

*HSHS St. John's Children's Hospital's Kohl's Gotta Dance: Rising Stars, 2014*



# Community Health Needs Assessment

FY2016 - FY2018

**A Collaborative Approach to Impacting Population  
Health in Sangamon County**



**HSHS  
St. John's  
Hospital**

HSHS St. John's Hospital is an affiliate of Hospital Sisters Health System, a multi-institutional health care system comprised of 14 hospitals and an integrated physician network serving communities throughout Illinois and Wisconsin.

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# HSHS St. John's Hospital Community Health Needs Assessment

## **I. EXECUTIVE SUMMARY**

### **BACKGROUND**

Provisions in the Affordable Care Act (ACA) require charitable hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt implementation strategies to meet the needs identified through the CHNA. The CHNA is a systematic process that identifies and analyzes community health needs, assets and resources to plan and act upon priority health needs. This assessment process results in a CHNA Report which is used to plan, implement and evaluate community benefit activities. Once the CHNA report is completed, a set of implementation strategies is developed based on the evidence, assets and resources identified in the CHNA process.

Every three years, affiliates of Hospital Sisters Health System, including HSHS St. John's Hospital, are required to conduct a CHNA, adopt an implementation strategy by an authorized body of the hospital and make the report widely available to the public. The hospital's previous CHNA Report and Implementation Strategy was conducted and adopted in FY2012. In addition, the hospital completes an IRS Schedule H (Form 990) annually to provide information on the activities, policies and community benefit provided by the hospital.

To comply with these requirements, HSHS St. John's Hospital (SJS) partnered with Memorial Medical Center (MMC), Southern Illinois University (SIU) School of Medicine and the Sangamon County Department of Public Health (SCDPH) to lead a collaborative approach in conducting a county-wide Community Health Needs Assessment.

The CHNA will serve as a guide for planning and implementation of health care initiatives that will allow the hospital and its partners to best serve the emerging health needs of Sangamon County. Data collected throughout the assessment process was supplemented with:

- Community asset review
- Qualitative data gathered through the CHNA Core Group with broad community representation
- Community survey to prioritize health focus areas
- Focus groups, including input from area health and social service providers as well as community members who identify with the needs addressed
- Community forums held in five locations identified to best represent all demographics
- Local leader input

## **IDENTIFICATION AND PRIORITIZATION OF HEALTH FOCUS AREAS**

After a thorough review of existing data sets, along with data from five community forums and an online survey, nine health focus areas were presented for consideration by the CHNA Core Group and respective Internal Advisory Councils. St. John's Internal Advisory Council used the defined criteria to narrow health focus areas to the following four:

### **1. ACCESS TO CARE**

- According to the Sangamon County Citizen's Survey:
  - i. 20.9 percent of residents are economically insecure about their family's health care – at least once in the past 12 months they did not have enough money to pay for health care or medicines for someone in their family.
  - ii. 19.1 percent of African Americans are uninsured vs. 9.2 percent of whites.

### **2. ASTHMA**

- Emergency Department and hospitalization rates as a result of unmanaged pediatric asthma are prevalent in our low-income and African American populations.

### **3. MENTAL HEALTH**

- There is a higher than average emergency department use and hospitalization rate for pediatric mental health in Sangamon County.

### **4. OVERWEIGHT / OBESITY**

- In spring 2014, the combined overweight and obesity rates of first and fourth graders in eight elementary schools was 33 percent.
- 56 percent of adults in Sangamon County are considered overweight or obese.

## **HSHS ST. JOHN'S HOSPITAL**

As part of the engagement process with key stakeholders, natural partnerships and collaborations will be used to operationalize an implementation strategy. The implementation strategy is a 'living document' – a set of strategies that can be adapted to the lessons learned while implementing community benefit programs and services relevant to the priority needs. The broader set of community health needs will continue to be monitored for consideration as future focus areas.

### **Introduction and background**

HSHS St. John's Hospital is a not-for-profit hospital serving Sangamon County, Primary Service Area (PSA) and the adjacent eight counties which constitute the secondary service area (SSA): Menard, Logan, Macon, Christian, Montgomery, Macoupin, Morgan and Cass.

St. John's completed the patient tower renovation project in FY13. Orthopedics, Surgical and Rehab Services are now on the ninth floor, which opened in December 2012. The eighth floor opened in July 2013. The 44-bed floor includes a 20-bed Neurology unit, including two beds for 24-hour epilepsy monitoring. To enhance patient safety, additional features were added to the rooms, such as hand rails to the bathroom, bathroom lights that come on automatically and wider doors for easy access to the room. The newly renovated sixth and seventh floors opened in FY14.

The new Surgery Center featuring advanced technology, surgical tools and amenities opened in FY14.

Services added in FY13 and FY14 include MAKOpasty® surgeon-guided robotic arm to treat osteoarthritis of the knee and hip, additional physical therapy locations through the purchase of Premiere Physical Therapy in Springfield, an obstetrical air transport team, 3D mammography and a patient advocate program to help patients and their families through the surgical process. A STAT Stroke Telemedicine network also was established in FY 14 to allow stroke patients in outlying communities the opportunity to receive advanced treatment at their home hospital.

## CURRENT SERVICES AND ASSETS

Major centers and services	Statistics	New services and facilities
<ul style="list-style-type: none"> <li>• AthletiCare – Sports Medicine Center</li> <li>• Geriatric Behavioral Health Services</li> <li>• Birth Center</li> <li>• Cancer Institute</li> <li>• Center for Living</li> <li>• Children’s Hospital</li> <li>• Connect</li> <li>• Level I Trauma Center</li> <li>• Gastroenterology</li> <li>• Health Centers / Priority Care</li> <li>• Home Health</li> <li>• Hospice</li> <li>• Intensive Care Unit</li> <li>• Neurosciences Institute</li> <li>• Orthopedics</li> <li>• Pain Management Center</li> <li>• Prairie Heart Institute – Heart &amp; Vascular Center</li> <li>• Radiology</li> <li>• Regional Wound Care Center</li> <li>• Rehabilitation Center</li> <li>• Sleep Center</li> <li>• TherapyCare</li> <li>• Third Age Living</li> <li>• Women’s Center</li> </ul>	<ul style="list-style-type: none"> <li>• Total Beds: 431</li> <li>• Total Colleagues: 2,399</li> <li>• Bedside RNs: 733 FTE</li> <li>• Inpatient admissions: 19,071</li> <li>• ED visits: 53,826</li> <li>• Births: 1,837</li> <li>• Inpatient surgeries: 5,213</li> <li>• Outpatient surgeries: 7,839</li> <li>• Case Mix Index: 1.69</li> <li>• Physicians on Medical Staff: 813</li> <li>• Volunteers: 676</li> <li>• Community Benefit: \$28,380,903</li> </ul>	<ul style="list-style-type: none"> <li>• Opened four newly remodeled floors in Patient Tower to create all private rooms and specific nursing units</li> <li>• Opened new 16,000 square foot Surgery Center.</li> <li>• MAKOpasty® robotic arm surgery</li> <li>• 3D mammography</li> <li>• STAT Stroke Telemedicine Network</li> <li>• Obstetrical air transport team</li> <li>• CinemaVision MRI goggles</li> <li>• HSHS Regional Trauma Center</li> </ul>

## RECENT AWARDS AND RECOGNITION

The Joint Commission	HealthGrades	Becker's Hospital Review	Leapfrog
<ul style="list-style-type: none"> <li>• Gold Seal of Approval for Advanced Certification in Disease-specific Care as a Primary Stroke Center and for Advanced Heart Failure</li> </ul>	<ul style="list-style-type: none"> <li>• 100 Best Hospitals for Cardiac Surgery</li> <li>• 5-star recipient for Cardiac Surgery, Coronary Bypass, Valve Surgery and Heart Failure Treatment</li> </ul>	<ul style="list-style-type: none"> <li>• One of 100 Hospitals with Great Heart Programs</li> </ul>	<ul style="list-style-type: none"> <li>• For the sixth consecutive ranking, HSHS St. John's Hospital has received an "A" in patient safety from The Leapfrog Group, an independent industry watchdog. St. John's is the only hospital in Sangamon and the surrounding counties to receive this top rating. Only 30 percent of hospitals nationwide earned an "A" during this ranking.</li> </ul>

## COMMUNITY DEFINITION AND DESCRIPTION

HSHS St. John's Hospital is located in the center of Springfield, Illinois and serves not only Sangamon County but also the surrounding counties (Cass, Christian, Greene, Logan, Macoupin, Menard, Montgomery, Morgan and Scott). The total primary and secondary service area of the hospital has a population of 425,189 people, 200,580 people from Sangamon County and 224,609 people from the surrounding counties. Additionally, St. John's provides tertiary care to residents of Bond, Brown, Clay, Coles, DeWitt, Effingham, Fayette, Greene, Marion, Mason, Moultrie, Piatt, Pike, Schuyler and Shelby counties. Aside from the city of Springfield, the economy of St. John's service area is primarily rural and is supported by small businesses, industries, mining and agriculture. Springfield, on the other hand, is an urban area supported by large businesses, such as the Illinois State Government and other industries.

Based on 2014 population estimates derived from the 2010 census, Sangamon County's population of 200,580 people is comprised of 83.04 percent Caucasians, 12.9 percent African Americans, 0.21 percent American Indians/Alaska Natives, 1.79 percent Asians, 0.02 percent Native Hawaiians/Other Pacific

Islanders, 0.57 percent people stating another race and 2.3 percent people stating two or more races. Thirty percent of Sangamon County's residents have a high school diploma, 8.54 percent hold an associate's degree, 19.64 percent have a bachelor's degree, 7.78 percent hold a master's degree and 3.56 percent have a professional school degree or doctorate degree. The current (as of January 2015) unemployment rate of Sangamon County is 6 percent, according to the US Bureau of Labor Statistics, and the median household income is \$55,449.

St. John's secondary service area is comprised of 224,609 people, of whom 88.72 percent are Caucasian, 7.38 percent are African-American, 0.22 percent are American Indian/Alaska Native, 1.08 percent are Asian, 0.02 percent are Native Hawaiian/Other Pacific Islander, 0.85 percent state another race and 1.75 percent state two or more races. Educational levels of this population reflect that 35.44 percent graduated high school, 8.17 percent graduated with an associate's degree, 14.84 percent graduated with a bachelor's degree, 5.76 percent graduated with a master's degree and 2.42 percent graduated with either a professional school degree or a doctorate degree. The average unemployment rate of the combined counties is 6.74 percent and the median household income is \$47,525.

St. John's Hospital employs more than 2,300 people, is a regional medical center and the flagship hospital of Hospital Sisters Health System. Dedicated to providing exceptional care to the whole patient, St. John's offers services spanning from primary care to complex tertiary care, including a Level I Trauma Center, a Birth Center, a Cancer Institute, a Children's Hospital, a Neurosciences Institute, a Pain Management Center, Prairie Heart Institute, a Regional Wound Care Center, a Sleep Center and many others.

## COMMUNITY HEALTH NEEDS ASSESSMENT POPULATION

For the purpose of this CHNA, HSHS St. John's 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.

### Demographics

HSHS St. John's Hospital service area is comprised of approximately 868.90 (2010) square miles with a population of approximately 200,258 (2014) and a population density of 227.40 (2010) per square mile. The service area consists of the following suburban and rural communities:

Cities	Townships	Villages	Unincorporated Communities
<ul style="list-style-type: none"> <li>• Auburn</li> <li>• Leland Grove</li> <li>• Springfield</li> <li>• Virden</li> </ul>	<ul style="list-style-type: none"> <li>• Auburn</li> <li>• Ball</li> <li>• Buffalo Hart</li> <li>• Capital</li> <li>• Cartwright</li> <li>• Chatham</li> <li>• Clear Lake</li> <li>• Cooper</li> <li>• Cotton Hill</li> <li>• Curran</li> <li>• Divernon</li> <li>• Fancy Creek</li> <li>• Gardner</li> <li>• Illiopolis</li> <li>• Island Grove</li> <li>• Lanesville</li> <li>• Loami</li> <li>• Maxwell</li> <li>• Mechanicsburg</li> <li>• New Berlin</li> <li>• Pawnee</li> <li>• Rochester</li> <li>• Springfield</li> <li>• Talkington</li> <li>• Williams</li> <li>• Woodside</li> </ul>	<ul style="list-style-type: none"> <li>• Berlin</li> <li>• Buffalo</li> <li>• Cantrall</li> <li>• Chatham</li> <li>• Clear Lake</li> <li>• Curran</li> <li>• Dawson</li> <li>• Divernon</li> <li>• Grandview</li> <li>• Illiopolis</li> <li>• Jerome</li> <li>• Loami</li> <li>• Mechanicsburg</li> <li>• New Berlin</li> <li>• Pawnee</li> <li>• Pleasant Plains</li> <li>• Riverton</li> <li>• Rochester</li> <li>• Sherman</li> <li>• Southern View</li> <li>• Spaulding</li> <li>• Thayer</li> <li>• Williamsville</li> </ul>	<ul style="list-style-type: none"> <li>• Andrew</li> <li>• Archer</li> <li>• Barclay</li> <li>• Barr</li> <li>• Bates</li> <li>• Bissell</li> <li>• Bradfordton</li> <li>• Breckenridge</li> <li>• Buckhart</li> <li>• Buffalo Hart</li> <li>• Cimic</li> <li>• Clayville</li> <li>• Farmingdale</li> <li>• Glenarm</li> <li>• Island Grove</li> <li>• Lowder</li> <li>• New City</li> <li>• Old Berlin</li> <li>• Riddle Hill</li> <li>• Salisbury</li> <li>• Toronto</li> <li>• Zenobia</li> </ul>

**Total Population Change, 2010 to 2014**

According to the U.S. Census data, the population in the region increased from 197,469 to 200,258 between the year 2010 and 2014 — a 1.41 percent increase.

Report Area	Total Population 2010 Census	Total Population 2014 Census	Total Population Change, 2010-2014	Percentage Population Change, 2010-2014
Sangamon County	197,469	200,258	2,789	1.41
State	12,827,943	12,921,524	93,581	0.7

Data Source: US Census Bureau, Decennial Census: 2010 to 2014. Source geography: Tract.

There was a significant increase in all ethnic groups in Sangamon County. The increase is because of a different, more detailed, data source used this year. The 'other race' category decreased from 35 percent in FY12 to 0.57 percent in FY15 (see pages 5 - 6).

**Population by age groups**

Population by gender was Male 47.97 percent and Female 62.03 percent and the region has the following population numbers by age groups:

Report Area	Total Population	Age 0 to 17	Age 18 to 24	Age 25 to 34	Age 35 to 44	Age 45 to 54	Age 55 to 64	Age 65+
County (#)	200,258	46,580	16,982	26,154	24,572	29,698	27,555	28,717
County (percent)	100	23.26	8.48	13.06	12.27	14.83	13.76	14.34
State	100	23.88	9.71	13.9	13.19	14.24	12.03	13.05

Data Source: US Census Bureau, Decennial Census: 2000 to 2010. Source geography: Tract

**Population without a high school diploma (age 25 and older)**

Within the report area there are 10,936 persons aged 25 and older without a high school diploma (or equivalent) or higher. This represents 8 percent of the total population aged 25 and older. This indicator is relevant because educational attainment is linked to positive health outcomes.

Report Area	Population Age 25+	Population Age 25+ with no HS Diploma	Percent Population Age 25+ with no High School Diploma
County	136,696	10,936	8
State	8,577,307	1,635,833	12.7

Note: This indicator is compared with the state average. Data Source: US Census Bureau, American Community Survey: 2007 to 2011. Source geography: Tract.

### Population in poverty (100 percent FPL and 200 percent FPL)

Poverty is considered a key driver of health status. Within the report area, 17.12 percent of the population is living below the Federal Poverty Level (FPL). This is higher than the statewide poverty level of 15 percent. This indicator is relevant because poverty creates barriers to access including health services, nutritional food and other necessities that contribute to poor health status.

Report Area	Poverty Rate	Extreme Poverty Rate (defined as living below 50 percent of the poverty threshold)
County	17.12 percent	9.2 percent
State	15.0 percent	6.9 percent

*Note: This indicator is compared with the state average. Data Source: Heartland Alliance: Social Impact Research Center, September 12, 2012.*

## II. ESTABLISHING THE CHNA INFRASTRUCTURE AND PARTNERSHIPS

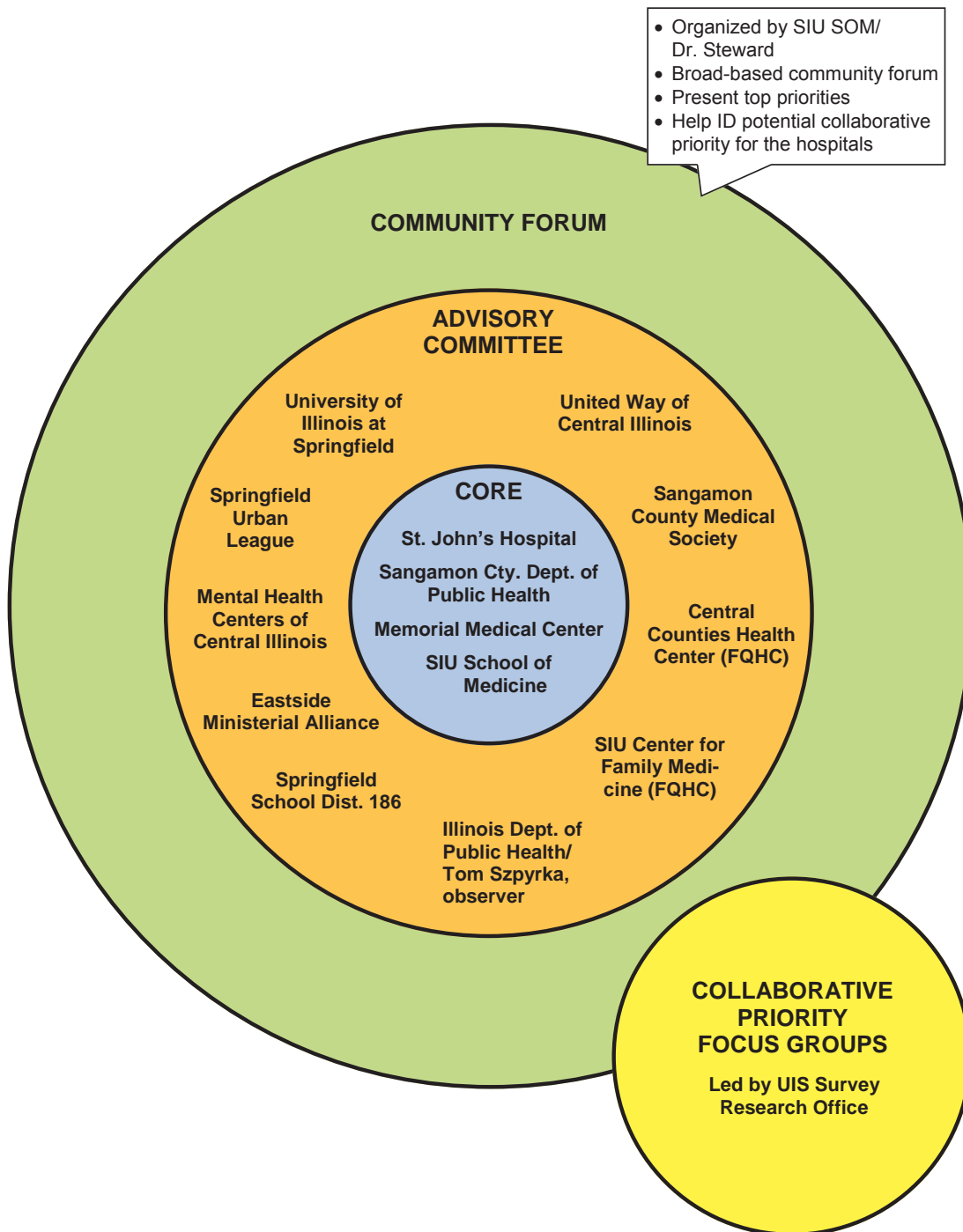
HSHS St. John's Hospital undertook a 15-month planning and implementation effort to develop the CHNA, identify and prioritize community health needs for its service area and formulate an implementation strategy to guide ongoing population health initiatives with partners and collaborators that share a common mission. As part of this process, St. John's leveraged existing relationships that provided diverse input for a comprehensive review and analysis of community health needs in the hospital's service area.

St. John's Hospital (SJS) worked collaboratively with Memorial Medical Center (MMC), Sangamon County Department of Public Health (SCDPH) and Southern Illinois University (SIU) School of Medicine to complete the Sangamon County Health Needs Assessment. The organizations agreed to identify one joint collaborative and develop implementation strategies around addressing the health focus area over the next three years. Each entity then took the list of health focus areas to their respective internal advisory councils to complete their individual CHNA and implementation strategy.

- *Memorial Medical Center* is an acute care hospital in Springfield, Illinois, that offers comprehensive inpatient and outpatient services. As a not-for-profit hospital, MMC falls under the provisions in the ACA requiring charitable hospitals to conduct a CHNA. Previously, MMC and SJS have participated in each other's external advisory councils for the CHNA process.
- *Sangamon County Department of Public Health* serves Sangamon County by providing personal and environmental health services which emphasize health promotion and the prevention of illness and disease. SCDPH is required to complete the Illinois Project for Local Assessment of Need (IPLAN) every five years. After a pilot with the two local hospitals the SCDPH received special permission from Illinois Department of Public Health to conduct its IPLAN every three years in collaboration with SJS and MMC.

- *SIU School of Medicine* is a medical school located in Springfield, Illinois. Its mission is to assist the people of central and southern Illinois in meeting their health care needs through education, patient care, research and service to the community. Within the last three years, SIU launched its Community Health and Service Department which wants to better address the needs of Sangamon County. This was not a mandate; however, it is a strategic initiative.

This chart represents the organization and responsibilities of the Sangamon County Health Needs Assessment partners. Specific details of each group are provided on subsequent pages.



**CHNA core group**

The following representatives made up the CHNA core group responsible for developing and driving the CHNA process (Appendix A: Sangamon County Community Health Needs Assessment Process).

Representative	Title	Organization
Kimberly Luz, MS, CHES	Director of Community Outreach; Community Benefit Coordinator	SJS
Angela Hall	System Director, Mission Integration & Community Benefit	SJS
Paula Gramley	Community Benefit Program Manager	MMC
Mitch Johnson, MBA, FACHE	Senior Vice President and Chief Strategy Officer	MMC
Jim Stone, MA, CPHA	Director of Public Health	SCDPH
Gail O'Neill, BS	Assistant Director of Public Health	SCDPH
Mary Hart	Community Planning Fellow	SCDPH
David Steward, MD, MPH	Associate Dean, Community Health and Service	SIU

**CHNA external advisory council**

Members of the CHNA external advisory council were chosen based on their unique expertise and experience. The CHNA external advisory council members were responsible for:

- Offering insight into issues affecting existing data.
- Identifying local community assets and gaps.
- Offering advice on which issues are the highest priority.

CHNA Steering Committee Member	Organization
Heather Burton	Central Counties Health Center, Federally Qualified Health Center
Reverend Sam Winger	Eastside Ministerial Alliance
Tom Szpyrka	Illinois Department of Public Health, Division of Health Policy
Jan Gambach	Mental Health Centers of Central Illinois
Carol Harms	Sangamon County Medical Society
Janet Albers, MD	SIU Center for Family Medicine, Federally Qualified Health Center
Jennifer Gill	Springfield School District 186
Altheal Randolph	Springfield Urban League
John Kelker	United Way of Central Illinois
Ashley Kirzinger	University of Illinois at Springfield Survey Research Office

### CHNA community forums

Community Forums were held at five locations in Sangamon County. The locations offered a variety of socioeconomic, educational and ethnic backgrounds. Two forums were held in rural locations to invite feedback from our farming and rural communities. During forums community residents were invited to:

- Provide input on community data.
- Help identify community assets and gaps.
- Assist in identifying priority health and quality of life issues.

### Collaborative priority focus groups

The core group commissioned University of Illinois Survey Research Office to conduct four focus groups around the joint collaborative. The purpose of these groups was to better define the issue, identify root causes and identify ways to address the issue. Focus groups included:

- Stakeholders – those providing health and social services within the defined boundaries.
- Young adults – 18 - 40 year olds who live within the defined boundaries with and without children.
- Senior adults – persons 65 and older living within the defined boundaries.
- M.E.R.C.Y. Community Mothers – single, homeless mothers seeking services from M.E.R.C.Y. Communities located within the defined boundaries.

### CHNA internal advisory council

The Internal Advisory Council was comprised of St. John's Hospital colleagues who were responsible for providing guidance and input around St. John's Hospital's final health focus areas. The internal advisory council members were responsible for:

- Identifying St. John's Hospital's top three priorities by following a set of defined criteria: magnitude, seriousness, feasibility and triple aim.
- Providing guidance and feedback on the implementation strategy which defines strategies to address needs identified in the CHNA.
- Recommending and overseeing community benefit policies and programs designed to carry out the mission of St. John's Hospital to provide exceptional health care services to the people of central Illinois.

Name	Responsibility
Bob Bunn	Vice Chair of SJS Board of Directors
Patty Allen, MBA	VP-Finance St. John's Hospital/Controller Central Illinois Division – HSHS
Christopher Campbell	VP and Strategy Officer
Douglas Carlson, MD	St. John's Children's Hospital Medical Director
Ann Derrick, RN, MSN	Executive Director, Post-Acute Care Strategy
Judy Shackelford, RN, PhD	Professor, St. John's College of Nursing
Charles Lucore, MD, MBA	CEO and President
Gurpreet Mander, MD, MBA	Chief Medical Officer
Samantha Maras, MS	Executive Director Oncology Services and Prairie Heart Institute- Interim

*CHNA internal advisory council, cont.*

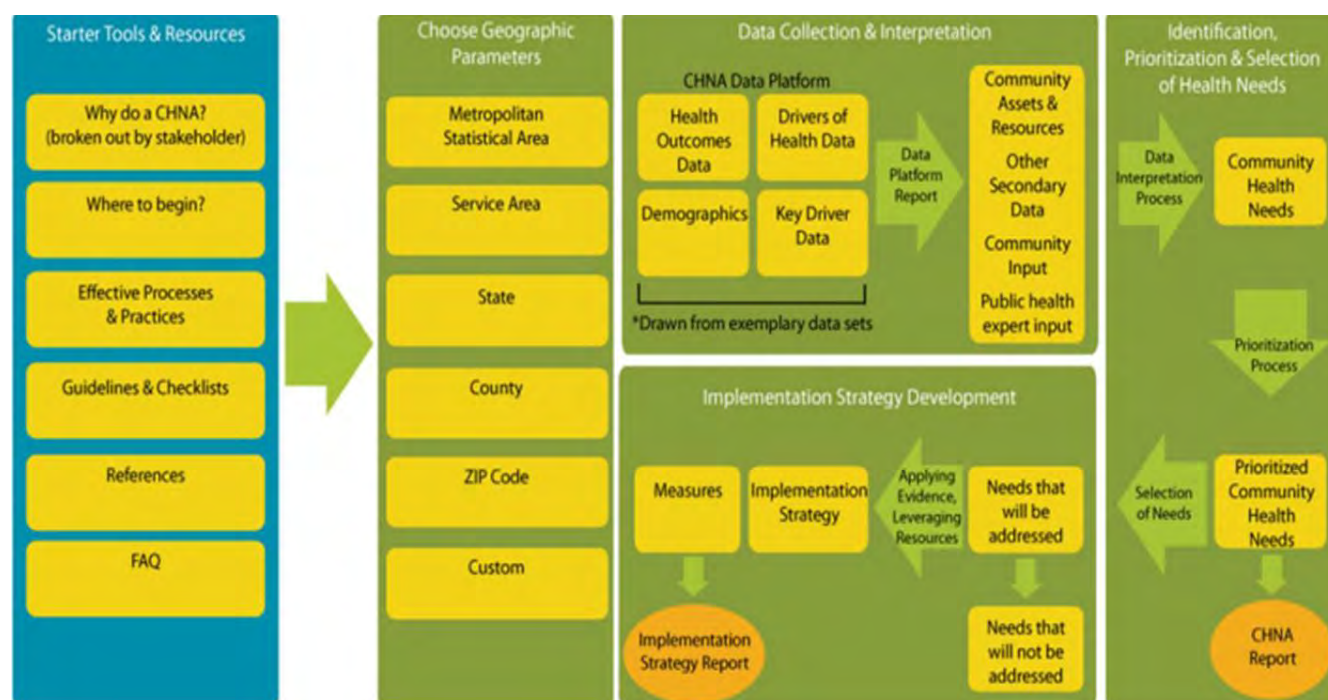
Kristina Maurer, RN	Hospice
Nick Nehman	Director, Strategic Planning and Business Development
Pat Graham	President of Parent Help Line Advisory Board
Diane Pugh, MA, CCC, SLP	Director, Mission Integration, Spiritual Care, Ethics, Community Based Innovation
Mary Rogers	Event Facilitator
Molly Wilson, MBA	Chief Communications Officer
Kim Luz, MS, CHES	Director of Community Outreach

### III. DEFINING THE PURPOSE AND SCOPE

The purpose of the CHNA was to 1) evaluate current health needs in the hospital's service area; 2) identify resources and assets available to support initiatives to address the health priorities identified; 3) develop an implementation strategy 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.

## IV. DATA COLLECTION AND ANALYSIS

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



### Description of quantitative sources

Source	Description
Healthy Communities Institute (HCI)	HCI CHNA System <sup>®</sup> is a customizable web-based information system that provides the data, tools and best practices to help hospitals meet health care reform and IRS 990 requirements for conducting community health needs assessments.
Behavioral Risk Factor Surveillance System (BRFSS)	The BRFSS is the largest, continuously conducted telephone health survey in the world. It enables the Centers for Disease Control and Prevention (CDC), state health departments and other health agencies to monitor modifiable risk factors for chronic diseases and other leading causes of death.
US Census	National census data is collected by the US Census Bureau every 10 years.
Centers for Disease Control	Through the CDC's National Vital Statistics System, states collect and disseminate vital statistics as part of the US's oldest and most successful inter-governmental public health data sharing system.

*Description of quantitative sources, cont.*

County Health Rankings	Each year the overall health of each county in all 50 states is assessed and ranked using the latest publically available data through a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.
Illinois Department of Public Health (IDPH)	IDPH collects and evaluates thousands of health statistics to measure progress toward state and national health objectives. These numbers also provide the basis for developing and implementing public health strategies for disease prevention and health promotion.
Coordinated Access to Community Health	CATCH is a group of volunteer physicians collaborating with Memorial Health System, St. John's Hospital and local social service agencies to provide a medical home to low-income residents in Sangamon County through access to comprehensive health services.
School Report Cards/Illinois State Board of Education	Source of information about Illinois public schools.
Central Counties Health Centers and SIU Center for Family Medicine	Federally Qualified Health Center Profiles submitted to Health Resources and Services Administration by Central Counties Health Centers and SIU Center for Family Medicine.
USDA Food Atlas	Gathers statistics on food environment indicators to stimulate research on the determinants of food choices and diet quality, and provides a spatial overview of a community's ability to access healthy food and its success in doing so.

**Description of qualitative sources**

Qualitative data was reviewed to help validate the selection of health priorities. In alignment with IRS Treasury Notice 2011-52.2 data reviewed represented 1) the broad interests of the community; and 2) the voice of community members who were medically underserved, minorities, low-income or suffering from chronic illnesses.

Report title	Lead entity	Area of expertise
Sangamon County Citizens' Survey	United Way of Central Illinois	Health and education disparities and resources
Voices for Children	Voices for Illinois Children	Child development
Springfield Urban League/Early Head Start Community Assessment	Springfield Urban League	Ethnic disparities
Sangamon County Department of Community Resources Need Assessment	Community Action Partnership	Low-income residents

In addition to qualitative and quantitative data sources, the hospital into input from people who represent the broad interests of the community served by the hospital, including those with special knowledge or expertise in public health (local, regional, state and/or tribal). Members of medically underserved, low-income and minority populations served by the hospital or individuals or organizations representing the interests of such populations also provided input. The medically underserved are members of a population who experience health disparities, are at risk of not receiving adequate medical care as a result of being uninsured or underinsured and/or experiencing barriers to health care because of geographic, language, financial or other barriers.

## **V. IDENTIFICATION AND PRIORITIZATION OF HEALTH FOCUS AREAS**

### **PRIORITIZATION OF HEALTH FOCUS AREAS**

As part of the identification and prioritization of health needs, the CHNA core group identified 22 health focus areas from extant data sources (see pages 14-15 for a list of quantitate and qualitative data sources).

The core group used a set of defined criteria (Diagram 1: Defined Criteria for Community Health Needs Assessment) to narrow the health focus area to 12. Following this process, the core group presented the 12 focus areas to the advisory council. Data was presented for each focus area and the advisory council was led through a forced ranking process to further narrow the list to nine focus areas for consideration as part of the FY16-FY18 CHNA.

The core group commissioned UIS Office of Survey Research to develop an on-line survey available for community members to provide feedback around the nine priority areas. Participants were asked to rank the top three focus areas by order of importance. They were also invited to list any additional health focus areas they thought should be considered.

Five community forums were presented in concurrence with the online survey (see Appendix B for community forum fliers). Forums were held in five locations around Sangamon County. The locations were selected in order to reach persons from varied socioeconomic, educational and ethnic backgrounds. Two forums were held in rural locations to invite feedback from our farming and rural communities. During forums community residents were invited to provide input on community data, help identify community assets and gaps and assist in identifying priority health and quality of life issues. (See Appendix C for a summary of the community forum and survey outcomes.)

HSHS St. John's Hospital's internal advisory council met to review community forum and survey feedback in addition to data around the nine health focus areas. The internal advisory council was then asked to force rank the issues to identify the top four FY16-FY18 CHNA Health Focus Areas (See Diagram 2: Prioritization of Health Focus Areas.)

Diagram 1: Defined Criteria for Community Health Needs Assessment

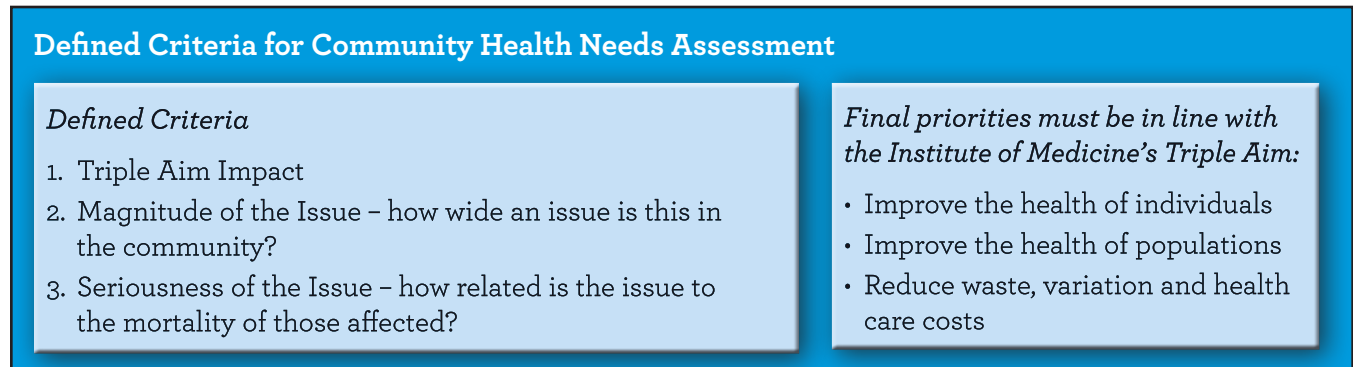
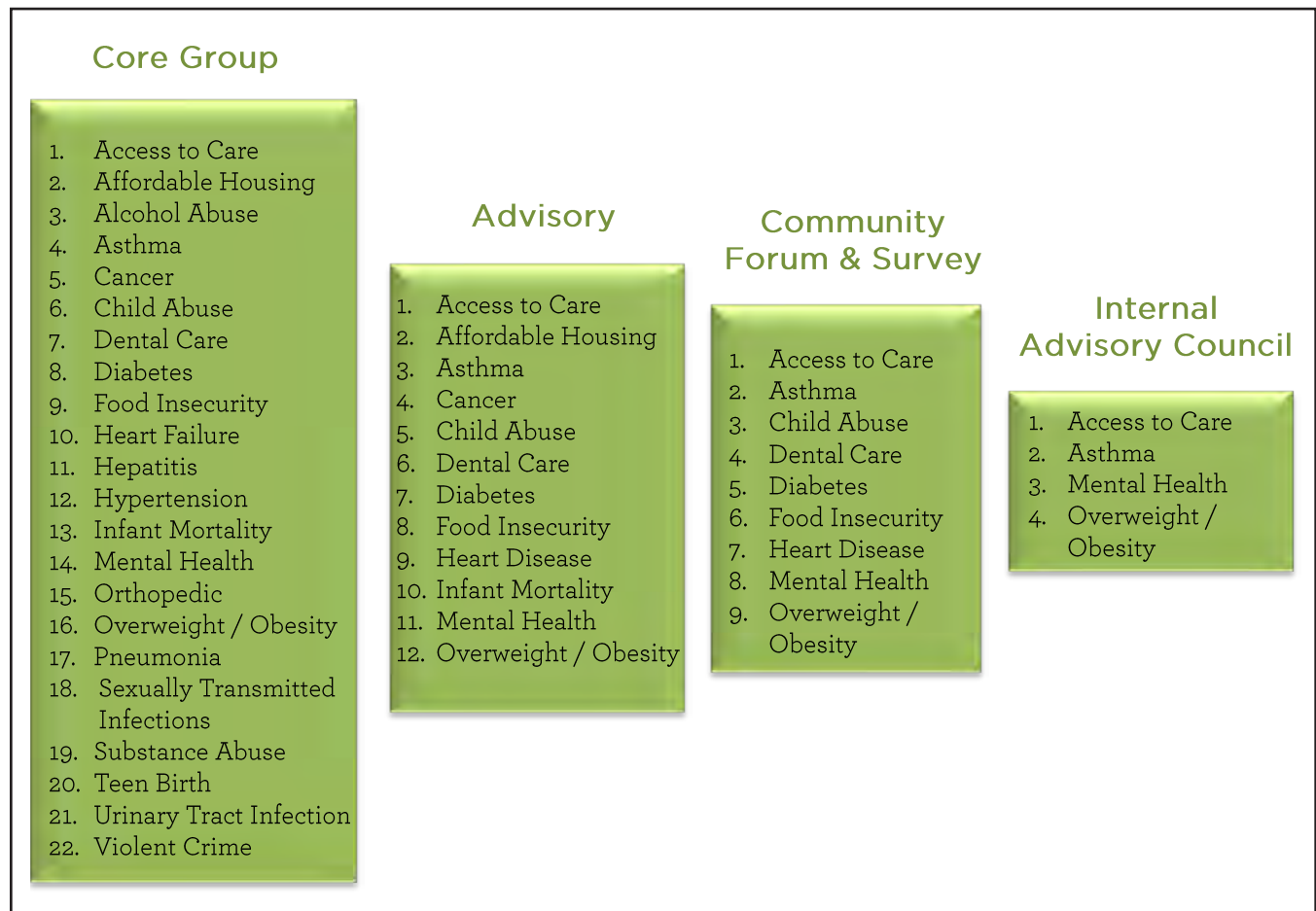


Diagram 2: Prioritization of Health Focus Areas



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

1. Access to care
2. Mental health
3. Pediatric asthma
4. Overweight/obesity

As an outcome of the prioritization process five of the nine health focus areas ranked by the community and internal advisory council were not identified as ranking high against the defined criteria and were not advanced for consideration for the implementation strategy.

In some cases the focus area is currently being addressed by another organization in the community or there is another organization within the community better equipped to address the need. While the list below will not be areas of primary focus for St. John's, the hospital will continue to participate in efforts with other organizations as appropriate and where the hospital can lend support.

1. Child abuse
  - In 2014 the Illinois Department of Children and Family Services entered into a year-long contract with the Mental Health Centers of Central Illinois to revamp the state's child protection training.
  - The goal of this partnership is to provide experiential training through simulated real-life situations to better train child welfare workers with the necessary skills to protect children.
2. Dental care
  - Dental care was not identified through the existing data sets; however, it was an issue brought to our attention by our advisory council and during the community forums.
  - During our assets and gaps process it was noted the Federally Qualified Health Centers are preparing to expand their dental services. Additionally there are new services such as Familia Dental which provide affordable dental care.
3. Diabetes
  - St. John's Hospital has representation on the Prairie Diabetes Alliance (PDA) which is run through the Central Illinois American Diabetes Association. Through our ongoing work with PDA and our initiatives around a FY12 identified needs: Metabolic syndrome. We will continue our efforts around diabetes prevention and management.
4. Food insecurity
  - St. John's Hospital continues to sponsor, organize and run the Eastside Farmers Market which began as a result of the FY12 CHNA.
  - St. John's Hospital also works closely with other organizations in the community who are actively addressing food security issues: genHkids Coalition, Illinois Stewardship Alliance, Downtown Springfield, Inc., to name a few.
5. Heart disease
  - Prairie Heart Institute at St. John's Hospital is committed to ongoing community education and outreach around heart disease.
  - The American Heart Association has a very active chapter in Sangamon County.

### **Joint collaborative**

After HSHS St. John's Hospital and Memorial Medical Center's internal prioritization processes were complete, representatives from the two organizations came together to discuss the joint collaborative. The separate internal advisory councils assisted in identifying possible areas for collaboration.

As part of the identification and prioritization of health needs, the hospitals considered the estimated feasibility and effectiveness of possible interventions to impact the collaborative health priority; 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 to address the health need.

The following assumptions were taken into consideration when identifying the joint collaborative.

HSHS St. John's Hospital and Memorial Medical Center will:

- Focus attention on areas of greatest need in the community (likely residents living in ZIP codes 62701, 62702 and 62703).
- Take a narrower, deeper dive into the issue rather than broad and community-wide approach; perhaps initially set goals for a targeted pilot project rather than trying to reach too wide a segment of the community.
- Be collaborative and invite other stakeholders to participate.
- Select something that will allow us to demonstrate measurable outcomes.
- Avoid competitive issues between the two hospitals.

Ultimately, Access to Care was selected as the joint collaborative.

## VI. DESCRIPTION OF COMMUNITY HEALTH NEEDS

See Appendix D for data supporting the following four health focus areas.

### ACCESS TO CARE

Access to care is broad and has many dimensions. In Sangamon County there is a direct correlation between access to care issues and zip codes ranked worst on the socio needs index (see diagram 3 below). Existing data shows a higher incidence of emergency department visits and hospitalization for chronic conditions that could be managed through regular visits with a general provider.

Diagram 3: Access to Care

	62711	62701, 62702, 62703
Socio Need Rank	Ranked best in the county	Ranked worst in the county
Total Population	15,300	68,750 (35 percent of county; 59 percent of city of Springfield)
Land Area	30.64 square miles	31.20 square miles

### MENTAL HEALTH

Children with social and emotional problems often come from circumstances in which they have been abused or neglected. Child abuse also surfaced as one of the top nine health focus areas in Sangamon County. Coordinating efforts with local child abuse prevention groups may lead to improved screening and early detection of mental health illnesses in the pediatric population. Existing data shows a high rate of unmanaged mental health illness in 15-17 year olds. The rate of emergency department visits and hospitalization in ZIP Codes ranked worst on the socio needs index has increased by 10 percent since 2010. Sangamon County community forums identified a lack of mental health services for children and youth as a primary reason for increased emergency department use.

### PEDIATRIC ASTHMA

Pediatric asthma has been identified as a health disparity in low-income zip codes in Sangamon County. The rate of emergency department use and hospitalization has increased in ZIP Codes ranked worst on the socio needs index. When left untreated, asthmatic children experience decreased stamina which may lead to a less than desirable daily physical activity output. Children need 60 minutes of physical activity each day, according to the Centers for Disease Control and Prevention. Uncontrolled asthma can also lead to scarring of the airways, chronic wheezing and shortness of breath which affect long-term lung function. The most important part of managing asthma is for the parent and child to be knowledgeable about asthma triggers, prevention and management strategies.

## **OBESITY**

Overweight and obesity was not identified as an issue according to pre-existing data sets. Recent statistics from the Springfield Collaborative for Active Child Health show the combined overweight and obesity rates of first and fourth graders in eight elementary schools reviewed was 33 percent. Furthermore, childhood obesity was identified as an issue by HSHS St. John's Hospital, Memorial Medical Center, SIU School of Medicine and genHkids (a local coalition working to advance childhood health and wellness). Despite lack of data obesity was discussed as a high priority during each of the community forums. A lack of resources for low-income residents was identified as a barrier to healthy behaviors. Feedback from the community survey also highlighted a lack of knowledge around nutrition and cooking abilities.

## **VII. DESCRIPTION OF RESOURCES AVAILABLE TO MEET PRIORITY HEALTH NEEDS**

Sangamon County and surrounding counties are served by two hospitals, HSHS St. John's Hospital and Memorial Medical Center. Residents are also served by several physician groups including, but not limited to, HSHS Medical Group; SIU Health Care and Springfield Clinic. Springfield, Illinois (in Sangamon County) is also home to the Central Counties Health Centers and SIU Family Medicine, two federally qualified health care facilities. Sangamon County offers numerous health and human service organizations and coalitions for its residents as well as residents of surrounding counties.

In addition to existing resources, Sangamon County has also deployed 2-1-1 – a United Way of Central Illinois initiative. 2-1-1 provides free and confidential information and referrals to anyone who calls. This program helps those with needs find resources for food, housing, employment, health care, counseling and more.

## **VIII. DOCUMENTING AND COMMUNICATING RESULTS**

This CHNA Report and Implementation Strategy are available to the community on the hospital's public website: [www.st-johns.org](http://www.st-johns.org). To obtain a hard copy, please call (217) 814-4308.

The hospital will also provide in its annual IRS Schedule H (Form 990) the URL of the web page on which it has made the CHNA Report and Implementation Strategy.

St. John's, Memorial Medical Center, SIU School of Medicine and the Sangamon County Department of Public Health will present the collaborative CHNA Report and Implementation Strategy to the community during a community forum to be held in Fall 2015.

# Implementation Strategy

## IX. IMPLEMENTATION STRATEGY

HSHS St. John's Hospital will continue to partner with the organizations making up the core group and advisory council to develop, implement, monitor and evaluate both new and ongoing initiatives that address the identified health focus areas. St. John's will also identify opportunities for additional collaboration in the county.

The high-level overview of implementation strategies and interventions are contained in the Implementation Strategy. An authorized body of the hospital approved and adopted the plan on October 7, 2015. The development of the implementation strategies and interventions include, but are not limited to, the following initiatives in each of the four categories.

### ACCESS TO HEALTH CARE

Reason for priority selection: St. John's Hospital's 2015 Community Health Needs Assessment identified access to care as a top priority through its community survey, advisory groups and data collection. Additionally, focus groups were held to better define access issues among the broader public and high-risk populations.

- I. **Population:** High-risk, underinsured or uninsured east side residents.  
Objective: Provide comprehensive health screenings to high-risk, underinsured or uninsured individuals residing on Springfield's eastside.
- II. **Population:** Residents of Enos Park neighborhood.  
Objective: Improve access to health care in Springfield's Enos Park neighborhood, in collaboration with Memorial Medical Center and Southern Illinois University (SIU) Center for Family Medicine FQHC.
- III. **Population:** Uninsured residents of Sangamon County.  
Objective: Partner with local health care and social service organizations to provide Open Enrollment events during the Affordable Care Act 2015-2016 Open Enrollment season.

### Strategies Identified:

1. Create a community health worker program to increase access to health care and coordination of care.
2. Develop an Enos Park Neighborhood Advisory Council and Providers Alliance to drive health changes and improved health outcomes.
3. Facilitate behavior modification and disease prevention or management by connecting high-risk individuals with a nurse navigator.
4. Assist with the development of personal health care action plan and care coordination.
5. Connect individuals with identified health care needs:
  - a. Specialty care
  - b. Primary care
  - c. Insurance
  - d. Other
6. Educate individuals on insurance benefits, patient responsibilities, proper utilization of health care resources, etc.
7. Increase awareness of community resources among providers and residents.

### **Anticipated Outcomes:**

1. Build meaningful connections between community residents and social service providers through increased awareness and visibility.
2. Increase number of insured residents in Sangamon County.
3. Increase use of wellness visits and preventive-care visits through education on insurance plan and benefits.
4. Increase number of individuals who have a primary care provider.
5. Improve health outcomes and quality of life for individuals participating in access initiatives.
6. Better management of chronic conditions and other health conditions.
7. Decrease use of Emergency Department for non-emergent care.
8. Decrease hospitalization for ambulatory sensitive conditions.

### **MENTAL HEALTH**

Reason for Priority Selection: St. John's Hospital's 2015 Community Health Needs Assessment identified access to care as a top priority through its community survey, advisory groups and data collection. Additionally, focus groups were held to better define access issues among the broader public and high-risk populations.

- I. **Population:** Children attending McClernand Elementary School and/or living in Enos Park Neighborhood.  
Objective: Increase access to pediatric mental health services through the MOSAIC Mental Health Initiative in Enos Park.
- II. **Population:** General Public.  
Objective: Increase access to mental health screening, intervention and educational services.
- III. **Population:** Pediatricians and primary care providers.  
Objective: Increase provider use of evidence-based protocols for the proactive management of diagnosed depressive disorders.  
Objective: Explore integrating behavioral health into primary care.

### **Strategies Identified:**

1. Provide behavioral health specialist to serve McClernand Elementary School and Enos Park .... Neighborhood for the 2015-2016, 2016-2017 and 2017-2018 school years.
2. Provide screening of all children attending McClernand Elementary School.
3. Develop and implement continuing medical education programs to address professional practice gaps around mental health screening, identification, diagnosis, treatment and evaluation.
4. Develop parent education series to assess concerns and detect children at risk of psychosocial and behavioral problems.

### **Anticipated Impact:**

1. Build meaningful connections between community residents and social service providers in Sangamon County for increased awareness and visibility.
2. Increase provider use of evidence-based protocols for the proactive management of diagnosed depressive disorders.

3. Improve clinical and community support for active patient engagement in treatment, goal setting and self-management.
4. Identify youth in need.
5. Link youth to effective services.
6. School-based education.
7. Increase awareness of signs and symptoms of mental health issues.

### **PEDIATRIC ASTHMA**

Reason for Priority Selection: St. John's Hospital's 2015 Community Health Needs Assessment identified access to care as a top priority through its community survey, advisory groups and data collection. Additionally, focus groups were held to better define access issues among the broader public and high-risk populations.

**Population:** Children (younger than 18 years) living with uncontrolled asthma.

- I. Objective: In collaboration with SIU School of Medicine, develop the Sangamon County's Local Asthma Champion designation action plan.
- II. Objective: Decrease school absenteeism because of uncontrolled asthma through parent and student education around quick relief vs. long-term control inhaler use.
- III. Objective: Better management of asthma in the pediatric population.
- IV. Objective: Partner with existing community groups to mobilize resources and streamline interventions to increase capacity for improved outcomes.
- V. Objective: Develop data-driven, neighborhood-specific interventions based on an analysis of patient data for pediatric asthma hospitalizations and Emergency Department visits where asthma was a primary or secondary diagnosis.

### **Strategies Identified:**

1. Social interventions to create an asthma action plan, discuss environmental triggers, housing assessment, etc.
2. Partner with schools in locations with high Emergency Department use and hospitalizations:
  - a. Provide education and tools necessary to control asthma symptoms.
  - b. Assist school in developing personalized asthma care plans.
  - c. Quick relief vs. long-term control inhaler education for parents and students.
3. Ongoing collaboration with SIU School of Medicine's asthma advocacy coalition.

### **Anticipated Outcomes:**

1. Reduce allergen levels in indoor environments.
2. Reduce misuse of emergency inhaler in schools.
3. Improve school attendance in children with chronic asthma.
4. Increase use of well-visits and preventive-care visits through education on insurance plan and benefits.
5. Better management of asthma.
6. Decrease use of Emergency Department for non-emergent care.
7. Decrease hospitalization for ambulatory sensitive conditions.

## **OVERWEIGHT AND OBESITY**

Reason for Priority Selection: St. John's Hospital's 2015 Community Health Needs Assessment identified access to care as a top priority through its community survey, advisory groups and data collection. Additionally, focus groups were held to better define access issues among the broader public and high-risk populations.

- I. **Population:** Residents of Springfield.  
Objective: Improve health outcomes by increasing access to nutrition, physical activity and behavioral health education for families at-risk for overweight and obesity.
- II. **Population:** Sangamon County Children ages 6-13.  
Objective: Continue to grow and expand Kohl's Gotta Dance program.
- III. **Population:** Sangamon County school children and their families.  
Objective: Improve health outcomes of school-aged children through school-based programs and interventions focused on improving school nutrition and increasing physical activity.
- IV. **Population:** East-side residents.  
Objective: Continue to expand and grow the East Side Farmers' Market to increase access to fresh, in-season produce.  
Objective: Continue to increase capacity for free cooking classes on Springfield's east side.

### **Strategies Identified:**

1. Develop a multi-disciplinary, community based, family approach to improve health for at-risk, overweight and obese children.
2. Increase access to fresh, in-season produce on Springfield's east side.
3. Develop skills to create healthy, affordable meals with minimal ingredients and equipment.
4. Continue to support the genHkids mission through monetary and in-kind donations and staff support for program development and implementation.
5. Facilitate behavior modification and disease prevention or management by connecting high-risk individuals with a care-coordination team.

### **Anticipated Impact:**

1. Improve health outcomes and quality of life for children and families in Sangamon County.
2. Increase access to affordable, in-season produce.
3. Improve individual and family commitment to behavior change.
4. Increase amount of daily physical activity minutes in program participants and in participating schools.
5. Increase amount of fruits and vegetables consumed daily by program participants.
6. Improve self-esteem, body image and confidence levels of program participants.

## **COMMITTED RESOURCES**

In addition to staff and facility resources, St. John's Hospital has allocated an increase in spending for discretionary community benefit activities to help support this implementation strategy.

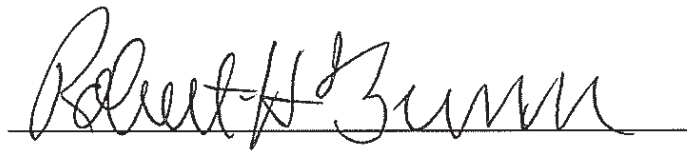
## **NEXT STEPS**

St. John's Hospital will leverage existing partnerships and community resources to coordinate strategic efforts to address identified community health focus areas that can be monitored, evaluated and improved upon over time with lessons learned from the field and evidence-based best practices.

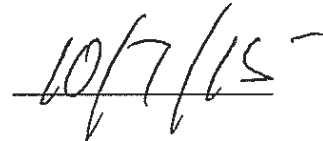
The significant awareness generated in the last 15 months of completing the Community Health Needs Assessment Report and Implementation Strategy provides us with key individuals and organizations who we can engage to refine and implement key activities related to each of the identified community health needs.

## **APPROVAL**

The St. John's Hospital Board of Directors reviews on an annual basis the prior fiscal year's Community Benefit report and approves the Community Health Needs Assessment and Implementation Strategy for addressing health focus areas identified.

A handwritten signature in black ink, reading "Robert H. Bunn", written over a horizontal line.

Bob Bunn, Vice Chair  
HSHS St. John's Hospital Board of Directors

A handwritten date "10/7/15" in black ink, written over a horizontal line.

Date

## X. STEPS TAKEN TO MEET THE LAST IMPLEMENTATION STRATEGY

Since the development of the last implementation strategy, the hospital has taken several steps to meet the strategies selected. The steps taken are set out below in the context of the programs developed to impact identified health focus areas. The list below is representative of the programs developed in direct response to the FY12 CHNA. The list is not inclusive of all hospital and community-based programs and services offered to better the health of the community.

### METABOLIC SYNDROME

#### **Kohl's Gotta Dance**

##### ***Hospital-based program***

The significance of dance reflects an intrinsic cultural orientation toward physical expression and creativity. For many groups, dance plays an important role as a means of emotional expression, interaction, support, respect and cohesion. Studies show dance has improved health outcomes in various populations. For example, dance has been shown to reduce stress, increase bone mineral density, increase physical activity in sedentary populations and decrease weight. Dancing to improve health is effective. Dancing regularly will slower your heart rate, lower or maintain healthy blood pressure and improve or maintain healthy cholesterol levels. Dancing can also improve circulation, lung performance, flexibility and help grow healthy, strong bones. Dancing teaches children to respect themselves and others by being a part of a team, learning to work together to achieve success and problem-solve within their groups to perfect difficult moves and steps. Above all, dancing leaves one feeling physically and mentally better.

##### **Outreach objective:**

Educate, empower and enable our community to combat diabetes, obesity and other health issues through a healthy diet and lifestyle.

##### **Program objective:**

Use the art of dance to increase a child's daily physical activity time (goal – 60 min./day), teach children lifestyles for a successful future (problem-solving, decision-making, verbal and non-verbal communication, accountability, responsibility, team-work, etc.) and introduce children to the arts.

##### **Learning objective:**

Participants will learn and practice skills to increase their ability to make healthy personal and social decisions.

##### **Direct outcomes:**

- Increase daily and weekly physical activity.
- Develop lifestyle skills: communication, problem-solving, teamwork, accountability, team work, self-respect, decision-making, etc.

##### **Indirect outcomes:**

- Healthier body composition measurements.
- Healthier social interactions.
- Decreased risky behaviors.

### **Progress**

Provide dance classes for students in fourth through ninth grades for 10 months. Students participate in one of the following: Hip Hop, Modern or Irish Dance. Students perform at a large theatre arts venue (Hoogland Center for the Arts or Sangamon Auditorium) at the end of the program. Students participate in a one-hour, weekly class and must attend 85 percent of classes in order to participate in the final performance. There are 120 students enrolled in seven classes. Classes are held in five locations around town. Each location was selected for its proximity to underserved neighborhoods.

### **Next steps**

#### **HOPE Institute partnership:**

Through a partnership with Hope Institute, 2014 classes expanded to include three classes for children living with mental and physical disabilities.

#### **School assembly:**

In school year 2015 - 2016, St. John's Children's Hospital will offer a music- and dance-based health program for students in K-6 with a focus on nutrition education and exercise.

#### **Student mentor program:**

Kohl's Gotta Dance students who have exceeded the eligible age for participation may apply to become a Gotta Dance student mentor. Students selected will have had good program attendance, shown leadership qualities, been respectful of classmates and instructor and be willing to work alongside Gotta Dance instructors as a teacher and mentor to younger students.

## **Health Care Professional Education**

### **Hospital-based program**

As a result of the 2012 CHNA, a team of health care providers was pulled together to look at practice gaps around metabolic syndrome in children and adults. The goal of this group was to identify practice gaps and research best practices and evidence-based policy to reduce the progression of metabolic syndrome.

#### **Outreach objective:**

Educate, empower and enable our community to combat diabetes, obesity and other health issues through a healthy diet and lifestyle.

#### **Program objective:**

Develop and implement CME programs to address the professional practice gaps (the practice gap is the difference between what actually occurs and what the ideal or evidence-based practice should be).

**Learning objective:**

1. Identify at-risk patients using recommended obesity screening tools.
2. Overcome communication barriers.
3. Overcome labels: Obesity is a scientific term, not a character label.
4. Identify strategies to assist in treating, reducing, or managing obesity and co morbidities.
5. Understand billing and coding under Medicaid law.
6. Understand the role of physical activity in the prevention and treatment of overweight and obesity.

**Direct outcomes:**

Standardize diagnostic and treatment protocols among Springfield and central Illinois health care providers.

**Indirect outcomes:**

Healthier populations.

**Progress**

This group developed and implemented a three-part multidisciplinary discussion on preventing childhood obesity and helping our children be healthy: Childhood Obesity in Central Illinois: Weighing In On the Problem. Sessions were executed during Grand Rounds.

CME event took place on Sept. 24, 2014: Restoring Healthy Families and Communities in an Obesogenic Environment: A Toolkit for Health Care Professionals.

**Next steps**

**Grand Rounds:**

The three-part multidisciplinary discussion will be offered to additional specialties during Grand Rounds.

**Childhood obesity focus area:**

This group will look at developing a multi-disciplinary approach to improving childhood health and wellness as it relates to childhood obesity.

## CARDIOVASCULAR DISEASE

### East Side Farmers' Market

#### *Hospital-based program*

The East Side Farmers' Market is a partnership between St. John's Hospital, the Downtown Farmers' Market and the Sangamon County Department of Public Health. The program provides an opportunity for local farmers to sell fresh produce on the East Side of town which has been identified as a food desert by the Health Food Financing Initiative. This provides increased access for WIC Clients to utilize their \$15 WIC Coupons as well as increased access for those without transportation downtown. The Market sets up on Mondays from 8 a.m. – 12:30 p.m. to coincide with WIC Education Days. Consumers have access to a Link/debit/credit card machine. As an incentive to participating in the East Side Farmers' Market, St. John's Hospital will provide 36, \$5 coupons at each of the 12 markets scheduled.

**Outreach objective:**

Educate, empower and enable our community to combat diabetes, obesity and other health issues through a healthy diet and lifestyle.

**Program objective:**

Provide access to fresh, in-season produce in a known food desert.

**Learning objective:**

Participant will learn how to select fresh, in-season produce for optimal taste.

**Direct outcomes:**

- Increase daily fruit and vegetable consumption.
- Increase access to fresh, local, in-season produce.
- Increase WIC Coupon redemption at Farmers' Market.

**Indirect outcomes:**

- Healthier body composition measurements.
- Healthier lipid panel measurements.
- Demystify the 'fresh is too expensive' myth.

**Progress**

This greatly enhanced our WIC Farmers' Market Program by opening a new Farmers' Market location in a known food desert. The market is located in the Sangamon County Health Department parking lot. It is open on Mondays to coincide with WIC Classes.

**Market participation criteria:**

- Vendors must sell produce or products to enhance healthy cooking (no baked goods, canned goods, etc.).
- Vendors must accept tokens which can be purchased using Link, debit and credit cards.
- Vendors must accept WIC coupons.

St. John's Hospital issues 36, \$5 coupons each market day. Families are encouraged to purchase a 'new' fruit or vegetable to taste with the money – something they would not generally spend money to try. Farmers have adopted the 'drive through' concept for seniors facing mobility issues and disabled patrons.

**Next steps**

**Expansion:**

ESFM is expanding to allow herbs, olive oil, cheese and other foods used to enhance meal preparation. We are also including additional services such as screenings and health education.

**Community garden partnership:**

St. John's is part of a local, grass-roots initiative called Seeds of Planning which will build three community gardens in low-income neighborhoods. This initiative will be spearheaded by a master gardener who will teach families "farm-to-plate" skills. Families also will work with a Lincoln Land Community College chef to learn safe food handling, produce preparation, meal planning, etc., using the produce they grow.

We will open up vendor space at the East Side Farmers' Market to allow Seeds of Planning families to sell a portion of the produce they grow.

## LIFESTYLE SKILLS

### Cooking Classes

#### *Hospital-based program*

St. John's Hospital will offer cooking classes for WIC families as well as local residents. Cooking classes will take place in the Sangamon County Department of Public Health. Cooking classes will be open to 20 participants each week; participants will have the option to take up to four cooking classes. Each participant will learn to cook fresh, in-season produce through hands-on instruction from a licensed chef. Participants will be able to take home the food prepared as well as a bag of produce from the Farmers' Market which will include vegetables and fruits from class instruction. This class is designed to teach participants how to select, store and prepare fresh, in-season produce.

#### Outreach objective:

Educate, empower and enable our community to combat diabetes, obesity and other health issues through a healthy diet and lifestyle.

#### Program objective:

Teach participants how to select and prepare in-season produce in order to increase daily vegetable and fruit consumption.

#### Learning objective:

Participants will learn how to incorporate in-season produce in daily menu.

#### Direct outcomes:

- Increase daily fruit and vegetable consumption.
- Develop cooking skills.

#### Indirect outcomes:

- Healthier body composition measurements.
- Healthier lipid panel measurements.

#### *Progress*

Implemented cooking classes to coincide with our new East Side Farmers' Market. Classes are held in the Sangamon County Health Department and taught by a St. John's Hospital chef.

Each person has a cooking station and learns, hands-on, how to incorporate in-season produce (being sold at the market) in their side dishes or main dishes.

Participants go home with the meal they prepared in a to-go container. In addition, they receive a bag containing the produce used in the meal's ingredient list. The goal is for the participant to prepare the produce at home and reinforce skills learned in the class.

#### *Next Steps*

This program will continue in the future in conjunction with the East Side Farmers' Market.

## Parish Nurse Program

### *Hospital-based program*

Parish Nursing scholarships will be provided to nurses from five East Side churches to attend the Parish Nurse program at St. John's College of Nursing. In return, nurses will provide a set number of health-related events in partnership with St. John's Hospital to their congregation. Events will include existing, greatly enhanced and new programs aimed at promoting healthy behavior change for a healthier lifestyle. Programs may include but are not limited to:

- Know Your Numbers, which includes free cardiovascular screenings
- Cooking classes combined with nutrition education and eating healthy on a budget information
- Events to promote physical activity for families
- Additional classes will include living within your budget, budgeting classes, resumé building, interview skills, communicating with your children, etc.
- Program design and implementation will be determined by congregation need

#### Outreach objective:

Educate, empower and enable our community to combat diabetes, obesity and other health issues through a healthy diet and lifestyle.

#### Program objective:

Use faith-based organizations to establish trusting relationships and implement healthy, sustainable behavior change/lifestyle management programs in our low-income neighborhoods.

#### Learning objectives:

The participant will be able to:

- Apply knowledge and skills to implement a health ministry in a faith community.
- Enhance the health of a congregation and community.
- Understand resources and expertise available to them through St. John's Hospital.

#### Direct outcomes:

- Increase access to annual screenings and sustainable behavior change/lifestyle management programs.

#### Indirect outcomes:

- Establish East Side residents in a medical home.
- Healthier neighborhoods.

### *Progress*

Progress on the Parish Nurse program has been slow. We currently have one Parish Nurse trained and providing services in one church on the East Side.

### *Next Steps*

Partner with SIU School of Medicine East Side Health Initiative.

## **XI. REFERENCES**

1. US Census Bureau, Decennial Census: 2000 – 2010
2. Community Health Assessment Tool, State Department of Health, data complete through 2012
3. US Census Bureau, American Community Survey: 2008 – 2012. Source geography: Tract
4. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006 – 2012. Accessed using the Health Indicators Warehouse. Source geography: County
5. US Census Bureau, Small Area Health Insurance Estimates, 2012
6. Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2010. Source geography: County
7. The Coalition for Children and Families of Northwestern Wisconsin
8. Illinois State Department of Health Healthy Youth Survey 2013
9. Illinois Hospital Association, 2014
10. Illinois Behavior Risk Factor Surveillance System, 2007-2009
11. Small Area Health Insurance Estimates, 2015
12. County Health Rankings, 2015
13. Healthy Community Institute data made available through Memorial Medical Center

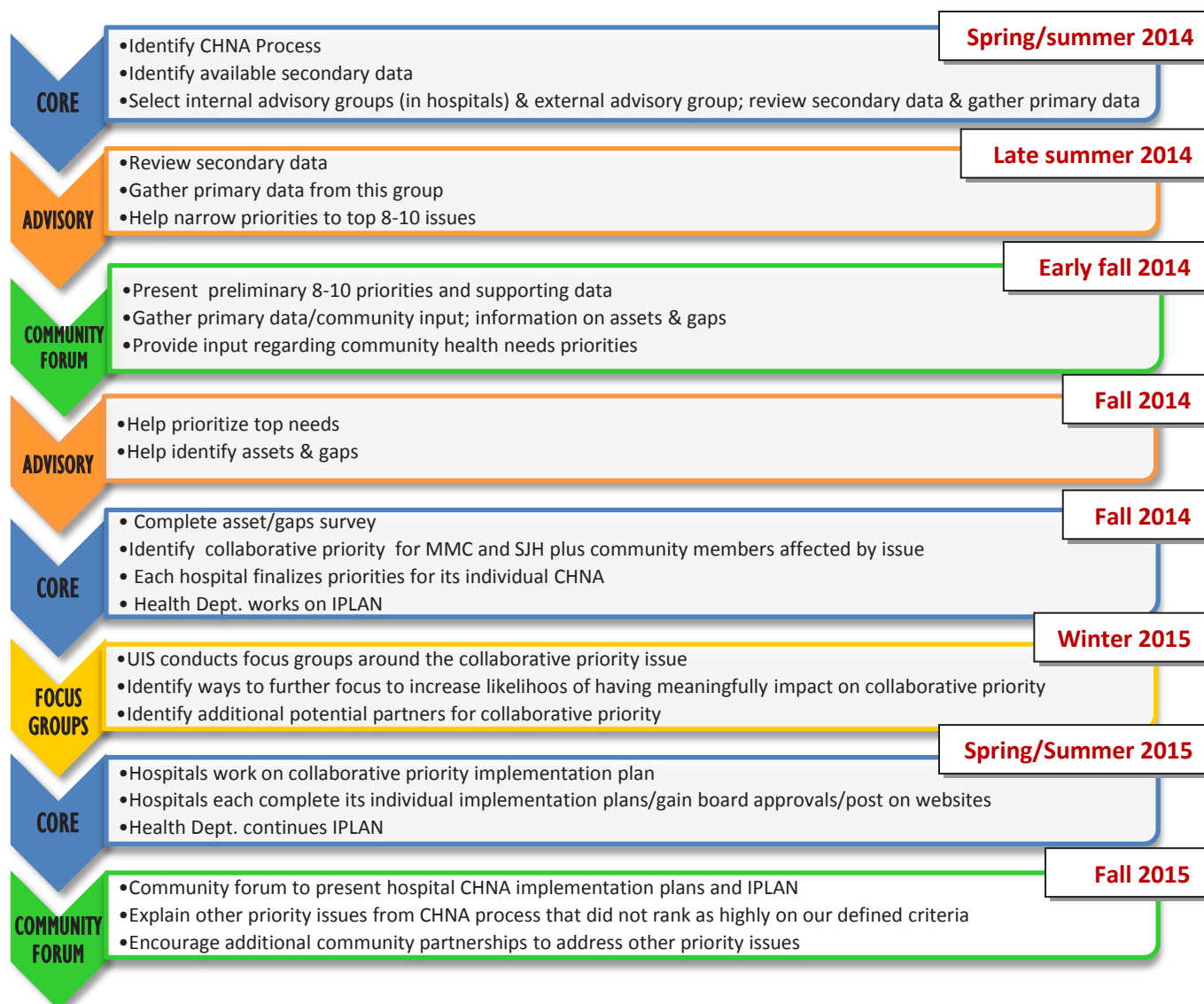
**Support documentation on file and available upon request.**

# Appendices

## Appendix A

### Sangamon County Community Health Needs Assessment Process

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



## Appendix B

### Community Forum Flyer

We want **YOUR** feedback.



Please join us at one of the following

## **Sangamon County Healthy Community Survey: Public Forums**

Wednesday, October 1	6 - 7:30 pm	Riverton Town Hall
Thursday, October 2	6 - 7:30 pm	Union Baptist Church
Monday, October 6	6 - 7:30 pm	Washington Park Botanical Garden
Wednesday, October 8	6:30 - 8 pm	Auburn Community Center
Thursday, October 9	6 - 7:30 pm	Lanphier High School

Participants will be asked to complete a survey to help identify priority health and quality-of-life issues in our community.

The survey also can be found online at [www.go.uis.edu/sangamonhealth](http://www.go.uis.edu/sangamonhealth)



AN AFFILIATE OF HOSPITAL SISTERS HEALTH SYSTEM

**St. John's  
Hospital**



## Appendix C

### Community Forum and Survey Results

#### The Results from Public Input for the 2015 Community Health Needs Assessment

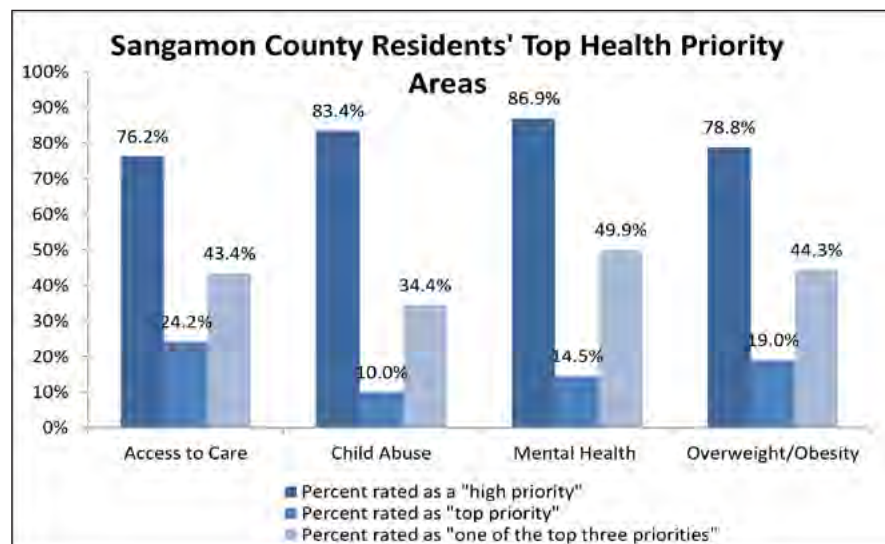
This brief is part of the Sangamon County Community Health Needs Assessment conducted by Memorial Medical Center, St. John's Hospital and the Sangamon County Department of Public Health in collaboration with SIU School of Medicine's Office of Community Health and Service. The purpose of this report is to synthesize the scope of the information collected during the Community Health Needs Assessment process. If you have any questions about this report, please contact the UIS Survey Research Office at (217) 206-6591 or [sro@uis.edu](mailto:sro@uis.edu). The full report provides detailed findings from the five community health forums as well as the results from the public survey, which allowed members of the Sangamon County community to provide input on the health priority areas in the region.

#### Access to care, child abuse, mental health and overweight/obesity are top health concerns

Sangamon County residents have a variety of health concerns ranging from specific illnesses affecting neighbors and family members to the absence of nutrition in the public school educational programs to the lack of access to proper health care and resources. Yet, when asked to identify the top health priority areas in Sangamon County, four priority areas are rated most important by the majority of Sangamon County residents. The four health priority areas are: access to care, child abuse, mental health and overweight/obesity.

As seen in the figure, survey respondents were asked three different questions aimed at gauging what they believed to be the top health priority areas in the region. Across the three question variations, these four health priority areas remained the most concerning to Sangamon County residents.

There were some differences across demographic groups (gender, race and ZIP Code).



A higher percentage of individuals living in 62703 report that food insecurity is a high priority than in any other region. Also, while child abuse ranks high in all ZIP Codes, it is ranked as less of a priority area among respondents in 62703 and 62711, 77.5 percent and 72.1 percent, respectively, rank it as a high priority. Almost 90 percent of respondents living in 62629 rank it as a high priority. When we examine whether demographic groups rated health priority areas differently, we only find a few significant differences (chi-squares in which significance is  $p < .05$ ).

Women are more likely than men to report that mental health and child abuse are a high priority. Eighty-six percent of women compared to 73.3 percent of men report that child abuse is a high priority. In addition, 91.3 percent of women compared to 74.8 percent of men report that mental health is a high priority. Overall, women rate the majority of all of the health priorities higher than the male respondents (the only exception is heart disease). In addition, African-American respondents are more likely to report that asthma, child abuse and heart disease are high priorities than either white respondents or respondents who do not identify as either white or African-American.

## Project Methodology and Sample Demographics

### Project Methodology

The Survey Research Office was asked by Memorial Medical Center, St. John's Hospital, the Sangamon County Department of Public Health, and SIU School of Medicine's Office of Community Health and Service to collect, record, and analyze public input for the 2015 Sangamon County Community Health Needs Assessment. The data that is included in this report is from two different but connected sources. First, it includes the survey responses completed by Sangamon County residents. The survey was available to residents online, at public forums, and at various locations throughout the community. In addition, public input from the five community health forums was recorded, transcribed, and coded in order to identify reoccurring themes as well as report on any additional health priority areas not previously identified.

Overall, 781 individuals completed the survey. Fifty-five of the surveys were completed at the community forums, 137 printed surveys were returned to the SRO, and 589 individuals completed the survey online. The survey was available to Sangamon County community members from September 22 to October 20, 2014. The five community forums were recorded and then transcribed using a combination of computer-assisted transcription software and human researchers. Transcriptions of all of the community forums are available at the full report.

	2012 ACS	Community Forum	Survey Respondents
<b>Gender</b>			
Female	52.0%	52.9%	75.2%
Male	48.0%	45.1%	22.3%
<b>Race</b>			
White	83.7%	78.0%	83.2%
African-American	12.0%	16.0%	11.3%
Asian	1.6%	6.0%	0.9%
Other	2.7%	0.0%	4.6%
<b>Ethnicity</b>			
Hispanic/Latino(a)	1.8%	2.2%	2.7%
Non-Hispanic/Latino(a)	98.2%	97.8%	97.3%
<b>Age</b>			
18-24 years old	6.0%	8.0%	4.8%
25-34 years old	12.8%	16.0%	18.4%
35-44 years old	12.8%	8.0%	18.9%
45- 54 years old	15.2%	14.0%	26.4%
55-64 years old	13.3%	26.0%	23.2%
65 and older	13.7%	28.0%	8.3%
<b>Education</b>			
Less than high school diploma	8.2%	0.0%	4.0%
HS diploma	28.6%	4.0%	8.5%
Some college/trade school	31.6%	6.0%	23.1%
College degree	20.1%	16.0%	18.7%
Advanced degree	11.6%	74.0%	45.7%

### ***Respondent Demographics***

The table presents the demographic characteristics of both samples (community forum participants, community survey participants) compared to the most recent population estimates according the 2012 American Community Survey. As you can see in the table, a higher percentage of females participated in the community survey compared to overall population estimates.

Three-fourths of the responses in the community survey are from female respondents while they only represent 52 percent of the Sangamon County population. In addition, we find that a higher percent of those who participated in the survey (forum participants and community participants) reported having advanced degrees compared to population estimates. For example almost three-fourths of individuals who attended the forums and completed a survey reported having an advanced degree as did 45.7 percent of those who completed a survey outside of the forum. This compares to only 11.6 percent of Sangamon County's population that has an advanced degree.

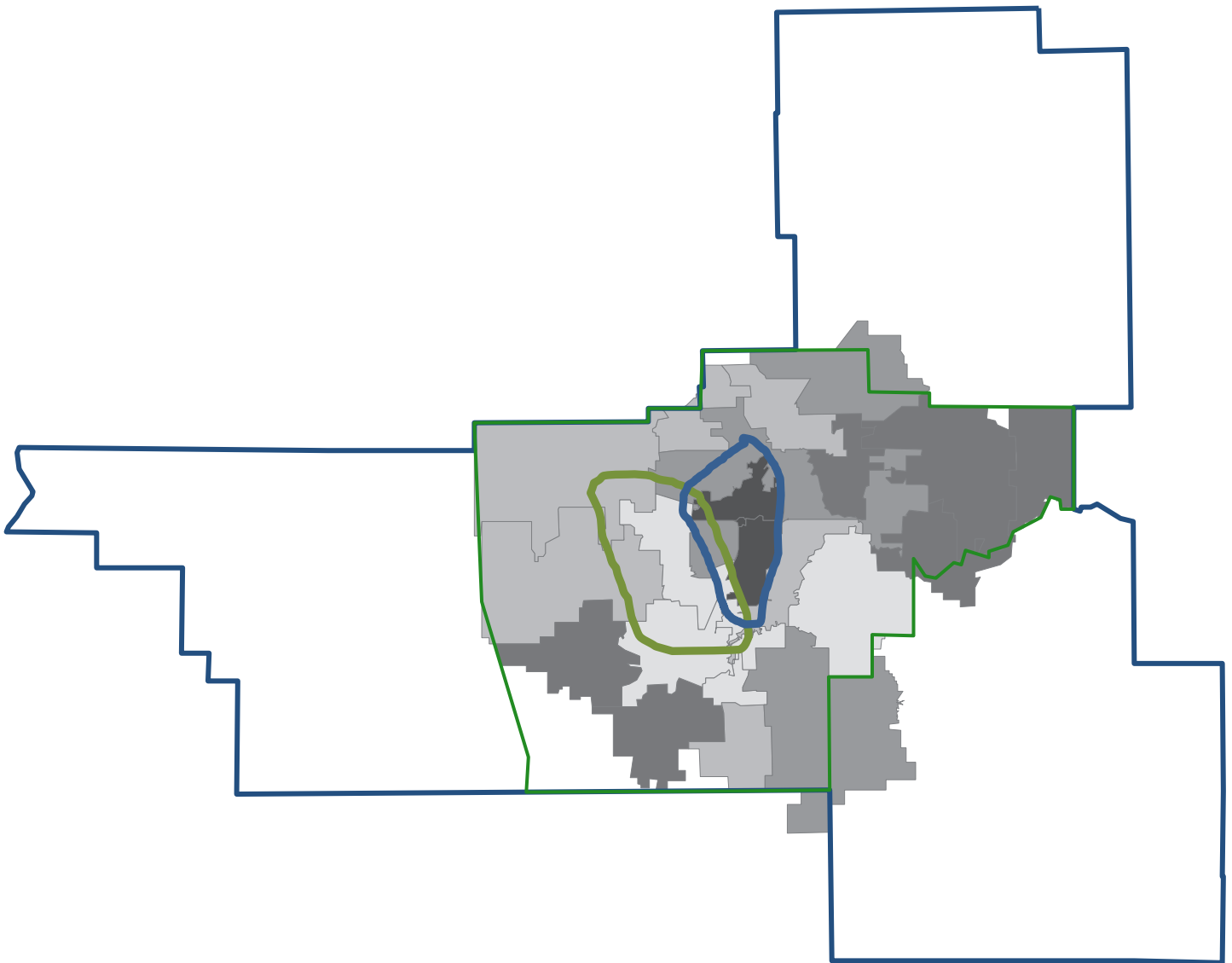
## Appendix D

### Health Focus Area Data Sets

#### SANGAMON COUNTY SNAPSHOT

Population	199,145	117,006	12,882,135
Age <18 (percent)	23	23	24
Age > 65 (percent)	15	14	13
White (percent)	83	76	71
Black (percent)	12	18	15
Latino (percent)	2.1	2.0	16

	62711	62701, 62702, 62703
Socio Need Rank	Ranked best in the county	Ranked worst in the county
Total Population	15,300	68,750 (35 percent of county; 59 percent of city of Springfield)
Land Area	30.64 square miles	31.20 square miles



## ACCESS TO CARE

### Access to Care

#### Indicators

##### Adults with a Usual Source of Health Care



County: Sangamon

Categories: Health / Access to Health Services

##### Adults with Health Insurance



County: Sangamon

Categories: Health / Access to Health Services

##### Children with Health Insurance



County: Sangamon

Categories: Health / Access to Health Services, Health / Children's Health

### Access to Primary Care

#### Indicators

##### Primary Care Provider Rate



County: Sangamon

Categories: Health / Access to Health Services

##### Non-Physician Primary Care Provider Rate



County: Sangamon

Categories: Health / Access to Health Services

### Qualitative Access Indicators

Access to care has been identified as a local issue by:

- Memorial Medical Center
- Springfield Urban League Head Start
- Sangamon County Medical Society/CATCH
- Sangamon County Citizens Survey

#### Sangamon County Citizens' Survey (2013)

- 11.3 percent do not have health care coverage (state average is 13.1 percent)
- One in four of uninsured people are under age 34
- 37.8 percent make less than \$15,000/year
- 19.1 percent of African Americans are uninsured vs. 9.2 percent of whites
- 13.8 percent do not have a primary care physician
- 20.9 percent are economically insecure about their family's health care – at least once in the past 12 months they did not have enough money to pay for health care or medicines for someone in their family

### **Number of uninsured**

*Source: Gilead Outreach and Referral Center 2012 Report, based on 2007 Census Bureau Data*

- Sangamon County Uninsured Residents < age 65: 15.9 percent
- Uninsured ages 0-18 who live below 200 percent Federal Poverty Level: 4.1 percent

### **Medically underserved areas and health manpower professional shortage areas**

as designated by U.S. Department of Health and Human Services, Health Resources & Services Administration

- Eight census tracts in Sangamon County

### ***Comments from forums and surveys***

- Transportation – both rural and in Springfield
- Access to care for low-income people with Medicaid is not equal to access for those with private insurance. Some cannot find physicians. Care that is available even when you have a doctor is not equal.
- Some people with Medicaid feel disrespected by the medical community.
- Communication is a continuing issue – helping people understand what is available. If they don't know, they cannot access it.
- Consider some nontraditional avenues of communicating with physicians: texting; video

## MENTAL HEALTH

### Age-Adjusted ER Rate due to Mental Health

This indicator shows the average annual age-adjusted emergency room visit rate due to mental health per 10,000 population aged 18 years and older.

County



Comparison: IL  
Counties

253.2

ER visits/10,000  
population 18+ years

Measurement  
Period: 2010-2012

County: Sangamon

[View Every County](#)

**Data Source:** Illinois Hospital Association  
**Categories:** Health / Mental Health & Mental Disorders

**Technical Note:** The distribution is based on data from 102 Illinois counties.

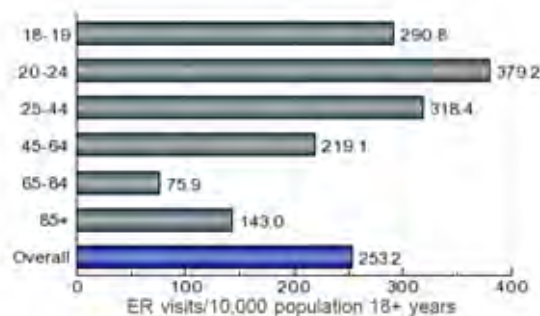
Rates were calculated using population figures from the 2010 U.S. Census. Rates based on fewer than 10 hospitalizations are unstable and are not reported.

**Maintained By:** Healthy Communities Institute

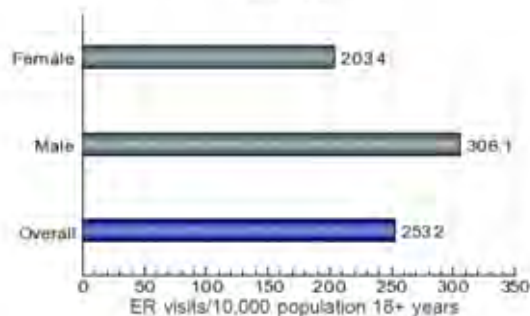
**Last Updated:** May 2014

#### Why is this important?

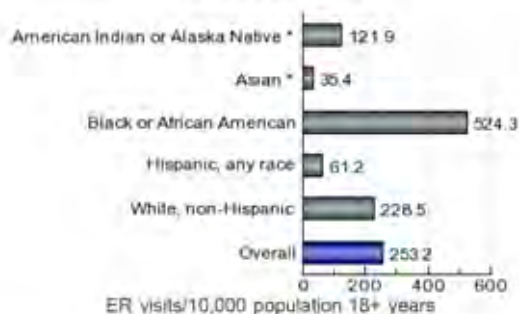
Psychological distress can affect all aspects of our lives. It is important to recognize and address potential psychological issues before they become critical. Occasional down days are normal, but persistent problems should be evaluated and treated by a qualified professional; proper management of mental/emotional health problems can prevent psychological crises warranting hospitalization.



#### Age-Adjusted ER Rate due to Mental Health by Gender



#### Age-Adjusted ER Rate due to Mental Health by Race/Ethnicity



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

## Age-Adjusted Hospitalization Rate due to Mental Health

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

County Time Period



Comparison: IL  
Counties 17

**91.2**

hospitalizations/10,000  
population 18+ years

**Measurement  
Period: 2010-2012**

### County: Sangamon

[View Every County](#)

**Data Source:** Illinois Hospital Association (I)

**Categories:** Health / Mental Health & Mental Disorders

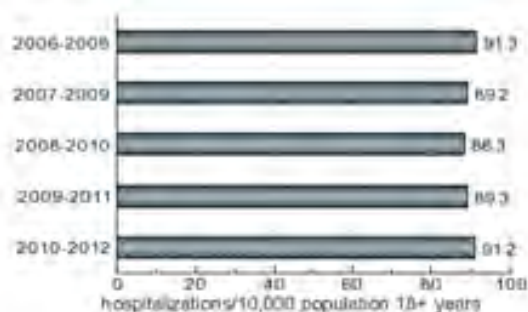
**Technical Note:** The distribution is based on data from 102 Illinois counties.

Rates were calculated using population figures from the 2010 U.S. Census. Rates based on fewer than 10 hospitalizations are unstable and are not reported.

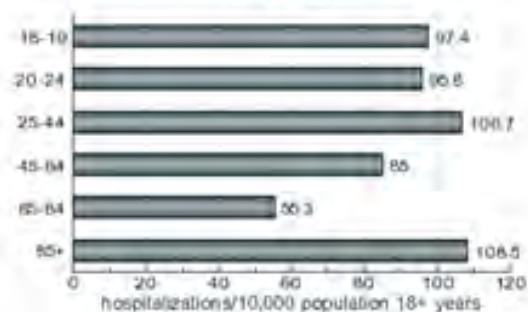
**Maintained By:** Healthy Communities Institute

**Last Updated:** May 2014

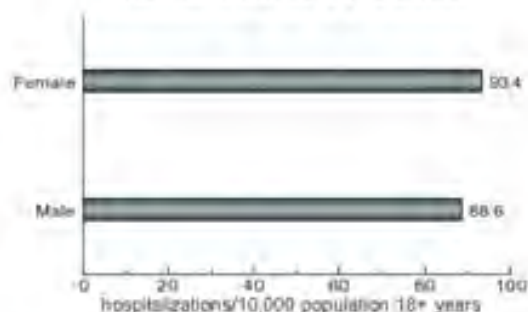
## Age



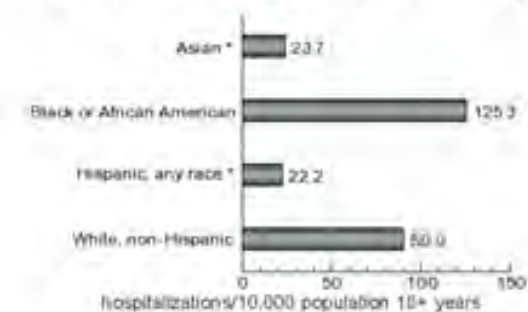
## Hospitalization Rate due to Mental Health by Age



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



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



\* Value may be statistically unstable and should be interpreted with

## Age

### Age-Adjusted Hospitalization Rate due to Mental Health

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

County Time Period



Comparison: IL  
Counties 17

**91.2**

hospitalizations/10,000  
population 18+ years

**Measurement  
Period: 2010-2012**

**County: Sangamon**

[View Every County](#)

**Data Source:** Illinois Hospital Association (1)  
**Categories:** Health / Mental Health & Mental Disorders

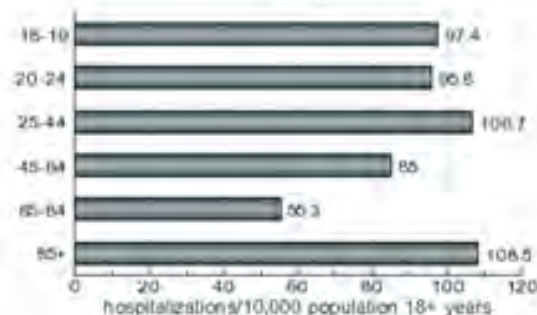
**Technical Note:** The distribution is based on data from 102 Illinois counties.

Rates were calculated using population figures from the 2010 U.S. Census. Rates based on fewer than 10 hospitalizations are unstable and are not reported.

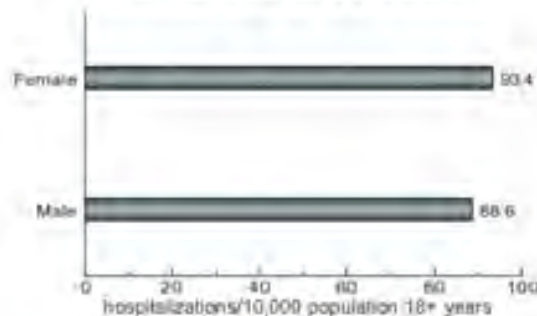
**Maintained By:** Healthy Communities Institute

**Last Updated:** May 2014

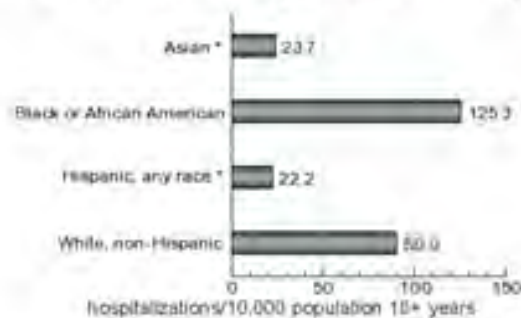
### Hospitalization Rate due to Mental Health by Age



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



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



## Age

### Age-Adjusted ER Rate due to Pediatric Mental Health

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

County



Comparison: IL  
Counties: 17

**85.8**

ER visits/10,000  
population under 18  
years

**Measurement  
Period: 2010-2012**

**County: Sangamon**

[View Every County](#)

**Data Source:** Illinois Hospital Association

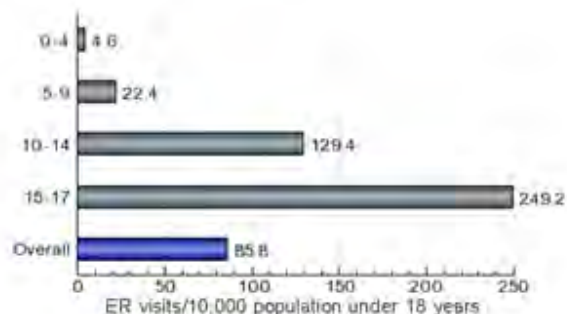
**Categories:** Health / Mental Health & Mental Disorders

**Technical Note:** The distribution is based on data from 97 Illinois counties.

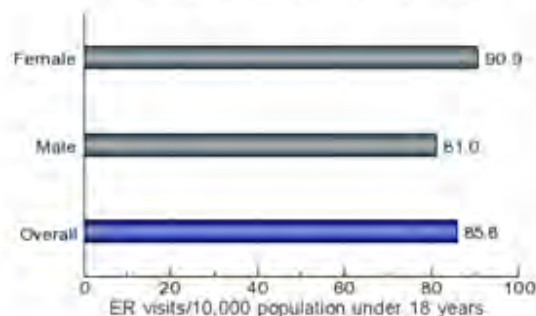
Rates were calculated using population figures from the 2010 U.S. Census. Rates based on fewer than 10 hospitalizations are unstable and are not reported.

**Maintained By:** Healthy Communities Institute

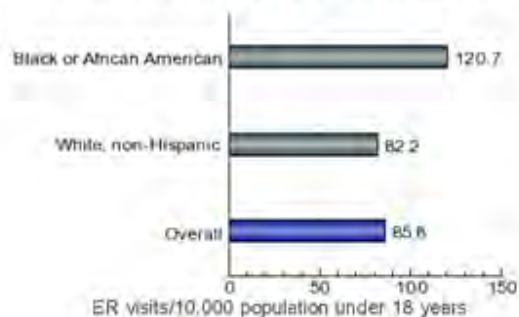
**Last Updated:** May 2014



### Age-Adjusted ER Rate due to Pediatric Mental Health by Gender



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



## Age-Adjusted Hospitalization Rate due to Pediatric Mental Health

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

County:  Time Period:



### County: Sangamon

[View Every County](#)

**Data Source:** Illinois Hospital Association 11  
**Categories:** Health / Mental Health & Mental Disorders

**Technical Note:** The distribution is based on data from 92 Illinois counties.

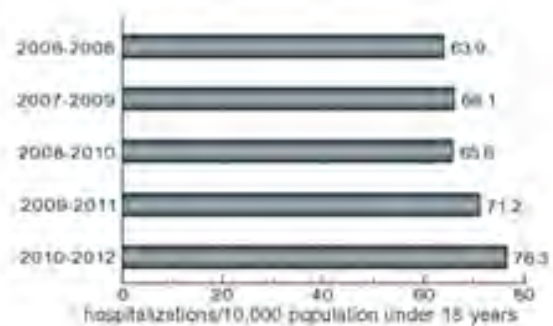
Indicator includes all primary ICD9 primary DX codes 290-319. Rates were calculated using population figures from the 2000 U.S. Census. Rates based on fewer than 5 hospitalizations are unstable and are not reported.

**Maintained By:** Healthy Communities Institute

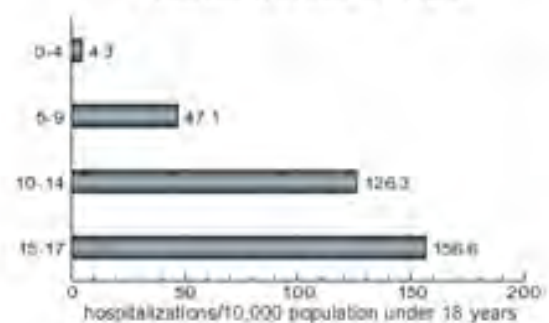
**Last Updated:** May 2014

### Why is this important?

Psychological distress can affect all aspects of our lives. It is important to recognize and address potential psychological issues before they become critical. Occasional down days are normal, but persistent problems should be evaluated and treated by a qualified professional; proper management of mental/emotional health problems can prevent psychological crises warranting hospitalization. According to the National Center for Health Statistics, treatment for mental disorders is a major cause of hospitalization for children and adolescents between the ages of 10 and 21 years.



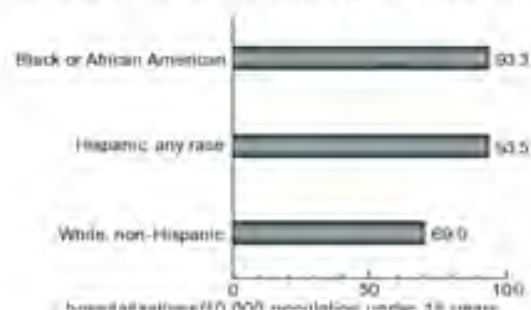
### Hospitalization Rate due to Pediatric Mental Health by Age



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



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



## Mental Health Zip 62711

### Indicators

#### Age-Adjusted ER Rate due to Mental Health



Zip Code: 62711

Categories: Health / Mental Health & Substance Use

#### Age-Adjusted Hospitalization Rate due to Mental Health



Zip Code: 62711

Categories: Health / Mental Health & Substance Use

#### Age-Adjusted ER Rate due to Pediatric Mental Health



Zip Code: 62711

Categories: Health / Mental Health & Substance Use

#### Age-Adjusted Hospitalization Rate due to Pediatric Mental Health



Zip Code: 62711

Categories: Health / Mental Health & Substance Use

## Mental Health Zip 62703

### Indicators

#### Age-Adjusted ER Rate due to Mental Health



Zip Code: 62703

Categories: Health / Mental Health & Substance Use

#### Age-Adjusted Hospitalization Rate due to Pediatric Mental Health



Zip Code: 62703

Categories: Health / Mental Health & Substance Use

#### Age-Adjusted ER Rate due to Pediatric Mental Health



Zip Code: 62703

Categories: Health / Mental Health & Substance Use

#### Age-Adjusted Hospitalization Rate due to Mental Health



Zip Code: 62703

Categories: Health / Mental Health & Substance Use

### **Community forums and surveys**

- Mental health was identified as a large community issue
- Mental health status affects child abuse (and child abuse can in return contribute to mental health issues)
- Poverty, hopelessness, racism affect mental health status

### **External advisory group**

- MHCCI's MOSAIC is successful. It needs to be expanded to more schools. Funding is an issue.
- There is a huge need for crisis services; stop using county jails as holding places for those with psychiatric issues
- SASS – Tri-department program between: DCFS, HFS, DHS.

### **Focus groups**

- Lack of knowledge of mental health services
- Lack of available mental health services for children and elderly
- Perception that African Americans are less likely to seek mental health care

## PEDIATRIC ASTHMA

### Age-Adjusted ER Rate due to Pediatric Asthma

This indicator shows the average annual age-adjusted emergency room visit rate due to asthma per 10,000 population aged under 18 years.

County



Comparison: IL  
Counties: 71

**99.1**

ER visits/10,000  
population under 18  
years

**Measurement  
Period: 2010-2012**

**County: Sangamon**

[View Every County](#)

**Data Source:** Illinois Hospital Association

**Categories:** Health / Respiratory Diseases

Health / Children's Health, Health /  
Environmental & Occupational Health

**Technical Note:** The distribution is based on  
data from 99 Illinois counties.

Rates were calculated using population figures  
from the 2010 U.S. Census. Rates based on  
fewer than 10 hospitalizations are unstable and  
are not reported.

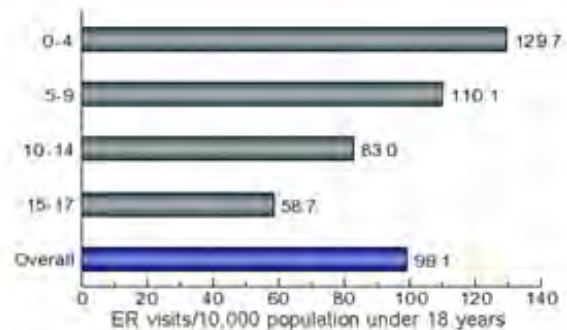
**Maintained By:** Healthy Communities  
Institute

**Last Updated:** May 2014

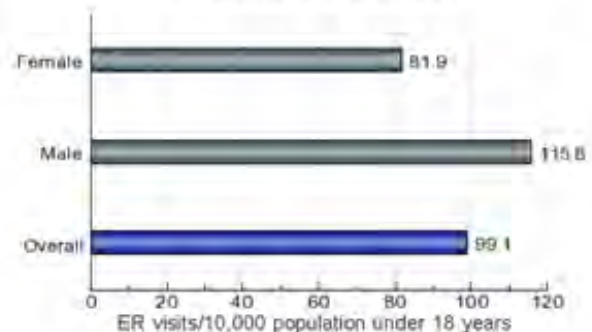
#### Why is this important?

Asthma is a condition in which a person's air passages become inflamed, and the narrowing of the respiratory passages makes it difficult to breathe. In the past thirty years, asthma has become one of the most common long-term diseases of children, but it also affects 15.7 million non-institutionalized adults nationwide. Symptoms can include tightness in the chest, coughing, and wheezing. These symptoms are often brought on by exposure to inhaled allergens, such as dust, pollen, mold, cigarette smoke, and animal dander, or by exertion and stress. Reducing exposure to poor housing conditions, traffic pollution, secondhand smoke and other factors impacting air quality can help prevent asthma and asthma attacks. There is no cure for asthma, but for most people, the symptoms can be managed through a combination of long-term medication prevention strategies and short-term quick relievers. In some cases, however, asthma symptoms are severe enough to warrant hospitalization, and can result in death.

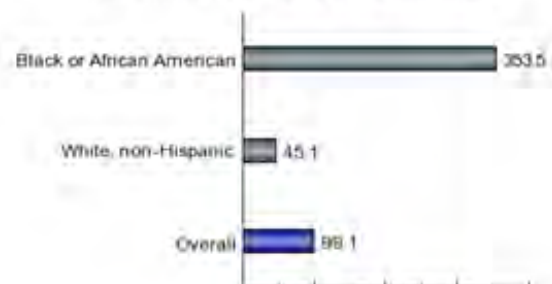
#### Ages



#### Age-Adjusted ER Rate due to Pediatric Asthma by Gender



#### Age-Adjusted ER Rate due to Pediatric Asthma by Race/Ethnicity



## Age-Adjusted Hospitalization Rate due to Pediatric Asthma

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

County Time Period



Comparison: IL  
Counties: 7

**12.5**

hospitalizations/10,000  
population under 18  
years

**Measurement  
Period: 2010-2012**

**County: Sangamon**

[View Every County](#)

**Data Source:** Illinois Hospital Association

**Categories:** Health / Respiratory Diseases  
Health / Children's Health, Health /  
Environmental & Occupational Health

**Technical Note:** The distribution is based on  
data from 47 Illinois counties.

Rates were calculated using population figures  
from the 2010 U.S. Census. Rates based on  
fewer than 10 hospitalizations are unstable and  
are not reported.

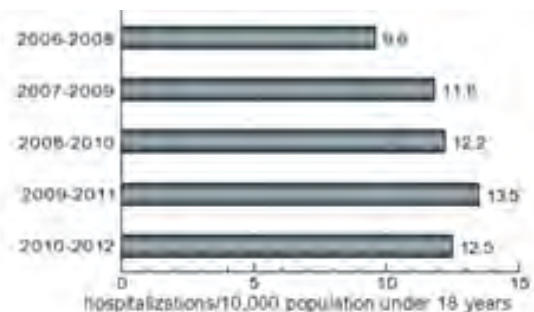
**Maintained By:** Healthy Communities  
Institute

**Last Updated:** May 2014

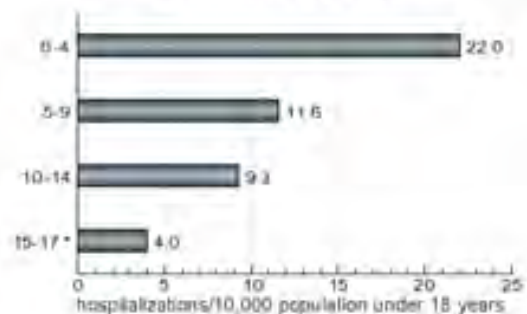
### Why is this important?

Asthma is a condition in which a person's air passages become inflamed, and the narrowing of the respiratory passages makes it difficult to breathe. In the past thirty years, asthma has become one of the most common long-term diseases of children, but it also affects 15.7 million non-institutionalized adults nationwide. Symptoms can include tightness in the chest, coughing, and wheezing. These symptoms are often brought on by exposure to inhaled allergens, such as dust, pollen, mold, cigarette smoke, and animal dander, or by exertion and stress. Reducing exposure to poor housing conditions, traffic pollution, secondhand smoke and other factors impacting air quality can help prevent asthma and asthma attacks. There is no cure for asthma, but for most people, the symptoms can be managed through a combination of long-term medication prevention strategies and short-term quick relievers. In some cases, however, asthma symptoms are severe enough to warrant hospitalization, and can result in death.

### Ages

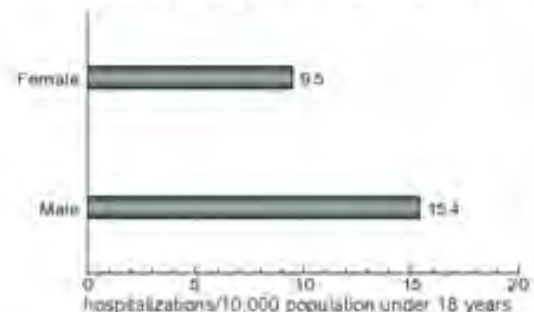


### Hospitalization Rate due to Pediatric Asthma by Age

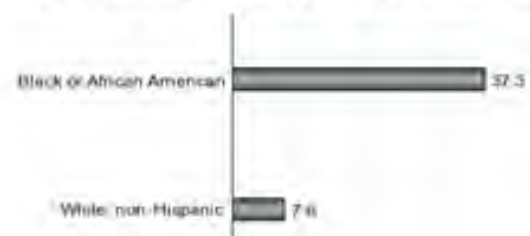


\* Value may be statistically unstable and should be interpreted with caution.

### Age-Adjusted Hospitalization Rate due to Pediatric Asthma by Gender



### Age-Adjusted Hospitalization Rate due to Pediatric Asthma by Race/Ethnicity



## Age-Adjusted ER Rate due to Pedi Asthma: ER Visits / 10,000; <18

Pawnee Riverton Rochester	Zip Code: 62558		47.4	Average Household Income
	Zip Code: 62561		27.9	
	Zip Code: 62563		23.1	
Auburn Chatham	Zip Code: 62615		31.0	
	Zip Code: 62629		32.1	
Springfield	Zip Code: 62702		134.1	\$48,870
	Zip Code: 62703		246.9	\$42,983
	Zip Code: 62704		89.5	\$68,921
	Zip Code: 62707		80.6	\$69,465
	Zip Code: 62711		16.6	\$115,156
	Zip Code: 62712		27.7	\$101,086

## ADDITIONAL DATA

Per 2013 FQHC reports to health Resources and services administration:

- Central counties FQHC – 10.8 percent of patients have asthma
- SIU Center for Family Medicine – 6.1 percent of patients have asthma
- CATCH reported asthma as a common diagnosis

### *Qualitative data*

Survey and forums

- Springfield School District 186 school nurses say asthma is a huge problem and a leading cause of absences.
- 67 percent of African American respondents identified it as a high priority vs. 43 percent of white respondents.

### *Advisory committee*

- Superintendent of Dist. 186 said asthma is a big issue and getting cooperation from parents (providing child's inhaler at school, etc.)
- New SIU Medical Legal Partnership has identified asthma as a project – helping renters whose homes have mold, pests, etc., to get landlords to address the issue.

## OVERWEIGHT / OBESITY

Overweight/obesity has been identified as an issue by

- Memorial Medical Center
- St. John's Hospital
- SIU School of Medicine
- genHkids

### *Springfield Collaborative for Active Child Health*

(SIU School of Medicine, District 186, Springfield Urban League/Head Start and the Illinois Department of Public Health are the partners)

- Programs in eight lower-income elementary schools in District 186 (Ridgely, Fairview, Enos, McClelland, Dubois, Iles, Lindsay and Butler)
- Spring 2014, the combined overweight and obesity rates of first and fourth graders in these eight schools was 33 percent

### *Comments from the community forums and surveys*

- Despite the lack of data, obesity was discussed at every forum and there were many comments on the surveys that recognize it as a problem.
- Few exercise resources available for low-income adults.
- Schools are the place to start to educate parents and students.
- Adults need education on nutrition and healthy eating.
- Many adults do not know how to cook for their families.
- The issues of food insecurity can overlap with obesity issues, but they are not identical issues.

Food insecurity also addresses the nutritional quality of the food that is available.

***Advisory group***

- Many organizations are addressing obesity: genHkids, Girls on the Run, YMCA, SJS, MMC
- Some groups addressing food insecurity are also addressing access to healthy foods:
  - Various community gardens
  - Farmers' markets
  - The Springfield Project (mini-Walmart for fresh foods and pharmaceutical access)
  - Illinois Stewardship Alliance

***Focus group***

- Lack of knowledge on nutrition to manage healthy sugar levels.
- Lack of knowledge on how to monitor diabetes and/or understand if managing properly.
- Cannot get in to speak with primary care provider to learn how to manage/eat healthier.

## **Appendix E**

### **Analysis of Public Input from Enos Park Focus Groups**

#### **SANGAMON COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT**

**Analysis of Public Input from Enos Park Focus Groups  
Conducted by UIS Survey Research Office**



Draft Report submitted on February 18, 2015

## PROJECT METHODOLOGY

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

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

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

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

The 43 participants were involved in one of the four focus groups. They were recruited using a variety of methods. The following details the specific methodology for each of the focus groups.

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

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

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

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

participated in this focus group and received \$50 financial incentive and breakfast for their participation. The focus group was held at Kumler Methodist Church.

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

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

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

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

Full transcripts of the focus group discussions are included at the end of this report.

## **SUMMARY OF FINDINGS**

### *Executive Summary*

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

### *Points of access to health care*

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

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

The lack of primary care providers seems to mainly affect younger adults in Enos Park. Some of the individuals report that they do not have a primary care provider located in Springfield, because they were not sure how to access one or understood the importance of maintaining a primary care provider. Individuals covered under Medicaid also reported that while they were assigned a primary care provider, they have difficulty making appointments with these individuals and therefore, are more likely to go to the emergency room.

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

#### **Possible solutions**

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

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<sup>1</sup> 2-1-1 is an easy to remember telephone number assigned by the Federal Communications Commission to streamline access to health and human services. 2-1-1 is available on a 24-hour basis to connect residents to a wide variety of human services or social services across the state. If someone needs information or referral services but has little or no prior knowledge or experience, dialing 2-1-1 is much simpler than other option. Once the person dials 2-1-1, a professional Information and Referral specialist will then either refer or connect that caller to the correct agency based on the services needed. Callers to 2-1-1 can get LIVE assistance with needs such as: food, shelter, counseling, income supports, employment, health care, services for specialized populations such as the elderly and persons with disabilities and much more. All calls are free, anonymous and confidential.

### *Trust of medical community*

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

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

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

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

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

#### **Possible solutions**

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

### *Transportation*

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

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

### **Possible solutions**

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

### ***Health literacy, health insurance, prescription medication***

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

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

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

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

### **Possible solutions**

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

### ***Other needed services***

#### **Utility assistance programs:**

Individuals frequently mentioned that the prohibitive cost of utilities in the Enos Park residents. This includes the weatherization of older homes to protect from harsh climates.

#### **Mental health services:**

As with the community survey, the lack of mental health services for both children and the elderly is a growing concern.

#### **Nutrition education:**

There are several social service agencies that are currently working on improving the nutritional education of Enos Park residents. These efforts could be benefited by increasingly collaboration and more financial support.