
HSHS
St. John's
Hospital

# 2021 Community Health Needs Assessment

An assessment of Sangamon County, Illinois conducted jointly by HSHS St. John's Hospital, Memorial Medical Center and Sangamon County Department of Public Health.

HSHS St. John's Hospital is an affiliate of Hospital Sisters Health System, a multi-institutional health care system comprised of 15 hospitals and an integrated physician network serving communities throughout Illinois and Wisconsin.

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# Executive Summary

## Background

Provisions in the 2010 Patient Protection and Affordable Care Act (ACA) require charitable hospitals to conduct a triennial community health needs assessment (CHNA) and accompanying implementation plan to address the identified needs. The CHNA asks the community to identify and analyze community health needs, as well as community assets and resources, to plan and act upon priority community health needs. This process results in a CHNA report which is used to develop implementation strategies based on the evidence, assets and resources identified in the CHNA process.

Triennially, HSHS St. John's Hospital conducts a CHNA, adopts an implementation plan by an authorized body of the hospital and makes the report widely available to the public. The hospital's previous CHNA report and implementation plan was conducted and adopted in FY2018.

In FY2021 (July 1, 2020 through June 30, 2021), St. John's Hospital conducted a collaborative CHNA in partnership with Memorial Medical Center and the Sangamon County Department of Public Health. Upon completion, the hospital developed a set of implementation strategies and adopted an implementation plan to address priority community health needs. The population of Sangamon County was assessed. Data collected was supplemented with:

1. Community gaps analysis review
2. Community assets review
3. Qualitative data gathered through a CHNA core group
4. Qualitative data reviewed by a community advisory council (CAC) with broad community representation
5. Focus groups, including input from area health and social service providers, as well as community members who identify with the needs addressed
6. Local leader input
7. Internal advisory council

## Identification and Prioritization of Needs

As part of the identification and prioritization of health needs, the CHNA core group identified 14 health focus areas from extant data sources. A pre-determined set of criteria (Diagram One: Defined Criteria for Community Health Needs Assessment) was used to narrow the health focus areas.

*Diagram One: Defined Criteria for Community Health Needs Assessment*

**Defined Criteria for Community Health Needs Assessment**

**Defined Criteria**

Triple Aim Impact

Magnitude of the Issue – How wide an issue is this in the community?

Seriousness of the Issue – How related is the issue to the mortality of those affected?

Feasibility – Considering available resources, how likely are we to make a significant impact on the issue?

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

Improve the health of individuals.

Improve the health of populations.

Reduce waste, variation and health care costs.

The core group also identified three major contributing factors as underlying to all health issue areas presented. Those areas are: social determinants of health; access to health and health care barriers; and equality, equity and justice in health care. (See Appendix I: Major Contributing Factors).

The CHNA core group provided a thorough review of existing and supplemental data sets around the 14 identified health focus areas to the community advisory council (CAC). The CAC used a forced ranking exercise with the defined criteria listed in Diagram One to narrow the number of health focus areas to six. These focus areas were presented to the community through 21 community focus groups (Appendix II: Data Review). The focus groups sought the community's feedback to prioritize the needs based on their perceptions and experiences.

Results from the survey were then presented to the CHNA core group's respective internal advisory councils for further review and approval. St. John's internal advisory council approved the three priority areas recommended through the CAC and focus group process. See appendix III for a complete list of needs considered.

These were the top three health needs identified based on the defined criteria, focus group results, stakeholder input from the CAC and internal input from St. John's leaders.
- Disparities in economy (income and wealth in the community), including disparities in education
- Mental and behavioral health services
- Access to health services, including food access and homeless issues

### Implementation Plan Development

As part of the engagement process with key stakeholders, attention was given to natural partnerships and collaborations that will be used to operationalize the implementation plan. The implementation plan is considered a "living document" – a set of strategies that can be adapted to the lessons learned while implementing community benefit activities and initiatives relevant to the priority needs. The broader set of community health needs will continue to be monitored for consideration as future focus areas.

## Hospital Background

St. John's Hospital is in Sangamon County, Illinois. For more than 150 years, the hospital has been a leader in health and wellness in Sangamon and surrounding counties. St . John's Hospital provides a wide range of specialties, including a level one trauma center, level two pediatric trauma center, neonatal intensive care unit, St. John's Children's Hospital and the nationally recognized Prairie Heart Institute.

St. John's Hospital partners with other area organizations to address the health needs of the community, living its mission to reveal and embody Christ's healing love for all people through its high quality Franciscan health care ministry, with a preference for 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 mid-sized communities in Illinois and Wisconsin. HSHS generates approximately $2 billion in operating revenue with 15 hospitals and has more than 200 physician practice sites. Our mission is carried out by 14,000 colleagues and 2,100 physicians in both states who care for patients and their families.

HSHS has a rich and long tradition of addressing the health needs in the communities it serves. This flows directly from our 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 $51,360,205.

## Current Hospital Services and Assets

| Major Centers and Services | Statistics |
|---|---|
| • Prairie Heart Institute Heart and Vascular Center<br>• ICU<br>• Emergency Services<br>• Rehabilitation Center<br>• AthletiCare – Sports Medicine Center<br>• Pain Medicine Center<br>• Cancer Care Center<br>• Neurosurgical Services<br>• EEG Department<br>• Laboratory<br>• Imaging<br>• St. John's Health Center and Priority Care<br>• Home Health<br>• Stroke Care<br>• Wound Care<br>• Surgery<br>• Endoscopy and Colonoscopy<br>• Women's Health<br>• Orthopedics<br>• Children's Health – St. John's Children's Hospital<br>• Level I Adult Trauma Center<br>• Level II Pediatric Trauma Center<br>• Level III NICU designated by IDPH as part of the Level III Administrative Perinatal Center | • Total Beds: 422<br>• Total Colleagues: 3,281<br>• Bedside RNs: 1,002<br>• Inpatient admissions: 19,133<br>• Outpatient registrations: 182,142<br>• ED visits: 49,869<br>• Births: 2,030<br>• Surgical cases: 19,529<br>• Physicians on Medical Staff: 1,178<br>• Volunteers: 522<br>• Community Benefit: $51,360,205 |

## Hospital Accreditations and Awards

| Accreditations | Awards |
|---|---|
| Main Lab<br>• Centers for Medicare and Medicaid Services Clinical Laboratory Improvement Amendments (CLIA) Certificate of Accreditation<br>• College of American Pathologists (CAP)<br>• American Association of Blood Banks (AABB) Point of Care<br>• Centers for Medicare and Medicaid Services Clinical Laboratory Improvement Amendments (CLIA) Certificate of Accreditation<br>• College of American Pathologists (CAP)<br>6th Street Health Center<br>• Centers for Medicare and Medicaid Services Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver<br>Montvale Surgical Suites:<br>• Centers for Medicare and Medicaid Services Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver<br>Level I Adult Trauma Center<br>Level II Pediatric Trauma Center<br>Emergency Department Approved for Pediatrics<br>Cardiac Rehab Program<br>• American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) certification<br>NICU Level III<br>• Designated by Illinois Department of Public Health as part of the Level III Administrative Perinatal Center<br>Cancer Center accredited by the Commission on Cancer Intersocietal Accreditation Commission:<br>• Nuclear cardiology accredited in myocardial perfusion imaging and muga's<br>• Vascular accredited in extracranial cerebro-vascular testing, peripheral venous testing, peripheral arterial testing and visceral vascular testing<br>• Echo accredited in adult transthoracic imaging, adult transesophageal imaging, adult stress imaging and pediatric transthor-acic imaging | • Recognized by the American Society for Gastrointestinal Endoscopy (ASGE) as a GI Center of Excellence<br>• American Heart Association, Get with the Guidelines Stroke Awards:<br>- Stroke GOLD PLUS<br>- Target: Stroke Honor Roll Elite, Advanced Therapy<br>- Target: Stroke Type II Diabetes Honor Roll<br>• Designated Blue Distinction Center for Maternity Care<br>• St. John's College of Nursing Accreditation with the Higher Learning Commission<br>• Nationally recognized with an 'A' for patient safety in the fall 2020 by Leapfrog<br>• The American Heart Association recognized SJS with:<br>- 2020 Get with the Guidelines<br>- Heart Failure GOLD PLUS Honor Roll achievement<br>- Heart Failure and Target: Heart Failure Programs<br>• SJS received two "Best of" Springfield awards from the Illinois Times:<br>- Best Medical Facility<br>- Best Pediatric Center<br>• 2020 Springfield State Journal-Register Reader's Choice Award Winner for:<br>- Best Hospital<br>- Best Children's Hospital<br>- Best Trauma Center<br>- Best Emergency Room<br>- Best Dietitian |

# Community Served by the Hospital

Although St. John's Hospital serves Sangamon, Cass, Christian, Greene, Logan, Macoupin, Menard, Montgomery, Morgan and Scott counties and beyond, for the purposes of the CHNA the hospital defined its primary service area and populations as Sangamon County. The hospital's patient population includes all who receive care without regard to insurance coverage or eligibility for assistance.

*Demographic Profile of Sangamon County*

| Characteristics | Illinois | Sangamon 2019 | Sangamon 2017 | %Change for County |
|---|---|---|---|---|
| Total Population | 12,625,136 | 194,672 | 196,452 | -1% |
| Median Age (years) | 37.4 | 40.8 | 39.9 | 2% |
| Age | | | | |
| Under 5 years | 5.9 | 5.8 | 5.8 | 0 |
| Under 18 years | 22.2 | 22.1 | 22.5 | -2% |
| 65 years and over | 16.1 | 18.4 | 17.2 | 7% |
| Gender | | | | |
| Female | 50.9 | 52 | 52 | 0 |
| Male | 49.1 | 48 | 48 | 0 |
| Race and Ethnicity | | | | |
| White (non-Hispanic) | 76.8 | 82 | 82.4 | -0.49% |
| Black or African American | 14.6 | 13 | 12.9 | 0.77% |
| Native American or Alaska Native | 0.6 | 0.3 | 0.5 | -66.67% |
| Asian | 5.9 | 2.2 | 2 | 9.09% |
| Hispanic or Latino | 17.5 | 2.4 | 2.3 | 4.17% |
| Speaks Language other than English at home | | | | |
| | 23.2 | 4.9 | 4.7 | 4.08% |
| Median household income | | | | |
| | 65,886 | 61,912 | 56,742 | 8.35% |
| % below poverty in the last 12 months | | | | |
| | 11.5 | 12.2 | 13 | -6.56% |
| High School graduate or higher, % of persons age 25+ | | | | |
| | 89.2 | 92.5 | 92.2 | 0.32% |

# Process and Methods Used to Conduct the Assessment

St. John's Hospital collaborated in the planning, implementation and completion of the CHNA in partnership with Memorial Medical Center and Sangamon County Department of Public Health. The process described in the narrative below is outlined in Diagram Two.

## Internal

St. John's Hospital undertook a 14-month planning and implementation effort to develop the CHNA, identify and prioritize community health needs for its service area and formulate an implementation plan to guide ongoing population health initiatives with like-missioned partners and collaborators. These planning and development activities included the following internal and external steps:

1. Identified the CHNA core group comprised of St. John's Hospital, Memorial Medical Center and Sangamon County Department of Public Health.
2. Convened a CAC to solicit input and help narrow identified priorities.
3. Conducted virtual community focus groups to get input from community members around the priorities identified.
4. Convened an internal advisory committee respective to each organization to force rank the final priorities and select the FY2022-FY2024 CHNA priorities.

## External

St. John's Hospital worked with a core group of partners to leverage existing relationships and provide diverse input for a comprehensive review and analysis of community health needs in Sangamon County.

Representation on the CAC was sought from health and social service organizations that:

1. Serve low-income populations
2. Serve at-risk populations
3. Serve minority members of the community
4. Represent the general community

The following community stakeholders were invited to serve on the external advisory committee:

- Sangamon County Department of Public Health* (core group)
- HSHS St . John's Hospital (core group)
- Memorial Medical Center (core group)
- United Way of Central Illinois*
- Springfield Urban League*
- Springfield School District 186*
- Springfield Police Department
- SIU Equity, Diversity and Inclusion
- SIU Center for Family Medicine, federally qualified health center, FQHC*
- Sangamon County Farm Bureau
- Catholic Charities*
- Central Counties Health Centers, FQHC*
- Greater Springfield Chamber of Commerce
- Lincoln Land Community College Workforce Equity*
- Memorial Behavioral Health*
- Sangamon County Department of Community Resources*
- NAACP*
- Phoenix Center*
- Springfield Immigrant Advocacy Network*
- Heartland Continuum*
- Senior Center*

** Denotes groups representing medically underserved, low-income and minority populations*

The CAC helped the core group review existing data and offered insights into community issues affecting that data. The CAC also helped identify local community assets and gaps in the priority areas and offered advice on which issues were the highest priority. See appendix IV for the CAC charter and meetings .

*Diagram Two: Sangamon County 2018 Community Health Needs Assessment*

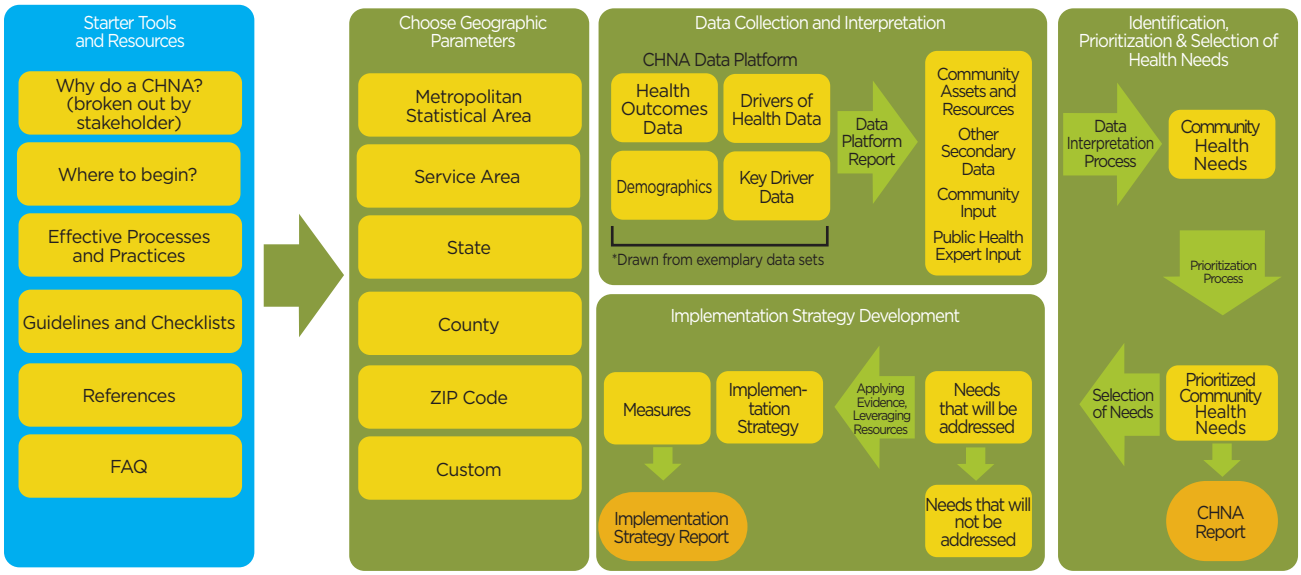

* Denotes groups representing medically underserved, low-income and minority populations.

# Defining the Purpose and Scope

The purpose of the CHNA is to 1) evaluate current health needs of the hospital's service area, 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, and 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 overarching framework used to guide the CHNA planning and implementation process is based on the Catholic Health Association's (CHA) Community Commons CHNA flow chart below:




## Data Sources

The CHNA process utilizes both primary data, including hospital data, focus groups and key stakeholder meetings, as well secondary data. Secondary data sources include the Behavioral Risk Factor Surveillance System (BRFSS), the U.S. Census Bureau and Centers for Disease Control and Prevention data sources. In addition, this data was supplemented with information from:

- State Health Improvement Plan: SHIP
- UIS Center for State Policy and Research Annual Report
- Illinois Kids Count Report
- USDA Food Map – Food Deserts
- HRSA Health Center Program: Central Counties Health Centers, Inc.
- HRSA Health Center Program: Southern Illinois University
- Sangamon County Citizen Survey
- 500 Cities Project
- County Health Rankings
- Illinois Report Card
- Illinois Kids Count Report
- Sangamon County Community Resources Client Needs Assessment
- Sangamon County Community Resources Stakeholder Assessment
- Illinois Public Health Community Map
- ALICE Report

The data was gathered into a written report/presentation and shared with community members through virtual focus groups and key stakeholder meetings as described below.

## Input from Persons Who Represent the Broad Interests of the Community

St. John's Hospital is committed to addressing community health needs in collaboration with local organizations and other area health care institutions. In response to the FY2018 CHNA, the hospital planned, implemented and evaluated strategies to address the top four identified community health needs: access to care, child maltreatment, maternal and infant health and substance abuse (drugs). This year's assessment built on that collaboration, actively seeking input from a cross section of community stakeholders with the goal of reaching consensus on priorities to best focus our human, material and financial resources.

### Input from Community Stakeholders

The CAC was used as the primary stakeholder group to review and force rank data. During a two-hour virtual meeting, community stakeholders were asked to review data presented and provide additional sources for priority areas not listed. The CAC also helped identify community assets and gaps which were weighed when considering the magnitude and feasibility of the priority areas. Lastly, their feedback was instrumental in developing the implementation plan.

The core group identified and facilitated 21 virtual focus groups with community members. Feedback was received from a diverse representation of Sangamon County based on age, race, ethnicity, socioeconomic status, disability status, religion, employment, education, sexual orientation, etc. (See Appendix V for a complete list of focus groups.) More than 200 individuals participated. Focus group outcomes were presented to the core group's respective internal advisory teams. The results were used to guide further discussion around final priority selection.

More information on focus group analysis will be documented in the Community Health Improvement Plan to be completed and approved by November 15, 2021.

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

HSHS and St. John's Hospital are committed to promoting and defending human dignity, caring for persons living in poverty and other vulnerable persons, promoting the common good and stewarding resources. We believe the CHNA process must be informed by input from the poor and vulnerable populations we seek to serve. To ensure the needs of these groups were adequately represented, we included representatives from such organizations as noted on page nine. These organizations serve the under resourced in our community, including low-income seniors, children living in poverty and families who struggle with shelter and food. Representatives of these organizations have extensive knowledge and quantifiable data  regarding the needs of their service populations. Actively including these organizations in the CHNA process was critical to ensure needs of the most vulnerable persons in our communities were addressed.

### Input on FY2018 CHNA

No written comments were received regarding the FY2018 CHNA.

# Prioritizing Significant Health Needs

Members of St. John's Hospital's administration team collaborated with key department leaders in the review and analysis of CHNA data.

As part of the identification and prioritization of health needs, the hospital considered the estimated feasibility and effectiveness of possible interventions by the hospital to impact these health priorities; the burden, scope, severity or urgency of the health need; the health disparities associated with the health needs; the importance the community places on addressing the health need; and other community assets and resources that could be leveraged through strategic collaboration in the hospital's service area to address the health need.

Based on the CHNA planning and development process the following community health needs were identified:

1. Disparities in economy (income and wealth in the community), including disparities in education
2. Mental and behavioral health services
3. Access to health services, including food access and homeless issues

As an outcome of the prioritization process, the following community health needs were also identified but will not be addressed directly by the hospital for the reasons indicated:

- Affordable housing: In the past year, a group of community stakeholders came together to address housing issues and disparities in Sangamon County. A representative from St. John's Hospital sits on that committee. St. John's will continue to lend its support to these efforts.
- Food access: This need is addressed by groups including the Central Illinois Food Bank, Illinois Coalition of Community Services, COMPASS for Kids, local school districts and the county health department. The hospital supports these efforts by donating money and in-kind resources to these programs and organizations.
- Maternal and infant health: As a result of the 2018 CHNA, a program was developed and implemented to address maternal/infant health issues for babies born <32 weeks. This program continues to be provided through St. John's Hospital NICU to address health and development challenges in premature infants. Additionally, the hospital continues to support local safe sleep initiatives driven by the health department.
- Obesity: St. John's participates in community initiatives to address obesity. Additionally, several of our programs addressing food access, chronic conditions, access to health, etc. are indirectly impacting obesity.
- Senior health: St. John's runs the Caregiver Interfaith Volunteer Services program which provides senior transportation to medical appointments.
- Tobacco use: The health department and local school districts currently have curriculum to address tobacco use in youth.
- Unmanaged chronic conditions: Access, early identification, prevention and management of chronic conditions is a major focus of the access to health collaborative developed as a result of the 2015 CHNA. This initiative continues today, and St. John's helps lead the development, implementation and expansion of access initiatives.
- Utility and rental assistance: This issue area has grown as a result of the pandemic. Several community-based organizations are addressing utility and rental assistance programs while preparing for post-pandemic needs. St. John's will participate in community discussions and plans to address these issues as they become more known.
- Violent crime: The access to care collaborative developed in response to the 2015 CHNA has led to a decrease in crime in the Enos Park neighborhood. By expanding the collaborative, we will continue to impact crime across the city and county. The hospital continues to support these initiatives and others through monetary and in-kind donations.

## Overview of Priorities

### Disparities in Economy

In Sangamon County, poverty disproportionately impacts minority populations, children and persons living with a disability. The county scores in the lowest %ile for children living in poverty and the second lowest %ile for families living in poverty. The county ranks higher than the state and nation for persons with a disability

living in poverty. Black and African American seniors over 65 are twice as likely to live in poverty in Sangamon County when compared to other counties in the state. In Springfield, the difference between minority and white incomes is greater than any other metro area nationally. The table below shows the disparity in poverty rates between races and age.

| Race | Sangamon County Population | Overall Living in Poverty | Children Living Living in Poverty |
|---|---|---|---|
| TOTAL | 100% | 13.1% | 20% |
| White / Caucasian | 82% | 15% | 15% |
| Black / African American | 12.6% | 59% | 59% |
| Hispanic / Latino | 2.5% | 20% | 20% |

*Source: US Census Data: 2015-2019; American Community Survey*

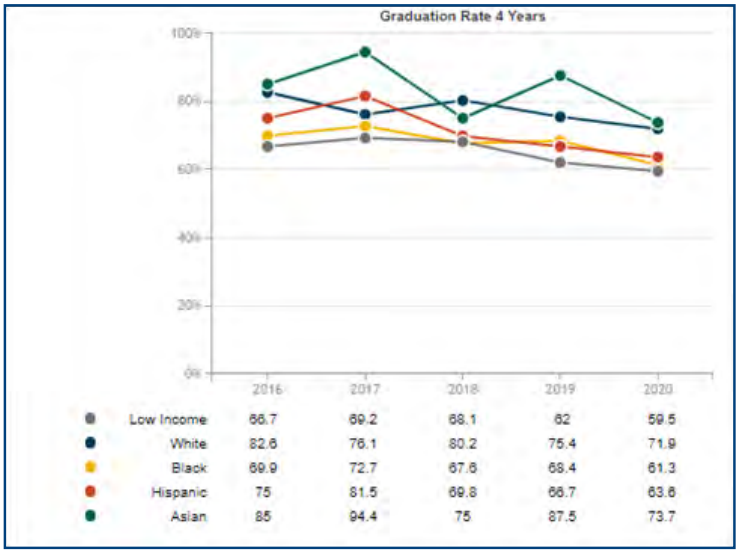



*Diagram Four: Graduation Rate 4 Years*

A key driver to poor economic outcomes and disparities in economy are disparities in education. In Springfield School District 186, low-income students have the lowest graduation rates. Additionally, White and Asian students have higher graduation rates than Black and Hispanic students (See Diagram Four: Graduation Rate 4 Years). Minority students and low-income students also are more likely to miss school days and experience chronic absenteeism.

While we recognize the pandemic has had a large impact on employment, current data also suggest employment and job training as the top needs for self sufficiency in low-income families and unemployed individuals. Sangamon County has an unemployment rate at 6.0%, compared to the state of Illinois at 7.10%. This has decreased drastically since the April 2020 spike at 15.0% resulting from COVID-19.

### Mental and Behavioral Health Services

Pre-pandemic data shows an increase in suicide rates since 2009. Depression, anxiety and suicide ideation were also trending up before the pandemic. While pandemic data is not readily available, anecdotally we hear from our health care and community partners of increased depression and anxiety.

Accidental drug overdose deaths have continued to rise in Sangamon County since the beginning of 2020. According to county coroner reports, substances such as heroin, alprazolam, alcohol and fentanyl have been leading culprits in drug overdose deaths. The county also has higher rates of hospitalization due to opioids and heroin compared to other counties in the state.

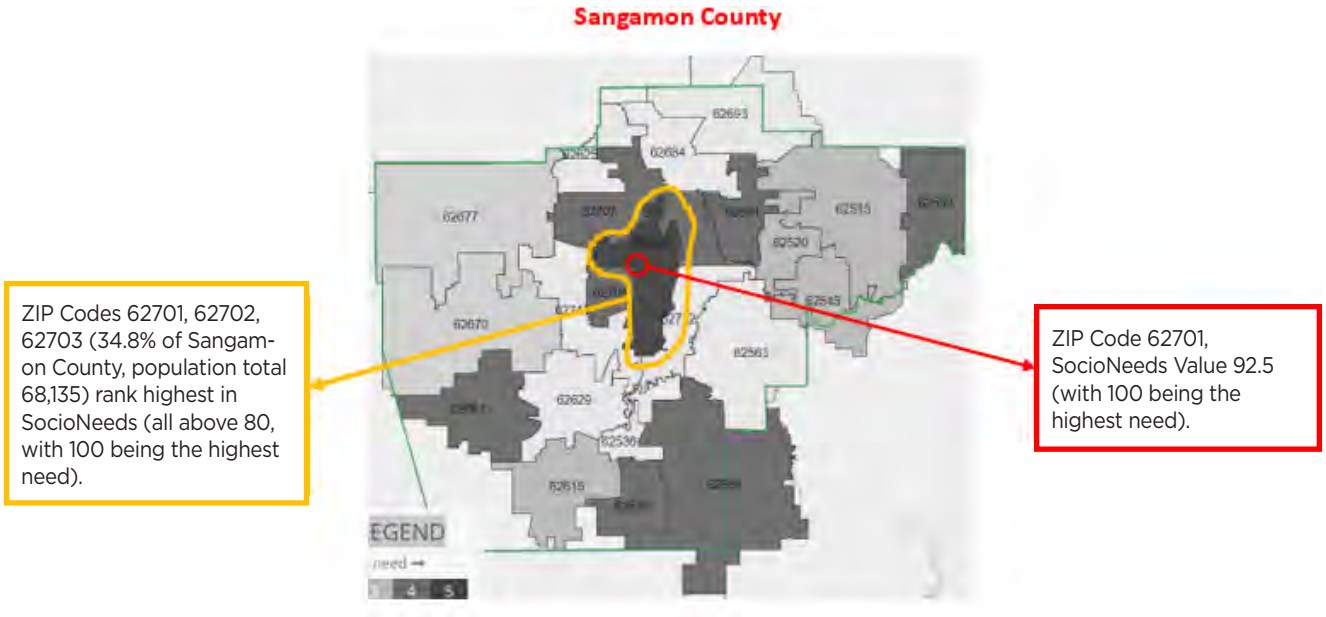
The following list of barriers to accessing mental and behavioral health services was identified through community discussions and focus groups with more than 200 community residents representing a diverse background:

- Barriers such as cost of care, transportation, long wait times and low number of providers prevent patients from accessing mental health treatment in a timely manner.
- Mental health providers are not experienced in addressing traumas related to immigration systems and racism.
- Lack of knowledge on when mental health assistance is needed.
- Easy availability of drugs and alcohol in the community, especially near community gathering places like schools and churches. This encourages self-medicating.
- A greater awareness of when, why and how to access mental health services is needed overall.
- There is a stigma associated with seeking mental health assistance.

### Access to Care

Access to care has many dimensions. In Sangamon County, there is a direct correlation between access barriers and ZIP code on the socio-needs index (see Diagram Five). Existing data shows these areas have a higher incidence of emergency department visits and hospitalization due to chronic conditions that could be managed through regular visits with a general provider. Access to care efforts since the 2015 CHNA have led to a measurable improvement in health. Using the effective and nationally recognized model in place, we are positive we can continue to see individual and population health improvement while we expand current access to care strategies.

*Diagram Five: Socioeconomic need that correlates with poor health outcomes.*




## Potential Resources to Address the Significant Health Needs

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

**Hospitals and related medical groups**

- HSHS St. John's Hospital
- HSHS St . Mary's Hospital's Behavioral Health and Substance Abuse Programs
- HSHS Medical Group
- Memorial Medical Center
- Memorial Behavioral Health
- Springfield Clinic
- SIU Healthcare
- SIU Center for Family Medicine, FQHC
- Central Counties Health Centers, FQHC
- Gateway Foundation
- Family Guidance Center

More than 100 agencies, organizations, non-profit organizations, governmental organizations, educational institutions, city and county resources, social service and health care organizations are available to meet identified needs.

Those organizations include, but are not limited to:
- Local social service organizations
- Local health care organizations
- Neighborhood associations in impacted neighborhoods
- County health department
- Public health department
- City of Springfield
- County offices
- Non-profit organizations
- Private and public schools
- Community coalitions and task forces
- 2-1-1 - a United Way of Central Illinois initiative that allows community residents to dial '2-1-1' to access needed resources .

## 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 implementation strategies.
- Developing a three-year implementation plan (FY2022 through FY2024) to address identified health needs .
- Integrating the implementation plan with organizational strategic planning and budgeting to ensure the proper allocation of human, material and financial resources.
- Presenting and receiving approval of the CHNA report and implementation plan by the hospital's governing board.
- Publicizing the CHNA report and implementation plan on https://www.hshs.org/StJohns/About-Us/Community-Health-Needs-Assessment. Hard copies available upon request.

## Approval

The FY2021 CHNA report was adopted by the hospital's governing board on May 5, 2021.

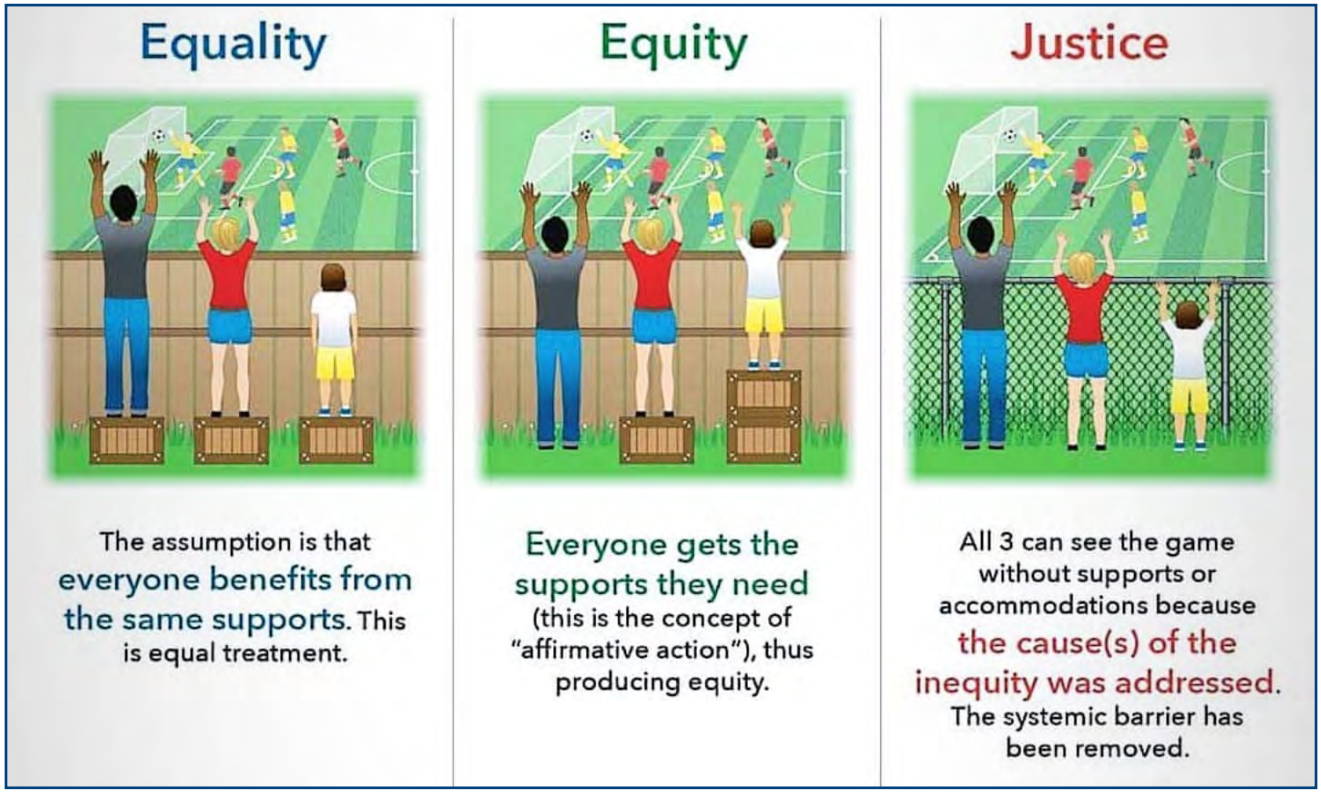
# APPENDIX I

## Major Contributing Factors

**HSHS Illinois Division ministries** have identified three major contributing factors for poor health outcomes: 1. Equality, Equity and Justice; 2. Social determinants of health; 3. Access to health and healthcare barriers. The Community Health Improvement Plan (CHIP) will guide strategies and shape policies in ways that promote health and health equity. The information below provides definitions of the three major contributing factors and a framework through which we will identify metrics to measure progress toward health equity.

**Defining inequities** across service areas is critically important to understanding the steps needed to achieve health equity. Urban and rural disparities remain despite progress in closing health and development gaps. Part of the CHNA process was to identify diverse individuals in our markets and focus efforts on gathering their feedback through surveys and/or focus groups to learn where health inequities persist.

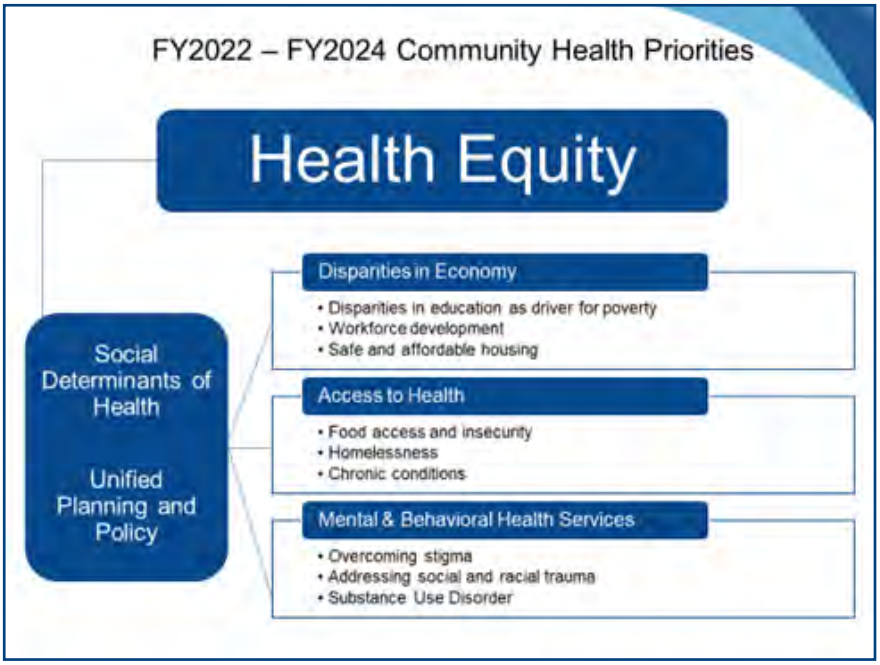
**Health equity** means everyone has a fair and just opportunity to be as healthy as possible. Achieving health equity requires identifying and addressing obstacles to health, such as poverty, quality education, safe and affordable housing, health care access, safe environments, safe neighborhoods, access to good jobs with fair pay and other determinants as described by the social determinants of health (SDOH). By clearly defining and understanding the differences between equality, equity and justice we can begin to identify gaps and barriers to achieving health equity and social justice in the health care delivery system.



**Social determinants of health** are the conditions under which people are born, grow, live, work and age. Medical care drives only 10% to 20% of a person's overall health. The other 80% to 90% is determined by the complex circumstances in which people are born, grow, live, work and age. The SDOH have a much deeper connection to a person's overall health than their genetic make up and overall risk factors. The SDOH are broken up into four categories: socioeconomic factors, physical environment, health behaviors and health care.


**Healthcare barriers** or health disparities fall into one of three categories: structural, financial and personal. Each category points to a measured difference in health outcomes that is closely linked with social or economic disadvantages. Health disparities negatively impact groups of people who have systematically experienced greater social or economic obstacles to health.


**The reality** is that health starts long before illness and even long before birth. The measurement of factors such as SDOH and health disparities or health care barriers can be used to support the advancement of health equity. The diagram below shows the framework our HSHS ministries will use to progress toward more equitable communities while addressing the top needs identified through the CHNA process.



# APPENDIX II

## FY2021 Focus Group Data Review

# Seven Priority Areas & Three Major Contributing Factors

- Access to Behavioral Health Services
- Access to Mental Health Services
- Affordable Housing
- Disparities in Economy
- Disparities in Education
- Food Access
- Homeless Issues

**Major Contributing Factors**

1. Access to Health and Healthcare
2. Social Determinants of Health
3. Racial Inequities and Inequalities

## Mental Health

The number of poor mental health days has increased since 2013.

People identified the following reasons as access barriers:

- Limited access to diverse providers
- Limited access to culturally competent providers
- Taboo topic within certain communities
- Overall participants stated cost was too high

## Behavioral Health

Drug and alcohol use is on the rise.

- In Sangamon County more than half of users are between the ages 25 – 44.
- Teens who use marijuana has spiked since 2014.
- Anecdotally, teens who experiment with alcohol has also steadily increased.
- Depression and anxiety are often noted as reasons people use substances.
- Lack of substance and alcohol abuse treatment services for youth.

## Disparities in Economy

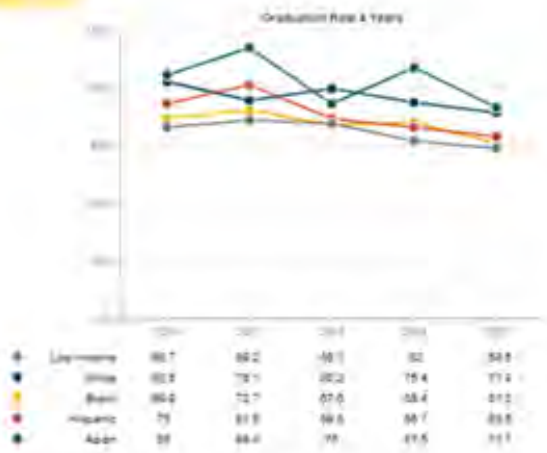
- Sangamon county scores in the lowest quartile for children living in poverty.
- And the second lowest quartile for families living in poverty.
- We are higher than the state and nation for persons with a disability living in poverty.
- Black and African American seniors over 65 are twice as likely to live in poverty in Sangamon County when compared to the state.
- In Springfield, differences between minority and white incomes are greater than any other metro area nationally.

## Poverty by Race

| Race | Population | Poverty |
|---|---|---|
| White | 82% | 15% |
| Black or AA | 12.6% | 59% |
| Hispanic | 2.5% | 20% |

## Food Access

- Currently, 16.5% of children experience food insecurity. This is projected to go up to 26.5% with COVID-19.
- In Sangamon County, 22,480 people are considered 'Food Insecure'. This means they have limited or uncertain availability of nutritional foods.
- According to the 2019 Sangamon Citizen's Survey, minoritized respondents were 30% more likely to report being unable to afford food in the last 12-months.
- Food insecurity impacts the unemployed and low income the greatest.
- Rural zip codes and inner-city zip codes are more likely to experience food insecurity.



## Disparities in Education

- The 2018 Sangamon County graduation rate was 85.3%.
- In 2019, District 186 graduation rate was 67%.
- Since 2016, graduation rates have steadily decreased for all demographics; most notably in low income and black students.
- 42% of District 186 students experienced chronic absenteeism.
- Of those students: black, Hispanic, Native American and low-income students were more likely to miss school days.

## Homelessness

In Sangamon County, homelessness has increased by 9%. Some reasons may be:

- Growing shortage of affordable rental housing
- Restrictions on obtaining rental housing
- Increase in poverty
- Access to Mental Health Services
- Access to SUD / Behavioral Health Services
- Transitional & Wraparound Services

## Affordable Housing

- In Sangamon County, almost 50% of renters spend more than 30% of their monthly income on rent.
- More renters report the inability to pay for utilities, especially since COVID-19
- 13% of renters report severe housing issues such as lack of kitchen and plumbing, and overcrowding.

# APPENDIX III

## 2021 Sangamon County Community Health Needs Assessment

## Priorities Analyzed, Reviewed and Prioritized

Fourteen original needs were identified by the core group using existing secondary data. The needs identified were:

1. Access to behavioral health services
2. Access to mental health services
3. Affordable housing
4. Disparities in education
5. Food access
6. Homeless issues
7. Maternal/infant health
8. Obesity
9. Senior health
10. Tobacco use
11. Unemployment
12. Unmanaged chronic conditions
13. Utility and rental assistance
14. Violence

The core group presented the 14 needs to the CAC and led them through a forced ranking exercise. At that time, the needs were narrowed to the following six:

1. Disparities in education
2. Access to mental health services
3. Affordable housing
4. Access to behavioral health services
5. Homeless issues
6. Food access

The core group then solicited input from community members from the 21 focus groups on the six priorities identified through the CHNA process. Following focus group analysis, each organization presented findings to their respective internal committees. St. John's Hospital's internal committee approved the recommended priorities which were adopted by the board of directors as the FY2021 CHNA priorities:

1. Disparities in economy (income and wealth in the community), including disparities in education
2. Mental and behavioral health services
3. Access to health

# APPENDIX IV

## 2021 Sangamon County Community Health Need Assessment

## Community Advisory Committee Letter and Meeting Dates

Dear Community Partner,

It is time again for HSHS St. John's Hospital (SJS), Memorial Medical Center (MMC), and the Sangamon County Department of Public Health (SCDPH), to conduct our joint Sangamon County Health Needs Assessment (CHNA). We hope you or someone from your organization can provide input through our Community Advisory Council (CAC).

**Community Advisory Council Meeting:** This year, we will conduct TWO virtual CAC meetings:

**Meeting One:** November 18, 2020, 9 – 11 a.m.

Agenda:
1. Introduction
2. Data Discussion: a thorough data dive will be sent to you one-week prior to the meeting. The data will include information surrounding the priorities we are asking you to rank.
3. Break Out Groups: the breakout groups will provide opportunity for deeper discussion around the priority areas and how they should be ranked based on the data presented.
4. Forced Ranking: you will be asked to rank the priorities.
5. Closing

**Meeting Two: July 14, 2021, 11:30 a.m. – 1 p.m.**

Agenda:
1. Introduction
2. Focus Group Analysis
3. Final Priority Review
4. Gaps and Assets Analysis
5. Current Initiatives
6. Health Risk Analysis
7. Who else should be at the table?

**First Person Data:** Following the first CAC meeting, we will conduct up to 10 Zoom Focus Groups (FG) with Sangamon County organizations and community members. These organizations and focus group invitees have been strategically selected in order to solicit feedback from a broad and diverse range of individuals.

**Final Priority Areas:** Finally, the hospitals and health department will take information learned from the CAC and FG to our internal teams for further discussion and ranking. SJS, MMC and SCDPH will once again select one priority area to focus on jointly over the next three years. You will be asked to participate in a second CAC meeting as we develop workgroups to address the identified needs.

We value your knowledge of our community, the work you do with your constituents, and the experience and wisdom you bring to the discussion. Thank you in advance for considering participating on the advisory council.

Please let us know by November 6, 2020; if you or someone else from your organization will serve in this role.

Please don't hesitate to reach out to us with any questions or further discussion.

Sincerely,

Kimberly Luz, M.S., C.H.E.S.
Division Director, Community Outreach HSHS Illinois
(217) 544-6464, ext. 50343 | Kim.luz@hshs.org

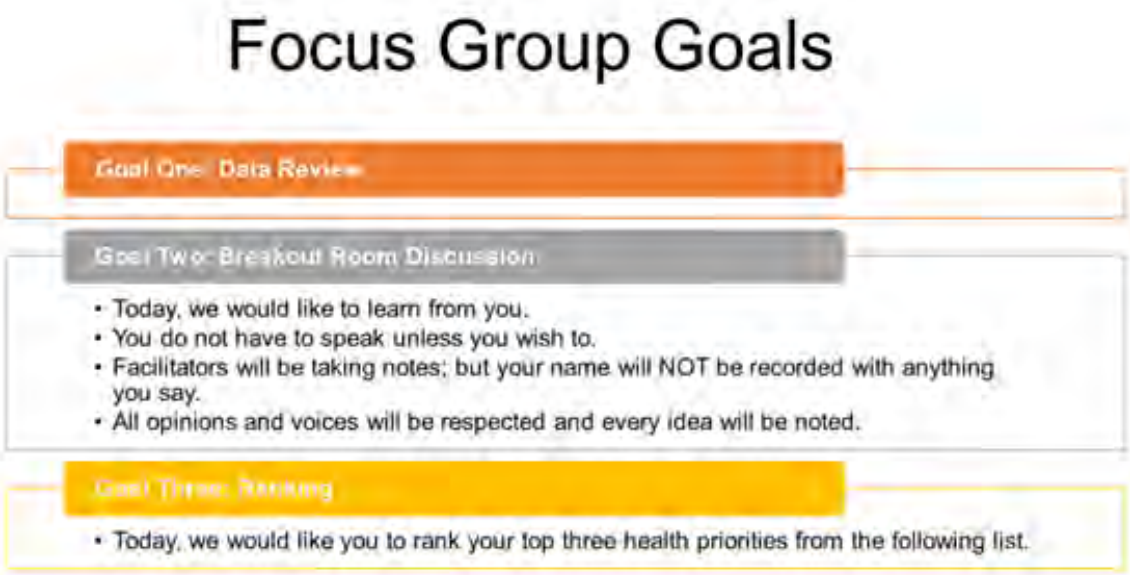
Becky Gabany, System Director, Community Services
Memorial Health System
(217) 788-3374 | Gabany.becky@mhsil.com

Bill Dart, Assistant Director of Public Health
Sangamon County Department of Public Health
(217) 535-3100, ext. 3700 | Bill.dart@co.sangamon.il.us

# APPENDIX V

## FY2021 Sangamon County Community Health Needs Assessment Focus Group Participants

**Focus group** participants and organizations were purposefully selected to solicit feedback from a diverse representation of Sangamon County. Representation was also sought from individuals with lived experiences and organizations serving individuals and populations most impacted by the six priority areas discussed. The list below provides an overview of the 21-focus groups conducted. Also included are the focus group goals and discussion questions asked to help further prioritize health issue areas and strategies.

# Discussion Questions

How do these issues impact you?

How do thse issues impact those you know?

What is the one thing we could do to improve these issues?

# APPENDIX VI

## Evaluation of the Impact of Strategies Taken to Address Significant Health Needs Identified in the FY2018 – FY2021 CHNA

Based on the CHNA planning and development process described the following community health needs were identified:

1. Access to care
2. Child maltreatment
3. Maternal and infant health
4. Substance abuse (drugs)

## ACCESS TO CARE

Access to care has many dimensions. In Sangamon County, there is a direct correlation between access barriers and ZIP codes ranked worst on the socioneeds index. Existing data shows social determinants of health and health disparities lead to a higher incidence of emergency department visits and hospitalization of individuals in low-income neighborhoods.

**Actions:** Response to the access to care concerns identified in the FY2015 CHNA led to measurable improvement in health for residents in the Enos Park neighborhood. Using the effective model in place, strategies will be adapted to meet the unique needs of additional neighborhoods in Springfield. By addressing access barriers in socio-economically disadvantaged neighborhoods, health outcomes will continue to improve.

**Goal:** Build on the success of the Enos Park Access to Care Collaborative and continue to enhance services in Enos Park while expanding the collaborative to the Pillsbury Mills neighborhood and other neighborhoods in Springfield, Illinois.

### Strategy 1:
### Continue Enos Park Access to Care Collaborative

***Note:*** *the final impact statement for this initiative will be completed in November 2021. We will update this section when all outcome measurements have been completed.*

Since FY2019, the collaborative has partnered with Memorial Medical Center (MMC) and SIU Center for Family Medicine to support ongoing efforts in Enos Park to improve access to health and health care.

The cross collaboration between Enos Park and Pillsbury Mills has increased patient capacity. The addition of a part-time community health worker (CHW) in FY2020 allowed us to expand engagement work with the Latinx population in these neighborhoods and beyond. Additionally, our CHWs were trained as PHW (pandemic health workers) to address the unique needs in the community during COVID-19 in both FY2020 and FY2021.

### Strategy 2:
### Expand Access to Care Collaborative to Pillsbury Mills neighborhood

In FY2020, the Access to Care Collaborative added a 1.0 FTE CHW to address the rising needs in the Pillsbury Mills neighborhood. Forty-two clients were added in FY2019, 53 were served in FY2020 and 32 additional clients are currently being served in FY2021. A new group called 'Moving Pillsbury Forward' was created to work with the City of Springfield around the redevelopment of the Pillsbury property which is seen as a main health issue and barrier to health improvement in the neighborhood.

### Strategy 3:
### Expand Provider Council to include providers serving Pillsbury Mills

The Provider Council has successfully provided education and training opportunities for social service and health providers serving the Enos Park Neighborhood. It has been expanded to include all neighborhoods in Springfield that have a CHW component, which includes the United Way funded CHW program on Springfield's east side. By uniting all teams, we can discuss complex cases and work together to identify resources and problem solve based on past experiences.

## CHILD MALTREATMENT

In Sangamon County, we continue to see an increase in reported cases of child abuse and neglect. Currently one in five children is abused or neglected. The likelihood of poor health outcomes and risky behaviors for children who experience abuse and neglect increase significantly. Child maltreatment includes physical, sexual and emotional abuse, neglect and the exploitation of children.

**Goal:** Integrate screening tools for early identification and intervention of child abuse in the health care setting.

### Strategy 1:
### Trauma-informed care education

The hospital will collaborate with existing partners to provide trauma-informed care (TIC) educational sessions for key stakeholders across sectors. A trauma-informed approach helps the stakeholder realize the widespread impact of trauma and potential paths for recovery through recognizing the signs and symptoms of trauma in individuals; understanding the appropriate steps to engage providers in intervention; fully integrating knowledge about trauma into policies, procedures and practices; and actively resisting re-traumatization.

In FY2020, TIC trainings were conducted with 200 healthcare students in EMT, pharmacy, RN, physical therapy, MD and social work.

In FY2021, SIU School of Medicine opened the Trauma Recovery Center. The center stemmed from the work being done through the Access to Care Collaboration; and was supported by both St. John's and Memorial hospitals.

### Strategy 2:
### Human trafficking training for emergency providers

Human trafficking (HT) rose 35.7% from 2016 to 2017 in the U.S. Additionally, the Human Trafficking in Illinois Fact Sheet reports an estimated 25,000 women and children are being trafficked as prostitutes with 1,818 victims rescued since 2012. Calls to the national HT Hotline estimate Illinois ranks 10th for the number of reported cases of HT in the U.S. The State Attorney's Human Trafficking Taskforce identified three points in Central Illinois as 'hotspots' of human trafficking activity due to their proximity to Interstate 55, which is federally recognized as providing easier access to transporting of victims due to its proximity to the railway and intersection through numerous cities and international airports: Peoria, Illinois; Springfield, Illinois; and Litchfield, Illinois.

The Human Trafficking of Person's report estimates one third of all trafficked victims are children. The National Institutes of Health estimates 33% of trafficking victims will seek care in a health care setting. The strategy is to train emergency department providers to identify and respond to suspected human trafficking victims and expand training across HSHS ministries in Illinois.

Emergency department trainings began in FY2020. HT protocol was also developed to accompany the policy adopted in FY2019. In FY2021, the HSHS Illinois Division (ILD) launched the Human Trafficking workgroup to scale up work being done in St. John's and St. Mary's Hospitals and expand policy, protocol and provider training across all ILD ministries.

## MATERNAL AND INFANT HEALTH

This priority addresses maternal and infant health through a three-pronged approach.
1. Focus on first time mothers.
2. Focus on pre-term NICU babies born ≥32 weeks.
3. Focus on accidental infant asphyxiation.

### Strategy 1:
### Explore the issue of infant mortality, particularly accidental asphyxiation

In Sangamon County, there were 27 total infant deaths reported in the first year of life in 2018. These deaths occurred in the home. Eighteen deaths were attributed to accidental asphyxiation. While the number of infants impacted does not represent a large percentage of total babies born, we feel education can better equip parents and guardians on infant safety post discharge.

In FY2020, we conducted three focus groups comprised of 18 community members and nine health care providers to identify safe sleep barriers and opportunities for awareness. From these community focus groups, messaging was developed and two awareness billboards were placed.

### Strategy 2:
### Beyond the NICU

Beyond the NICU employs trained NICU nurses to give vulnerable parents of premature children the support they need to provide their at-risk babies with the best possible start in life. Since infant outcomes are closely tied to maternal health and well-being, this program focuses on assessing and improving maternal mental health and family preparedness.

In FY2020, 28 babies graduated from the program; 20 new babies entered the program; and 16 babies carried over from FY2019. There are a total of 36 babies in the program with 132 to date. Note: FY2021 data will be available in November 2021. This report will be updated accordingly when outcome measurements are available.

### Strategy 3:
### Continue to Support Nurse-Family Partnership®

This program, supported by St. John's, Memorial Medical Center and the Springfield Community Foundation ended in fall 2020. All families were transitioned to a community health worker. Transition discussions were finalized in FY2021. All families are currently being served under the Access to Health and other community health worker collaborations as part of the SIU School of Medicine community health department.

## SUBSTANCE ABUSE (DRUGS)

Fatal and non-fatal drug overdose has increased significantly in Sangamon County since 2014. While the recent trend has shown an increase in opioid and heroin use, officials report the use of methamphetamine is on the rise. Emphasis is needed on both prevention and treatment moving forward.

### Strategy 1:
### Sangamon County Opioid Task Force

St. John's Hospital identified two individuals to serve as hospital liaisons on the Sangamon County Opioid Task Force (SCOT) led by the Sangamon County Department of Public Health. One colleague also serves on the education subcommittee. With the onset of COVID-19, the health department was forced to shift focus and these meetings are on hold.

### Strategy 2:
### Opioid Education Event

St. John's Hospital participated in the planning and implementation of an interprofessional opioid education event led by instructors from St. John's College of Nursing. The event provided education on care, treatment and management of patients with opioid use disorder.

This event was held in FY2020 with 200 students in attendance. A member of the community benefit team sat on the planning team and provided education on adverse childhood experiences and trauma-informed care.

In FY2021, the substance, treatment and recovery program was fully deployed in St. John's Hospital's emergency department. This collaborative program is done in partnership with Gateway Foundation. The initiative is focused on warm handoff services for treatment and recovery of patients presenting with substance use disorder in the emergency department.

The following colleagues work together to identify, screen, assess and transition patients from the emergency department directly to a treatment bed:

- **Engagement Specialist:** A certified addictions counselor, who promotes substance use disorder treatment services and programs to engage potential clients, completes intake screenings and assessments, evaluates patients' needs, determines appropriate program placement and completes related forms and records. Maintains collaborative working relationships and regular communication with referral sources to plan and coordinate services and resolve potential barriers to effective treatment.
- **Recovery Coach:** A staff person with lived experience who provides support and outreach to individuals in recovery or seeking recovery. Serves as a role model by exhibiting long-term stable personal recovery and use of appropriate coping skills. Maintains relationships with and knowledge of resources for clients. Consults with other treatment team members. Provides resources to assist with recovery and transition.
- **Clinical Supervisor:** A clinical leader who is responsible for providing direct supervision to team members delivering services. Oversees client services and ensures compliance with established program standards and service delivery objectives. Responsible for orienting and training staff. Serves as resource to assigned staff in identifying and resolving complex case problems. Interprets and enforces area policies and procedures and initiates corrective actions. Assumes client caseload in response to workload or staffing shortages. Interfaces with key staff at assigned community resources to foster exceptional relationships.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