A Joint Community Health Needs Assessment of Montgomery and Macoupin Counties:

HSHS St. Francis, Hillsboro Area, & Carlinville Area

2021

HSHS St.Francis Hospital

Hillsboro Area Hospital

Carlinville Area Hospital

SIU MEDICINE
POPULATION SCIENCE AND POLICY

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Note: The following report was created by a team from the Department of Population Science and Policy at SIU School of Medicine in partnership with the hospitals. This report could not have been made possible without the work from Nicole M. Summers-Gabr, Ph.D., Jessica Grim, MPH, Corbin Conigilo, B.S. and Kim Luz, M.S. Additional funding support was provided by Blue Cross Blue Shield of Illinois.

Executive Summary

HSHS St. Francis Hospital, Hillsboro Area Hospital and Carlinville Area Hospital & Clinics Community Health Needs Assessment (CHNA) 2021

Provisions in the 2010 Patient Protection and Affordable Care Act state that in order for hospitals to maintain a non-profit status, they must conduct an assessment every three years to understand local community health needs. Moreover, this assessment must take input from individuals the community serves, make the report publicly accessible and adopt an implementation strategy based on community health needs identified in the assessment.

Triennially, hospitals conduct a CHNA, adopt an implementation strategy in the same tax year and make the report widely available to the public.

This year HSHS St. Francis Hospital (SFL) partnered with Hillsboro Area Hospital (HAH) and Carlinville Area Hospital & Clinics (CAH&C), local health care organizations that share the same service area: Macoupin and Montgomery Counties. The last CHNA for SFL was conducted and adopted in FY2018 and conducted and adopted for HAH and CAH&C in FY2019. The assessment was led by the Southern Illinois University School of Medicine Department of Population Science and Policy (PSP) under the direction of assistant professor Nicole M. Summers-Gabr, Ph.D. The role of the university partnership was to:

- Collect secondary data
- Host an advisory council meeting to present the strengths and concerns of health needs in the community
- Facilitate focus groups to understand the context behind the greatest issues
- Collect demographic data from the advisory council and focus group members to document community representation
- Analyze focus group data
- Present findings to SFL, HAH and CAH&C

Identification and Prioritization of Needs

The following health needs were identified based on burden, scope, severity, health disparities, secondary data sources, input by local leaders and the ability to collaborate with other assets in the community.

- Access to Mental and Behavioral Health Treatment
- Workforce Development
- Food Insecurity

Implementation Plan Development

Secondary data and focus group conversations helped identify key areas and strategize how to address them. However, more investigation is necessary to understand the reasons for these being such prevalent issues in the community and which solutions fit the community. Therefore, the next step is to survey the community. Data on risk factors and solutions related to the three priorities will be collected during summer 2021. Results from this survey will inform the implementation plan and determine metrics on its success.

Hospital Background

HSHS St. Francis Hospital

SFL is a critical access hospital located in Montgomery County, Illinois. For more than 143 years, the hospital has provided health and wellness services to Macoupin and Montgomery Counties. SFL provides a wide range of specialties, including a cancer care center, cardiopulmonary, emergency care, orthopedics, rehabilitation services, woman and infant's center, surgery center, sleep studies, radiology, laboratory, heart care, and mind-body health services.

SFL partners with other area organizations to address the health needs of the community, with a focus on the poor and vulnerable. The hospital is part of Hospital Sisters Health System (HSHS), a highly integrated health care delivery system serving more than 2.6 million people in rural and midsized communities in Illinois and Wisconsin. With 15 hospitals, scores of community-based health centers and clinics, nearly 2,300 physician partners and more than 13,000 colleagues, HSHS is committed to its mission "to reveal and embody Christ's healing love for all people through our high-quality Franciscan health care ministry."

SFL has a rich and long tradition of addressing the health needs of the communities it serves. This flows directly from its Catholic identity. In addition to community health improvement services guided by the triennial CHNA process, the hospital contributes to other needs through our broader community benefit program. This includes health professions education, subsidized health services, research and community building activities. In FY2020, the hospital's community benefit contributions totaled $6,851,178.

Current Hospital Services and Assets

Table 1. SFL Services and Assets

Major Centers and Services	Statistics	New Service and Facilities
• Cancer Care Center • Cardiopulmonary • Emergency Care • Orthopedics • Rehabilitation Services • Family Maternity Center • Surgery Center • Sleep Studies • Radiology • Laboratory • Heart Care • Mind-Body Health Services	• Total beds: 25 • Total colleagues: 202 • Bedside RNs: 58 • Inpatient admissions: 1,380 • ED visits: 10,990 • Births: 202 • Inpatient surgeries: 203 • Outpatient surgeries: 1,894 • Physicians on medical staff: 22 • Volunteers: 250 • Community Benefit: $6,851,178	• New nine- bed ED opened May 1, 2020. • St. Francis Way Clinic opened April 1, 2021 to treat addiction disorders.

Hospital Accreditations and Awards

SFL is accredited by and received the gold seal of approval from The Joint Commission and is licensed by the Illinois Department of Public Health. The hospital is also approved by the Centers for Medicare and Medicaid Services (CMS). SFL earned a "5-star rating" from CMS regarding patient experience. CMS scores hospitals from one to five based on the 11 publicly reported measures in HCAHPS patient experience survey. The latest rating is based on survey data collected between Oct.1, 2018 and Sept. 30, 2019. Only 215 hospitals nationwide achieved a 5-star rating.

SFL also received the 2016 Bronze and 2017 Silver Award for Progress toward Excellence from ILPEx.The ILPEx Bronze and Silver Awards are granted to those organizations who demonstrate effective, systematic, well-deployed approaches that respond to the overall requirements of most Baldrige Framework for Performance Excellence criteria items and are aligned with organizational needs.

SFL ranked in the 95th percentile for three consecutive years on the HSHS Culture of Safety Survey. SFL received the 2016 and 2017 Practice GreenHealth Partner for Change award.

Hillsboro Area Hospital

HAH is a 25- bed hospital located in Montgomery County, Illinois. Since 1916, the hospital has been an anchor institution in Hillsboro, Illinois. HAH provides a wide range of specialties, including emergency, inpatient, and transitional care, diagnostic imaging, laboratory, rehabilitation, and respiratory services, a sleep clinic, surgery, podiatric medicine, a specialty clinic, as well as integrated behavioral health care.

HAH is dedicated to positively affecting the health and welfare of the community. The core values of the hospital are community, teamwork, service, excellence, respect and stewardship. In FY2019, the hospital's community benefit contributions totaled $3,066,245.93.

Since opening a new building in 1975, the hospital has expanded its services to include Douglas Telfer Outpatient Clinic, Heartland Home Care Facilities, Tremont Assisted Living Facility and the Special Care Cottage for Dementia and Alzheimer's.

Current Hospital Services and Assets

Table 2. HAH services and assets

Major Centers and Services	Statistics	New Services and Facilities
• Emergency Care • Inpatient Care • Transitional Care (Swing Bed) • Diagnostic Imaging • Laboratory • Rehabilitation Services • Respiratory • Sleep Clinic • Surgery • Podiatric Medicine • Tremont Assisted Living Center • Hillsboro Specialty Clinic • Integrated Behavioral Health	• Total Beds: 25 • Total Colleagues: 252 • Bedside RNs: 17 • Inpatient admissions: 337 (227 I/P; 110 SWB) • ED visits: 4,816 • Births: 0 • Inpatient surgeries: 23 • Outpatient surgeries: 863 • Physicians on medical staff: 10 • Volunteers: 15 • Community Benefit: $3,066,245.93	• Integrated Behavioral Health • Level 1 Dry Needling Program • First Steps Playgroup • Online Bill Pay

Hospital Accreditations and Awards

HAH has accreditation and licensure from: the U.S. Department of Health and Human Services, the American College of Radiologists, the Illinois Department of Public Health and the Illinois Healthcare Association. The hospital also achieved accreditation by Det Norske Veritas. HAH is affiliated with the American Hospital Association, the Illinois Hospital Association and the Illinois Critical Access Hospital Network.

HAH was named one of the St. Louis Post-Dispatch's top places to work from 2014-2019. Additionally, HAH was named one of the top 100 critical access hospitals by iVantage Health Analytics in 2015. It received a four-star rating in the Hospital Consumer Assessment of Health Plans (HCAHPS) survey in 2019.

Carlinville Area Hospital and Clinics

CAH&C is a rural,-independent critical access provider offering award-winning inpatient, outpatient and rehabilitation care to the people of Carlinville and surrounding communities. This comprehensive offering also includes a 24-hour STAT Stroke and STAT Heart designated emergency department. The hospital is led by a group of progressive

leaders and has more than 250 dedicated team members. Its updated facilities and strong medical community enable it to provide more than a dozen specialties and subspecialties.

Current Hospital Services and Assets

Table 3. CAH&C services and assets

Major Centers and Services	Statistics (FY 2020)	New Services and Facilities
• Diagnostic Imaging • Emergency Care • Infusion and Chemotherapy • Inpatient Care • Integrated Behavioral Health • Laboratory • MRI Suite • Podiatric Medicine • Rehabilitation Services • Respiratory • Rural Health Clinic(s) • Sleep Clinic • Specialty Outpatient Clinic • Surgery • Transitional Care (Swing Bed) • Walk-in Clinic • Wound Clinic	• Total beds: 25 • Total colleagues: 286 • Bedside RNs: 88 • Inpatient admissions: 423 • ED visits: 5,610 • Births: 0 • Inpatient surgeries: 26 • Outpatient surgeries: 383 • Physicians on medical staff: 9 • Volunteers: 130 • Community Benefit: $13.9 million	• Dry Needling Services • Gynecological Outpatient Services • Senior Behavioral Health • Women's Health – Pelvic Floor

Hospital Accreditations and Awards

CAH&C has accreditation and licensure from the U.S. Department of Health and Human Services, the Health Facilities Accreditation Program (HFAP), The Joint Commission and the Illinois Department of Public Health. CAH&C Is affiliated with the American Hospital Association, the Illinois Hospital Association and the Illinois Critical Access Hospital Network.

Communities Served by the Hospitals

The service area is comprised of two counties: Macoupin County and Montgomery County. This territory covers approximately 203.49 square miles with a population of approximately 29,479. The population density is 144.87 persons per square mile. The patient population includes all who receive care without regard to insurance coverage or eligibility for assistance.

Demographic Profile of Macoupin County

Table 4. Macoupin County demographic profile

Characteristics	IL 2019	Macoupin County 2019	Macoupin County 2010	% Change for County
Total Population	12,770,631	45,463	47,765	-4.8%
Age				
Median Age (Years)	43.3	43.7	41.7	4.8%
Under 5 Years	767,193	2,292	2,818	-18.7%
Under 18 Years	2,891,526	9,683	10,775	-10.1%
65 Years and Over	1,942,534	8,895	8,171	8.9%
Gender				
Female	6,498,459	22,928	24,369	-5.9%
Male	6,272,172	22,535	23,548	-4.3%
Race and Ethnicity				

White (non-Hispanic)	7,829,850	43,670	46,596	-6.3%
Black or African American	1,783,708	434	359	20.9%
Native American or Alaska Native	15,108	82	126	-34.9%
Asian	692,370	222	129	72.1%
Hispanic or Latino	2,186,387	560	418	34.0%
Language Spoken At Home Other Than English	2,779,838	680	930	-26.9%
Median Household Income	$65,886	$55,159	$47,178	16.9%
Percent Below Poverty Line In The Last 12 Months	11.5%	13.9%	12%	15.8%
Educational Attainment				
High School Graduate or Higher, Percent of Persons Age 25+	89.2%	91.3%	86.8%	5.2%
Bachelor's Degree or Higher, Percent of Persons Age 25+	34.7%	18.4%	15.0%	22.7%

Source: U.S. Census Bureau, 2010 American Community Survey 5 Year estimates; U.S. Census Bureau, 2019 American Community Survey 5 Year estimates

Demographic Profile of Montgomery County

Table 5. Montgomery County demographic profile

Characteristics	IL, 2019	Montgomery County, 2019	Montgomery County, 2010	% Change for County
Total Population	12,770,631	28,828	30,104	-4.2%
Age				
Median Age (Years)	43.3	43.3	41.4	4.6%
Under 5 Years	767,193	1,491	1,703	-12.5%
Under 18 Years	2,891,526	5,776	4,683	23.3%
65 Years and Over	1,942,534	5,655	5,199	8.8%
Gender				
Female	6,498,459	13,694	14,359	-2.8%
Male	6,272,172	15,134	15,745	3.9%
Race and Ethnicity				
White (non-Hispanic)	7,829,850	26,883	28,632	-6.1%
Black or African American	1,783,708	1,078	952	13.2%
Native American or Alaska Native	15,108	50	47	6.4%
Asian	692,370	71	111	-36.0%
Hispanic or Latino	2,186,387	510	459	11.1%
Language Spoken At Home Other Than English	2,779,838	549	910	39.7%
Median Household Income	$65,886	$52,748	$40,864	29.1%
Percent Below Poverty Line In The Last 12 Months	11.5%	16.6%	14.0%	18.6%
Educational Attainment				
High School Graduate or Higher, Percent of Persons Age 25+	89.2%	87.7%	83.5%	5.0%
Bachelor's Degree or Higher, Percent of Persons Age 25+	34.7%	16.7%	13.3%	25.6%

Source: U.S. Census Bureau, 2010 American Community Survey 5 Year estimates; U.S. Census Bureau, 2019 American Community Survey 5 Year estimates

Process and Methods Used to Conduct the Assessment

The FY2021 CHNA was led by a core team comprised of leaders from SFL, the HSHS Illinois Division, HAH, CAH&C and facilitated by PSP. The entities collaborated on the planning, implementation and completion of the

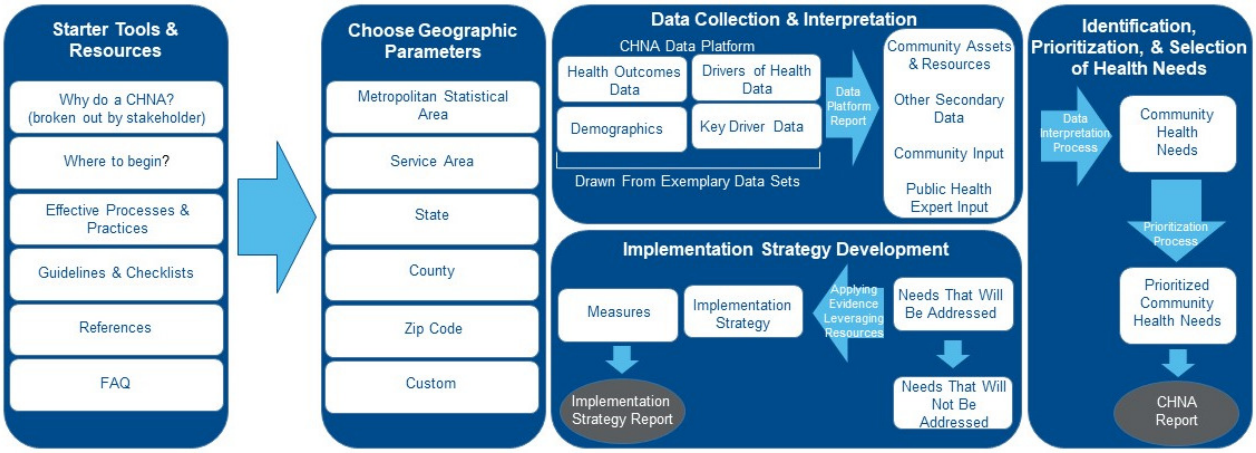
assessment.

Purpose of a CHNA:

1. Evaluate current health needs of the hospital service areas
2. Identify resources and assets available to support initiatives to address the health priorities identified
3. Develop an implementation plan to organize and help coordinate collaborative efforts impacting the identified health priorities
4. Establish a system to track, report and evaluate efforts that will impact identified population health issues on an ongoing basis

Data Collection and Analysis

The framework used to guide the CHNA planning and implementation is based on the Catholic Health Association's Community Commons CHNA flow chart below:



CHNA Protocol

The protocol included going through four key stages. Each stage builds off the work of the last to finalize the top three priorities. These stages are secondary data collection, initial priority selection, primary data collection and final priority selection. This protocol was approved by the SIU School of Medicine IRB and designated as protocol 21-776.

Stage 1: Secondary Data Collection

The CHNA process began by collecting data from preexisting sources on community demographics, housing, poverty, education, labor and health. Some data was provided by SFL, HAH and CAH&C. The remaining data was obtained from the sources below:

- Data USA
- Federal Reserve Bank of St. Louis
- Housing Action Illinois
- Illinois Department of Public Health
- Illinois State Board of Education
- Kids Count Data Center
- National Cancer Institute
- Macoupin County Health Department
- Montgomery County Health Department
- Policy Maps
- RJWF County Health Rankings

Stage 2: Initial Priority Selection

The data was compiled into a presentation by PSP and recommendations were given around initial priority selection. The hospitals selected the remaining top 14 priorities They are:

- Access to Behavioral Health Treatment
- Access to Dental Care
- Access to Exercise
- Access to Mental Health Treatment
- Affordable Health Care
- Child Abuse and Neglect
- Cost Burdened Renters
- Diabetes and Obesity
- Food Insecurity
- Future Water Issues in Rural Areas
- Human Trafficking
- Student Mobility
- Workforce Development
- Unmanaged Chronic Conditions

Stage 3: Primary Data Collection

The three forms of primary data collection were a demographic survey, a community advisory council meeting and focus groups.

Demographic Survey: The demographic survey documented how participants represented the general community. Everyone on the community advisory council and those who participated in the focus groups took the 17-item demographic survey. It was administered via Zoom sessions by providing a link to take the survey on REDCap.

Community Advisory Council Meeting: A meeting of stakeholders from Montgomery and Macoupin County was held on February 24, 2021 via Zoom. Out of 24 invited stakeholders, 20 stakeholders consented to meet with representatives from SFL, HAH, CAH&C and PSP. A total of 18 (38.9% female) took the demographic survey. They represented various fields (e.g., ministry, education, health, law enforcement) as well as special population groups (e.g., rural, at-risk, and youth). Youth participants participated virtually. The average age of participants was 46.1 years (SD = 17.3) with a range of 15 years to 71 years. This diverse group of individuals helps ensure the conversation about and voting on community health needs was determined by a broad representation of the community and not just those in the hospitals or in positions of power.

The Community Advisory Council Meeting met for 120 minutes with the following agenda:

Table 6. CAC meeting agenda

Time (am)	Agenda Item	Agenda Item Description
9:00 - 9:15	Introduction	Introduced facilitators/presenters, provided an overview of the CHNA process, and review priority areas.
9:15 - 9:20	Survey	Provided a link via s Zoom chatbox to click on and fill out a 5-minute demographic survey (Appendix A) on REDCap
9:20 - 10:25	Data Presentation	PSP presented the secondary data (Appendix H) from the sources described above. During this time strengths and concerns about community data were highlighted. Potential reasons for each priority area were also described.
10:25 - 10:45	Breakout Session of Assigned Topic	Three breakout sessions ensued. Each breakout group was assigned a facilitator and one of three topics to discuss for 20 minutes: housing and poverty, education and labor or health. The questions for this portion of the session were: a. What surprised you most? b. What made you most concerned? c. How did this issue either impact people you know or work with as part of your job? d. To your knowledge, why is this an issue for your community? Do you have data that you can share with us?

		e. What made you most proud of your community? f. Are there any other comments from the group?
10:45 - 10:55	Breakout Session of Other Topics	Participants were given an extra 15 minutes to discuss their thoughts and opinions on any of the remaining topical areas or what could have been missed. The questions for this portion of the session were: a. What makes you most concerned in the other topics we did not get to discuss yet [housing/poverty, education/labor, health]. Why does this issue concern you? b. Is there anything in your personal experiences with your organization or in with others in your life that we have not highlighted in this data? c. Do you feel we left anything off the list that should be considered as a health priority? d. If so, what supporting data can you share to justify the addition?
10:55 - 11:00	Voting	Participants rated their top five priorities from 5 (highest importance) to 1 (lowest importance). Participants were encouraged to consider the Triple Aim Impact, or to consider the magnitude, seriousness and feasibility of each priority. Votes were sent through the chatbox to a facilitator.

Results from forced ranking led to six significant needs. They are:

1. Access to Behavioral Health Treatment
2. Access to Mental Health Treatment
3. Child Abuse and Neglect
4. Unmanaged Chronic Conditions
5. Food Insecurity
6. Workforce Development

Focus Groups: The hospitals hosted four online focus groups on March 4, 5, 15 and 17. Fifteen out of the 29 community members invited consented to participate. The focus groups were facilitated by PSP via Zoom and scheduled both during and outside of typical business hours to accommodate work/school schedules. The seasons were recorded and transcriptions were produced by Windy City Transcription to use for analysis. The majority of the participants were female (73.3%). The average age was 55.47 years (SD = 20.99) with a range of 15 years to 76 years. Once again, the discussions about and voting on community health needs was determined by a broad representation of the community and not just those in the hospital or in positions of power.

Each focus group was 60 minutes long with the following example agenda:

Table 7. Focus Group agenda

Time (pm)	Agenda Item	Agenda Item Description
6:00 – 6:05	Introduction	Introduced facilitators/presenters, provided an overview of the CHNA process and reviewed priority areas.
6:05 – 6:10	Survey	Provided a link via Zoom chatbox to click on and fill out a 5-minute demographic survey (Appendix A) on REDCap.
6:10 - 10:25	Data Presentation	PSP presented a shortened version of the secondary data (Appendix H) with a particular focus on the six significant needs listed above.
10:25 - 10:55	Discussion	Participants took part in a guided discussion about the data. Each priority was given approximately five minutes. contingent upon participants' interest and specialties. Participants were asked the following questions: a. What concerned you most about this theme? b. Why do you think this is happening? c. How do you think it should be fixed?

		d. Is there anything that you think we should explore more in this topic? e. Do you have any data sources to support this?
10:55 - 11:00	Voting	Participants rated their top three priorities from 3 (highest importance) to 1 (lowest importance). Participants were encouraged to consider the Triple Aim Impact as they voted, or to consider the magnitude, seriousness and feasibility of each priority. Votes were sent through the chatbox to a facilitator.

Results from forced ranking led to three significant needs. The top three were:

1. Access to Mental Health Treatment
2. Workforce Development
3. Food Insecurity

Stage 4: Final Priority Selection

The internal advisory council from the hospitals reviewed the final three priorities, as well as the rankings for the other six. The council decided that due to its close ties with mental health access, behavioral health access would be combined with mental health access to create a single priority of access to mental and behavioral health treatment. Based on the CHNA planning and development process described, the following community health needs were identified:

Access to Mental and Behavioral Health Treatment

Workforce Development

Food Insecurity

Identified Overview of Priorities

Access to Mental Health and Behavioral Health Services

Mental and behavioral health are a challenge for both adults and youth in this service area.. Mental health surfaced as a priority for SFL in FY2015 and FY2018. It also emerged as a priority for HAH in FY2019 and as a priority for CAH&C in 2016. Data for adults suggests there are two times as many suicides for Montgomery County and four times as many suicides for Macoupin County than state levels. In addition, there were more opioid overdose deaths among adults in both counties than cocaine and alcohol overdose deaths combined. These issues persist in youth with around one in four youth in middle school and one in three high school students in Hillsboro reporting moderate to very severe depression. Additionally, around one in five youth vaped or consumed alcohol recently and one in 10 youth used marijuana.

Part of the reasons these issues could have persisted over the years is that there is little access to social workers, psychologists and psychiatrists in this area compared to state averages. Focus groups confirmed the challenges of obtaining mental health access in a timely manner and also shared the view that when services are available there is not always a supportive network encouraging treatment.

Workforce Development

Less than one in five adults has a college degree. Approximately 50% of residents have a high school degree or less. This suggests is there is a gap in the market for specialty training jobs (is this what you mean?). Alternatively,

it could mean there are not enough jobs that require a college education to keep residents in the community. The average age in both counties is higher than the state average which shows it is a challenge to keep younger populations in the community. Participants in the focus group conversations noted the only high paying jobs are in the school district, the hospitals or the prison.

Workforce development issues may be exacerbated by the lack of internet access. A large segment of the does not own a computer or lacks internet access compared to the state level. While this may be because the average age of the population is higher and less familiar navigating the internet, it can also result in a number of consequences. Specifically, lack of internet access poses barriers to telehealth treatment, e-learning opportunities and applying for jobs. Focus group participants reported seeing individuals go to fast food restaurants and library parking lots to access the internet and apply for jobs. Focus group participants believe workforce development is related to mental and behavioral health and that more people would stay in the community if internet access improved.

Food Insecurity

Food insecurity impacts all ages, but especially the youth. Nearly one in five children were found to be food insecure, and one in 10 people overall. A lack of access to grocery stores only compounds the problem. Focus group discussions revealed the challenges around accessing nutritious food and reported residents often rely on convenience stores to purchase student lunch supplies. While large grocery stores with fresh produce can be found in cities nearby, not everyone may have the time or transportation to travel.

Focus group participants mentioned short-term food insecurity is being addressed by local food pantries, meals offered at churches and neighborhood initiatives to share excess food. However, more long-term and cohesive solutions are needed.

Input from Persons Who Represent the Broad Interests of the Community

SFL, HAH and CAH&C are committed to address community health needs in collaboration with local organizations and other area health care institutions. The FY2021 assessment sought input from a broad section of community stakeholders.

Input from Community Stakeholders

The FY2021 assessment was designed to better document community inclusion. PSP created an electronic demographic survey for the community advisory council (CAC) and focus group participants to document these inclusion efforts. This survey documented basic information such as gender, age, and profession. In total, 33 individuals completed the survey. While the CAC was mostly male and the focus groups were majority female, the gender dispersion was nearly even (45.5% male; 54.5% female). No participants identified as transgender or non-conforming. The age range across all participants was from 15 years old to 71 years old, with an average age of 50.4 years old and a median age of 51 years old.

Almost 67% of CAC members worked outside of health care (e.g., hospitals, clinics, public health departments) and 100% of the focus group participants worked outside of health care. In addition to the nine retirees, participants worked in ministry, law enforcement, public education, farm bureau, social work, public housing and economic development. This information demonstrates the majority of the stakeholders were not employed by the hospitals.

Input from Members of Medically Underserved, Low Income and Minority Populations

To best understand the reasons for and solutions to the greatest health priorities concerning the community, the hospitals invited a diverse group of individuals who would be directly impacted to be part of the CAC and focus groups.

Youth were included for the first time in FY2021 to better learn about their health concerns first hand. Out of the 33 participants, 15.5% were youth.

FY2021 was also the first year demographic data was collected from CAC and focus group participants to capture how it provides a good representation of the population.

All participants had voting power and time to discuss their thoughts and opinions on the priority areas and the data associated with it. Across adult and youth participants, both racial/ethnic minorities and sexual minorities were represented: 3.03% identified as Native American and 3.03% identified as African American/Black. Additionally, 9.10% reported being a member of the LGBTQ2+ community.

All participants reported having medical insurance; however, there was also some differences in socioeconomic status as indicated by income, employment, and education. Among all participants, 18.20% reported a household income level less than $49,999, but only 3.03% reported their household income fell below the federal poverty line. Out of the adult participants, 10.71% reported their employment status as disabled. In addition, 7.14% indicated they were not homeowners. Finally, while adult education was higher on average than the general population, 7.14% of adult participants had completed some high school and 17.9% had completed some college, thus indicating that not all participants were from positions of power or privilege.

Input from Communities on Past CHNAs

No written comments were received regarding the SFL FY2018 CHNA, the HAH FY2019 or the CAH&C FY2019.

Potential Resources to Address the Significant Health Needs

The following resources will be considered when developing the implementation plan:

Access to Mental and Behavioral Health Treatment

Table 8. Mental and behavioral health resources

Service Area	Resource Type	Resource Name	Link or Name
Both	Event	U of I Extension – Managing Stress During Peak Seasons	https://extension.illinois.edu/events/2021-04-01-managing-stress-during-peak-seasons
Montgomery	Prevention	Sources of Strength	Hillsboro High School; https://sourcesofstrength.org/
	Treatment	Blues Program	HAH; https://thebluesprogram.weebly.com/
		Psychiatric Mental Health Nurse Practitioners -	**Sandra Cania** Phone: 217-839-1526 Fax; 217-839-1538 Website: https://www.healthcare4ppl.com/physician/illinois/gillespie/sandra-l-cania-1316441868.html **Jennifer Thery** Phone: 618-288-5019 Website: https://sia-llc.net/about-us
		Consulting Psychiatrist for Sandra Cania -	**Arif Habib, M.D.** Phone: (618) 876-7515 Fax; (618) 876-7596 Website: https://www.gatewayregional.net/gateway-regional-medical-center/findadoctor/habib-arif-md-3706
		Consulting Psychiatrist for Jennifer Thery -	**Sanjay Nigram, M.D.** Phone: 618-288-5019 Website: https://sia-llc.net/about-us
		Psychologist -	**Michele Womontree, Psy.D.** Phone: 217-523-2001 Website: https://doctor.webmd.com/doctor/michele-womontree-65da74b8-6769-459c-bf79-15697d5abf09-overview
Macoupin	Treatment	Macoupin County Health & Wellness Center	https://mcphd.net/health-wellness-center-recovery-center/
		School Linked Health Center	https://mcphd.net/school-linked-health-center?/
		Behavioral Health Services	https://mcphd.net/maple-street-clinic/#Behavioral

Workforce Development

Table 9. Workforce development resources

Service Area	Resource Type	Resource Name	Link or Name
Both	Dual credit	Lincoln Land Community College "First Semester Program"	https://www.llcc.edu/academics/high-school-programs/first-semester-experience/
		Lincoln Land Community College	https://www.llcc.edu/academics/high-school-programs/dual-credit/
	Dual credit; Technical training	Lincoln Land Technical Education Center	https://sites.google.com/a/ltec41.org/ltec-home-website/
	Job training for those on food Stamps or Unemployment Insurance	Workforce Innovation and Opportunity Act (WIOA) Job Training	http://www.west-central.org/job-training.php
	Job placement for ages 16-24	Youth Work Experience Program	http://www.west-central.org/job-training.php
	Early college credit	Lincoln Land Community College "College Now"	https://www.llcc.edu/academics/high-school-programs/college-now-2/
Montgomery	Multi-service	Montgomery County Job Center	http://www.west-central.org/employment_Montgomery.php
Macoupin	Multi-service	Macoupin County Job Center	http://www.west-central.org/employment_Macoupin.php

Food Insecurity

Table 10. Food insecurity resources

Service Area	Resource Type	Resource Name	Link or Name
Both	Event	U of I Extension – Container Gardening with Vegetables	https://extension.illinois.edu/events/2021-04-06-container-gardening-vegetables
		U of I Extension – 4-H Salsa Gardening for Kids	https://extension.illinois.edu/events/2021-04-20-4-h-salsa-gardening-kids
		U of I Extension – Bread Making	https://extension.illinois.edu/events/2021-04-02-4-h-bread-making-hillsboro
		U of I Extension - Community Supported Agriculture Boxes | Eat Fresh, Eat Local	https://extension.illinois.edu/events/2021-04-21-community-supported-agriculture-boxes-eat-fresh-eat-local
Montgomery	Food Pantries/banks	CEFS Montgomery County Outreach	https://www.cefseoc.org/
		Litchfield Food Pantry	https://www.llcc.edu/wp-content/uploads/2020/12/Montgomery-County-Local-Food-Pantries2.pdf
		Panhandle Food Pantry	
		St. Clare Center	
		Witt Food Pantry	
Macoupin	Food Pantries/banks	Area Caring Center (2 locations: Gillespie, IL and Mt. Olive, IL)	https://www.llcc.edu/wp-content/uploads/2020/03/Macoupin-County-Local-Food-Pantries.pdf
		Brethren Church (Only serves old Virden School District)	
		Brighton Food Pantry	

		Bunker Hill United Methodist Church	
		Carlinville Food Pantry	
		Girard Food Pantry (only serves old Girard School District)	
		Shipman United Methodist Church	
		Staunton Helping Hands Resource Center	
		United Methodist Church (Northwestern School District)	

Next Steps

After completing the FY2021 CHNA process and identifying the top priority health needs, next steps include:

- Collaborating with community organizations and government agencies to develop or enhance existing strategies.
- Developing a three-year implementation plan (FY2022 - FY2024) to address identified health needs.
- Integrating the implementation plan into organizational strategic planning and budgeting to ensure the proper allocation of human, material and financial resources
- Presenting and getting the CHNA report and implementation plan approved by the hospitals' governing boards in the same tax year the CHNA was conducted
- Publicizing the CHNA report and implementation plan widely on https://www.hshs.org/stfrancis/, http://www.hillsboroareahospital.org/ and https://www.cahcare.com/ and CHNA partner websites and make accessible in public

Approval

The FY2021 CHNA Report was adopted by the SFL governing board on May 11, 2021.

The FY2021 CHNA Report was adopted by the HAH board of directors on June 17, 2021

The FY2021 CHNA Report was adopted by the CAH&C board of directors on June 17, 2021

APPENDICES

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APPENDIX A

Macoupin and Montgomery County Demographic Survey

If there was one health concern that you could improve in your community, what would it be?

Have you ever served on an advisory council for HSHS St. Francis or Hillsboro Area Hospital before?
- O Yes
- O No

Have you ever participated in a focus group for HSHS St. Francis or Hillsboro Area Hospital before?
- O Yes
- O No

What is your profession (e.g., social worker, electrician, retired, student)?

What is your employment status?
- O Employed Full-Time
- O Employed Part-Time
- O Unemployed, seeking opportunities Unemployed, not seeking opportunities
- O Retired
- O Prefer not to say
- O Other

If you selected other, what is your employment status?

What is your age?

Are you a veteran?
- O Yes
- O No

What is your gender?
- O Male
- O Female
- O Transgender
- O Non-Conforming
- O Other

If other, what is your gender?

Are you a member of the LGBTQ2+ community?
- O Yes
- O No

What is your race (select all that apply)?
- ☐ Native American or Alaska Native Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other

If other, what is your race?

Are you Hispanic or Latino?
- O Yes
- O No

What is the highest level of education you have completed?
- O 8th grade
- O Some high school
- O High school
- O Some college
- O Associate's degree
- O Bachelor's degree
- O Master's degree
- O Ph.D., law or medical degree
- O Other

What is your household income level?
- O Less than $25,000
- O $25,000 - $34,999
- O $35,000 - $49,999
- O $50,000 - $74,999
- O $75,000 - $99,999
- O $100,000 - $149,999
- O $150,000 - $199,999
- O $200,000 or more

Does your income fall below the federal poverty line? For reference, use the table below.

Federal Poverty Line Indicators	
$12,760	Individual
$17,240	2
$21,720	3
$26,200	4
$30,680	5
$35,160	6
$39,640	7

- O Yes
- O No

Do you currently have health insurance?
- O Yes
- O No

Are you currently a homeowner?
- O Yes
- O No

Who invited you to be part of the community health needs assessment process?

APPENDIX B

Survey Results: Community Advisory Council

Table 11. Advisory Council Demographic Data

Miscellaneous binary questions	No	Yes
Have you ever served on an advisory council for HSHS St. Francis or Hillsboro Area Hospital before?	64.7%	35.3%
Have you ever participated in a focus group for HSHS St. Francis or Hillsboro Area Hospital before?	55.6%	44.4%
Are you a veteran?	100.0%	0.0%
Are you a member of the LGBTQ2+ community?	94.1%	5.9%
Do you currently have health insurance?	100.0%	0.0%
Does your income fall below the federal poverty line?	94.4%	5.6%

Table 12. Advisory Council Occupation and Employment Data

What is your profession?	Frequency	Percent
Student	3	16.8%
Refuse To Respond	2	11.1%
Administrator	1	5.6%
Behavioral Health	1	5.6%
CEO/Public Health Administrator	1	5.6%
Chief of Police	1	5.6%
Community and Economic Development	1	5.6%
Community Outreach/Social Worker	1	5.6%
Educator	1	5.6%
Executive Director	1	5.6%
Farm and Rural Development Advocate	1	5.6%
Hospital Administrator	1	5.6%
Hospital CEO	1	5.6%
Pastor	1	5.6%
Property Manager for Public Housing	1	5.6%

Table 13. Advisory Council Employment Status Data

What is your employment status?	Frequency	Percent
Employed Full-Time	14	77.8%
Employed Part-Time	2	11.1%
Unemployed, seeking opportunities	1	5.6%
Unemployed, not seeking opportunities	1	5.6%

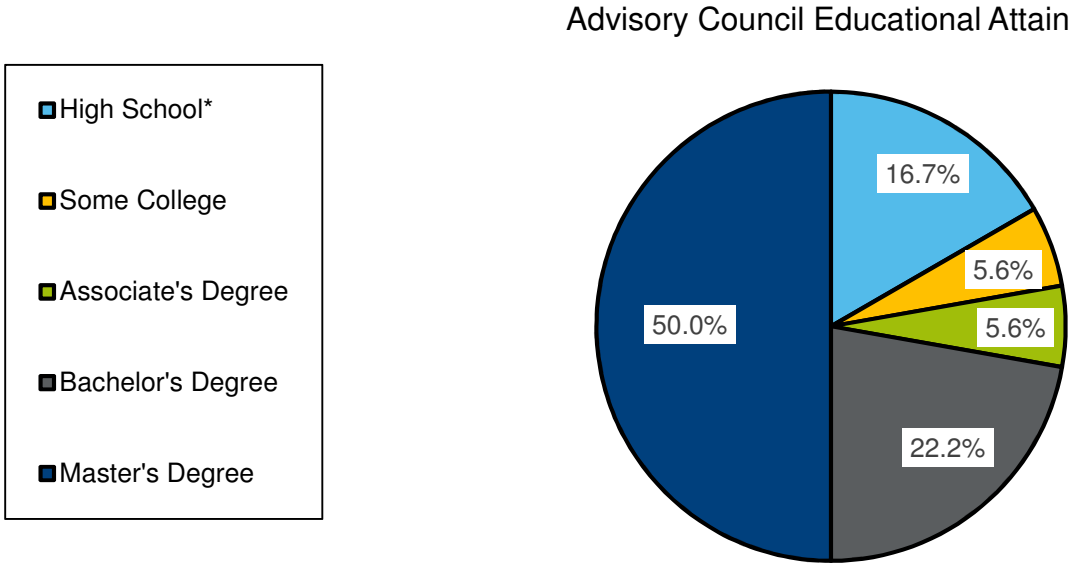
Table 14. Advisory Council Gender Orientation Data

What is Your Gender?	Frequency	Percent
Male	11	61.1%
Female	7	38.9%

Table 15. Advisory Council Race/Ethnicity Data

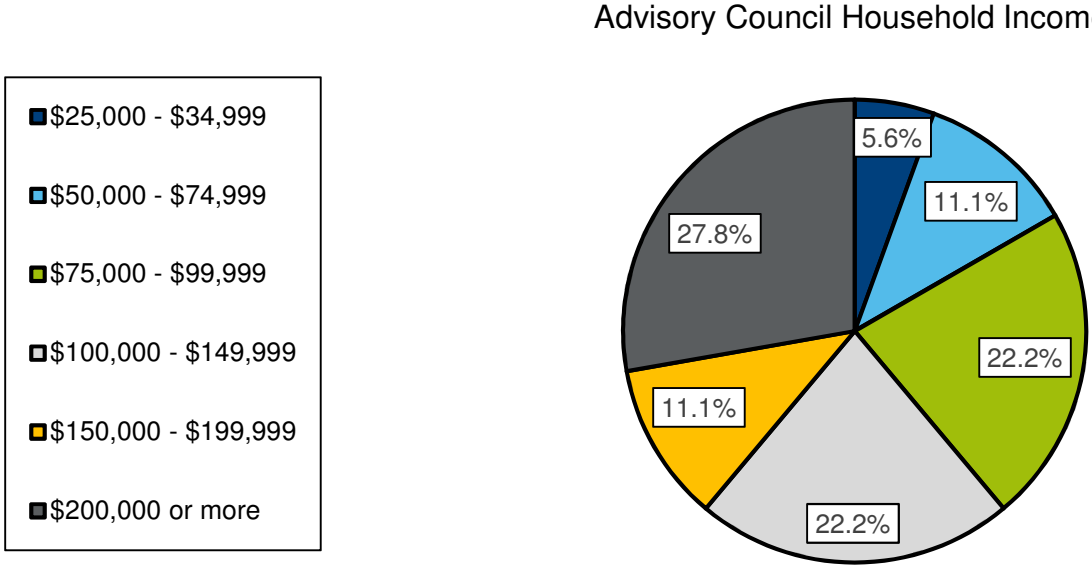
What is your race/ethnicity? (Select all that apply)	Frequency	Percent
White	17	94.4%
Black or African American	1	5.6%
Native American or Alaska Native	1	5.6%
Asian	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%

Figure 1. Advisory Council Educational Attainment Data



*Current high school students selected 'high school' instead of middle school.

Figure 2. Advisory Council Household Income Data



APPENDIX C

Survey Results: Focus Groups

Table 16. Focus Group Health Concerns Data

If there was one health concern that you could improve in your community, what would it be?	Frequency	Percent
Mental health	7	46.5%
Behavioral health needs	2	13.3%
Anxiety	1	6.7%
Affordable health care	1	6.7%
Homelessness and low-income residents	1	6.7%
Child abuse and neglect	1	6.7%
Obesity	1	6.7%
Childcare	1	6.7%

Table 17. Focus Group HSHS/ Hillsboro Area Hospital Advisory Council Service Data

Have you ever served on an advisory council for HSHS St. Francis or Hillsboro Area Hospital before?	Frequency	Percent
No	14	93.3%
Yes	1	6.7%

Table 18. Focus Group HSHS/Hillsboro Area Hospital Focus Group Service Data

Have you ever participated in a focus group for HSHS St. Francis or Hillsboro Area Hospital before?	Frequency	Percent
No	12	80.0%
Yes	3	20.0%

Table 19. Focus Group Occupation and Employment Data

What is your profession?	Frequency	Percent
Retired	9	60.0%
Disabled	3	20.0%
Student	2	13.3%
Nurse	1	6.7%

Table 20. Focus Group Employment Status Data

What is your employment status?	Frequency	Percent
Retired	9	60.0%
Disabled	3	20.0%
Employed, Part-Time	2	13.3%
Unemployed, seeking opportunity	1	6.7%

Table 21. Focus Group Age Demographic Data

What is your age?	Frequency	Percent
15	2	13.3%
31	1	6.7%
43	2	13.3%
59	1	6.7%
65	2	13.3%
69	2	13.3%
70	2	13.3%
73	1	6.7%
74	1	6.7%
76	1	6.7%

Table 22. Focus Group Veteran Status Data

Are you a veteran?	Frequency	Percent
No	15	100.0%
Yes	0	0.0%

Table 23. Focus Group Gender Orientation Data

What is your gender?	Frequency	Percent
Male	4	26.7%
Female	11	73.3%

Table 24. Focus Group Sexual Orientation Data

Are you a member of the LGBTQ2+ community?	Frequency	Percent
No	13	86.7%
Yes	2	13.3%

Table 25. Focus Group Race/Ethnicity Data

What is your race/ethnicity? (Select all that apply)	Frequency	Percent
White	15	100.0%
Black or African American	0	0.0%
Native American or Alaska Native	0	0.0%
Asian	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%

Table 26. Focus Group Educational Attainment Data

What is the highest level of education you have completed?	Frequency	Percent
8th grade	1	6.7%%
Some high school	2	13.3%
High school	1	6.7%
Some college	4	26.7%
Bachelor's degree	2	13.3%
Master's degree	3	20.0%
Ph.D., law, or medical degree	2	6.7%

Table 27. Focus Group Household Income Data

What is your household income level?	Frequency	Percent
$35,000-$49,999	5	33.3%
$50,000-$74,999	1	6.7%
$75,000-$99,999	2	13.3%
$100,000-$149,999	4	26.7%
$150,000-$199,999	1	6.7%
$200,000 or more	2	13.3%

Table 28. Focus Group Poverty Data

Does your income fall below the federal poverty line?	Frequency	Percent
No	15	100.0%
Yes	0	0.0%

Table 29. Focus Group Health Insurance Data

Do you currently have health insurance?	Frequency	Percent
No	0	0.0%
Yes	15	100.0%

Table 30. Focus Group Home Ownership Data

Are you currently a homeowner?	Frequency	Percent
No	4	26.7%
Yes	11	73.3%

APPENDIX D
Focus Group Conversation Results

Executive Summary

Focus group participants were asked to share their thoughts related to the six priority areas selected by the CAC. The three main topics discussed within each priority area were biggest concern, resources or solutions and further investigation.

One of the common concerns across the priorities was a lack of access to services. Participants shared concerns about the lack of access to mental and behavioral health treatment, as well as the lack of social workers to assist neglected children, a lack of broadband access and employment opportunities and a lack of grocery stores nearby. Participants believe many of the biggest concerns within each priority area are directly related to access issues. Many of the resources that participants listed are related to improving access to these services.

Participants acknowledged several of the priorities are linked together, specifically mental health and behavioral health treatment access. Participants also noted many of these priorities are generational health issues and carry over from parents to children. Consequently, childhood was a major focus on future prevention ideas. More specifically, school-based programs (e.g., mental health interventions, dual credit opportunities) and adult support systems (e.g., more social workers) were described as a necessity to change the future of all six priority areas.

Access to Behavioral Health Treatment

Biggest Concern

Participants were concerned about many issues highlighted in the behavioral health data including mortality rates, substance use and handgun possession on school premises. However, most of each focus group's discussion narrowed in on the topic of substance use in both youth and adults. Participants cited reasons for youth substance use as accessibility, parental influence through their own usage, mental health in the community, too much free time and to fit in with the norm. One youth participant stated:

> *"It's become such a normal thing and it's almost like the roles have changed where if you choose to stay healthy and not participate in those risk behaviors you're on the outside and you're like considered – you know – you don't fit in with what's normal."*

Participants also shared fears about the likelihood of substance use increasing across all ages due to COVID-19, legalization of marijuana and a lack of knowledge about the long-term effects of vaping. For instance, one person reported:

> *"You know honestly, I think it's pretty spot-on and kind of scary, but since now marijuana is legal and it's really becoming about being legal and illegal, all of these behaviors are illegal for … So that is, to me, those are all just still very scary things and a lot of that is just really related to how they're brought up, what they see in their everyday lives and availability, so I'm worried that the marijuana one will actually go up because it's going to be more easily accessible.*

Resources or Solutions

In terms of substance use in adults, one participant mentioned there is a new recovery program coming near SFL. One proposed solution to youth substance us was to have more activities for youth to occupy their time with rather than vaping and drinking. This could be accomplished by seeking input from youth to learn what they would like to see in the community.

Future Investigations

The only area participants seemed curious to learn more about are the reasons behind premature deaths such as farm accidents or lack of access to proper health care (e.g., gynecological care).

Access to Mental Health Treatment

Biggest Concern

Participants reported being mostly concerned about the low number of providers in their community and poor insurance coverage for testing. To elaborate a participant stated:

"If an insurance company or carrier will not cover a test or procedure you're just screwed. They will not even allow you to have the tests unless you can prove that your insurance will cover it or you can pay thousands out-of-pocket to pay for these tests. The tests I had done out-of-pocket would have been – I think it was somewhere between twelve and fourteen hundred dollars just to be tested."

Youth participants reported they believe the magnitude of the issue is even greater than the data suggests because not all of their peers were honest about mental health struggles in both the Hillsboro youth survey and the biannual school testing.

"When I look around at my school and I see what people post on social media there are a lot of people that struggle and I wish that everyone would be more open. I know a lot of people when you guys did these surveys, I heard a lot of people say they lied on them and they're not going to say how they feel on a survey, which saddens me because like I know I was one hundred percent honest even though it was kind of odd putting all my information out there. I was like I have to be honest because when you look at our county and our community, we have to see what the real issues are. It just surprises me with these numbers"

Resources or Solutions

Participants shared a few ideas of what they believed could help address mental health in their community. They suggested advertising mental health services better, providing child care while receiving mental health treatment and breaking down the stigma of mental illness. One way a participant elaborated to destroy the stigma of mental illness with youth specifically is by finding a venue in which brave youth can share stories of their struggles so others can see mental health struggles are experienced by people from all backgrounds or social groups.

Future Investigations

Participants had many questions around the topic of mental health. First, there was great interest around the Sources of Strength and the Blues Program that HAH is sponsoring at Hillsboro High School. Participants were curious about the results and future expansion of the program to the junior high school and other school districts. Participants also wanted to know about the true availability of mental health services. For example, what are the referral services like at the school-level, are all mental health providers accurately counted and tracked and the average wait time to get an appointment. One participant shared:

"I think six months to get in to talk to a psychologist about my emotional issues even knowing that I had a severe disease. It took over six months just to get an appointment with someone that my insurance would pay for."

Access to Behavioral Health Treatment

Biggest Concern

Participants thought all the data around child abuse and neglect was interrelated and not one particular statistic was the most concerning. Rather, participants discussed many concerns and reasons why they felt that this is a prevalent issue. They included a lack of providers, fear of repercussions from reporting that could be experienced by the reporter or victim and victims believing that abuse was normal. Some comments by participants included:

"My concern there too is that the teacher who reports it often fears for themselves because some of the people who are involved, the parents, are horrible; they're violent, and I have a couple of stories that I've heard about their experiences. So DCFS can only do so much, so hands are tied on both ends I think; this is a very difficult situation and it's sad, it's really sad because it is the children who suffer."

"There is not enough providers per 10,000 kids, like three, that's ridiculous. I think there needs to be way more; they're overrun and they can't do their jobs properly and thoroughly because they have to rush through it to get to the next one to make sure that kid is taken care of too."

"In our community you see a lot of that because it's generation-to-generation. and people don't really think there is much wrong with that if they've been raised that way. Some people don't understand or accept betterment from how they were raised."

One youth indicated all data around caregiver punitive punishment were concerning even when it came to parent-child communication:

"Of course you want the numbers to be zero for things like 'hitting you with a hard object,' 'slap or hit you,' – those are still not good numbers. But the fact that nearly 25 percent of kids said that their parents 'call them names like stupid or dumb,' and barely over half said that their parents don't even 'listen to their side.'"

Resources or Solutions

Participants believed the best ways to help families in these circumstances is to increase the number or mental health and social service providers to make the case load more manageable. Others believe more early intervention is needed at the school level. One participant noted neighborly check-ins and involvement would better help identify and intervene in these cases.

Future Investigations

One area which needs further study is the extent of child abuse and neglect in Montgomery County because there is not information available on the number of documented cases.

Workforce Development

Biggest Concern

Participants were concerned about many areas related to workforce development. Concerns include low bachelor's degree achievement, poor employment opportunities and a how a lack of internet access effects economic opportunities. It was reported the only major local employers are the school district, the hospital and the prison. Therefore, people may have to leave to get a job. Additionally, as they search for better opportunities, it may be impossible to engage in e-learning or submit resumes due to poor internet connection. Participants reported:

> *"My son-in-law has been applying for jobs and he lives just a short distance from me; theirs is so bad he goes and sits at Hardee's parking lot so that he can actually do resume."*

> *"At our library our Wi-Fi is free and it's open and we have people who sit outside even after the library is closed just to use the Wi-Fi."*

Other participants highlighted that workforce development is related to with mental health so this was the most important concern to address out of all of the priorities:

> *"I've always said that education and economic development go hand-in-glove and honestly, I think that also fits with the mental health side of things. If the job that you do had meaning, whether it's in the actual work or what it provides for your family, then I think that really serves well on the mental health side too."*

> *"But I would agree with [Participant Name], both my parents were teachers, although my dad farmed most of his life, but he was also a teacher, and I think to me it's like [Participant Name] said earlier, the chicken or the egg. I think to me, it's the workforce development in developing the economy so that if we have a good economy and nice places to live, the people are wonderful, then you can get more physicians. You may get a fulltime psychiatrist; you may be able to attract more child psychologists to the community which would help with the whole mental health issue. So, I'm like [Participant Name], to me I think this was the number one thing when you look at cause and effect and you can have the biggest bang for the buck."*

Resources or Solutions

Most of the solutions that participants posed involved a focus on education. One idea was to promote the certificate training at Lincoln Land Community College and offer transportation services to the training. Another solution involved changing dual credit opportunities. All four schools in the county have educational foundations which offer scholarships that are typically for high school graduates. The educational foundations could help fund scholarships for youth still in high school to afford dual credit for programs like College Now at Lincoln Land which costs $450. Another solution was to have a position where someone has more time to work closely with youth to sort through available scholarships and help youth apply.

Future Investigations

There were no gaps in the data or areas in which participants thought needed to be explored more.

Unmanaged Chronic Conditions

Biggest Concern

Nutrition-related diseases (diabetes and heart disease) as well as lung cancer were among the greatest concerns. This is due to how unmanaged conditions were interrelated with mental health, the costs of medications (e.g., insulin) making it difficult to get treatment and the lack of knowledge around vaping. For instance, one youth participant described how future cancer statistics may be a concern:

> *"I feel like now a lot of kids will get lung cancer now. and that's where it's starting like now and a little bit ahead of us when the vaping epidemic started."*

An adult participant touched on how the unmanaged chronic conditions could be related to childhood experiences:

"I think everything kind of goes back to mental illness when you have a high ACES [Adverse Childhood Experiences] score, when you've been through trauma, there are higher rates of all that and when there is not enough people to manage that and not enough people who are getting treated for that, then that's all stored in the body."

Resources or Solutions

One youth participant thought the top chronic conditions were most connected with nutrition. Poor nutritional choices and lack of time can lead to unhealthy eating which can in turn be related to diabetes, heart disease and cancer. The root cause of poor nutrition needs to be considered. An adult participant thought that county-wide screenings need to be promoted more to identify issues sooner and educate the community.

Future Investigations

Participants were interested in learning more about these issues to understand the rate, not the frequency, of cases and compare them to other Illinois counties or states. Another participant raised the question as to why Macoupin County had more cases than Montgomery County. One participant was curious as to how many unmanaged cases were due to lack of access to health care or healthy food vs. a lack of self-care.

Food Insecurity

Biggest Concern

Participants reiterated findings in data which suggest there is a shortage of grocery stores. Without money for food and gas, residents must rely on convenience stores like Casey's to buy basic items like children's lunch supplies. One participant said:

"…because there was no lunch prepared for them, and the other is their only access to food was something like Casey's, so it was chocolate milk and Pop-Tarts and the children were overweight; they didn't have – they were obviously malnourished and it affected all their life."

Participants also indicated that since COVID-19 began food insecurity has increased. One participant shared about meals given at their local church:

"We've just been doing drive-thru and walk-up, hand them a bag lunch and usually it's a hot lunch, and we actually had an increase when we actually would have them come inside and meet downstairs in the dining room. We've given usually between sixty and seventy meals out every Wednesday morning at eleven o'clock so it's a real thing. I know also in the Hillsboro schools there was a program developed at the high school because the high school students had food to eat over the weekends and we've had that already going at the grade school too..."

Resources or Solutions

Participants mentioned the Methodist Church and St. Agnes Church both provide meals for community members. They could be valuable partners in the future to host meal programs. One community mentioned a neighborhood garden overflow box where people can donate or take whenever they please. To the participant's knowledge the garden overflow box is well used and no food goes to waste. Building more garden overflow boxes could provide healthy food to those in need.

Future Investigations

Participants had no remaining inquiries about the food insecurity data.

APPENDIX E

HSHS St. Francis Hospital FY2018 Evaluation

Evaluation of the impact of any actions that were taken, since the immediately preceding CHNA conducted in FY2018, to address significant identified health needs.

In FY2018, SFL conducted a community health needs assessment (CHNA). Primary and secondary data was gathered from multiple sources to assess the hospital's primary service area. Based on the data and the prioritization process, the following priority community health needs were selected:

- Substance Abuse
- Mental Health
- Diabetes and Obesity

Below is an evaluation of the impact of the actions taken in response to the hospital's FY2018 CHNA.

Substance Abuse and Mental Health

Coalition Building

The Macoupin/Montgomery County Mental Health Coalition formed in March 2016. Members included leaders from law enforcement, health care, clergy and school systems. The goals were to:

1. Guide and participate in the planning, development and implementation of projects and programs intended to improve addiction education and behavioral health of the SFL service area.
2. Create a unified, county-wide process for intake and post-intake handling of criminal and non-criminal individuals with mental health and substance abuse needs introduced to the system by law enforcement and other social service agencies.
3. Improve access to psychiatrists and rehab facilities for youth and adults.

Outcomes: This group continues to meet. In FY2020, they developed a pocket guide for law enforcement and first responders with resources for substance abuse disorder (SUD) and mental health situations. This group also launched a program in conjunction with the schools to provide a safe number for students to call if they are having thoughts of self-harm, suicide, depression, sadness, etc.

Coordinated Care Delivery

In a partnership with the Illinois Telehealth Network (ITN), a pilot program was created to address behavioral health provider shortages in rural areas using telemedicine. This pilot program consists of three phases:

1. Implement assessments via telemedicine to patients presenting in the ED using the service provider Locust Street Resource Center in Carlinville, Illinois.
2. Adding consistent post-acute behavioral health services via telehealth services to expand phase 1.
3. Having a community health worker coordinate care and track remote monitoring technology as part of the overall patient care plan.

Outcomes: This program continues to provide crisis assessments to SFL ED patients presenting with behavioral health issues. An outpatient services component was added in FY2021 to include the addition of a clinical supervisor, engagement specialist (ES) and recovery coach (RC). Through a partnership with Gateway Foundation, patients presenting with SUD can voluntarily work with an ES to determine the level of treatment and recovery needed. Once determined, the ES works with the treatment facility to secure a bed and warm handoff between the ED and a treatment facility. The RC is available help if the patient is not ready to go directly to treatment or to help the patient transition back into the community following treatment.

Diabetes and Obesity

Diabetes Self-Management

Provide a free six-week course to community members living with pre-diabetes/diabetes.

Outcomes: The community outreach facilitator was certified by the American Association of Diabetes Educators and an eight-module diabetes self-management course is in development. In June of 2018 a referral-based relationship was developed with local primary physicians to help ensure future enrollment. The program has been

put on hold in response to the COVID pandemic.

St. Clare's Community Garden

Montgomery County contains areas known as "food deserts," where residents do not have easy access to healthy food. Food deserts tend to be mostly low-income households. Without access to transportation, many of these individuals must walk, bike or ride transit to get food so the amount of food and the time to buy food is limited. Lack of mobility may also be a barrier to access to healthy food. The FY2018 CHNA identified diabetes and obesity as a top priority. To help improve access to nutrient dense foods and fresh produce St. Clare's Community Garden was created.

Outcomes: This program was put on hold in FY2020, due to the onset of COVID. As planting had already occurred, SFL colleagues volunteered to maintain and harvest the garden. All produce was donated to the local food pantries and the summer feeding program to help meet rising demand. The garden manager is working closely with local food pantries in FY2021 and 100% of the produce will be donated to help meet the increase in food demand as a result of the pandemic.

Summer Feeding Program

With 27% of children in the Litchfield community living below the poverty line, SFL partnered with First Baptist Church of Litchfield and Illinois Coalition for Community Services to bring a free summer lunch program to the community in May 2017. The church applied for a grant through the W.D. Kilton Trust and received additional funding for the program. A free lunch is provided over the summer months Monday through Friday for any child up to eighteen years old. Transportation is provided.

Outcomes: This is the fourth year of the lunch program run by volunteers offering a free lunch to all school-aged children June 1 - July 31. Thanks to an additional partnership with the Central Illinois Food Bank, the program was able to provide 2,300 meals and feed an average of 45 kids each weekday in 2020. Meals were provided 'to o' to follow COVID and social distancing guidelines.

APPENDIX F

Hillsboro Area Hospital FY2019 Evaluation

Evaluation of the impact of any actions that were taken, since the immediately preceding CHNA conducted in FY2019, to address significant identified health needs

In FY2019, HAH conducted a CHNA. Primary and secondary data was gathered from multiple sources to assess the hospital's primary service area. Based on the data and the prioritization process, the following priority community health needs were selected:

- Mental Heath
- Transportation
- Improved Awareness
- Access to Urgent Care
- Chronic Illnesses

Below is an evaluation of the impact of the actions taken in response to the hospital's FY2019 CHNA:

Mental Health

Education for Parents about Mental health issues facing youth

Letters were sent to parents regarding the two-session assessment survey conducted by the PSP, as well as letters describing the two suicide prevention programs taking place at Hillsboro High School (Sources of Strength and the Blues Program).

Address Teen Suicide

HAH supported a schoolwide assessment of students at Hillsboro High School and Hillsboro Middle School in 2019. The assessment, created and administered by PSP, was completed by approximately 750 students. A community steering committee formed to assess the data and selected two evidence- based programs to implement at Hillsboro High School in 2020 (Sources of Strength and the Blues Program).

Community Awareness Education on Mental Health

Through fund-raising for these two evidence based programs the community was made aware of the new mental health programs. In February 2020 the steering committee raise $37,000 at an event sponsored by the hospital. Additional funds were acquired during in 2020.

Education on Awareness and Understanding of Self-Esteem

Implementation of the Sources of Strength Program in October 2020 and the Blues program in March 2021 help raise awareness and educate youth about the importance of self-esteem.

Address Mental Health Disorder "Triggers"

The Sources of Strength and Blues programs at Hillsboro High School are designed to address mental health triggers.

Integrated Behavioral Health

The hospital also added two professionals to its integrated behavioral medicine staff in 2020. The four-person department is staffed by hospital nurses and a contracted psychiatrist.

Telepsych Services

Telepsychology services efforts are on hold due to the inability to recruit a tele-psychologist.

Transportation

Summer Lunch Program

HAH reimbursed the Hillsboro School District for student transportation costs associated with the free summer lunch program in 2019. Volunteers delivered groceries to families in need in 2020.

Ride Scheduling

HAH helps patients schedule rides through Quad County Health and Central Illinois Public Transportation. When

patients cannot afford to pay, the hospital assists with paying the taxi service serving the western section of the county.

Improved Awareness

Workplace Wellness

An employee wellness program was added at HAH in December 2019. The Allscripts Wellness plan provides a personalized coaching experience. The coach helps team members with many different aspects of their health, including weight management, healthy eating, diabetes, hypertension, smoking cessation and more. Each team member received a scale, blood pressure cuff and activity tracker.

Special Presentations

In July 2019 summer lunch participants heard presentations on health professions and living a healthy life. In November of 2019, HSHS partnered with Fusion Fitness and Aquatics and Springfield Clinic to provide a health fair designed for elementary school age children. This fair provided 25 stations to educate students and their parents on healthy lifestyles.

Health Care Career Exploration

High school students who want to learn more about specific health careers can attend monthly meetings where they review health-related topics and visit various departments. Sessions are offered evenings and during the day on non-school days.

Community Education

In November of 2019 HAH began a series of Lunch and Learn events for the community. The first was a presentation titled “An Apple a Day Keeps the Doctor Away” which focused on healthy diets and eating habits. Due to COVID-19, all additional presentations were postponed.

Access to Urgent Care

Telehealth Services

Telehealth was disrupted by the pandemic, but the telecommunication platform Zoom was used to connect assisted living facility residents with their primary care physicians. A contract for telemedicine services to supplement our hospitalists is in the process of being implemented.

Urgent Care

HAH has been unable to recruit a physician to establish urgent care services. This effort will continue.

Chronic Illnesses

Lung Cancer

In 2019 HAH partnered with PSP to conduct a lung cancer research survey. After surveying 270 people educational materials were developed to educate the community about the importance of lung cancer screening. A billboard was installed in December 2020 to help bring awareness to the community.

Pulmonologist

HAH has continued its contractual relationship with a pulmonologist from Springfield Clinic.

APPENDIX G

Carlinville Area Hospital & Clinics FY2019 Evaluation

Evaluation of the impact of any actions that were taken, since the immediately preceding CHNA conducted in FY2019, to address significant identified health needs

In FY2019, CAH&C conducted a community health needs assessment (CHNA). Primary and secondary data was gathered from multiple sources to assess the hospital's primary service area. Based on the data and the prioritization process, the following priority community health needs were selected:

- Obesity Education
- Diabetes Prevention
- Mental Health
- Improved Access to Activities
- Workforce Development

Below is an evaluation of the impact of the actions taken in response to the hospital's FY2019 CHNA:

Obesity Education

The hospital addressed obesity education by providing programming aimed at youth on the importance of recreation, exercise and healthy eating. Obesity education also impacted other issues identified as significant, such as diabetes and mental health.

The hospital continued to support existing programs. Lunch Bunch provides meals to children and families during the summer months and the Third Day Project provides snack bags on long weekends. The hospital also supported the University of Illinois Extension's Health Jam, the Auxiliary 5K and Wellness Fair, other local 5K sponsorships and sports team sponsorships.

The hospital also explored partnerships with the University of Illinois Extension for nutrition programing and promoted wellness by allowing the community to use the walking path on hospital grounds.

Diabetes Prevention

The hospital encouraged recreation and exercise at all ages and provided prevention programs.

The hospital also continued developing a chronic care management program with focus on diabetes, is migrating toward a patient-centered medical home and developed a relationship with an endocrinologist.

Mental Health

The hospital improved access to mental health, substance use and misuse counseling. This included access to local mental health case management services for persons dealing with depression, grief and loss. The hospital also developed services for persons identified with adverse childhood experiences (ACES).

The hospital improved access to preventative care and case management services and established a local health care workforce development team. The hospital also explored tele-psychiatry for mental health counseling and continued its relationship with Locust Street Resource Center to help with the evaluation and placement of patients. The hospital also explored tele-behavioral health crisis assessment and added a social worker to the rural health clinics.

Improved Access to Activities

The hospital continued group activities and developed additional activities as needed. They included the Senior Series, a golf clinic, fall and balance classes, a Parkinson support group, exercise classes, aquatic classes and a cancer support group.

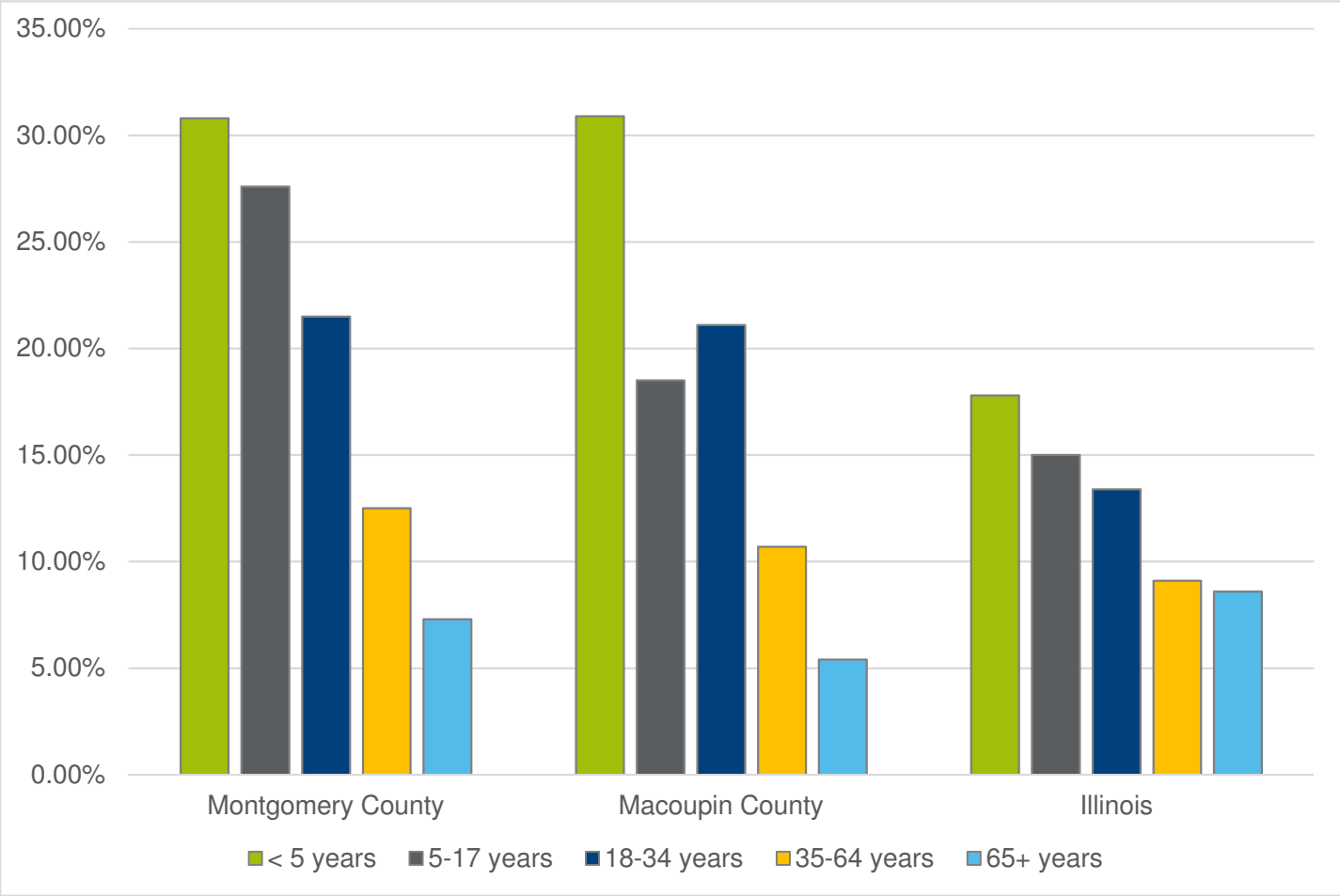
Workforce Development

The hospital continued its support of the Macoupin CEO Program, the High School 2 Health Care Program and provided tours of the hospital to students. The hospital also continued offering clinical rotations for nursing students.

APPENDIX H

Secondary Data Analysis

Figure 3. Percentage of poverty by age groups



Note. In the state of IL, poverty is highest among residents under 65, with children under 5 making up the biggest percentage. In Macoupin and Montgomery Counties, 31% of children under 5 live in poverty, compared to the state average of 18%.

Table 31. Disproportionate rate of poverty and homelessness in Illinois

Illinois			
	White	**Black/African-American**	**Other**
Percent total Population	72.0%	14.0%	14.0%
Percent of persons in poverty	53.0%	30.0%	17.0%
Percent of homelessness population	36.0%	59.0%	5.0%

Note. At the county level, poverty and race are difficult to understand due to a lack of county-specific information. At the state level the majority of those experiencing homelessness are Black/African-American.

Table 32. Percentage of children in poverty and other socioeconomic factors

	Montgomery County	Macoupin County	Illinois	U.S.
Total children in poverty	28.4%	21.4%	17.1%	18.5%
White children in poverty	-	20.0%	9.0%	10.0%
Black / African-American children in poverty	-	6.0%	34.0%	31.0%
Hispanic/Latino children in poverty	-	73.0%	20.0%	23.0%
Children in single-parent household	39.0%	31.0%	32.0%	34.0%
Uninsured children	3.0%	3.0%	3.0%	6.0%

Note. Children of color, disproportionately live in poverty compared to children who are White. In Illinois, 9% of White children live in poverty, whereas 20% of Hispanic children and 34% of Black/African-American children live in poverty. In Macoupin County, 20% of White children and 73% of Hispanic children live in poverty.

Table 33. Homelessness in Illinois and South Central Continuum of Care (CoC)

Indicator	South Central Illinois CoC	Illinois
2019*	94	10,199
Homeless per 10,000 people	2.4	8.0
Homelessness by Population	Total ↓ by 62.0%	Total ↓ by 34.0%
Sheltered	↓ by 72.0%	↓ by 32.0%
Unsheltered	↑ by 9.0%	↓ 43.0%
Family	↓ 81.0%	↓ 46.0%
Individual	↑ by 2.0%	↓ 25.0%
Veteran	N/A	↓ 48.0%
Chronic	↓ 73.0%	↓ 43.0%

Note. Count of homeless population based on one night of the year.

Table 34. Percentages of residents experiencing housing and renting cost-burdens

Owner Type	Indicator	Montgomery County	Macoupin County	Illinois
Homeowners	Homeowners	76.4%	76.7%	66.1%
	Cost-burdened homeowners	15.9%	13.2%	23.0%
	Severely cost-burdened homeowners	5.5%	4.8%	9.4%
Renters	Renters	23.6%	23.3%	33.9%
	Cost-burdened renters	33.5%	45.4%	44.6%
	Severely cost-burdened renters	14.6%	23.6%	22.8%

Table 35. Households (HH) in Macoupin County above the Federal Poverty Line earning less than the basic cost of living for the county

Macoupin County, 2017		
Town	**Total HH**	**% ALICE & Poverty**
Benld	615	44.0%
Brighton	874	31.0%
Bunker Hill	767	43.0%
Carlinville	2,015	42.0%
East Gillespie	102	30.0%
Gillespie	1,381	45.0%
Girard	748	36.0%
Lake Ka-Ho	107	52.0%
Medora	179	38.0%
Modesto	101	38.0%
Mount Clare	127	47.0%
Mount Olive	801	34.0%
Nilwood	105	38.0%
Palmyra	271	54.0%
Sawyerville	104	53.0%
Shipman	204	29.0%
Staunton	2,295	41.0%
Virden	1,453	36.0%
Wilsonville	259	58.0%

Note. The ALICE poverty indicator stands for Asset Limited, Income Constrained, Employed)The ALICE metrics for this indicator represents households with income above the poverty line but below basic costs of living which are developed based on a county specific analysis of monthly costs. The Household Survival Budget reflects the bare minimum that a household needs to live and work. It does NOT include emergency savings or future savings.

Table 36. Households (HH) in Macoupin County above the Federal Poverty Line earning less than the basic cost of living for the county

Montgomery County, 2017		
Town	**Total HH**	**% ALICE & Poverty**
Coalton	132	46.0%
Coffeen	258	58.0%
Donnellson	101	73.0%
Farmersville	310	42.0%
Fillmore	133	48.0%
Hillsboro	1,572	39.0%
Irving	160	57.0%
Litchfield	3,220	48.0%
Nokomis	923	46.0%
Panama	126	43.0%
Raymond	409	38.0%
Schram City	312	44.0%
Taylor Springs	209	52.0%
Witt	364	44.0%

Figure 4. Percentage of educational attainment

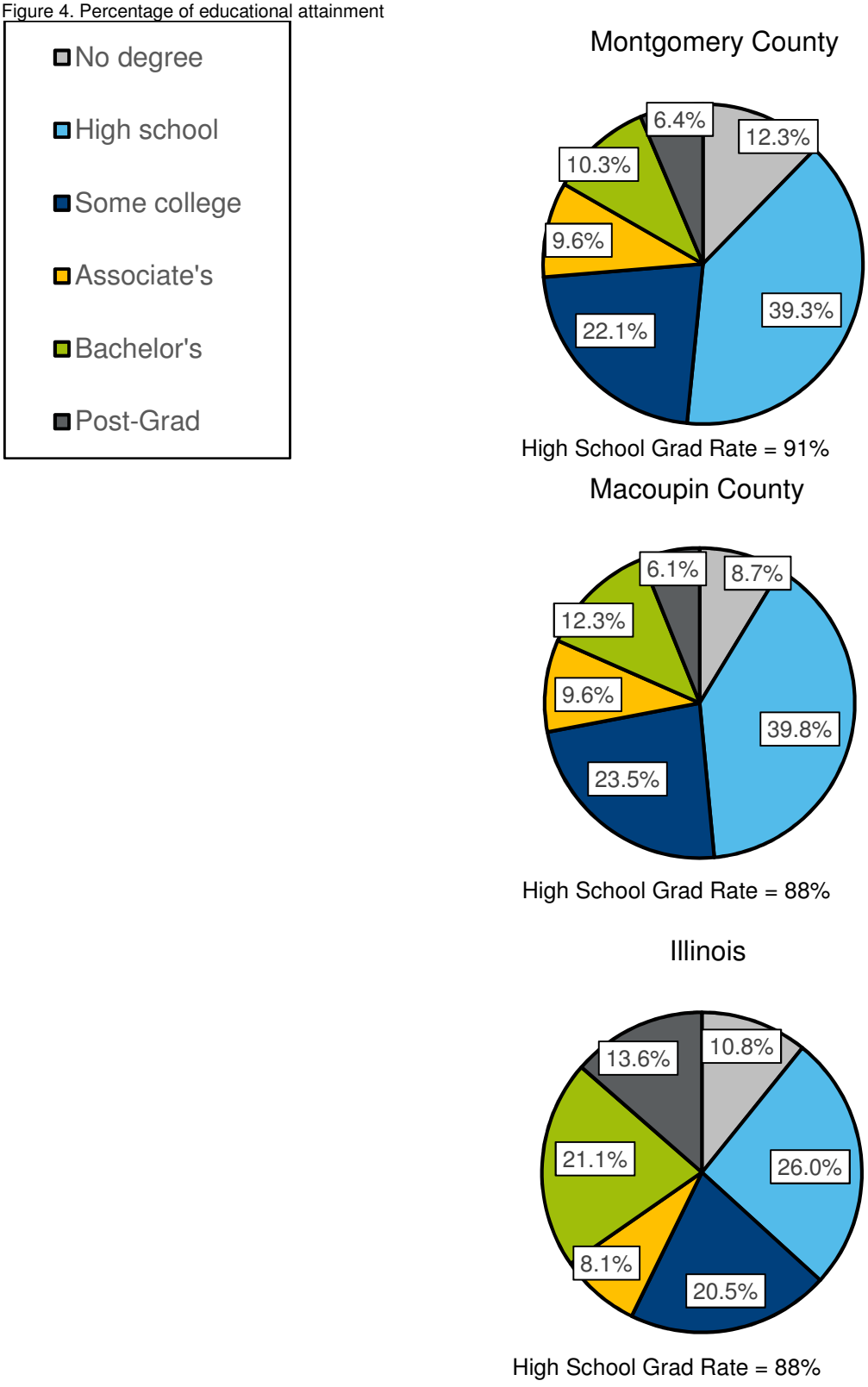


Figure 5. Percentage of veterans by war

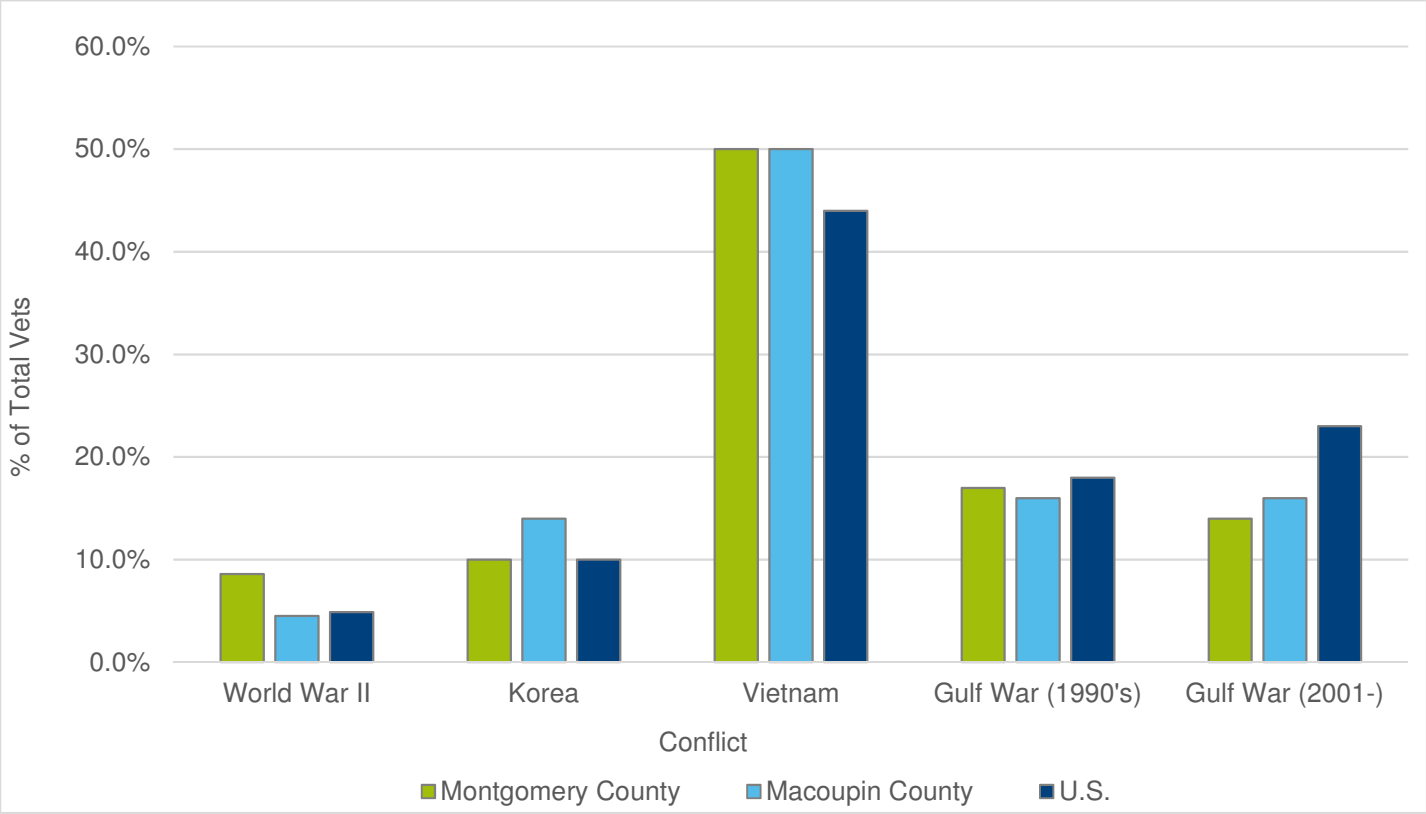


Table 37. Education attendance information

Indicator	Montgomery County	Macoupin County	Illinois
Enrollment	4,066	7,967	1,957,018
Chronic absenteeism	7.0%	7.0%	11.0%
Attendance rate	96.3%	96.8%	---
Dropout rate	3.8%	3.5%	3.5%
Student mobility	10.5%	7.8%	6.2%

Note. Montgomery and Macoupin County have a 4% lower absenteeism rate than the state average. However, Macoupin, and especially Montgomery, have higher student mobility rates, meaning children change schools, than the state average

Table 38. Population distribution of employment

	Montgomery County	Macoupin County	Illinois	U.S.
Population 16 years and over	23,779	37,018	10,215,498	259,662,880
In labor force	51.0%	59.5%	65.2%	63.4%
Not in labor force	49.0%	40.5%	34.8%	36.6%
Civilian labor force (employed)	48.7%	55.5%	61.2%	59.6%
Civilian labor force (unemployed)	2.3%	3.9%	3.9%	3.4%
Armed forces	< 0.0%	< 0.0%	0.2%	0.4%

Figure 6. Unemployment rate of Montgomery and Macoupin County

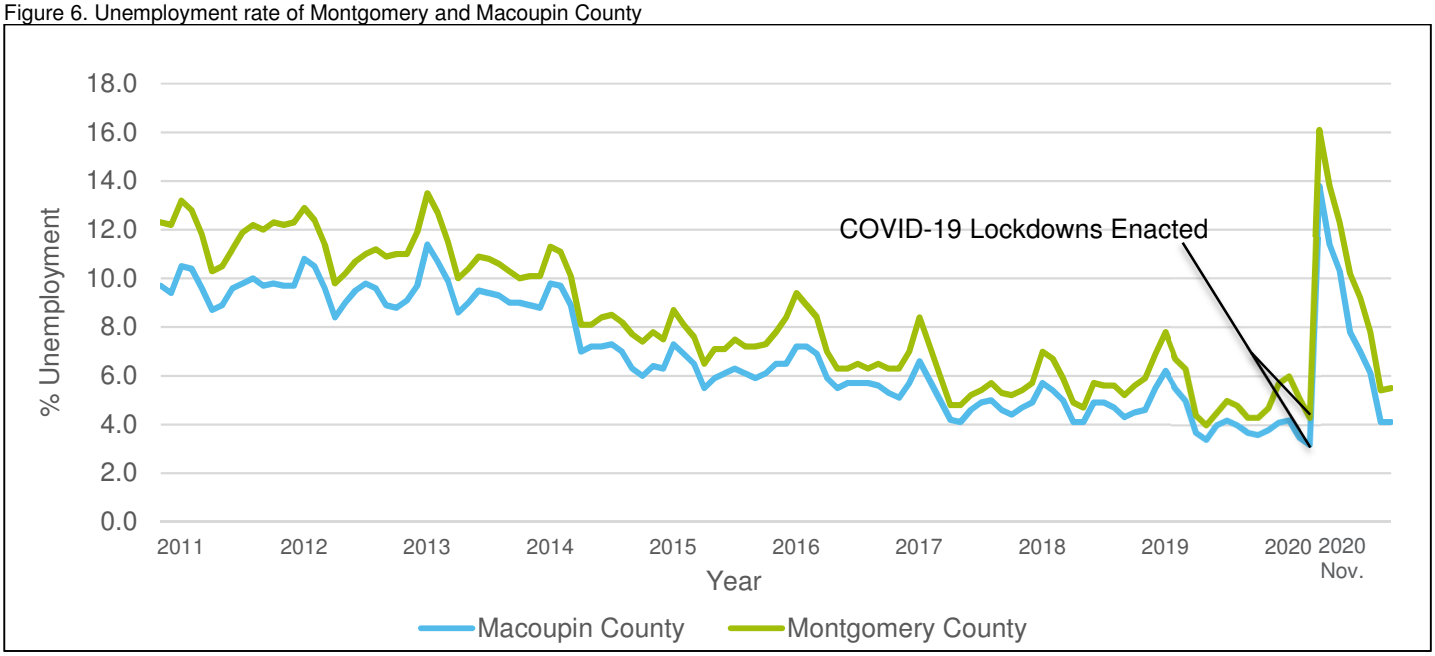


Table 39. Percentage of population with computer and internet access

	Montgomery County	Macoupin County	Illinois	U.S.
Households with a computer	84.9%	87.7%	89.9%	90.3%
Households with broadband internet subscription	74.9%	79.1%	82.7%	82.7%

Table 40. Food Insecurity information

	Montgomery County	Macoupin County
Residents above other nutrition program threshold of 185% poverty	41.0%	36.0%
Residents between 165-185% poverty	8.0%	10.0%
Residents below SNAP threshold of 165% poverty	51.0%	54.0%
Insecurity rate (children)	20..2%	17.1%
Insecurity rate (0verall)	12.1%	10.9%
Food insecure people	3,500	4,990
Average meal cost	$2.64	$3.16
Annual food budget shortfall	$1,566,000	$2,666,000

Note. Food insecurity in both Montgomery and Macoupin County is particularly high amongst children. Around 1 in 5 children is unsure of where their next meal will come from. The average meal cost is slightly lower in Macoupin than Montgomery County which might explain why the food insecurity rates are slightly lower. Regardless, food insecurity is experienced much more by children than by the population overall.

Table 41. Confirmed cases of COVID19

	Montgomery County	Macoupin County	Illinois	U.S.
Positive COVID-19 cases	2,435	4,252	1,116,372	25,456,670
Deaths caused by COVID-19	55 (2.23% of cases)	101 (2.38% of cases)	19,067 (1.71% of cases)	427,626 (1.68% of cases)
COVID-19 vaccines administered	-	3,519	1,789,175	26,193,682

Table 42. Percentages of insurance types of residents

Insurance Source	Montgomery County	Macoupin County	Illinois
Medicare	23.5%	23.4%	19.4%
Medicaid	11.6%	10.2%	9.2%
Employer-based	38.4%	41.0%	41.7%
Self-insured	15.4%	15.9%	18.5%
Uninsured	6%	6%	8%

Table 43. Percentages of various health factors

	Health Factors	Montgomery County	Macoupin County	Illinois
Hospital visits	Visited a doctor in the past year	78.6%	79.4%	77.3%
	I go to the doctor regularly for check-ups	47.9%	48.4%	48.8%
	I only go to the doctor when I'm very ill	31.8%	30.9%	29.6%
Medication	I take my prescription medicines exactly as prescribed	68.6%	68.6%	65.7%
	I take medicine as soon as I don't feel well	12.2%	11.5%	13.4%
	Medication has improved the quality of my life	28.5%	28.6%	27.4%
Physical activity and nutrition	I follow a regular exercise routine	18.6%	19.4%	25.0%
	My medical conditions limit my lifestyle somewhat	17.5%	16.8%	14.2%
	In general, I feel I eat right	29.4%	29.6%	33.4%

Note. Montgomery and Macoupin County residents seem to follow the state average in their hospital visits and medication usage, but a smaller proportion of residents in both counties reported following a regular exercise routine or eating right.

Table 44. Ratio of residents to healthcare professionals

Clinical Care	Montgomery County	Macoupin County	Illinois
Primary Care	1,600:1	4,130:1	1,250:1
Dentists	1,590:1	2,830:1	1,280:1
Mental Health Providers	1,360:1	1,890:1	440:1

Note. The ratio of mental health providers is roughly 4 times higher at the county level than state level.

Table 45. Ratio of providers per 10,000 children

Clinical Care	Montgomery County	Macoupin County
Family Medicine Physicians	21.6	5.0
Licensed Social Workers	8.3	3.0
Pediatricians	0.0	4.0
Psychiatrists	0.0	0.0
Psychologists	0.0	0.0

Table 46. Percentage of health behaviors

Health Behaviors	Data Year	Measurement	Montgomery County	Macoupin County	Illinois
Adult Smoking	2017	% adult population who are current smokers	16.0%	16.0%	15.0%
Excessive Drinking	2017	% adults reported heavy drinking or binge drinking	20.0%	20.0%	21.0%
Disconnected Youth	2014-2018	% teens (16-19 years) who are neither working nor in school	8.0%	-	6.0%
Sexually Transmitted Diseases	2017	Number of newly diagnosed chlamydia cases per 100,000 population	70	102	589.9
Violent Crimes	2014 & 2016	Number of reported violent crime offenses per 100,000 population	37	75	403

Table 47. Percentage of physical and mental health behaviors

	Health Behaviors /Socioeconomic Factors	Data Year	Measurement	Montgomery County	Macoupin County	Illinois
Nutrition	Adult Obesity	2016	% of adult population (age 20 and older) that reports a body mass index (BMI) ≥ 30.	31.0%	28.0%	30.0%
	Children Eligible For Free/Reduced Lunch	2017-2018	% children enrolled in public schools that are eligible for free or reduced price lunch.	51.0%	50.0%	49.0%
	Limited Access to Healthy Foods	2015	% of population who are low-income and do not live close to a grocery store.	8.0%	6.0%	4.0%
Physical Activity	Access to Exercise	2010 & 2019	% adult with adequate access	45.0%	61.0%	91.0%
	Physical Inactivity	2016	% of adults age 20 and over reporting no leisure-time physical activity.	27.0%	23.0%	22.0%
	Poor Physical Health Days	2017	Average number of physically unhealthy days reported in past 30 days of adults.	3.9	3.6	3.8
Mental Health	Poor Mental Health Days	2017	Average number of mentally unhealthy days reported in past 30 days of adults.	4	4.1	3.8
	Frequent Mental Distress	2017	% of adults reporting 14 or more days of poor mental health per month.	12.0%	11.0%	11.0%

Table 48. Percentage of health behavior mortality

Health Behaviors/Socioeconomic Factors	Data Year	Measurement	Montgomery County	Macoupin County	Illinois
Alcohol-impaired Deaths	2014-2018	% of driving deaths with alcohol involvement	27.0%	28.0%	32.0%
Drug Overdose	2016-2018	Number of drug poisoning deaths per 100,000 population.	21	26	21
Homicides	2012-2018	Number of deaths due to homicide per 100,000 population.	-	-	7
Suicides	2014-2018	Number of deaths due to suicide per 100,000 population.	21	39	11
Premature Deaths	2016-2018	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	426	700	330
Child Mortality	2015-2018	Number of deaths among children under age 18 per 100,000 population.	17	23	50
Motor Vehicle Crash Deaths	2012-2018	Number of motor vehicle crash deaths per 100,000 population.	30	57	34
Injury Deaths	2014-2018	Number of deaths due to injury per 100,000 population.	127	203	62

Table 49. Number of deaths due to overdose based on age group

Occurrence	Montgomery County	Macoupin County	Illinois
Total	56	94	63,991
Under 25	4	8	3,226
Ages 25-44	30	47	22,170
Ages 45+	22	39	38,595

Note. Deaths due to overdose are most prevalent among individuals between the ages of 25-44

Table 50. Number of deaths due to overdose based on type

Indicator	Montgomery County	Macoupin County
Any Drug Overdose Death	8	9
Opioid Overdose Deaths	6	7
Cocaine Overdose Deaths	1	3
Alcohol Overdose Deaths	1	1

Table 51. Leading causes of death

	Montgomery County	Macoupin County	Illinois
Total	357	556	110,012
Heart Disease	62	129	24,747
Cancer	79	132	23,877
Accidents	31	31	6,013
Stroke	18	21	5,853
Chronic Lower Respiratory	27	40	5,639
Alzheimer's Disease	18	16	4,029
Diabetes	6	7	2,879
Kidney Disease	6	3	2,644
Influenza & Pneumonia	9	23	2,562
Septicemia	10	11	1,790

Note. Heart disease and cancer are the leading causes of death at the county and state level.

Table 52. Number of cases of child abuse and neglect

	Montgomery County	Macoupin County	Illinois	U.S.
Substantiated Cases	-	233	31,384	678,765

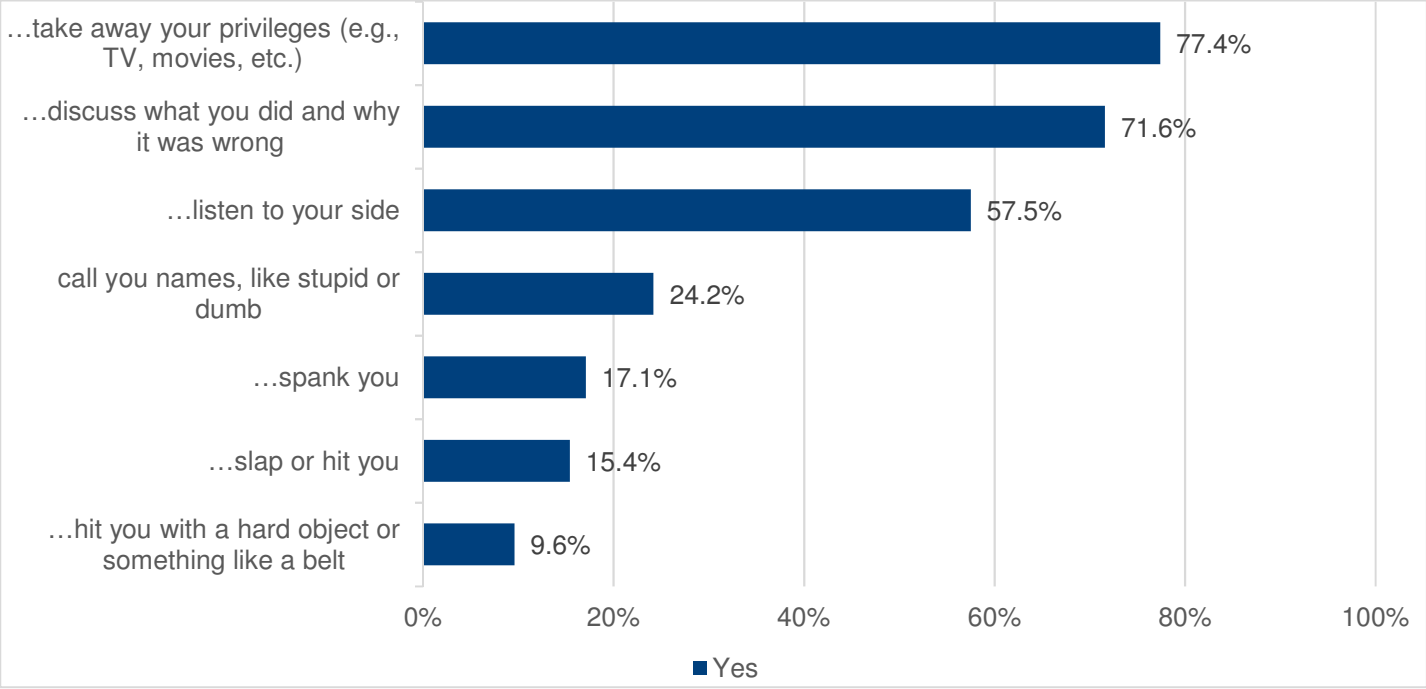
Note. Information at the county level involving child abuse and neglect is scarce. More resources are needed.

Table 53. Information on sex trafficking in Illinois

# of Children Trafficked Since 2011	Average Age of Trafficked Children	DCFS Investigations with Human Trafficking Allegations 2011-2017	% of Trafficked Persons Who are Female Children	% of Trafficked Persons Who are Black/African-American
970	13.89	1037	87.0%	53.0%

Note. Information at the county level involving sex trafficking is scarce and more resources are needed. From the information at the state level there were nearly 1,000 children across Illinois, with the majority being female and the average age being 14.

Figure 7. Percentage of parental discipline types among Montgomery County (Hillsboro)



Note. The majority of Hillsboro youth reported that their caregivers used less severe forms of punishment such as taking away privileges. A smaller portion of the youth reported more severe forms of punishment used by their caregivers like name calling and physical punishment.

Figure 8. Montgomery County (Hillsboro) youth risk and protective factors

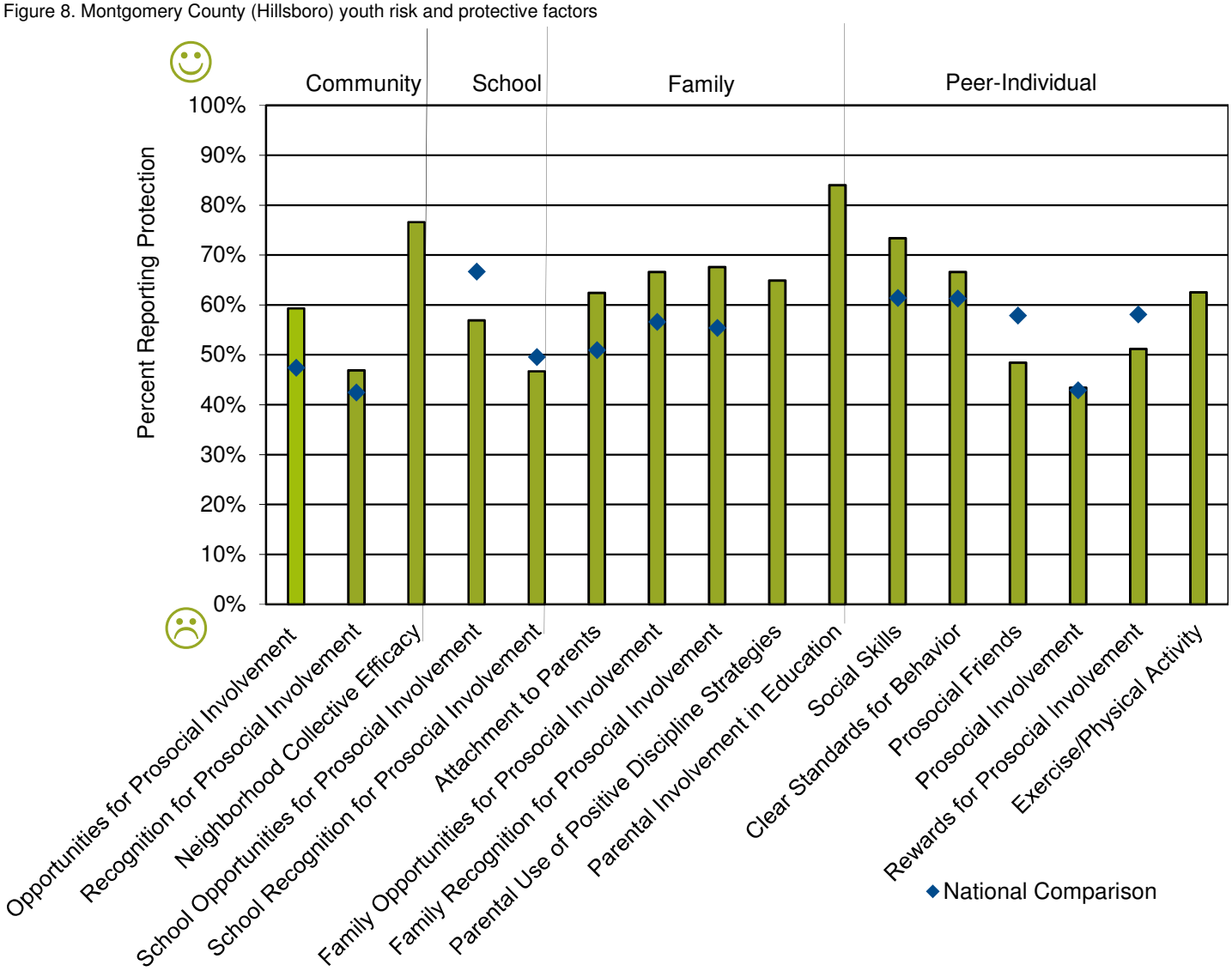


Figure 9. Montgomery County (Hillsboro) youth risk and protective factors

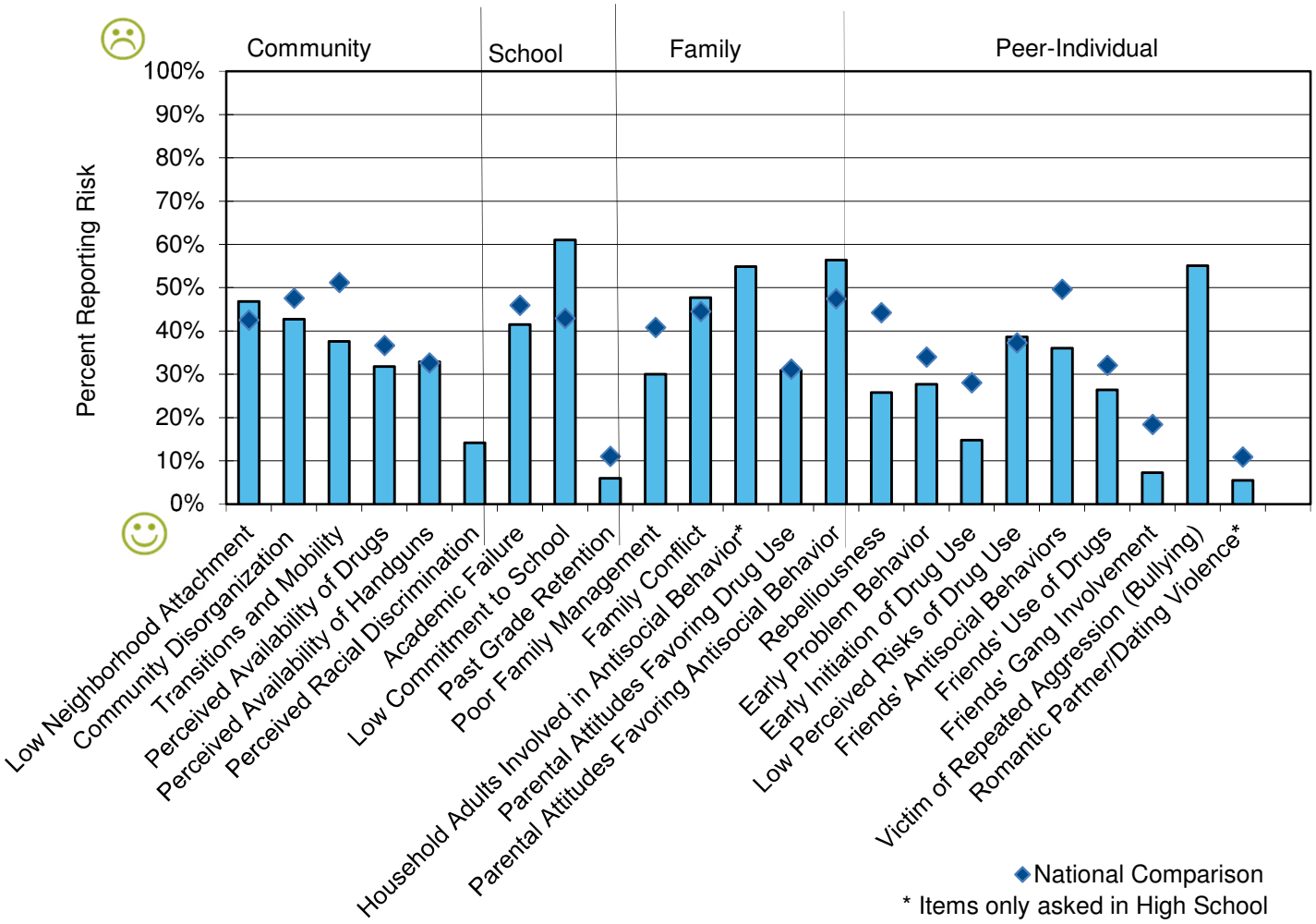
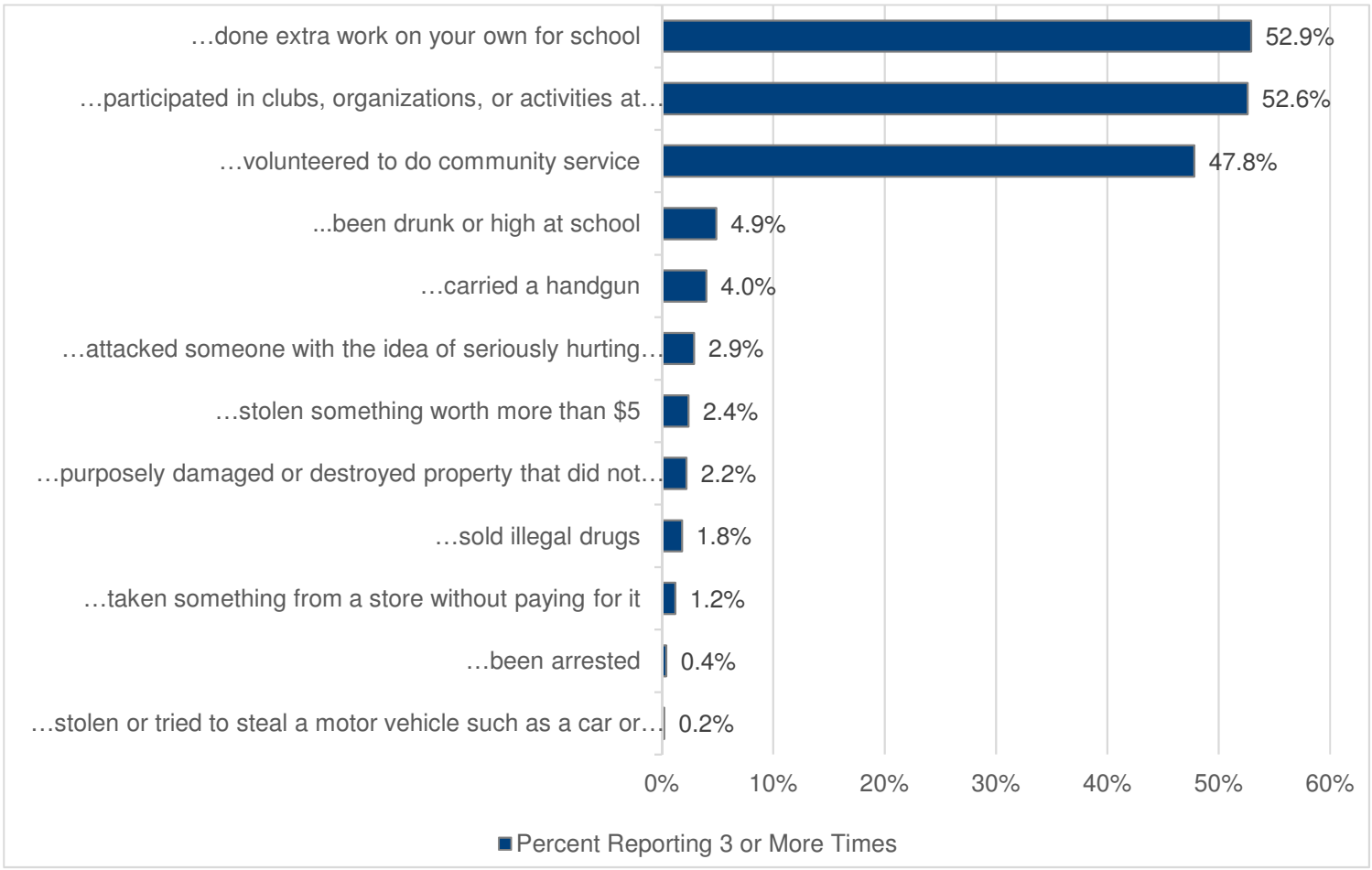
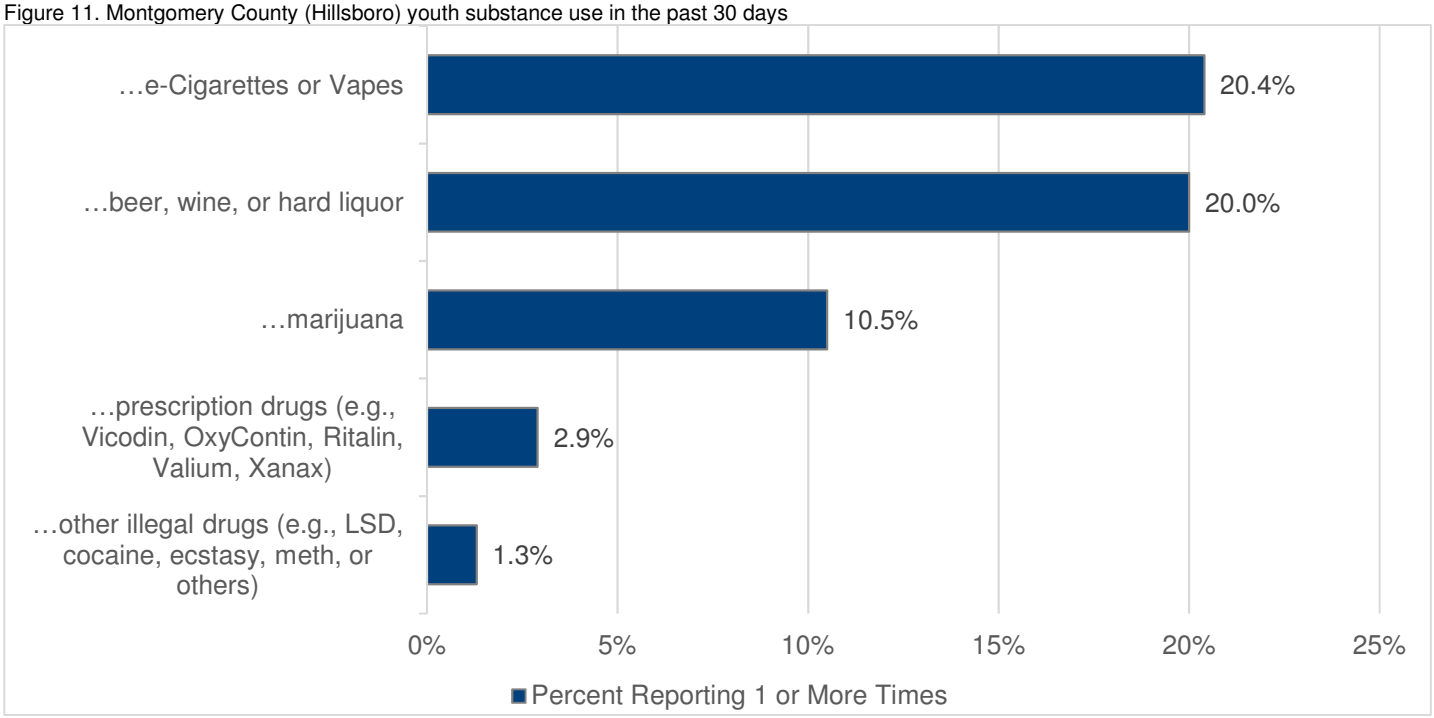


Figure 10. Montgomery County (Hillsboro) youth risk and protective factors



Note. Over 50% of Hillsboro youth participated in school or organizational activities at least 3 times or more per year. One item that is concerning is that 4% of youth reported to have carried a handgun to school at least 3 times or more.

Figure 11. Montgomery County (Hillsboro) youth substance use in the past 30 days



Note. While data suggests that substance use in Montgomery and Macoupin County is not as large of an issue as it is on state or national levels, responses to the local survey from Hillsboro youth suggest a slightly different picture. Specifically, data indicates that in the past 30 days 1 in 5 kids vaped or drank.

Figure 12. Percentage of Montgomery County (Hillsboro) youth with clinical depression

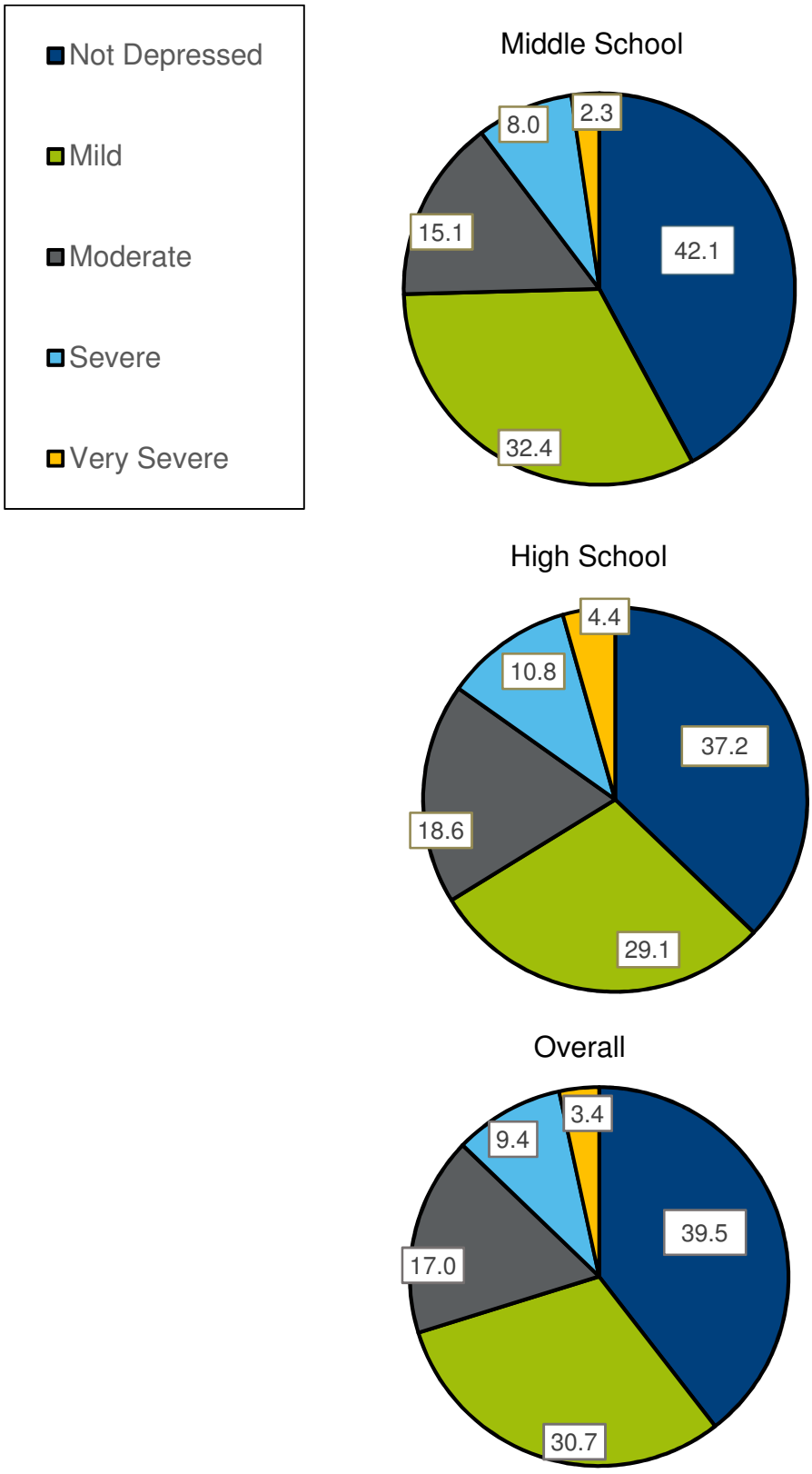


Table 54. Top 10 emergency room discharges

Diagnosis	Discharges
Chest pain, unspecified	644
Acute upper respiratory infection, unspecified	608
Other chest pain	550
Urinary tract infection, site not specified	502
Unspecified abdominal pain	467
Chronic obstructive pulmonary disease w/ (acute) exacerbation	371
Pneumonia, unspecified organism	362
Low back pain	360
Syncope and collapse	322
Non-infective gastroenteritis and colitis, unspecified	293

Note. Approximately 56% of patients who presented in the Emergency Department have one or more chronic condition (obesity, depression, hypertension, diabetes, etc.)

Table 55. Preventable and non-emergent emergency room visits

	Total	Preventable	Non-Emergent	PCP Treatable
Commercial	9,184	436	1,259	1,728
Medicaid	11,230	695	1,062	2,378
Medicare	10,714	874	1,611	1,750
Other	638	19	42	57

Note. 6.3% of total emergency room visits were preventable, while 12.5% were non-emergent.