments and the accompanying CHIPs can be found at memorial.health/about-us/community/community-health-needs-assessment. Final priorities for all Memorial Health hospitals are listed in the graphic below.

FY25–27 FINAL PRIORITIES

DMH
MENTAL HEALTH
RACISM
CANCER AND UNEMPLOYMENT

JMH
MENTAL HEALTH
HEART DISEASE
CANCER AND HEALTHY EATING

LMH
MENTAL HEALTH
HEALTHY WEIGHT
CANCER

SMH
MENTAL HEALTH
CHRONIC DISEASES
HOMELESSNESS AND SUBSTANCE USE

TMH
MENTAL HEALTH
HEART DISEASE/STROKE
ACCESS TO PRIMARY CARE

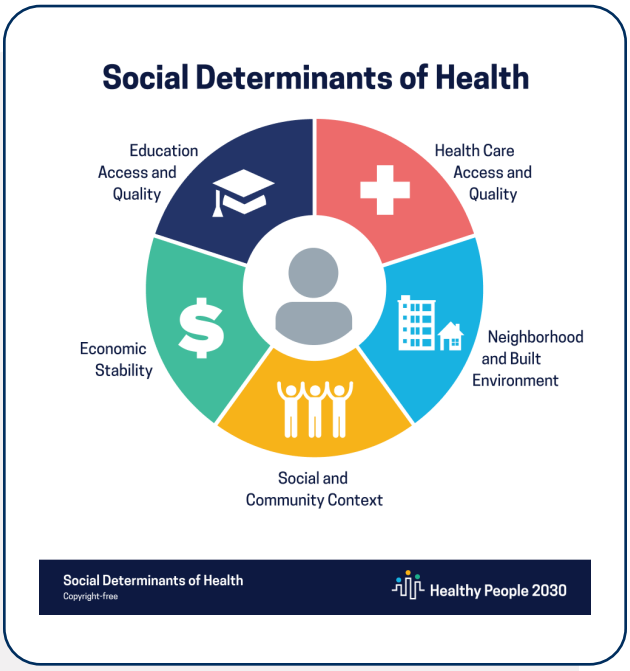
COMMITMENT TO ADDRESSING COMMUNITY HEALTH FACTORS AND HEALTH EQUITY

According to the Centers for Disease Control and Prevention, health equity is when everyone has a fair and just opportunity to attain their highest level of health. Across many health measures, we know that not everyone gets this fair chance. Historical and present-day systems of inequality continue to undermine the opportunities for well-being for particular groups of people. Memorial Health is committed to moving toward greater health equity both within our health system and in our broader communities.

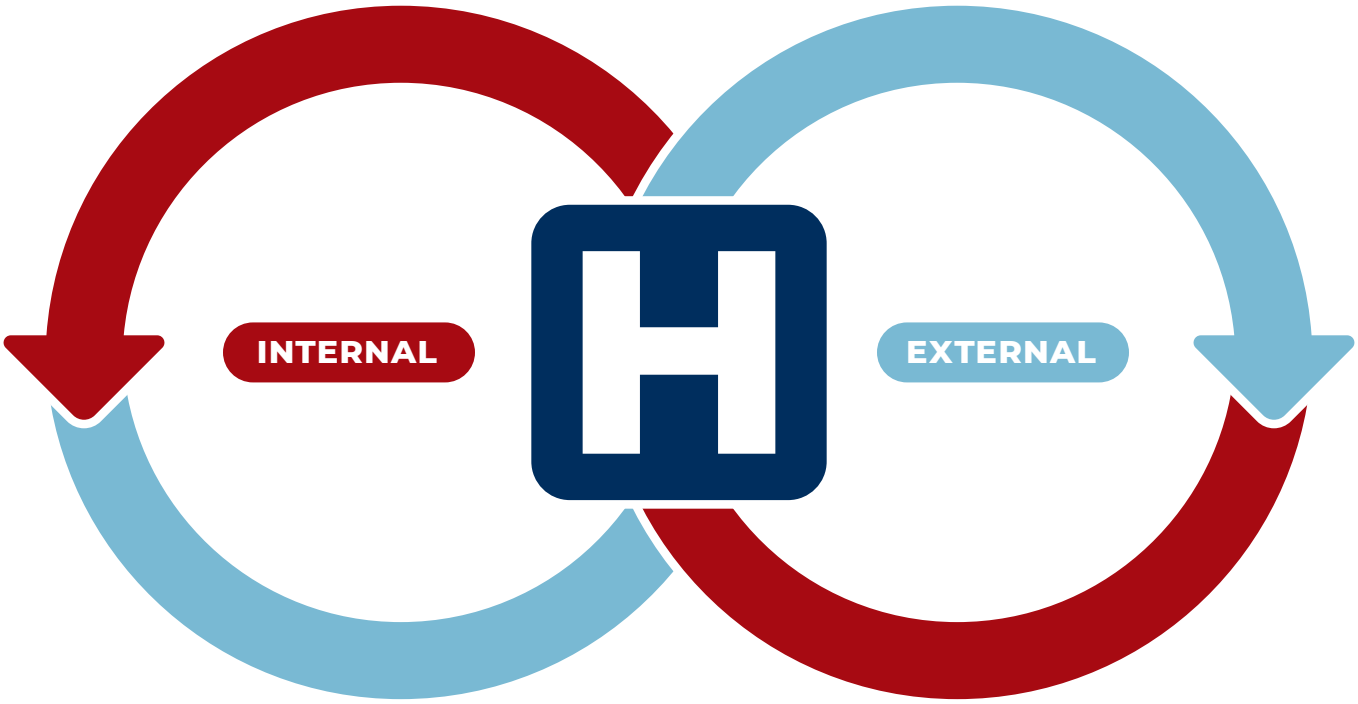
Social and structural factors are key drivers of health, often called "social determinants of health." The American Hospital Association (AHA) estimates that 40% of a person's health comes from socioeconomic factors like income, education and community safety. Other structural factors like discrimination and exclusion due to a person's race, gender, sexuality, age, veteran status, disability, immigration status and more can be included here, too. The AHA then attributes 10% of a person's health to the physical environment, like shelter, air and water quality. Another 30% comes from health behaviors like diet, exercise and drug and alcohol use, leaving the final 20% to come from access to and quality of healthcare.

The social and structural elements drive health at these other levels, too. Exercise outdoors is difficult if pollution and community safety are problems, and racism and economic marginalization shapes who has access to safe neighborhood spaces. Drug and alcohol use can result from the trauma that comes through exposure to community violence and the impact of various forms of marginalization. Access to healthcare can be limited by socioeconomic factors like transportation and insurance as well as by past experiences of discrimination leading to medical distrust.

Committing to health equity requires a collaborative and multifaceted approach. Within our health system, we provide education and support to colleagues to ensure we are offering culturally competent and inclusive care. All hospitals have "health equity projects" that work to identify and resolve particular health disparities in our patient outcomes. We also partner with groups like the Illinois Health and Hospital Association, the American Hospital Association, Vizient, Press Ganey and others to measure our progress and identify actionable goals.



Given that the driving health factors happen outside of the healthcare system, Memorial Health makes a strong investment in community health, including having a community health coordinator assigned at each affiliate hospital to initiate and coordinate community partnerships. Careful attention is paid to these social, structural, environmental and behavioral aspects of health, and this focus guides the CHNA process at all points. We can visualize some key efforts to address these social and structural determinants of health both inside and outside the walls of our hospitals in the following way:



INTERNAL

- Screening patients for social determinants Connecting patients to community resources
- Equity analysis in quality improvement projects
- Updating electronic health records for accurate information on LGBTQ+ patients
- Participating in the Illinois Health and Hospital Association Equity in Healthcare Progress Report
- Stratifying patient satisfaction scores to identify and address trends or patterns
- Annual colleague trainings regarding culturally sensitive data and unconscious bias in medicine

EXTERNAL

- Engaging with community through volunteerism
- Partnering with local homelessness, recreation and education initiatives
- Investing in the community, including economic development and youth initiatives

INTRODUCTION TO SPRINGFIELD MEMORIAL HOSPITAL

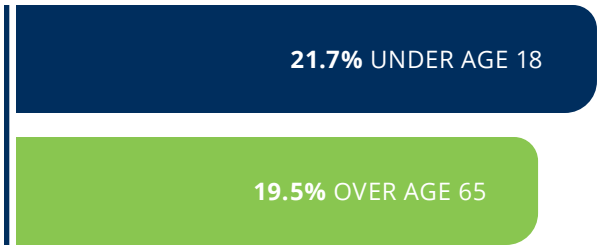
SMH is a 500-bed acute care, nonprofit hospital in the state capital of Springfield, Illinois, that offers comprehensive inpatient and outpatient services. Since 1970, SMH has been a teaching hospital affiliated with Southern Illinois University School of Medicine for the purpose of providing clinical training for residents. In 2021, the hospital earned its fourth consecutive Magnet® Hospital designation from the American Nurses Credentialing Center for nursing excellence. The hospital is accredited by The Joint Commission and is a member of the American Hospital Association, the Illinois Health and Hospital Association and Vizient. SMH services include the Southern Illinois Level 1 Trauma Center, Memorial Heart & Vascular Services, Memorial Rehab Services, Family Maternity Suites, Regional Cancer Center, Memorial Wellness Center and Memorial Transplant Services. SMH is also a Joint Commission-designated Comprehensive Stroke Center. As a nonprofit community hospital, SMH provides millions of dollars in community support each year, both for its patients and in support of community partnerships.

OUR COMMUNITY

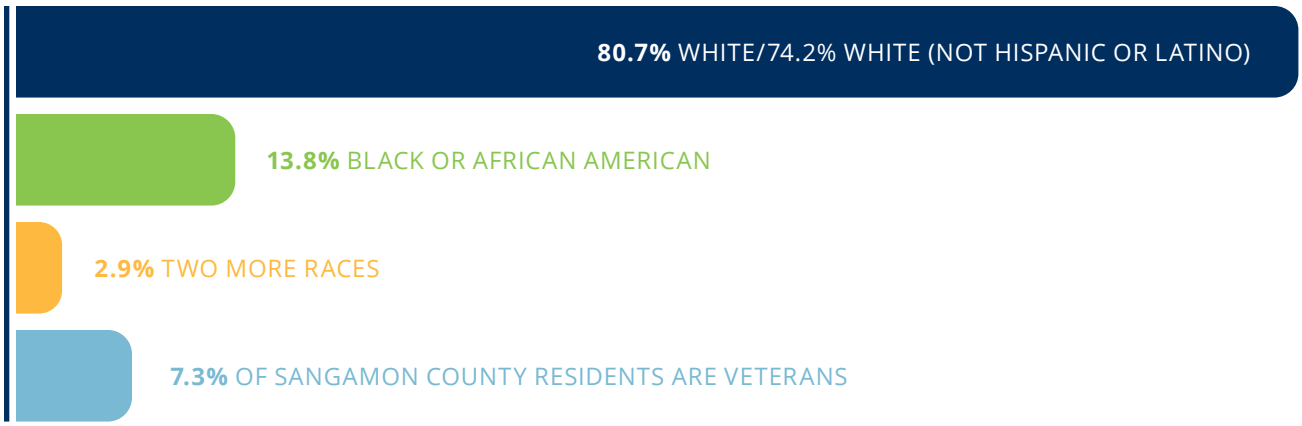
DEMOGRAPHIC OVERVIEW

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

Population Age



Race and Hispanic Origin and Population Characteristics



EDUCATION AND HEALTHCARE RESOURCES

Southern Illinois University School of Medicine is located in Springfield. SMH serves as a major teaching hospital for SIU School of Medicine, which has more than 300 medical students studying in Springfield during their second through fourth years of medical school, as well as more than 300 residents and fellows participating in 32 different specialty programs.

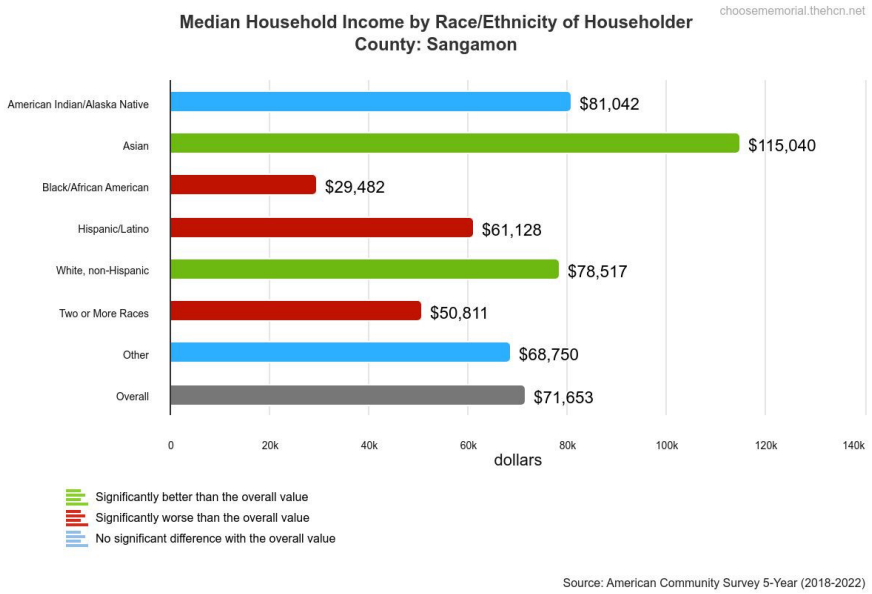
Springfield is also home to two higher education institutions: University of Illinois at Springfield and Lincoln Land Community College.

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

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

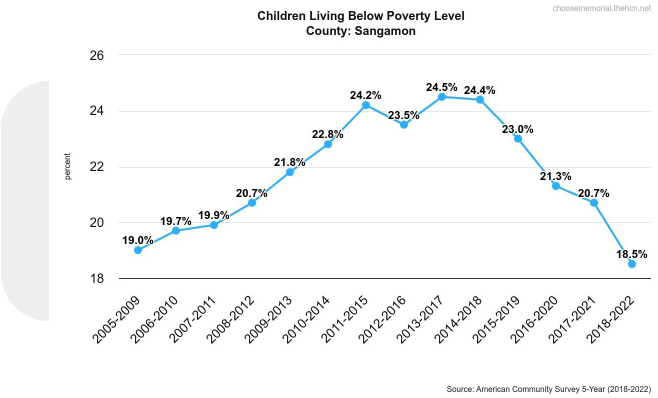
ECONOMICS

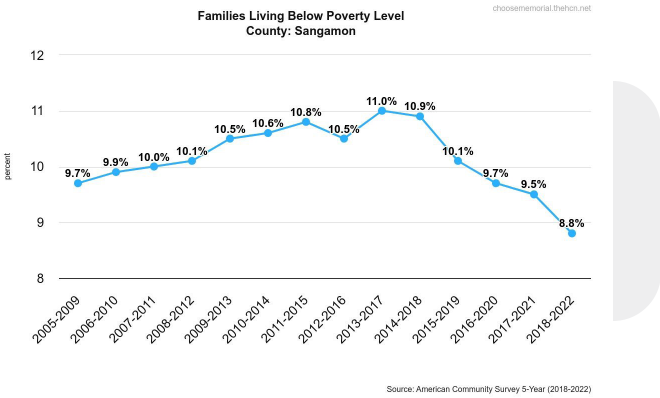
The median household income in Sangamon County is $71,653, lower than both the Illinois and the US value.

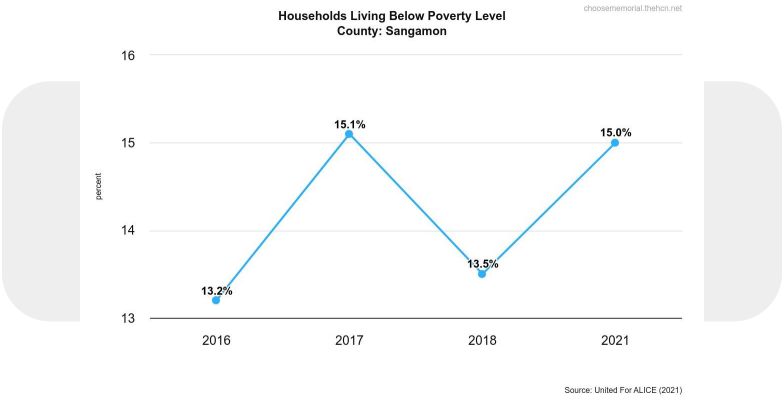


Source: American Community Survey 5-Year (2018-2022)

ALICE (Asset Limited, Income Constrained, Employed) is a way of defining and understanding financial hardship faced by working households that earn above the federal poverty line, but not enough to afford a "bare bones" household budget. According to United for Alice in 2022, 12 percent of households in Sangamon County were at the federal poverty level but a total of 24 percent of households are considered at the ALICE threshold or lower, which means they do not have enough to afford the basics in the communities where they live.







SOCIAL VULNERABILITY INDEX

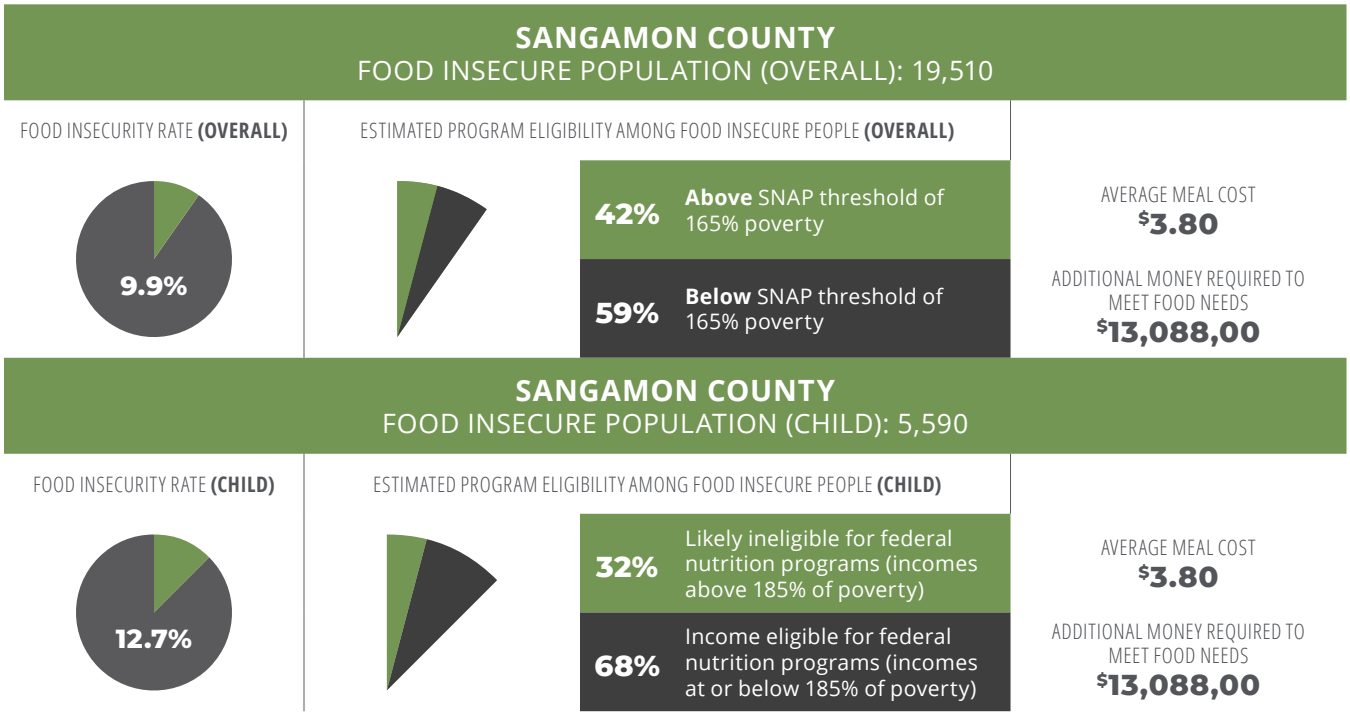
Natural disasters and infectious disease outbreaks can also pose a threat to a community's health. Socially vulnerable populations are especially at risk during public health emergencies because of factors like socioeconomic status, household composition, minority status or housing type and transportation. The Social Vulnerability Index (SVI) ranks census tracts on 15 social factors, such as unemployment, minority status and disability. Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability). Sangamon County's 2018 overall SVI score is 0.4, indicating a low to moderate level of vulnerability.

HEALTH EQUITY INDEX

The 2024 Health Equity Index created by Healthy Communities Institute is a measure of socioeconomic need that is correlated with poor health outcomes. An index value 0 (low need) to 100 (high need) shows the greatest need. Sangamon County has a 95.1 and 85.7 score for zip codes in Springfield (62703 and 62702) followed by 83.9 in Loami.

FOOD INSECURITY INDEX

The 2023 Food Insecurity Index, also created by Healthy Communities Institute, measures economic and household hardship correlated with poor food access. An index value from 0 (low need) to 5 (high need) is assigned to each zip code. The zip code of 62703 showed the highest need with a score of 92.9.



RESIDENTIAL SEGREGATION

Racial/ethnic residential segregation refers to the degree to which two or more groups live separately from one another in a geographic area. Although most overt discriminatory policies and practices, such as separate schools or seating on public transportation based on race, have been illegal for decades, segregation caused by structural, institutional and individual racism still exists in many parts of the country. The removal of discriminatory policies and practices has impacted institutional and individual acts of overt racism, but has had little effect on structural racism, like residential segregation, resulting in lingering structural inequalities.

Residential segregation is a key determinant of racial differences in socioeconomic mobility and, additionally, can create social and physical risks in residential environments that adversely affect health. The residential segregation index ranges from 0 (complete integration) to 100 (complete segregation). The index score can be interpreted as the percentage of either Black or white residents that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area. Sangamon County has a Residential Segregation—Black/White score of 56.2. In other words, 56% of either Black or white residents would have to move to different geographic areas in order to produce a de-segregated residential distribution. Illinois has an overall score of 71.5.

ASSESSING THE NEEDS OF THE COMMUNITY

ALL HOSPITAL AFFILIATES OF MEMORIAL HEALTH CONDUCTED THE 2024 CHNA USING THE SAME TIMELINE, PROCESS AND METHODOLOGY.

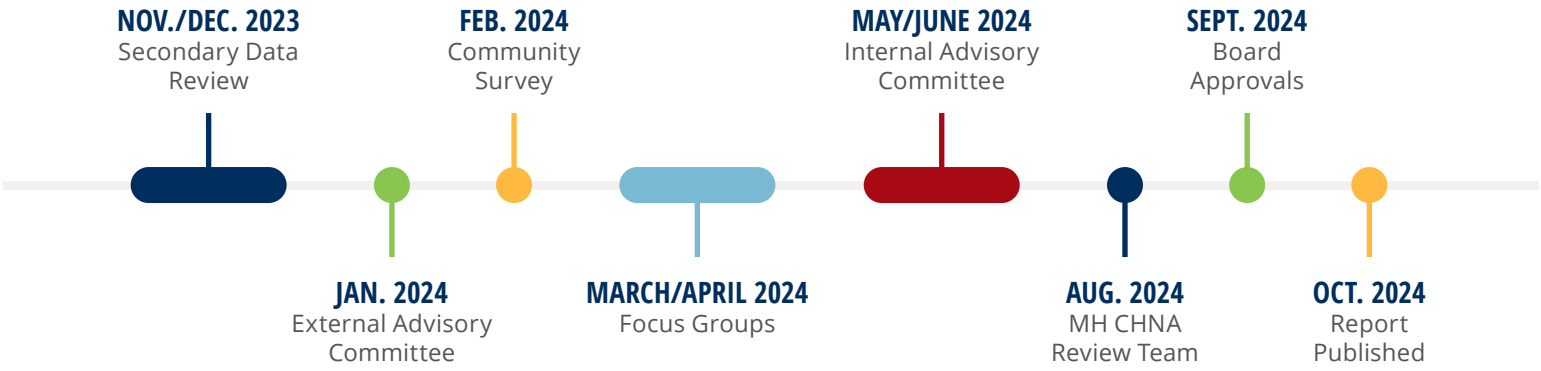
FEEDBACK FROM THE LAST COMMUNITY HEALTH NEEDS ASSESSMENT

To inform the CHNA process, written or verbal comments for the last CHNA and Community Health Implementation Plan (CHIP) are reviewed and considered. There were no comments received from the public regarding the 2021 CHNA or the FY22-24 CHIP.

OVERSIGHT

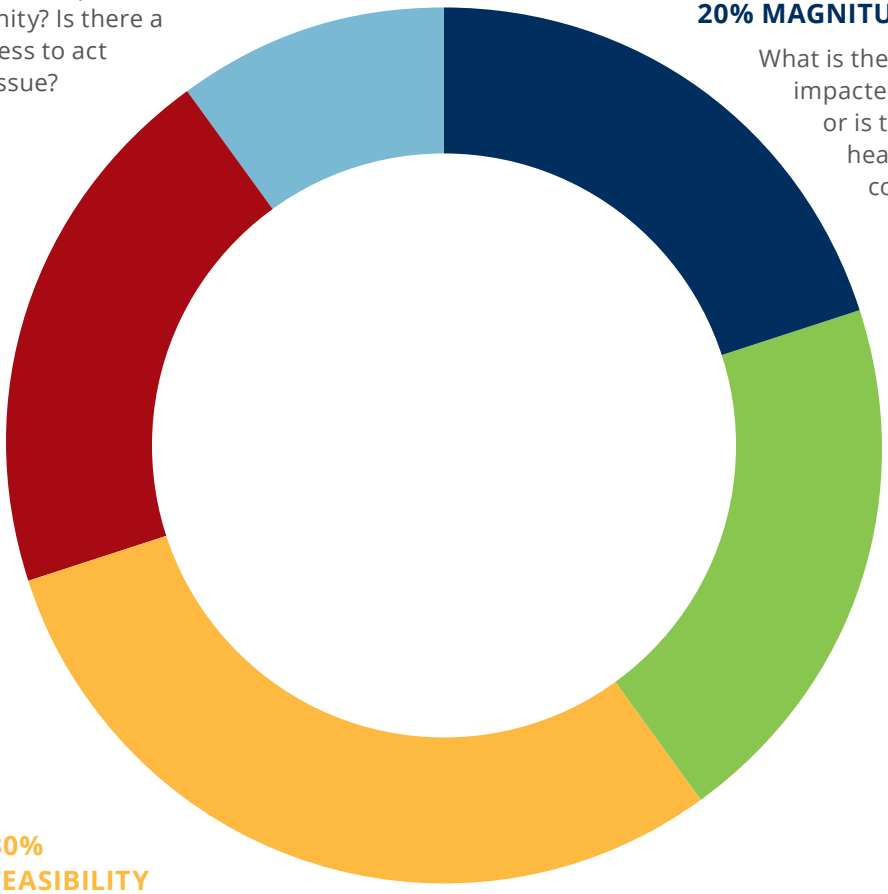
The CHNA process for Springfield Memorial Hospital was led by the SMH Community Health coordinator, Galia Cossyleon. The CHNA was completed in partnership with HSHS St. John's Hospital and the Sangamon County Department of Public Health. Steps 1-2 of the CHNA process were completed collaboratively. Final priorities selected by the Internal Advisory Committee have been shared between the partners and implementation strategies will be discussed to identify ways to partner for maximum impact. The process was also supported by the Memorial Health director of Community Health.

TIMELINE



PRIORITIZATION CRITERIA

The following criteria were referenced throughout the process. Final priorities were selected by ranking identified issues with these criteria, weighted to reduce individual bias and subjectivity resulting in a more objective and rational decision-making process.



10% POTENTIAL TO COLLABORATE

Is this issue important to the community? Is there a willingness to act on the issue?

20% MAGNITUDE

What is the number of people impacted by this problem or is this a trending health concern for the community?

20% EQUITY

Does the issue have the greatest impact on people who are marginalized, vulnerable or living in poverty?

20% SEVERITY

How severe is this problem or is it a root cause of other problems?

30% FEASIBILITY

Ability to have a measurable impact, availability of resources and evidence-based interventions available.

PROCESS

STEP 1: SECONDARY DATA COLLECTION

Primary and secondary qualitative and quantitative data were collected as the first step to identifying local community health needs. A variety of data was reviewed to assess key indicators of the social determinants of health including economic stability, education access/quality, healthcare access/quality, neighborhood/built environment and social/community context. As mentioned earlier in the report, these non-medical factors influence the health outcomes of the community and represent the conditions in which people are born, grow, live, work and age.

Memorial Health engages Conduent Healthy Communities Institute to provide a significant source of secondary data and makes it publicly available online as a free resource to the public. The HCI site provides local, state and national data to one accessible, user-friendly dashboard reporting more than 100 community indicators reflecting health topics, social determinants of health and quality of life. When available, specific county indicators are compared to other communities, state-wide data, national measures and Healthy People 2030. Many indicators also track change over time or identify disparities. The data can be found here: memorial.health/about-us/community-health/healthy-communities-data.

Additional secondary data and partner reports were reviewed for a nuanced understanding of community health indicators, including:

- 500 Cities and PLACES Data Portal
- 2023 ALICE in the Crosscurrents: COVID and Financial Hardship in Illinois
- Centers for Disease Control and Prevention (WONDER)
- Illinois Health Data Portal
- Illinois Violent Death Reporting System
- Illinois Kids Count Report
- Illinois Public Health Community Map
- Illinois Report Card
- Illinois Youth Survey
- Race in the Heartland, University of Iowa and Iowa Policy Project
- Sangamon County Department of Public Health
- Robert Wood Johnson Foundation County Health Rankings
- State Health Improvement Plan: SHIP
- State Unintentional Drug Overdose Death Reporting System
- UIS Center for State Policy and Research Annual Report
- United States Census
- USDA Food Map—Food Deserts
- Healthy People 2030

STEP 2: PRIMARY DATA COLLECTION

Primary data was collected directly from the community in three ways: an external advisory committee, interviews and focus groups. Participants included those who represent, serve or have lived experience with local low-income, minoritized or at-risk populations. These methods provided an opportunity to engage community stakeholders and hear their reactions to the secondary data and provide their experiences in the community.

External Advisory Committee

The EAC consisted of 23 participants and was asked to review the secondary data collected to identify significant health needs in the community based on both the data as presented and their experience in the community. The following organizations were represented:

- Springfield School District 186
- AgeLinc
- Sangamon County Farm Bureau
- Central Counties Health Center – Federally Qualified Health Center
- Memorial Behavioral Health
- Motherland Gardens Community Project
- SIU School of Medicine, Office of Equity, Diversity and Inclusion
- SIU School of Medicine, Strategy, Communication and Engagement
- Springfield Immigrant Advocacy Network
- Springfield Urban League
- Senior Center of Central Illinois
- SIU Center for Family Medicine – Federally Qualified Health Center
- United Way of Central Illinois
- Community Care Connection
- Greater Springfield Chamber of Commerce
- YMCA
- Heartland Housed
- Lincoln Land Community College, Open Door and Workforce Equity Program
- Sangamon County Department of Public Health, Health Education
- SIU Medicine's Office of the Chief Medical Officer - representing medically underserved, low income and minority populations

Community Survey

Q: *How do you rate your health?*

Q: *Why don't local residents access healthcare when they need it?*

Q: *Is racism a problem in Sangamon County?*

A survey in both online and paper format was distributed throughout the county to gather feedback. Several community partners helped distribute the survey, including local schools, human service agencies and the Sangamon County Department of Public Health. The survey was available in English and Spanish. The survey asked several demographic questions to identify basic characteristics of respondents. The questions centered around age, gender, race, ethnicity, income and education. Participants were asked how they rate their health and the health of the community in addition to assessing adverse childhood experiences experienced in the home, exposure to racism and local challenges to maintaining a healthy lifestyle. The survey also provided an opportunity to write in the biggest health problem in the community. In Sangamon County, more than 849 surveys were completed. A copy of the survey can be found in Appendix I. A summary of who took the survey and the findings are below:

- 76.7% identified as female.
- 21.3% reported at least some college education.
- 36.13% reported a household income of less than $40,000.
- 82.05% identified as white (compared to 80.7% population).
- 14.76% identified as Black or African American (compared to 13.8% population).
- More than 60% reported that healthcare is not accessed when needed due to financial barriers (inability to pay out-of-pocket expenses, lack of health insurance coverage and inability to pay for prescriptions).
- 53.50% reported motivation, effort or concern as a challenge to maintaining a healthy lifestyle.
- 53.2% reported lack of education or knowledge as a challenge to maintaining a healthy lifestyle.
- 66.8% reported they had sometimes or frequently witnessed someone being treated differently because of their race.
- 56% reported they agreed or strongly agreed that racism was a problem.
- 57.5% had experienced emotional abuse in their household.
- 53.6% reported mental illness in the household.

Focus Groups

Eight focus groups and interviews were conducted with community members representing diverse identities throughout the county. Representation included those of diverse age, race, ethnicity, education, socioeconomic status and more. The following organizations participated in focus groups:

1. **Springfield Immigrant Advocacy Network (SIAN).** SIAN's clients expressed their concerns regarding their lack of access to healthy and culturally diverse foods. This stems from the accessibility to transportation and affordability of products. They also mentioned their concerns about maternal and infant health as they have faced microaggressions or lack of resources as they navigate pregnancy and motherhood.

2. **Public School District 186 Superintendent's Student Roundtable.** The school district invited us to talk to a group of high school students from all three high schools in Springfield (Springfield High School, Lanphier High School and Southeast High School). The students expressed their concerns around the mental health stigma and how it should be addressed both in clinical and nonclinical settings. The students also discussed substance use within the schools and how they often feel peer pressured to consume substances. Lastly, they talked about the diversity and accessibility of food within their schools, such as serving sizes, snacks and cost and variety of food choices in vending machines.

3. **Heartland HOUSED Continuum of Care Lived Experience group.** This group of people were currently experiencing homelessness. They explained challenges they face when trying to access care, including stigma and aggressions when visiting the hospital or a provider's office. They addressed the challenges of storing their prescriptions and the risk of losing their medications to theft. The group also expressed a need for more access to mental health resources and the need for a "person to talk to."

4. **Southern Illinois University Office of Community Care.** This group was composed of community health workers and program specialists in areas including access to care, maternal infant health, serious mental illnesses, etc. The participants discussed the severity of the health issues and concerns in our community, as well as ideas and suggestions on how to address it. The participants shared their concerns about the food desert on the east side of Springfield and the lack of appropriate transportation for their clients.

5. **The Springfield Project Neighborhood Leaders Monthly Meeting.** A group of Springfield residents shared their concerns regarding the lack of healthy food and fresh produce on the east side of Springfield. Attendees discussed services available to deliver low-cost food and Meals on Wheels. This focus group resulted in a group now called Springfield Eats that is working to address food insecurity as well as the food desert through diverse strategies on the east side of Springfield.

6. **Interview with Addictions Therapist at Springfield Memorial Hospital.** This interview was held to better understand and identify the common problems being faced by patients. Additionally, discussion focused on the patient perspective.

7. **Wooden It Be Lovely.** Program participants represent women who are healing from lives of poverty, addiction and abuse. Discussion focused on programs and services offered, as well as the needs seen within their clients. Mental health providers and resources are in high need, as well as better opportunities for workforce development and integration for clients who are struggling with substance use disorders.

STEP 3: INTERNAL ADVISORY COMMITTEE

The Internal Advisory Committee reviewed primary and secondary data collected and recommended final priorities for board approval based on the selected criteria. Each potential priority was force-ranked by the criteria category. The IAC consisted of SMH colleagues listed below:

1. SMH Chaplain
2. SMH Family Maternity Suites Nurse Manager
3. SMH Inpatient Advanced Care Management Manager
4. SMH Psychiatric Services Director
5. SMH Emergency and Trauma Services System Administrator
6. Memorial Wellness Center Primary Care Physician
7. SMH Mental Health Crisis System of Care Regional Director
8. Memorial Behavioral Health President
9. Springfield Memorial Hospital President and CEO

STEP 4: MEMORIAL HEALTH CHNA REVIEW COMMITTEE

Memorial Health developed a CHNA/CHIP Review Committee. This was new to the MH CHNA process in the 2024 cycle. The purpose of this team was to review the CHNA findings for all MH hospitals and identify a shared priority. Sharing these regional needs provided an opportunity to discuss potential strategies to create a regional impact or inform health system strategy. The review committee included Memorial Health colleagues in the following roles:

- MH Chief Administrative Officer
- MH Vice President for Equity and Experience
- MH Vice President and Chief Quality Officer
- Hospital Presidents/CEOs
- Director of Community Health
- Community Health Coordinators

This group identified mental health, which was selected as a priority in every hospital CHNA, as the system-wide priority.

ADDRESSING THE NEEDS OF THE COMMUNITY

The sections below will provide deeper insight into the selected priorities. These priorities will be featured in the FY25-27 community health implementation plan. An explanation of additional identified health needs that were not chosen as final priorities is also included. MH is committed to meeting the needs of our communities and will continue to collaborate with community partners to address priorities outside those identified in the CHNA as resources allow.

SELECTED PRIORITIES

The priorities selected by SMH are:

1. Chronic Diseases
2. Mental Health
3. Substance Use
4. Homelessness

CHRONIC DISEASES

Chronic diseases last a year or more and require individuals to receive ongoing healthcare services and/or adjust their lifestyles significantly. In the United States, the majority of illnesses, deaths and disabilities are caused by chronic diseases.

According to the CDC, most preventable chronic diseases are caused by risk factors including smoking, poor nutrition, physical inactivity and excessive alcohol use. Examples of chronic diseases include heart disease, obesity, cancer and diabetes. Sangamon County residents are heavily impacted by asthma, diabetes, cardiovascular diseases, hypertension, poor nutrition and oral health problems.

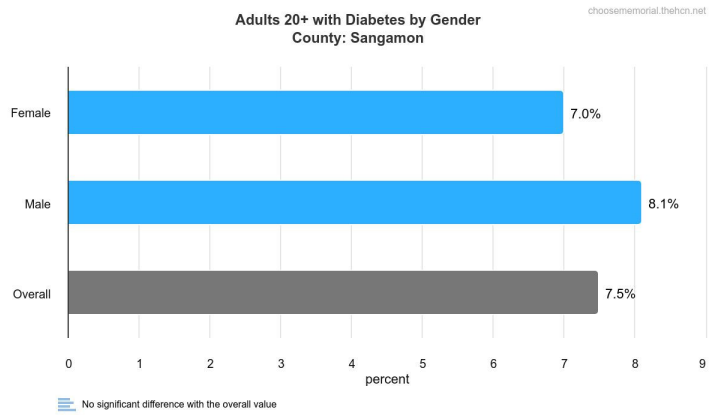
Chronic diseases were ranked as a major health concern on the CHNA due to the number of people impacted, the impact of chronic disease on quality of life/lifespan, the ability to find existing evidence-based strategies and the clear identification of an equity issue when reviewing who was being impacted.

When asked to rank health concerns on the community survey, respondents chose chronic diseases as the fourth-highest health concern for Sangamon County.

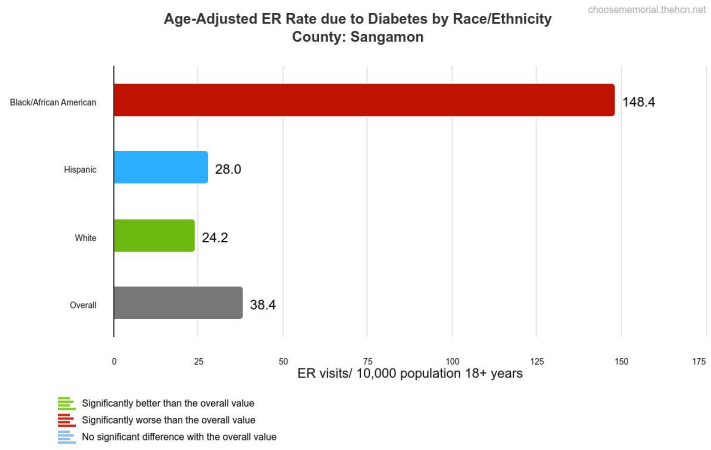
- Nearly 1 in 3 Illinoisans are living with obesity. In Sangamon County, 35% of adults had a BMI of 30 or greater.
- Nearly 1 in 3 Illinoisans have high blood pressure and high cholesterol.

Disparities were identified within these chronic diseases based on race, gender, age and income. These disparities can be seen below and will help inform strategies of how to reach those most impacted by chronic diseases in Sangamon County.

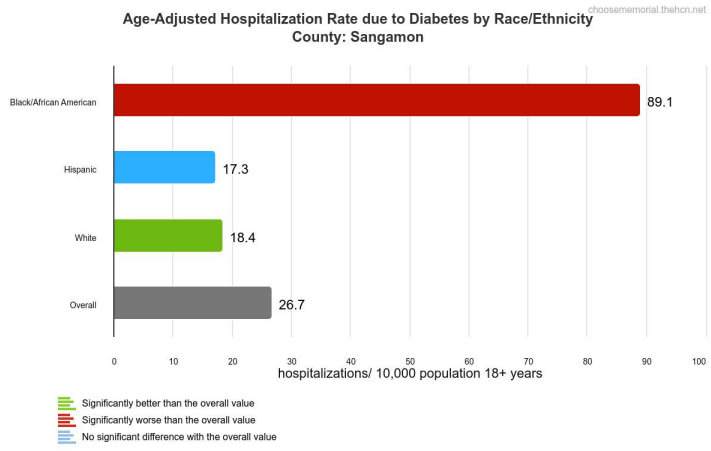
- Diabetes is more prevalent in Hispanic and Black/African Americans, particularly people who do not have a high school diploma.
- Adult asthma is more prevalent among Black or African American residents, as well as for women and lower-income households.
- Obesity has the highest prevalence among the Black/African American population, particularly among those without a college degree.
- High blood pressure and high cholesterol are more prevalent among Black/African American and white individuals in nonurban areas.



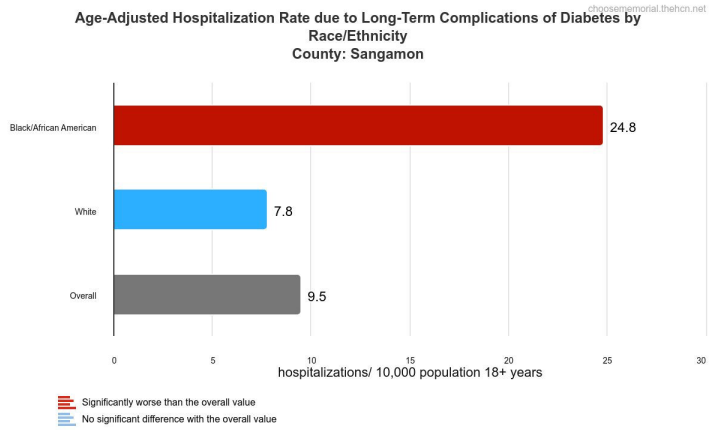
Source: Centers for Disease Control and Prevention (2021)



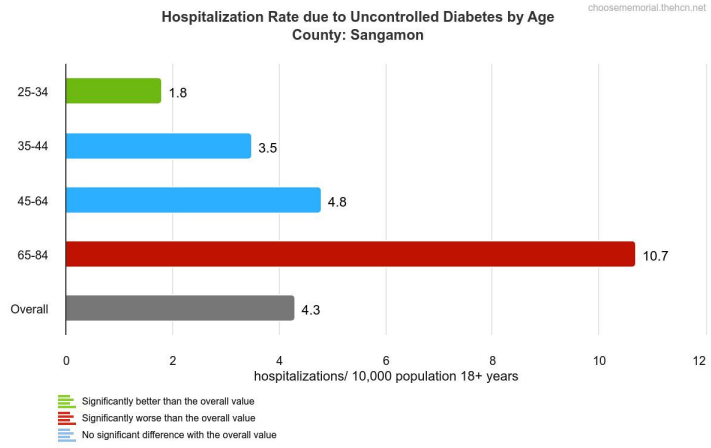
Source: Illinois Health and Hospital Association (2020-2022)



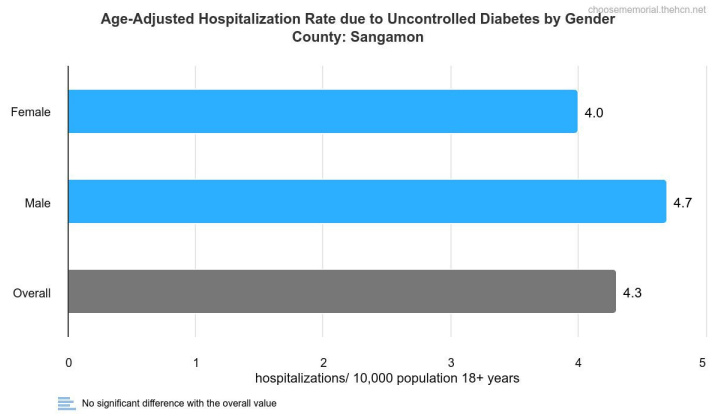
Source: Illinois Health and Hospital Association (2020-2022)



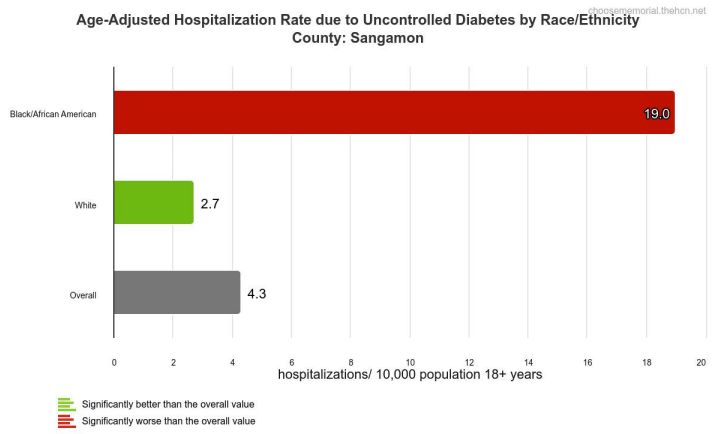
Source: Illinois Health and Hospital Association (2020-2022)



Source: Illinois Health and Hospital Association (2020-2022)

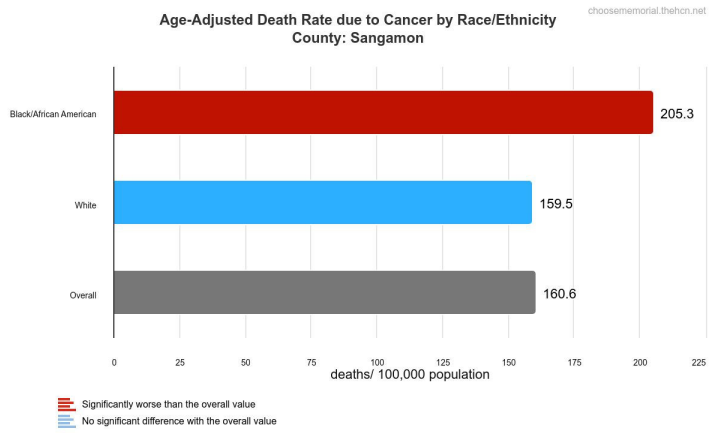


Source: Illinois Health and Hospital Association (2020-2022)



Source: Illinois Health and Hospital Association (2020-2022)

According to the National Cancer Institute, the cancer incidence rate for Sangamon County and the age-adjusted death rate for cancer is higher than the Illinois and U.S. values. Cancer is the second-leading cause of death in Sangamon County. And while the overall death rate has been trending down since 2018, the Black/African American population death rate is significantly higher than the white and overall population impacted by cancer deaths.



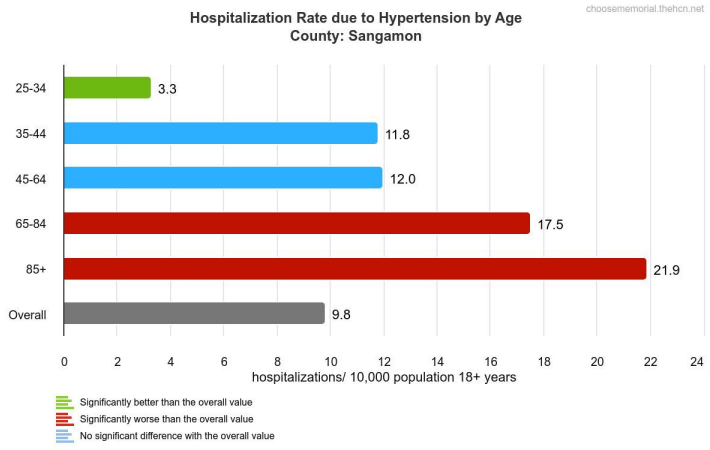
Source: National Cancer Institute (2016-2020)

The types of cancer with the highest incidence rates (per 100,000) of Sangamon County are breast cancer (148.3), prostate cancer (121.4) and lung cancer (39.5).

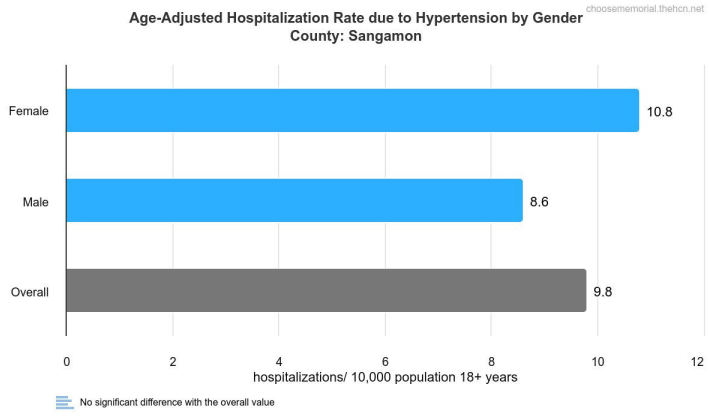
- Hispanic women are more impacted by breast cancer than the overall population, with an incidence rate of 227.
- Black/African Americans are more impacted by prostate cancer than the overall population, with an incidence rate of 181.
- Black/African American males are more impacted by lung cancer, with an incidence rate of 52.

Heart disease is the leading cause of death in Sangamon County. Heart disease encompasses a variety of different diseases affecting the heart, including coronary artery disease, which causes heart attacks, anginas, heart failure and arrhythmias. According to CDC - PLACES, 6.5 percent of Sangamon County residents have been told by a health professional that they have coronary heart disease. According to the National Environmental Public Health Tracking Network, the death rate due to heart attacks in Sangamon County has decreased steadily since 2012, but in 2021 the rate of 61.7 per 100,000 people was still higher than the Illinois value of 56.8.

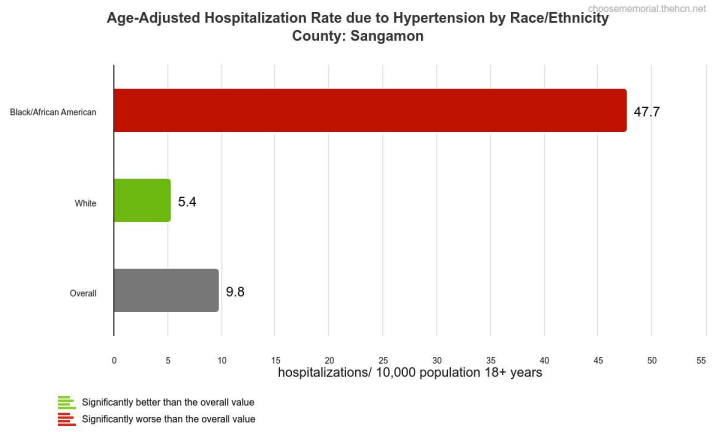
High blood pressure continues to be prevalent in Sangamon County. According to the Illinois Health and Hospital Association, the age-adjusted rate of hospitalization due to uncontrolled hypertension is 9.8, higher than the state rate of 4.5. This number has been increasing since 2016-2018 reporting period. Eighty percent of those diagnosed with high blood pressure are taking medications to decrease a major risk factor for heart disease. There are disparities in those experiencing high blood pressure based on age, gender and race.



Source: Illinois Health and Hospital Association (2020-2022)



Source: Illinois Health and Hospital Association (2020-2022)



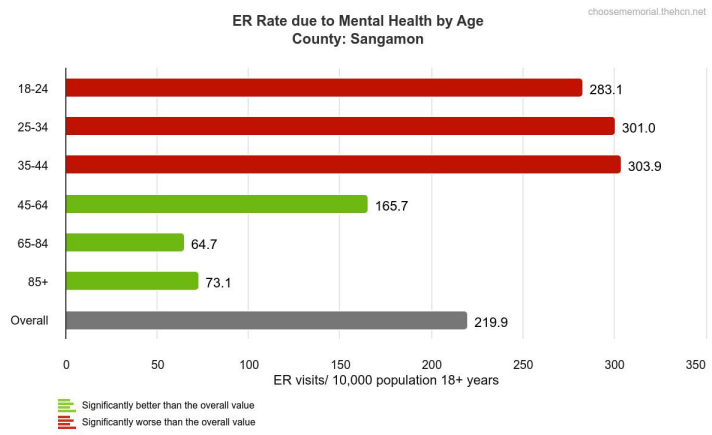
Source: Illinois Health and Hospital Association (2020-2022)

MENTAL HEALTH

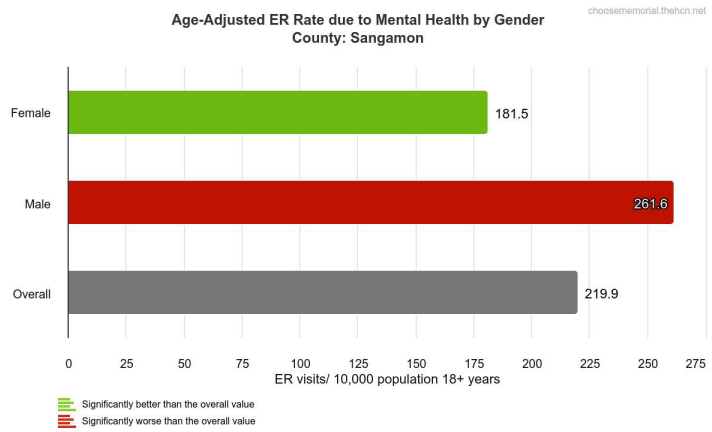
Local residents identified mental health as a concern in the secondary data, but also throughout the conversations and surveys held during the CHNA process. When asked to rank health concerns on the community health survey, participants ranked mental health number one. Based on the prioritization criteria, mental health scores highly because of the number of people it is impacting, the severity of that impact and a high desire to address the concern by the community. Mental health is also considered a possible root cause of substance use disorder.

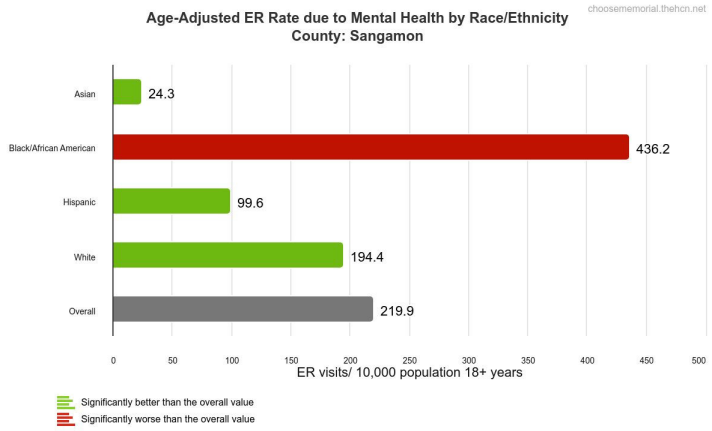
The CHNA process found that:

- Slightly more than 1 in 10 residents reported having 14 or more days of poor mental health in the past month.
- The highest prevalence of poor mental health days for Sangamon County residents was seen in those 18–24 years of age, Black or African Americans and those who identified as “other race” and lower income-groups.
- 54.7% of the community survey respondents reported that individuals with mental health challenges are not receiving sufficient healthcare.
- 53.61% of the community survey respondents reported that they had experienced mental illness in their household.



Source: Illinois Health and Hospital Association (2020-2022)

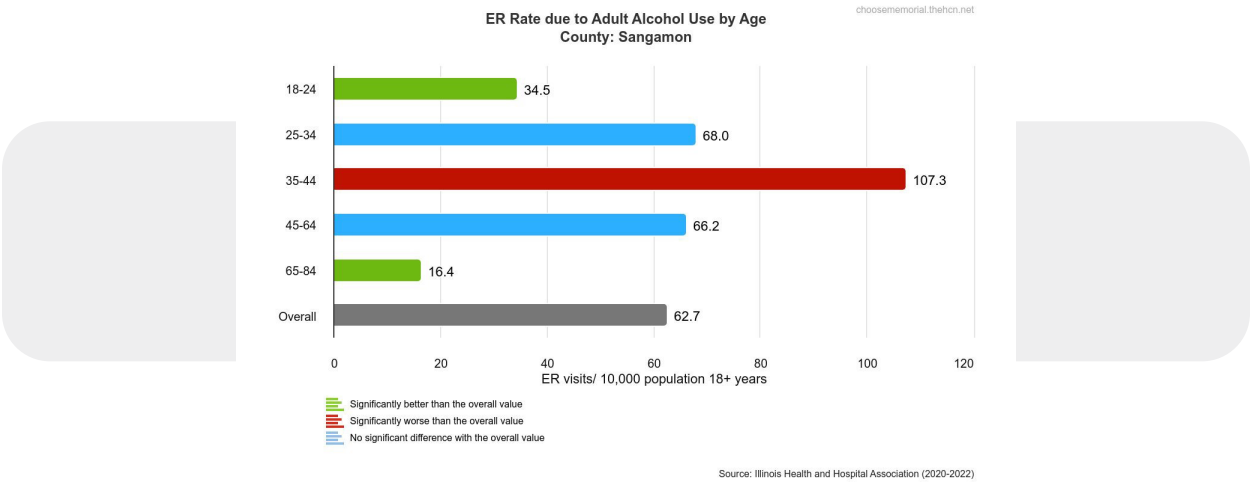

choosememorial.thehcn.net
Age-Adjusted ER Rate due to Mental Health by Gender
County: Sangamon
Female
181.5
Male
261.6
Overall
219.9
0
25
50
75
100
125
150
175
200
225
250
275
ER visits/ 10,000 population 18+ years
Significantly better than the overall value
Significantly worse than the overall value

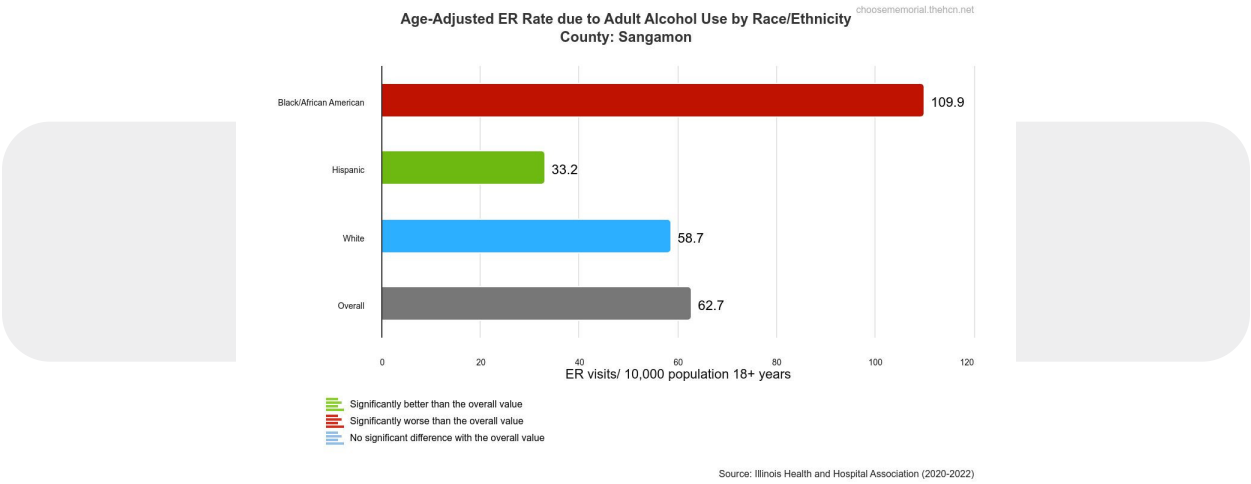

choosememorial.thehcn.net
Age-Adjusted ER Rate due to Mental Health by Race/Ethnicity
County: Sangamon
Asian
24.3
Black/African American
436.2
Hispanic
99.6
White
194.4
Overall
219.9
0
50
100
150
200
250
300
350
400
450
500
ER visits/ 10,000 population 18+ years
Significantly better than the overall value
Significantly worse than the overall value

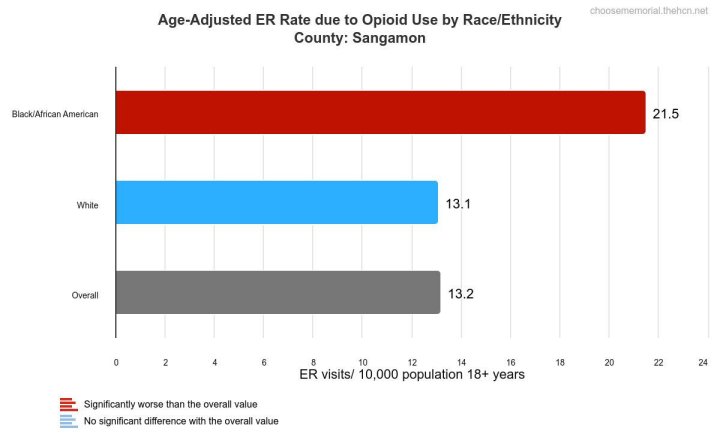
SUBSTANCE USE

Substance use is a root cause of several chronic diseases. The CHNA process showed that substance use is occurring in Sangamon County at higher rates than the Illinois and U.S. rates, negatively impacting the health of our community. It was "written in" as the biggest problem in the county in the survey and ranked the third most important health concern. Due to the number of people impacted and the severity of use, substance use was ranked highly against other potential priorities and was chosen as a health priority. Additional data supporting the selection include:

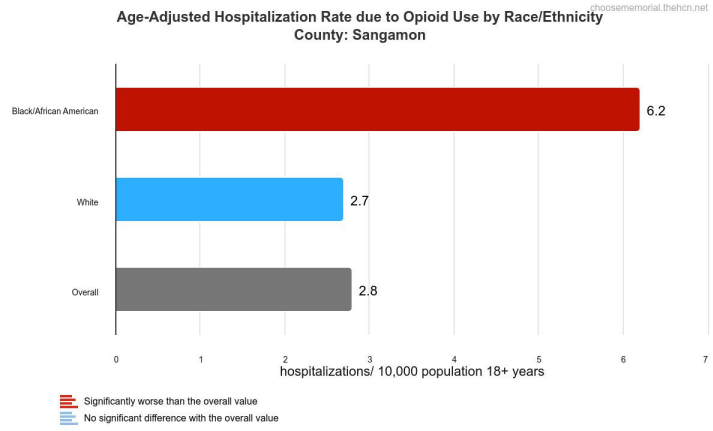
- In 2021, CDC - PLACES reported that 16.2 percent of adults were binge drinking in Sangamon County, higher than the US value of 15.5 percent.
- Thirty percent of community health survey respondents reported that they had experienced chronic substance use/ dependency in their household.
- The age-adjusted Emergency Department usage rate due to alcohol use reported by the Illinois Health and Hospital Association was worse in Sangamon County than any other county served by Memorial Health.
- In 2023, 23 percent of driving deaths involved alcohol.
- Thirty-seven percent of teens in Sangamon County use alcohol.
- Twenty-two percent of teens in Sangamon County use marijuana.



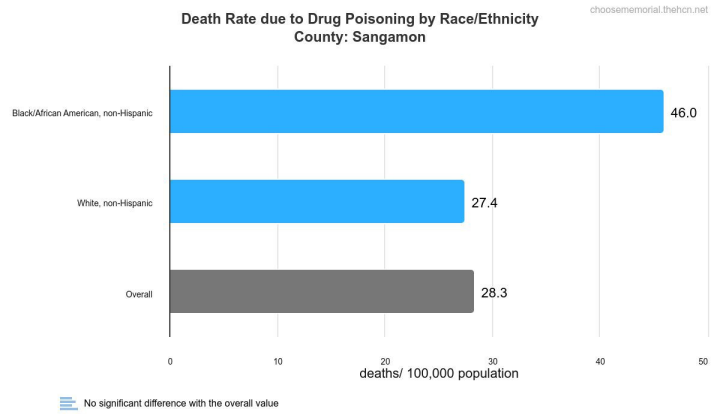




Source: Illinois Health and Hospital Association (2020-2022)



Source: Illinois Health and Hospital Association (2020-2022)



Source: County Health Rankings (2019-2021)

HOMELESSNESS

Respondents to the Sangamon County community health survey ranked homelessness as the second-highest health concern in Sangamon County. Additionally, 56 percent of respondents stated that people experiencing homelessness (PEH) in Sangamon County are not receiving sufficient healthcare. Due to its high severity and impact on all forms of health, homelessness ranked high during the prioritization scoring. It was also highly ranked during the external advisory committee and mentioned throughout the community survey and focus groups.

- In 2022, the Point-In-Time count identified 188 adults in Sangamon County were living in an emergency shelter, transitional housing, experiencing homelessness or were living in a place not meant for human habitation. Forty-one percent of those individuals had physical or mental health needs. In 2023, that number increased to 306.
- In Sangamon County, 13 percent of households experienced at least one of the following housing problems: overcrowding, high housing costs, lack of kitchen facilities or lack of plumbing facilities.
- Black individuals and Native Americans entered homelessness for the first time and returned to homelessness at higher rates than other racial and ethnic groups.
- Black Illinoisans are eight times more likely to become homeless than other groups.
- PEH die 20 years earlier than housed Illinois residents.
- PEH are at higher risk of being victims of violent crimes and/or being murdered.
- African Americans represent 40 percent of the homeless population in Sangamon County.
- PEH experience multiple comorbidities related to drug abuse, hypertension, alcohol abuse, psychoses, chronic pulmonary disease and depression.
- Hospital utilization increases during periods of unstable housing, particularly among those with chronic conditions that are exacerbated by homelessness. (https://dph.illinois.gov/content/dam/soi/en/web/idph/publications/idph/topics-and-services/life-stages-populations/hmmr-report-201722.pdf illinois.gov)

HEALTH NEEDS NOT SELECTED

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

Educational Disparities – While educational disparities were identified as the top concern with the external advisory committee, it was the last health concern ranked on the community health survey. According to the Race in the Heartland report, Springfield is one of the top 10 metro areas identified as having extremely segregated schools. Low-income students have the lowest graduation rate. In addition, Black and Hispanic students have lower graduation rates than white and Asian students. While we recognize educational disparities are a significant health concern for Sangamon County, it was not chosen as a priority to be addressed in the CHIP due to its lower ranking when compared to other needs and the prioritization criteria. SMH does not have the expertise or the resources to effectively address the need. There is also a lack of identified effective interventions to address the need.

Affordable Housing – During the Internal Advisory Committee, participants discussed affordable housing as a root cause for homelessness. The Internal Advisory Committee chose to focus on "Homelessness" as a whole.

Food Access – The Internal Advisory Committee recognized food access as a growing concern for Sangamon County residents, particularly for those living in the Springfield area. Specifically, we recognize the food desert on the east side of Springfield that leads to unhealthy eating habits. It was decided that food access would likely be addressed under the broad priority of chronic diseases as a tool for prevention and chronic disease management.

Disparities in Economy – The racial wage gap was identified as a concern by the External and Internal Advisory Committees. Further, issues related to inability to pay for healthcare and prescription costs were identified in the survey. However, this was not chosen as a priority for the SMH CHIP due to a lack of expertise or competencies to effectively address the need.

OVERSIGHT

The CHIP process for Springfield Memorial Hospital was led by the SMH community health coordinator, Galia Cossyleon. The process was also supported by the SMH president and CEO, Jay Roszhart, and Memorial Health director of community health, Angela Stoltzenburg.

SEPT. 2024
2024 CHNA Report Approved by the Memorial Health Community Benefit Committee AND Internal Advisory Committees Reviews FY25-27 CHIP Strategies

OCT. 2024
MH CHNA/CHIP Committee Review FY25-27 CHIP Strategies

NOV. 2024
SMH Hospital Board Approves FY25-27 CHIP AND MH Community Benefit Committee Approves FY25-27 CHIP

CHIP DEVELOPMENT

Once the CHNA priorities were finalized for each affiliate hospital, each affiliate hospital used the same process to identify and select the strategies for the FY25-27 CHIP. Evidence-based strategies for each priority were researched by the community health leaders using the following tools:

- "What Works for Health" – Robert Wood Johnson's County Health Rankings and Roadmaps
- Healthy People 2030 Evidence-Based Resources
- Promising Practices – Conduent Healthy Communities Institute

Final strategies were selected with the input of the community, internal Memorial Health stakeholders and additional strategic considerations.

COMMUNITY INPUT

The community health leaders met community partners and organizations working to address the final priority areas. Through these meetings, gaps were identified that could serve as potential projects or initiatives. Areas for collaboration were also discussed with local partners in addition to a review of focus group conversations and survey responses.

INTERNAL INPUT

Community health leaders spend much of their time in the community, working alongside those who have been engaged in work around the final priorities for years. The insight and expertise of community health leaders were relied on as the CHIP was developed. Members of the Internal Advisory Committees were also consulted throughout the process to identify hospital resources available to implement programs.

STRATEGIC PLANS AND COMMITMENTS

Memorial Health's strategic plan was reviewed and considered to be a guiding document as Memorial Health deepens its commitment to community health. Evolving work around equity, diversity and inclusion helped shape and prioritize strategies and potential projects. Organizations who are conducting their work in an anti-oppressive and inclusive way are prioritized for partnership. Existing strategies, programs and partnerships were reviewed for effectiveness and alignment with the 2024 CHNA priorities to determine their inclusion in the FY25-27 CHIP.

FY25–27 STRATEGIES

The following strategies are planned to take place FY25-27. Each strategy below contains the following details:

Targeted Priorities
The specific identified priorities that will be addressed by the strategy.

Anticipated Impact
The short- and/or long-term outcome(s) resulting from the strategy.

Social Determinants of Health Areas of Impact
Any social determinants of health that will be addressed by the strategy.

Hospital Resources
The resources that SMH plans to commit to address the health need.

Community Partners
Any local organizations and agencies that are taking the lead or collaborating with SMH to implement the strategy.

Equity/Disparities
Any identified disparities that will be addressed by the strategy and if the strategy will support low-income, disadvantaged communities.

Measures of Success
The outcome measures that will be tracked to prove that the strategy accomplished its goal(s).

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Solid Rock Youth Transitional Services
TARGETED PRIORITY(IES)	■ MENTAL HEALTH ❒ CHRONIC DISEASE ■ HOMELESSNESS ❒ SUBSTANCE USE
ANTICIPATED IMPACT	To increased coordinated services for youth exiting the foster care system. To improve coordination between members of the Continuum of Care and the hospital. To decrease youth experiencing homelessness.
SOCIAL DETERMINANTS OF HEALTH IMPACT	■ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ❒ MARKETING ■ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ❒ PRINTING/SUPPLIES
COMMUNITY PARTNERS	
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO - 40% of youth who leave the foster care system will be homeless in 18 months - 26,000 youth age out of foster care system every year
MEASURES OF SUCCESS	Fund at least $50,000 annually FY25-27 to support Supportive Housing and Transitional Housing Initiative

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Access to Care Program
TARGETED PRIORITY(IES)	❒ MENTAL HEALTH ■ CHRONIC DISEASE ■ HOMELESSNESS ❒ SUBSTANCE USE
ANTICIPATED IMPACT	To improve access to healthcare services. To increase access to health screenings. To improve community awareness of health resources and social service system resources. To enhance communication between community members and health providers. To increase use of healthcare services. To improve adherence to recommendations from healthcare providers. To reduce demand for emergency and specialty services.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ❒ EDUCATION ACCESS AND QUALITY ■ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ■ HEATLH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	❒ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ❒ MARKETING ■ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ■ OTHER SUPPORT ❒ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Southern Illinois University - Office of Community Care HSHS St. John's Hospital
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO This program serves people who live in low income or marginalized areas of Springfield. Additionally, Social Determinants of Health screenings will identify people at high risk for poor health outcomes or struggling with food insecurity, housing, transportation and/or low income.
MEASURES OF SUCCESS	FY25: Explore and plan for improved SDOH screening process and referrals to the program from the SMH Emergency Department FY26-27: # of clients who show improvement in chronic disease management for clients enrolled in program # of clients that report that their health outcomes have improved after graduation

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Certified Recovery Support Specialist at Emergency Department
TARGETED PRIORITY(IES)	■ MENTAL HEALTH ❒ CHRONIC DISEASE ❒ HOMELESSNESS ■ SUBSTANCE USE
ANTICIPATED IMPACT	To increase referrals for patients who are screened for substance use disorder at Emergency Department. To increase number of community members who access SUD resources.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ❒ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Gateway Foundation Family Guidance Center
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO - The highest mortality rates from substance overdose were seen among Black or African- American residents, while the lowest rates were among Hispanic residents and those who identify as "other race" - The rate of Emergency Department visits for nonfatal opioid events is highest among Black/African American individuals - Overall, Emergency Department visit rates for substance and alcohol use are highest among Black or African American residents. 21% of 211 callers were looking for resources for substance use disorder
MEASURES OF SUCCESS	FY25: Explore and plan with Human Resources and Trauma and Emergency Services Departments for the integration of a CRSS FY26-FY27: If determined feasible. Hire, train and embed CRSS into Emergency Department operations. # of screenings completed # of referrals provided to patients for recovery

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Chronic disease self management classes
TARGETED PRIORITY(IES)	❒ MENTAL HEALTH ■ CHRONIC DISEASE ❒ HOMELESSNESS ❒ SUBSTANCE USE
ANTICIPATED IMPACT	To empower patients to manage their chronic diseases more successfully. To improve quality of life for participants. To decrease burden on emergency department services to address uncontrolled chronic diseases.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ❒ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ■ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Kumler Outreach Ministries, G.A.N.T., SIAN, SING, Springfield Eats, SIU Office of Community Care
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO - Obesity has the highest prevalence among the Black/ African American population, particularly among those without a college degree - High blood pressure and high cholesterol, higher prevalence among Black/African American and white in nonurban territories - Black Americans experience kidney failure at three times the rate of whites; they also suffer from some of the highest rates of diabetes and hypertension, two leading causes of kidney failure - Black/African American adults are 73% more likely to have diabetes (diagnosed and undiagnosed) than white adults and more than twice as likely to die from diabetes-related causes
MEASURES OF SUCCESS	# of community members who complete the program # of community members who complete leader trainings

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Community Healing Circles
TARGETED PRIORITY(IES)	■ MENTAL HEALTH ❒ CHRONIC DISEASE ❒ HOMELESSNESS ❒ SUBSTANCE USE
ANTICIPATED IMPACT	To increase sense of community To increase awareness about mental health resources, racialized-trauma, vicarious trauma and the importance of self care.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ❒ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ❒ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ■ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Unveiling Black Springfield Black Lives Matter Springfield SIU Office of EDI SIU Survivor Recovery Center
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO The highest prevalence of poor mental health days was seen in those 18–24 years of age, Black or African Americans and those who identified as "other race" and lower income groups.
MEASURES OF SUCCESS	# of Community Healing Circles offered per year # of people attending each Healing Circle % of participants that report the Healing Circles have improved their sense of community

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Free Cancer Screenings
TARGETED PRIORITY(IES)	❒ MENTAL HEALTH ■ CHRONIC DISEASE ❒ HOMELESSNESS ❒ SUBSTANCE USE
ANTICIPATED IMPACT	To increase cancer awareness. To increase early detection. To decrease cancer death incidence rate.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ❒ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ■ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Regional Cancer Partnership
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO - Black people have higher new cancer rates for prostate, colon and rectal cancer compared to other groups and one of the highest rates of new breast cancers. - Black people have the highest mortality rate for most leading cancer types, including female breast, prostate, colon and rectal cancer. - Research shows that the overall rate of cancer screening is lower among Black, Hispanic, Asian and AIAN populations compared to their white counterparts.
MEASURES OF SUCCESS	FY25-27: Distribute colorectal cancer screening kits annually. # of kits distributed # of kits returned # of positive results referred to primary care physician - Plan and participate in the promotion of breast, prostate and lung cancer awareness activities. - Provide cancer awareness support resources to community partners.

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	G.A.N.T. Senior Luncheons
TARGETED PRIORITY(IES)	❒ MENTAL HEALTH ■ CHRONIC DISEASE ❒ HOMELESSNESS ❒ SUBSTANCE USE
ANTICIPATED IMPACT	To increase awareness regarding health literacy, chronic disease management and resources available to the senior population served by G.A.N.T.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ■ NEIGHBORHOOD AND BUILT ENVIRONMENT ❒ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	❒ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ❒ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ❒ PRINTING/SUPPLIES
COMMUNITY PARTNERS	The Salvation Army
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO - Black people have higher new cancer rates for prostate, colon and rectal cancer compared to other groups and one of the highest rates of new breast cancers. - Diabetes is more prevalent in Hispanic and Black/African American, particularly people with less than high school diploma - Adult asthma more prevalent among Black or African American residents, as well as for women and lower- income households - Obesity has a highest prevalence among the Black/ African American population, particularly among those without a college degree - High blood pressure and high cholesterol have a higher prevalence among Black/African American and white individuals in nonurban territories
MEASURES OF SUCCESS	Fund $5,000 annually.

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Helping Hands Springfield
TARGETED PRIORITY(IES)	❒ MENTAL HEALTH ❒ CHRONIC DISEASE ■ HOMELESSNESS ❒ SUBSTANCE USE
ANTICIPATED IMPACT	To increase emergency shelter services provided for people experiencing homelessness. To increase case management and housing opportunities for people experiencing homelessness.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ❒ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	❒ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ❒ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ■ OTHER SUPPORT ❒ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Heartland Continuum of Care
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO - Black and Native Americans entered homelessness for the first time and returned to homelessness at higher rates than other racial and ethnic groups. - The disproportionality in homeless numbers is staggering nationally and even more so locally as people of color experience homelessness at significantly greater rates. - For instance, while 13% of the U.S. population is African American, African Americans represent 40% of the homeless population in the country.
MEASURES OF SUCCESS	$105,000 provided FY25 and FY26.

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Inpatient Food Pantry
TARGETED PRIORITY(IES)	❒ MENTAL HEALTH ■ CHRONIC DISEASE ■ HOMELESSNESS ❒ SUBSTANCE USE
ANTICIPATED IMPACT	To provide immediate food resources to food insecure patients. To increase connectedness and referrals to local food pantries. To reduce 72-hour readmission rate.
SOCIAL DETERMINANTS OF HEALTH IMPACT	■ ECONOMIC STABILITY ❒ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ❒ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Springfield Eats EcoFluent Motherland Gardens Community Project
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO - In Sangamon County 9.9% of the population are food insecure - 12.7% of children in Sangamon County face food insecurity
MEASURES OF SUCCESS	FY25: Develop a pilot program design. FY26: Launch Springfield Memorial Hospital Inpatient Food Pantry and begin tracking # of patients screened for food insecurity # of patients who screened positive for food insecurity and received a food box and food pantry referral.

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Intricate Minds
TARGETED PRIORITY(IES)	■ MENTAL HEALTH ❒ CHRONIC DISEASE ❒ HOMELESSNESS ■ SUBSTANCE USE
ANTICIPATED IMPACT	To reduce stigma regarding mental health, HIV and safe drug use.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ■ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Heartland Continuum of Care, Sangamon County Public Health
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO - The highest mortality rates due to substance overdose were seen among Black or African American residents, while the lowest rates were among Hispanic residents and those who identify as "other race" - The rate of emergency department visits for nonfatal opioid events is highest among Black/African American individuals - Overall, Emergency Department visit rates for substance and alcohol use are highest among Black or African American residents. 21% of 211 callers were looking for resources for substance use disorder
MEASURES OF SUCCESS	Fund $20,000 annually.

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Kumler Outreach Ministries
TARGETED PRIORITY(IES)	❒ MENTAL HEALTH ■ CHRONIC DISEASE ❒ HOMELESSNESS ❒ SUBSTANCE USE
ANTICIPATED IMPACT	To increase awareness about chronic disease management, prescription and medical treatment adherence and healthy habits.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ❒ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	❒ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ❒ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO - Kumler Outreach Ministries serves people experiencing homelessness, people who are uninsured or underinsured, as well as low income people in our community. - Over 50% of their clients are African American
MEASURES OF SUCCESS	Fund $6,000 annually.

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Springfield Memorial Mile
TARGETED PRIORITY(IES)	■ MENTAL HEALTH ■ CHRONIC DISEASE ❒ HOMELESSNESS ❒ SUBSTANCE USE
ANTICIPATED IMPACT	To increase opportunities for physical activity outdoors. To increase awareness of mental health and mental health resources.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ■ MARKETING ❒ CONSULTANT/EXPERT ❒ FINANCIAL SUPPORT ❒ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	❒ YES ■ NO
MEASURES OF SUCCESS	# of community members who check in at the Springfield Memorial Mile # of community members who access the resources along the Mile

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	MOSAIC at District 186
TARGETED PRIORITY(IES)	■ MENTAL HEALTH ❒ CHRONIC DISEASE ❒ HOMELESSNESS ❒ SUBSTANCE USE
ANTICIPATED IMPACT	To increase mental health awareness, decrease stigma and increase access to mental health services by embedding behavioral health consultants within the public schools in Springfield.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ❒ MARKETING ■ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ❒ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Springfield Public Schools District 186 and Memorial Behavioral Health
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO - The highest prevalence of poor mental health days was seen in those 18–24 years of age, Black or African Americans and those who identified as "other race" and lower income groups.
MEASURES OF SUCCESS	Fund $131,000 to MBH annually. % average improvement for the Generalized Anxiety Disorder Score for High School and Middle School students % average improvement for the Patient Health Questionnaire for High School and Middle School students % average improvement for Pediatric Symptom and Checklist (PSC-17) for elementary students

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Motherland Community Garden Project
TARGETED PRIORITY(IES)	❒ MENTAL HEALTH ■ CHRONIC DISEASE ❒ HOMELESSNESS ❒ SUBSTANCE USE
ANTICIPATED IMPACT	To reduce disparities in access to fresh and healthy food in underserved communities. To support sustainable food systems in the marginalized areas of Springfield to promote healthy eating and self-care activities.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ■ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ❒ HEATLH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ❒ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ■ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Motherland Gardens Community Project Culinary Medicine - SIU School of Medicine SIU Office of Community Care Springfield Eats Memorial Wellness Center Ecofluent.
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO - In Sangamon County, African American residents have a 27% food insecurity rate - 20% of non-white residents in Sangamon County reported there was a time they could not afford food
MEASURES OF SUCCESS	Funding $7,500 in FY25

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Springfield Immigrant Advocacy Network
TARGETED PRIORITY(IES)	❒ MENTAL HEALTH ■ CHRONIC DISEASE ❒ HOMELESSNESS ❒ SUBSTANCE USE
ANTICIPATED IMPACT	To increase awareness regarding health literacy, chronic disease management and resources available to the population served by SIAN.
SOCIAL DETERMINANTS OF HEALTH IMPACT	■ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ❒ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ■ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO - This organization serves the immigrant population of Springfield - Diabetes is more prevalent in Hispanic and Black/African American individuals, particularly those without a high school diploma
MEASURES OF SUCCESS	Fund $15,000 annually FY25-27.

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Shifting Into New Gear (SING)
TARGETED PRIORITY(IES)	■ MENTAL HEALTH ❒ CHRONIC DISEASE ■ HOMELESSNESS ■ SUBSTANCE USE
ANTICIPATED IMPACT	To improve integration of justice-involved community members after incarceration.
SOCIAL DETERMINANTS OF HEALTH IMPACT	■ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ❒ MARKETING ■ CONSULTANT/EXPERT ❒ FINANCIAL SUPPORT ■ OTHER SUPPORT ❒ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Sangamon County Public Health Department
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO In 2021, Black Americans were imprisoned at 5.0 times the rate of whites, while American Indians and Latinx people were imprisoned at 4.2 times and 2.4 times the white rate, respectively.
MEASURES OF SUCCESS	Provide organizational development consulting offered by Memorial Health to assist Executive Director.

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	The Confess Project
TARGETED PRIORITY(IES)	■ MENTAL HEALTH ❒ CHRONIC DISEASE ❒ HOMELESSNESS ■ SUBSTANCE USE
ANTICIPATED IMPACT	To increased mental health awareness and reduce stigma in underrepresented communities. To improve awareness of local mental health resources. To increase usage of mental health resources.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ❒ EDUCATION ACCESS AND QUALITY ■ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ■ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Memorial Behavioral Health
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO - The highest prevalence of poor mental health days was seen in those 18–24 years of age, Black or African Americans and those who identified as "other race" and lower income groups.
MEASURES OF SUCCESS	FY25: # of local barbers/hairstylists who have completed Mental Health Advocate Training FY26- FY27: % of trained barbers/hairstylists who report they have implemented the skills learned in their shops

SPRINGFIELD MEMORIAL HOSPITAL COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

IDENTIFIED PRIORITIES: Mental Health, Chronic Disease, Homelessness, and Substance Use

STRATEGY	Wooden It Be Lovely
TARGETED PRIORITY(IES)	■ MENTAL HEALTH ❒ CHRONIC DISEASE ■ HOMELESSNESS ■ SUBSTANCE USE
ANTICIPATED IMPACT	To increased mental health awareness. To increase access to substance use disorder recovery services and resources. To increase number of people living in recovery.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ❒ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ❒ PRINTING/SUPPLIES
COMMUNITY PARTNERS	
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	❒ YES ■ NO
MEASURES OF SUCCESS	Fund $20,000 annually FY25-27.

REGIONAL STRATEGIES

The MH CHNA/CHIP Review Committee identified the shared priority of mental health. The following four collaborative strategies will be implemented to address mental health across the service areas of all five Memorial Health hospitals.

MEMORIAL HEALTH COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

SHARED PRIORITY: Mental Health

STRATEGY	Free Community Anti-Racism Training
TARGETED PRIORITY(IES)	■ MENTAL HEALTH
ANTICIPATED IMPACT	To create an inclusive community culture of belonging. To create awareness of how marginalized groups are affected by racism in their community. To cultivate anti-racist communities that actively identify and oppose racism. To actively influence communities to change policies, behaviors and beliefs that perpetuate racist ideas and actions. To bring awareness to the trauma caused by racism and its contribution to mental health.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ❒ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ❒ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ■ MEETING SPACE/VIRTUAL PLATFORM ■ MARKETING ■ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Springfield Immigrant and Advocacy Network Springfield Coalition On Dismantling Racism
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO People of color and all those whose lives have been marginalized by those in power experience life differently from those whose lives have not been devalued. They experience overt racism and bigotry far too often, which leads to a mental health burden that is deeper than what others may face. Discrimination is a challenge that can't be controlled and can have a negative impact on health and safety throughout life.
MEASURES OF SUCCESS	FY25: Identify trainers, curriculum and training locations. Explore ability to award CEUs to participants. Develop marketing campaign to encourage attendance. FY26 and FY27: One in-person training held in each county each fiscal year. At least two virtual trainings held for the Memorial service area each fiscal year. # of participants at each training

MEMORIAL HEALTH COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

SHARED PRIORITY: Mental Health

STRATEGY	"Wellness on the Go" Health Literacy Kits at Public Libraries
TARGETED PRIORITY(IES)	■ MENTAL HEALTH
ANTICIPATED IMPACT	To improve mental health awareness and knowledge of free, local mental health resources. To increase usage of mental health services. To empower individuals to address the mental health of themselves, their family and friends.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ❒ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ❒ SOCIAL AND COMMUNITY CONTEXT ■ HEATLH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ❒ MEETING SPACE/VIRTUAL PLATFORM ■ MARKETING ❒ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Memorial Behavioral Health Public Libraries Heritage Behavioral Health Center
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO Libraries are embedded in their communities and provide free access to resources for everyone. They have access to and serve diverse sectors of the population regardless of age, income, race, gender, religion, sexual orientation and housing status.
MEASURES OF SUCCESS	# of library partners # of kits distributed to libraries # of times the wellness kits are checked out by patrons Self-reported feedback from patrons who check out the health literacy kits including: Increased knowledge of local mental health resources. Motivation to seek help from 988 and 211 to assist themselves or others when in need.

MEMORIAL HEALTH COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

SHARED PRIORITY: Mental Health

STRATEGY	Free Community Trauma Informed Care Trainings
TARGETED PRIORITY(IES)	■ MENTAL HEALTH
ANTICIPATED IMPACT	To increase understanding of trauma. To increase use of trauma-informed practices. To reduce the possibility of re-traumatization. To create a safe physical and emotional environment for community members served by participants.
SOCIAL DETERMINANTS OF HEALTH IMPACT	❒ ECONOMIC STABILITY ❒ EDUCATION ACCESS AND QUALITY ❒ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ❒ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ■ MEETING SPACE/VIRTUAL PLATFORM ■ MARKETING ■ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ❒ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	Heritage Behavioral Health Center Memorial Behavioral Health
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	❒ YES ■ NO
MEASURES OF SUCCESS	FY25-27: One in-person training held in each county each fiscal year. At least two virtual trainings held for the Memorial service area each fiscal year. # of participants who complete the training # of participants earning CEUs Participant will self report an increase in the following after completing the training: - "Agree" or "Strongly Agree" they understand the effect of trauma on a person's thoughts, feelings, and behaviors. - "Agree" or "Strongly Agree" that they have learned things they did not know previously about trauma. - "Agree" or "Strongly Agree" that the training met a need in their community. - "Agree" or "Strongly Agree" that the training helped destigmatize trauma.

MEMORIAL HEALTH COMMUNITY HEALTH IMPLEMENTATION PLAN

FY25-27

SHARED PRIORITY: Mental Health

STRATEGY	MH Mental Health Commission
TARGETED PRIORITY(IES)	■ MENTAL HEALTH
ANTICIPATED IMPACT	To increase understanding of mental health landscape in Memorial Health service area. To identify opportunities to improve mental health outcomes in Memorial Health service area.
SOCIAL DETERMINANTS OF HEALTH IMPACT	■ ECONOMIC STABILITY ■ EDUCATION ACCESS AND QUALITY ■ NEIGHBORHOOD AND BUILT ENVIRONMENT ■ SOCIAL AND COMMUNITY CONTEXT ■ HEALTH CARE ACCESS AND QUALITY
HOSPITAL RESOURCES	■ COLLEAGUE TIME ■ MEETING SPACE/VIRTUAL PLATFORM ■ MARKETING ■ CONSULTANT/EXPERT ■ FINANCIAL SUPPORT ■ OTHER SUPPORT ■ PRINTING/SUPPLIES
COMMUNITY PARTNERS	
EQUITY/DISPARITIES Does this strategy address any identified disparities and/or support low-income and disadvantaged communities?	■ YES ❒ NO The commission will seek to identify disparities in root causes, service delivery and outcomes related to mental health.
MEASURES OF SUCCESS	FY25: Explore the creation of a MH Mental Health Commission.

ADOPTION OF THE CHIP

The SMH Board of Directors approved the FY25-27 CHIP on Nov. 14, 2024. The Memorial Health Community Benefit Committee approved the FY25-27 CHIP on Nov. 18, 2024.

PUBLIC AVAILABILITY AND CONTACT

The 2024 Springfield Memorial Hospital Community Health Needs Assessment and FY25-27 Community Health Implementation Plan are publicly available online at https://memorial.health/about-us/community-health/community-health-needs-assessment/ and hard copies are also available. For additional questions or to request a hard copy, please contact the director of community health, Angela Stoltzenburg, at stoltzenburg.angela@mhsil.com

FUTURE STEPS

Over the next three years, the strategies will be implemented to create the anticipated impact described above. The measures of success identified in this plan will be formally reviewed at least twice annually by the Memorial Health Community Benefit Committee. Over this three-year period, needs may become less pressing, new community resources or programs may become available, barriers may challenge implementation, a strategy may be found ineffective, or a new need may present itself. If we must significantly shift our strategies or identified priorities, those changes will be reviewed and approved by the MH Community Benefit Committee and the SMH Board of Directors.

Springfield Memorial Hospital

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