Sangamon County—Illinois

2021

Community Health Needs Assessment

Springfield Memorial Hospital

174-0456 09/20/21

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EXECUTIVE SUMMARY

In 2021, Springfield Memorial Hospital (SMH) completed a Community Health Needs Assessment (CHNA) for Sangamon County, Illinois, as required of nonprofit hospitals by the Affordable Care Act of 2010.

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

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

Springfield Memorial Hospital collaborated with HSHS St. John's Hospital (SJH) and the Sangamon County Department of Public Health (SCDPH) to complete the 2021 CHNA. Community health needs were prioritized based on reviews of secondary community data, as well as primary data gathered from a Community Advisory Committee (CAC) and community focus groups that sought input from the community and those who are minoritized and underserved. Access to health, the social determinants of health and racial inequities and inequalities were considered in all parts of the process. SMH then convened an Internal Advisory Committee (IAC), which approved the final priorities selected by SMH, as listed below.

1. Mental/Behavioral Health
2. Economic Disparities
3. Access to Health

MH Community Health leaders additionally agreed on a health system priority of Mental Health to be addressed in our Community Health Implementation Plans (CHIPs).

The Memorial Health Board of Directors' Community Benefit Committee approved the 2021 Community Health Needs Assessment report and final priorities on July 23, 2021. Approval was also received from the Springfield Memorial Hospital board of directors. This report is available online at memorial.health/about-us/community/community-health-needs-assessment/ or by contacting MH community health at CommunityHealth@mhsil.com.

An implementation plan is being developed to address the identified needs, which SMH will implement during FY22–FY24. The plan will be posted at the same website upon its completion, anticipated prior to January 2022.

INTRODUCTION

MEMORIAL HEALTH

Memorial Health of Springfield, one of the leading healthcare organizations in Illinois, is a community-based, not-for-profit corporation dedicated to our mission to improve lives and strengthen communities through better health. Our highly skilled team has a passion for excellence and is dedicated to providing a great patient experience for every patient every time.

Memorial Health includes five hospitals: Springfield Memorial Hospital in Sangamon County; Decatur Memorial Hospital in Macon County; Lincoln Memorial Hospital in Logan County; Taylorville Memorial Hospital in Christian County; and Jacksonville Memorial Hospital in Morgan County. Memorial Health also includes primary care, home care and behavioral health services. Our more than 9,000 colleagues, partnering physicians and hundreds of volunteers are dedicated to improving the health of the communities we have served since the late nineteenth century.

The Memorial Health Board of Directors' Community Benefit Committee is made up of board members, community health leaders, community representatives and senior leadership who approve and oversee all aspects of the MH community benefit programs, CHNAs and CHIPs. Strategy 3 of the FY22–25 MH Strategic Plan is to "build diverse community partnerships for better health" by building trusting relationships with those who have been marginalized, partnering to improve targeted community health inequities and outcomes and partnering to support economic development and growth of our communities. These objectives and strategy are most closely aligned with the MH goal of being a Great Partner, where we grow and sustain partnerships that improve health.

CHNAs are available for each of the counties where our hospitals are located—Christian, Logan, Macon, Morgan and Sangamon counties. These assessments and the accompanying CHIPs can be found at memorial.health/about-us/community/community-health-needs-assessment/. Final priorities for MH are listed in the graphic below.

Memorial Health

Our Mission

Why we exist:

To improve lives and build stronger communities through better health

Our Vision

What we aspire to be:

To be the health partner of choice

FY22–24 Final Priorities

Decatur Memorial Hospital

1. Mental/Behavioral Health
2. Economic Disparities
3. Access to Health

Springfield Memorial Hospital

1. Mental/Behavioral Health
2. Economic Disparities
3. Access to Health

Lincoln Memorial Hospital

1. Youth Mental Health
2. Obesity
3. Substance Use

Jacksonville Memorial Hospital

1. Mental Health
2. Obesity
3. Cancers

Taylorville Memorial Hospital

1. Mental Health
2. Obesity
3. Lung Health

Memorial Health Priority

Mental Health

Introduction to Springfield Memorial Hospital

SMH is a 500-bed acute care, nonprofit hospital in the state capital of Springfield, Illinois, that offers comprehensive inpatient and outpatient services. Since 1970, SMH has been a teaching hospital affiliated with Southern Illinois University School of Medicine for the purpose of providing clinical training for residents. In 2020, the hospital earned its fourth consecutive Magnet® Hospital Designation by the American Nurses Credentialing Center. The hospital is accredited by The Joint Commission and is a member of the American Hospital Association, the Illinois Hospital Association and Vizient.

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

As a nonprofit community hospital, Springfield Memorial Hospital provides millions of dollars in community support each year, both for its patients and in support of community partnerships. During the past three years, SMH community benefit support has totaled more than $292 million.

COVID-19 AND COMMUNITY HEALTH

On the afternoon of Saturday, March 14, MH leaders gathered with their peers from other local healthcare organizations at a news conference announcing that Springfield Memorial Hospital was treating the first known patient hospitalized with COVID-19 in central Illinois. MH mobilized its Hospital Incident Command System (HICS). Incident Command protocols are intended to provide short-term leadership during a crisis, such as a severe weather event or an accident that brings a rush of injured patients to the hospital. Usually, Incident Command teams are only mobilized for a few hours or days. But the team handling the COVID-19 response quickly became the longest-running Incident Command in Memorial history.

Respiratory clinics sprang up overnight to test and treat patients. Colleagues sidelined by the cancellation of elective procedures were redeployed to new roles. Providers began using telehealth to connect with patients. In April and May, as COVID-19 restrictions began to lift statewide, many restaurants, businesses and churches reopened for the first time since the pandemic began. Community Health colleagues from Memorial Health distributed signs and educational materials organizations could use to encourage mask-wearing, handwashing, social distancing and other infection prevention practices. In partnership with the Office of Equity, Diversity and Inclusion at SIU School of Medicine, MH also distributed more than 2,500 signs to organizations that primarily serve people of color and other marginalized communities. Over 80,000 masks were provided throughout our region to more than 70 partnering organizations.

Our health system and the entire region came together to care for the sick and slow the spread of the virus during an unprecedented and unforgettable year. The impact of the COVID-19 pandemic is hard to overstate in regards to community health, racial disparities and the social determinants of health. As such, and in the wake of the murder of George Floyd, MH committed its support and resources to Equity, Diversity and Inclusion (EDI) and issued a pledge outlining ways it intended to advance EDI throughout our institution and communities. The pandemic influenced how we conducted our health needs assessments and, more importantly, strengthened our resolve to improve lives and build stronger communities through better health.

Equity, Diversity and Inclusion *Pledge*

- We will use our resources to work toward greater equity within our organization and community.
- We will promote a culture of respect, acceptance and understanding.
- We will examine and challenge the conscious and unconscious biases that create barriers to healthcare—not only outward displays of prejudice, but also the unacknowledged biases that can subconsciously affect our perceptions of people different from ourselves.
- We will create spaces where colleagues feel safe discussing concerns about equity, diversity and inclusion.
- We will listen to and elevate the voices of individuals from underrepresented communities in discussion and decision-making.
- We will expand our Community Benefit programs that increase access to care for people and communities of color, in collaboration with other organizations that share our mission and values.
- We will actively recruit, hire and promote diverse candidates so that our colleagues more accurately reflect the communities we serve.
- We will not tolerate and strongly reject expressions of discrimination or hate speech from anyone who enters our facilities, including patients, visitors and colleagues.

Our Values

Safety

- We put safety first.
- We speak up and take action to create an environment of zero harm.
- We build an inclusive culture where everyone can fully engage.

Integrity

- We are accountable for our attitude, actions and health.
- We honor diverse abilities, beliefs and identities.
- We respect others by being honest and showing compassion.

Quality

- We listen to learn and partner for success.
- We seek continuous improvement while advancing our knowledge.
- We deliver evidence-based care to achieve excellent outcomes.

Stewardship

- We use resources wisely.
- We are responsible for delivering equitable care.
- We work together to coordinate care.

Community Health Factors

Community health is produced at the intersection of a multitude of contributing societal factors, both historical and current. At times, these factors are the direct result of policies and practices, both current and historical, put in place by the healthcare industry; just as frequently, these factors are the result of larger societal structures of which healthcare is only a part. Three major contributing factors were identified as affecting many of the health indicators across our region and the communities we serve—access to health and healthcare, the social determinants of health and racial inequity and inequality.

ACCESS TO HEALTH AND HEALTHCARE

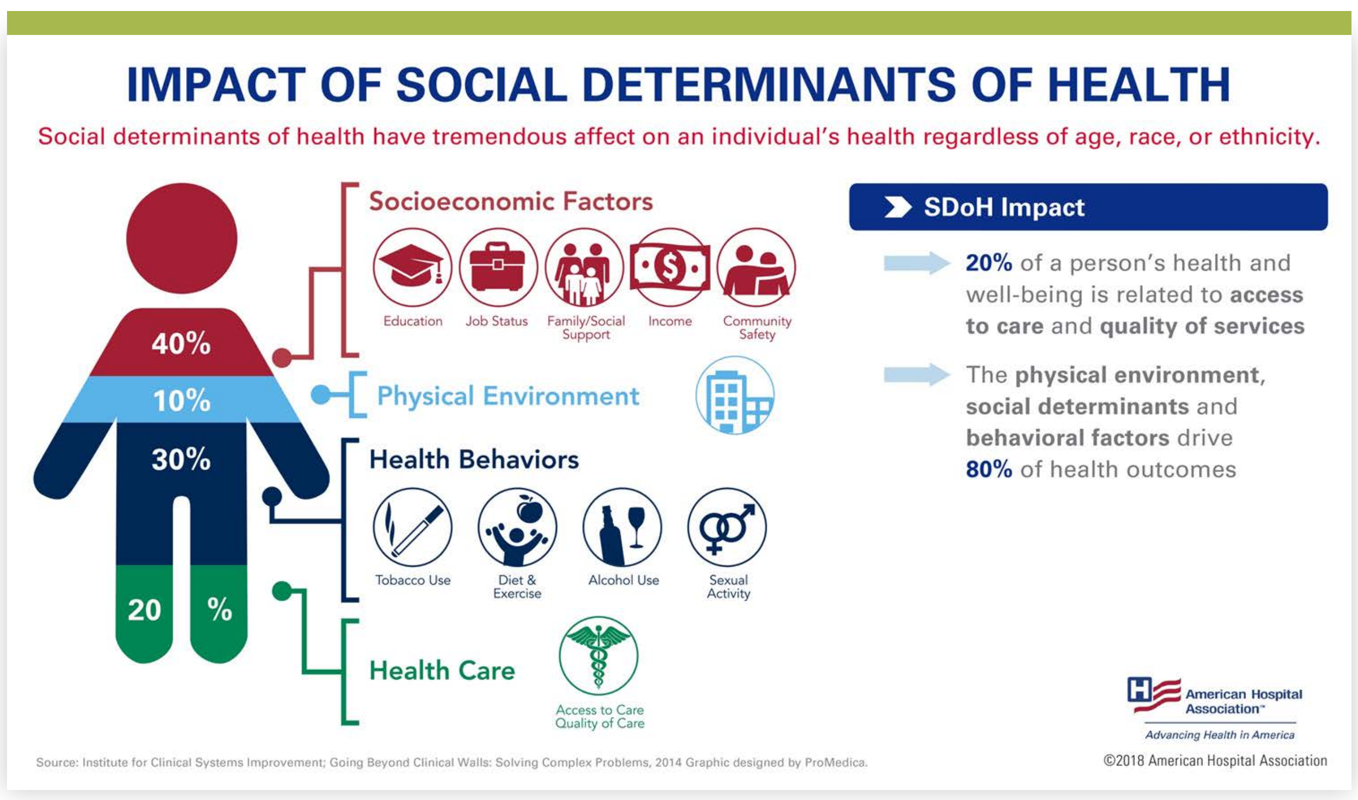
Access to health and healthcare is a multilayered contributing factor including structural, financial and personal components. The presence of facilities, availability of providers, hours of operation and access via public transportation all have a significant impact on access to health and healthcare as determined by the organization's structural decisions.

In addition to structure, access to health can be hindered by financial considerations when community members are uninsured, underinsured and/or unable to pay copays and deductibles. While financial considerations are beyond the dedicated control of healthcare providers, institutions can be creative and strategic in utilizing organizational resources to support publicly funded organizations that are working locally to bridge financial barriers.

Personal considerations may include questions of acceptability and general attitude toward seeking certain services, lack of trust with the healthcare industry, concerns over cultural norms being respected, language barriers and the like. While it is a challenge to change attitudes, access can be improved in many ways, such as ensuring that individuals do not face barriers due to language by providing clear guidance on how to access interpreters or ensuring there are supportive services available to meet a person's spiritual or cultural needs. It can also train colleagues to have high-impact encounters with patients in which individuals feel valued and respected.

SOCIAL DETERMINANTS OF HEALTH

In addition to access to health and healthcare, another major contributing factor is the social determinants of health. If put into percentages, access to health as described above accounts for 20% of positive health outcomes. The other 80% are determined by socioeconomic factors (40%), physical environment (10%) and health behaviors (30%). Socioeconomic factors and physical environment, which represent 50% of positive health outcomes, can be largely attributed to the zip codes where community members reside. Socioeconomic factors include education, job status, family and social support, income and community safety. Health behaviors can include tobacco and alcohol use, diet and exercise, sexual activity and more. It is important to note that negative individual health behaviors can stem from unmitigated trauma brought on by structural factors like socioeconomic and physical environments. As such, it is critical for healthcare providers to be out in communities partnering with local residents, community leaders, schools and community groups to educate on healthy behaviors, advocate for structural change and to learn how to better serve patient populations.



RACIAL INEQUITY AND INEQUALITY

Racial inequities and inequalities negatively impact the health of minoritized community members. Equality – providing everyone the same thing—is often confused with equity, which refers to providing people what they need when they need it in order to achieve an outcome. As previously noted, the location of one's community has a profound impact on health outcomes. Through laws, policies and practices, both current and historical, black and brown communities are more likely to have underfunded public schools, fewer opportunities for stable employment, inadequate family incomes and diminished community safety. Within the U.S. context, racial segregation is high and communities of color are congregated in zip codes with lower life expectancy, income and resources. This segregation is evident locally as well, as each county where Memorial Health hospitals are located sees disparities in health outcomes and income across racial lines. These structures and the consequences thereof create a fundamental inequality that delivers inequitable supports.

In the five counties where our hospitals reside...

Logan
Macon
Sangamon
Morgan
Christian

People who are **black** live on average **3 to 7.5 years less than** those who are white.

People who are black also experience disparities in:

- **Preventable hospital stays**
- **Diabetes**
- **Stroke**
- **Heart failure**
- **ED utilization for pneumonia, mental health, asthma and many others**

SECTION I—COMMUNITY SERVED & DEMOGRAPHICS

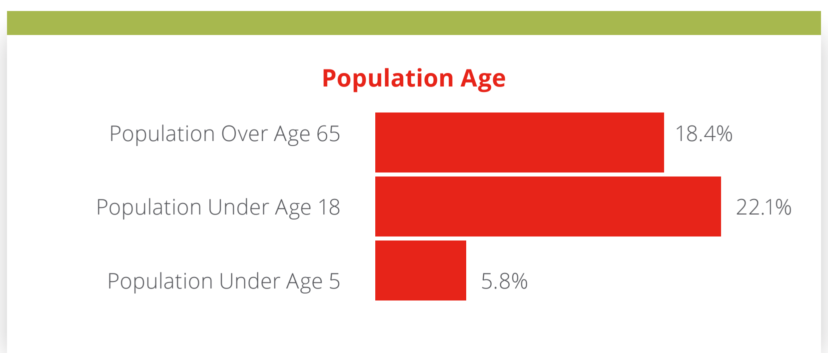
GENERAL INFORMATION

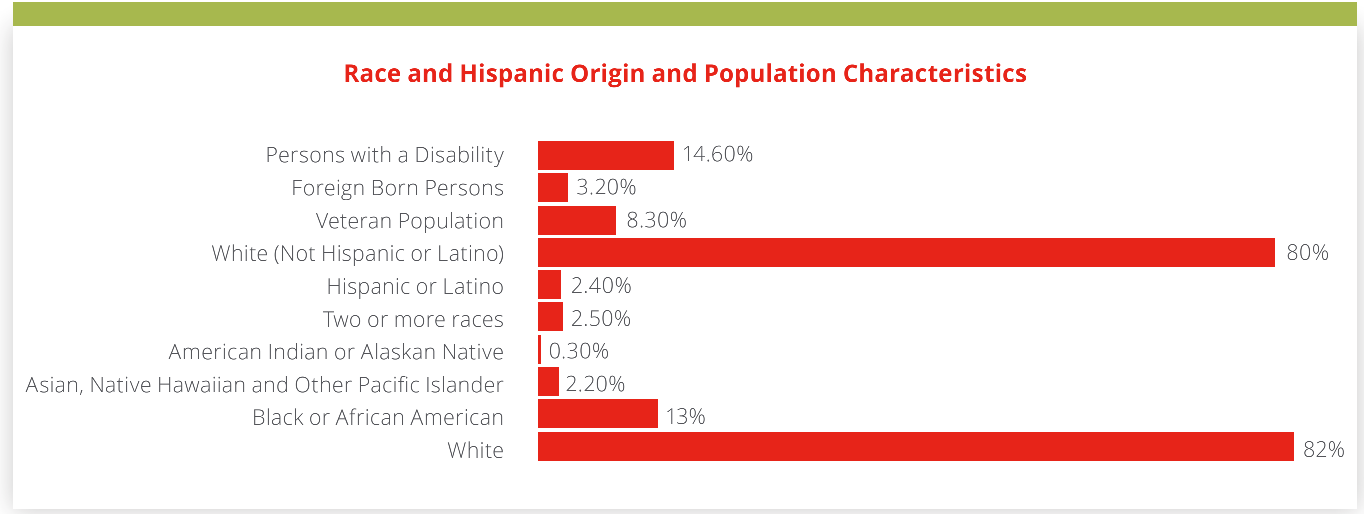
SMH is located in Springfield, Illinois, near the center of the state. Springfield is the capital city and the county seat. Sangamon County is largely rural and agricultural, with healthcare and state and local government being the largest employers. The majority of patients served by SMH come from Springfield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

The following statistics, from the U.S. Census Bureau's Quick Facts, came from Healthy Communities Institute. Source: U.S. Census Bureau Quick Facts, last updated in December 2020.

POPULATION

The population of Sangamon County is 194,672 and the largest urban setting in Sangamon County is Springfield, with a population of 114,694.





EDUCATION AND HEALTHCARE RESOURCES

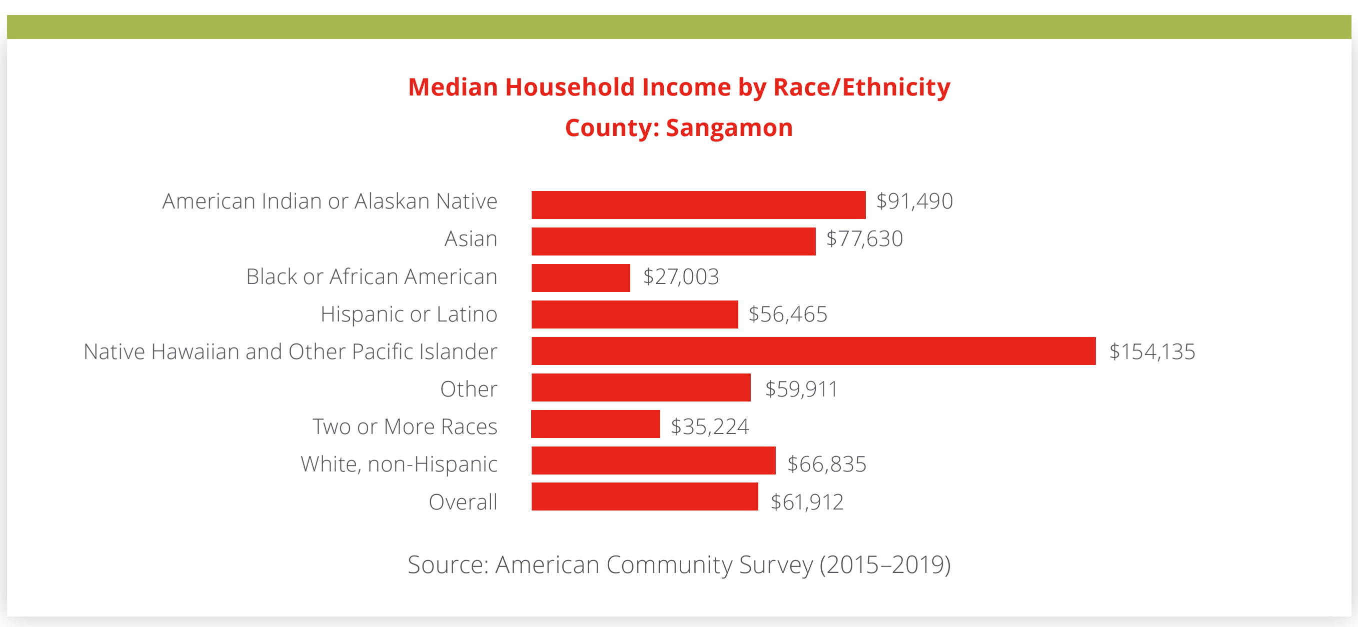
Southern Illinois University School of Medicine is located in Springfield. SMH serves as a major teaching hospital for SIU School of Medicine, which has more than 300 medical students studying in Springfield during their second through fourth years of medical school, as well as more than 300 residents and fellows participating in 32 different specialty programs. Springfield is also home to two higher education institutions: University of Illinois at Springfield and Lincoln Land Community College.

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

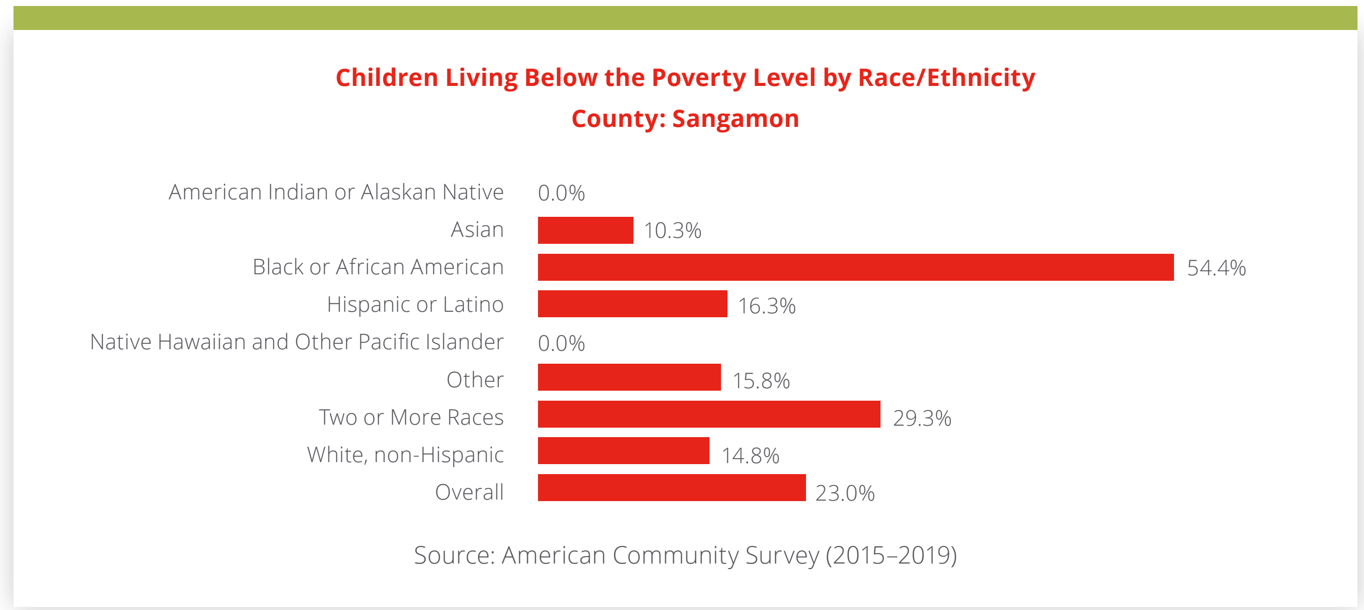
- Central Counties Health Centers, FQHC—Federally Qualified Health Center
- Family Guidance Center
- Gateway Foundation
- HSHS St. John's Hospital
- Orthopedic Center of Central Illinois
- Sangamon County Department of Public Health
- SIU Center for Family Medicine, FQHC
- SIU Healthcare Clinics
- Springfield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

ECONOMICS

ALICE (Asset Limited, Income Constrained, Employed) is a way of defining and understanding financial hardship faced by households that earn above the federal poverty line (FPL), but not enough to afford a "bare bones" household budget. In Illinois, 12% of households live below the FPL, and an additional 23% qualify as ALICE. Sangamon County has 33% of households living below the FPL or qualifying as ALICE.



Source: American Community Survey (2015–2019)



Source: American Community Survey (2015–2019)

EQUITY—RESIDENTIAL SEGREGATION, SOCIAL VULNERABILITY INDEX AND UNDER-RESOURCED ZIP CODES

Racial/ethnic residential segregation refers to the degree to which two or more groups live separately from one another in a geographic area. Although most overt discriminatory policies and practices, such as separate schools or seating on public transportation based on race, have been illegal for decades, segregation caused by structural, institutional, and individual racism still exists in many parts of the country. The removal of discriminatory policies and practices has impacted institutional and individual acts of overt racism, but has had little effect on structural racism, like residential segregation, resulting in lingering structural inequalities. Residential segregation is a key determinant of racial differences in socioeconomic mobility and, additionally, can create social and physical risks in residential environments that adversely affect health. The residential segregation index ranges from 0 (complete integration) to 100 (complete segregation). The index score can be interpreted as the percentage of either Black or White residents that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area.

Sangamon County has a Residential Segregation—Black/White score of 55, as compared to an overall score of 71 in Illinois, with county scores ranging from 19 to 85.

In other words, 55% of either Black or White residents would have to move to different geographic areas in order to produce a desegregated residential distribution.

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

Sangamon County's 2018 overall SVI score is 0.4357. A score of 0.4357 indicates a low to moderate level of vulnerability.

Though county vulnerability could be low to moderate, the high level of residential segregation indicates vulnerability likely varies by tract or zip code. The 2021 SocioNeeds Index, created by Conduent Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes. The index is calculated from six indicators, one each from the following topics: poverty, income, unemployment, occupation, education and language. The indicators are weighted to maximize the correlation of the index with premature death rates and preventable hospitalization rates. All zip codes, counties and county equivalents in the United States are given an Index Value from 0 (low need) to 100 (high need).

In Sangamon County, the zip codes estimated with the highest socioeconomic need are 62701, 62703 and 62702.

SECTION II—METHODOLOGY, INPUT, ANALYSIS

COLLABORATING PARTNERS

During the 2015 and 2018 CHNA process, SMH collaborated with SJH, a 439-bed regional medical center and children's hospital, and SCDPH. The SCDPH used this collaboration to complete their Illinois Project for Local Assessment of Needs (IPLAN). The collaborative process was beneficial to both hospitals and the health department, and received positive feedback from the larger community. SMH, SJH and the SCDPH collaborated on the 2021 CHNA as well and have communicated intent to collaborate on a shared priority. The first meeting of the Core Team for the 2021 CHNA process took place in March 2020. The general process steps outlined below were used by the Core Team to conduct the CHNA. Members of key participant groups are also listed below and will be referenced throughout this report.

Core Team Members

The Core Team is responsible for planning, executing and reporting on all aspects of the CHNA and CHIP process.

- Becky Gabany, Memorial Health, System Director, Community Engagement
- Lingling Liu, Memorial Health, Equity, Diversity and Inclusion Program Coordinator
- Kimberly Luz, HSHS St. John's Hospital, Division Director, Community Outreach
- Bill Dart, Sangamon County Department of Public Health, Assistant Director (through June 2021)
- Gail O'Neill, Sangamon County Department of Public Health, Director of Public Health (beginning June 2021)

Internal Advisory Council (IAC)

(Springfield Memorial Hospital & Decatur Memorial Hospital)

The IAC is responsible for providing strategic direction and insight regarding internal operations and how those initiatives may align with and compliment addressing the health needs of the community. They are also responsible for recommending final priorities for board approval.

- Becky Gabany, System Director, Community Engagement, Memorial Health (Core Team)
- Bob Scott, Senior Vice President & Chief Human Resources Officer, Memorial Health
- Chuck Callahan, President, MH Hospital Group & CEO, Springfield Memorial Hospital
- Diana Knaebe, System Administrator, Memorial Behavioral Health
- Drew Early, President & CEO, Decatur Memorial Hospital
- Florence Holmes, Clinician, Memorial Behavioral Health, Equity Diversity Inclusion (EDI) Coalition Development Team (CDT) member, Sangamon County resident
- Harold Armstrong, Computer Operator, Decatur Memorial Hospital, EDI CDT Member, Macon County resident
- Jay Roszhart, President, MH Ambulatory Group
- Julie Bilbrey, Executive Director, Decatur Memorial Hospital Foundation
- Kristi Olson-Sitki, Magnet Coordinator, Springfield Memorial Hospital
- Lance Millburg, System Administrator, Performance Improvement, Memorial Health
- Linda Jones, Vice President, Ancillary Operations, Springfield Memorial Hospital
- Lingling Liu, Equity, Diversity and Inclusion Program Coordinator, Memorial Health (Core Team)

- Rajesh Govindaiah, MD, Senior Vice President and Chief Medical Officer, Memorial Health
- Robert Ellison, System Administrator, Business Development & Governmental Affairs, Memorial Health
- Sharon Norris, Assistant Vice President and Chief Nursing Officer, Decatur Memorial Hospital
- Tamar Kutz, Vice President, Quality and Operations, Decatur Memorial Hospital

Community Advisory Council (CAC)

Charter: The CAC of the Sangamon County 2021 CHNA exists to help SMH review existing data and offer insights into community issues pertaining to that data. The CAC will help identify local community assets and gaps in the priority areas and will offer a ranking of issues by highest priority.

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

**Indicates groups representing low-income, underserved and/or minoritized populations.*

Community Focus Groups/Interviews

Community focus groups/interviews provide deeper insight to the Core Team, CAC and IAC about their personal experiences related to key health indicators.

- Asian Indian Women's Organization*
- Chinese American Association *
- Citizens Club of Springfield (open to general public)
- City Council: Alderman Shawn Gregory & Mayor James Langfelder*
- Community Foundation for the Land of Lincoln
- Divine Nine Sororities & Fraternities*
- Eastside Neighborhood Associations*
- Hispanic Women of Springfield*
- Islamic Society of Greater Springfield*
- Ministerial Alliance*
- NAACP - Springfield Chapter*
- Race Health Equity Partnership – Annual Alonzo Homer Kenniebrew, MD, Forum*
- Springfield Black Chamber of Commerce*
- Springfield Center for Independent Living*
- Springfield Coalition on Dismantling Racism*
- Springfield Immigrant Advocacy Network*
- Springfield Urban League*
- The Phoenix Center*
- United Way of Central Illinois: Vision Councils*
- University of Illinois at Springfield & Community Health Roundtable (open to general public)

**Indicates groups representing low-income, underserved and/or minoritized populations.*

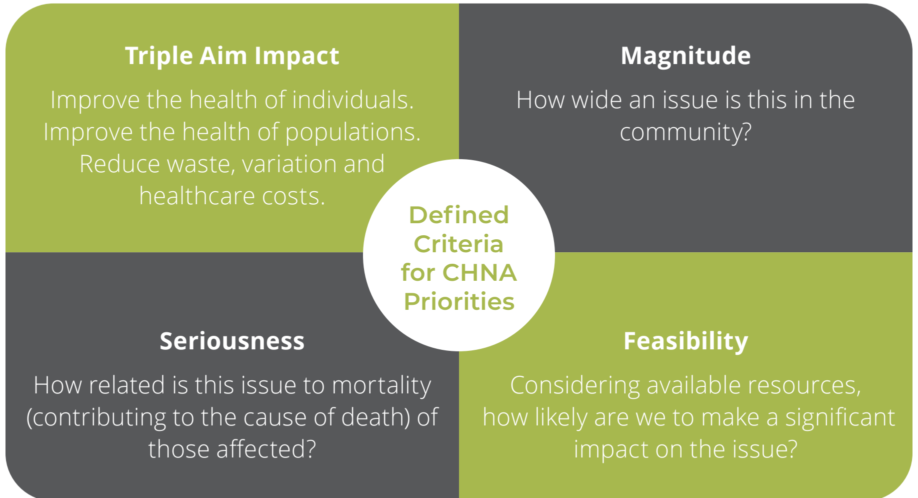
Internal Community Health Leaders

Community Health leaders are colleagues of MH who are responsible for the Community Health programming in their respective communities, as well as completion and execution of the CHNAs and CHIPs for the county in which their hospital is located.

- Memorial Health: Becky Gabany, System Director, Community Health
- Decatur Memorial Hospital: Sonja Chargois, Coordinator, Community Health & EDI (beginning 8/2021)
- Jacksonville Memorial Hospital: Lori Hartz, Director, Community Health
- Lincoln Memorial Hospital: Angie Stoltzenburg, Director, Community Health
- Springfield Memorial Hospital: Lingling Liu, Coordinator, Community Health & EDI
- Taylorville Memorial Hospital: Darin Buttz, Director, Community Health

CRITERIA FOR DETERMINING NEED

The following criteria were used by MH affiliates during the 2015 and 2018 CHNA processes for determining significant need, and were used again during the 2021 CHNA.



FEEDBACK FROM THE LAST CHNA

No written comments were received regarding the FY2018 CHNA, though verbal feedback was provided encouraging increased inclusion of community members who do not have a college degree. Community surveys have been a key data source in previous CHNAs; however, the timing for this process resulted in the expression of survey fatigue as a result of the COVID-19 pandemic, the U.S. Census, the bi-annual Sangamon County Citizens survey and the 2020 presidential election. For these reasons, a community survey was not conducted this cycle and focus groups became the primary means of soliciting first-person feedback.

SECONDARY DATA COLLECTION

The CHNA process relies on secondary data to help understand positive and negative outcomes of various health indicators in our community. This data provides the basis for the force-ranking process undertaken by community input groups.

Conduent Healthy Communities Institute Data

The most significant source of secondary data was collected and analyzed through memorial.health/about-us/community/community-health-needs-assessment/, a web-based community health data platform developed by Conduent Healthy Communities Institute and sponsored by Memorial Health. The site brings data and reporting tools to one accessible, user-friendly location. The site includes a comprehensive dashboard of more than 100 community indicators covering more than 20 topics in the areas of health, social determinants of health and quality of life. That data is primarily derived from state and national public secondary data sources. Specific Christian County indicators are compared to other communities, state-wide data, national measures and Healthy People 2020/30. Many indicators also track change over time or identify disparities.

During the 2018 CHNA, HCI's data scoring tool for Sangamon County indicators was used to summarize and compare multiple indicators across the community dashboard and to rank these indicators based on highest need. Comparison scores went from 0 (best) to 3 (worst). These indicators were grouped into various topic areas. Members of the CHNA Core Team reviewed all indicators ranked 1.5 or higher, and additionally noted disparities in specific indicators to identify community health needs.

Additional Data Sources

Additional secondary data reports were reviewed for a nuanced understanding of community health indicators. Information from these sources were summarized in presentations to the IAC, CAC and focus groups/interviews.

- 500 Cities Project
- ALICE Report
- Robert Wood Johnson County Health Rankings
- COVID-19 Community Response Fund Data
- HRSA Health Center Program: Central Counties Health Centers, Inc.
- HRSA Health Center Program: Southern Illinois University
- Illinois Kids Count Report
- Illinois Public Health Community Map
- Illinois Report Card
- Sangamon County Citizen Survey
- Sangamon County Community Resources Client Needs Assessment
- Sangamon County Community Resources Stakeholder Assessment
- State Health Improvement Plan: SHIP
- UIS Center for State Policy and Research Annual Report
- USDA Food Map—Food Deserts

Community Health Indicators from Secondary Data Dive

Fourteen health indicators were identified by the Core Team from the review of secondary data and reports. These indicators were presented to the CAC for review and prioritization.

- Access to behavioral health services
- Access to mental health services
- Affordable housing
- Disparities in education
- Food access
- Homeless issues
- Maternal/infant health
- Obesity
- Senior health
- Tobacco use
- Unemployment
- Unmanaged chronic conditions
- Utility and rental assistance
- Violence

Additionally, the three major contributing factors—social determinants of health, access to health and racial inequity and inequalities—described earlier in this report were identified as playing a key role in outcomes across all of these health indicators.

PRIMARY DATA COLLECTION

Primary data was collected in two ways: through the CAC as well as community focus groups. Representatives were included from organizations that serve low-income, minoritized and at-risk populations in Sangamon County. Community focus groups and interviews were conducted with persons who are often marginalized and could provide feedback regarding their lived experiences as they relate to the community health indicators identified in the secondary data review.

Community Advisory Council

The CAC was brought together in a two-hour virtual meeting to review existing data around the 14 health indicators and offer insight into community issues contributing to those data points. The CAC was asked to force-rank the top three health needs they perceived as most urgent. They were asked to do this based on the defined criteria for CHNA priorities and also taking into account the three major contributing factors. The CAC also helped identify community assets and gaps which helped shape the foundation of the CHIP.

The CAC narrowed down the community health indicators to seven priority areas, which were presented to the community focus group/interview participants to further prioritize the community's health needs.

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

Community Survey

In past CHNA cycles, a community-wide survey has been conducted. The Core Team decided to forgo this component of the assessment this cycle, based on community feedback referenced earlier in this report. The Sangamon Citizens Club completed a survey in 2020 with a focus on health. This survey was reviewed and considered during the secondary data review. Without using a community-wide survey, there were limitations in soliciting input from those who were unable to attend one of the focus group sessions.

Focus Groups/Interviews

More than 20 virtual focus groups were conducted with community members representing diverse identities throughout the county. Representation included those of diverse age, race, ethnicity, religion, education, socioeconomic status, LGBTQ identity, disability status and more. More than 200 individuals participated in these sessions, with two sessions being open to the general public. Most sessions were scheduled with a particular organization which was asked to invite its constituents to participate. Like the CAC, participants were asked to consider the defined criteria for CHNA priorities, as well as the three major contributing factors, in their prioritization. Three separate data sets were reviewed with open discussion held in between.

Data Set 1

- Access to Behavioral Health Services
- Access to Mental Health Services

Data Set 2

- Disparities in Economy
- Disparities in Education
- Food Access

Data Set 3

- Affordable Housing
- Homeless Issues

Participants were asked to share how these issues affected them and those they know, as well as one thing that could be done to improve these indicators. Following the open discussions, participants were asked to force-rank the top three health needs they perceive as most urgent. The seven indicators were ranked as follows, with one being the highest priority:

1. Disparities in Economy
2. Disparities in Education
3. Access to Mental Health Services
4. Safe and Affordable Housing
5. Food Access
6. Homeless Issues
7. Access to Behavioral Health Services

The four top-ranked indicators scored very high. Preliminary review of feedback showed disparities in economy and education were closely linked during the open discussion segments of the community focus groups/interviews. Access to behavioral health services was often considered part of access to mental health services by participants, and housing was considered a priority but strongly linked to mental health.

Access to health issues came up repeatedly and participants organically added this in as their vote, without being given that option, multiple times.

Theming Focus Group/Interview Feedback

The Southern Illinois University School of Medicine Student National Medical Association (SNMA) assisted with systematic theming of community focus group/interview feedback. The SNMA is the oldest and largest independent, student-run organization focused on the needs and concerns of Black medical students in the United States. One of their commitments is to addressing the needs of underserved communities and volunteer service. Most focus groups had multiple pages of notes from multiple scribes. The SNMA compiled the session notes from each group and organized them into outline format with key themes for each data set presented. These notes were then further analyzed by the Core Team to identify overarching themes. General feedback/themes about the CHNA process are included below and priority-specific feedback is included later in this report.

- Very grateful and surprised to be included and given a voice
- Overall lack of trust or skepticism in the healthcare community by those who have been marginalized
- Needs and concerns for each indicator varied within identity groups
- Sentiment that healthcare leaders have the access and resources to put pressure on these systems to change
- A desire for healthcare professionals to be proximate to the community

POTENTIAL TO COLLABORATE

Following this data collection and analysis process, Core Team discussions were held, as well as discussions with internal affiliate community health leaders, to determine areas of potential collaboration. There is a strong willingness to continue collaboration efforts around access to health in Sangamon County, with all Core Team members in agreement that there are opportunities to collaborate in all areas. Internal Community Health leaders are especially interested in collaborating on strategies related to mental health.

> “Get to know us, y’all need to get to know us. Others are coming in to be a part of what we have and we want you to, too.”

INTERNAL ADVISORY COMMITTEE

The IAC was brought together in a 90-minute virtual meeting on May 6, 2021, to review the results of the CHNA and to determine final priorities. Considering the defined criteria for CHNA priorities, major contributing factors, community feedback and key partners’ willingness to collaborate, the final priorities selected were:

- Mental/Behavioral Health
- Economic Disparities
- Access to Health

SECTION III—SIGNIFICANT HEALTH NEEDS

SELECTED PRIORITIES

Springfield Memorial Hospital

1. Mental/Behavioral Health
2. Economic Disparities
3. Access to Health

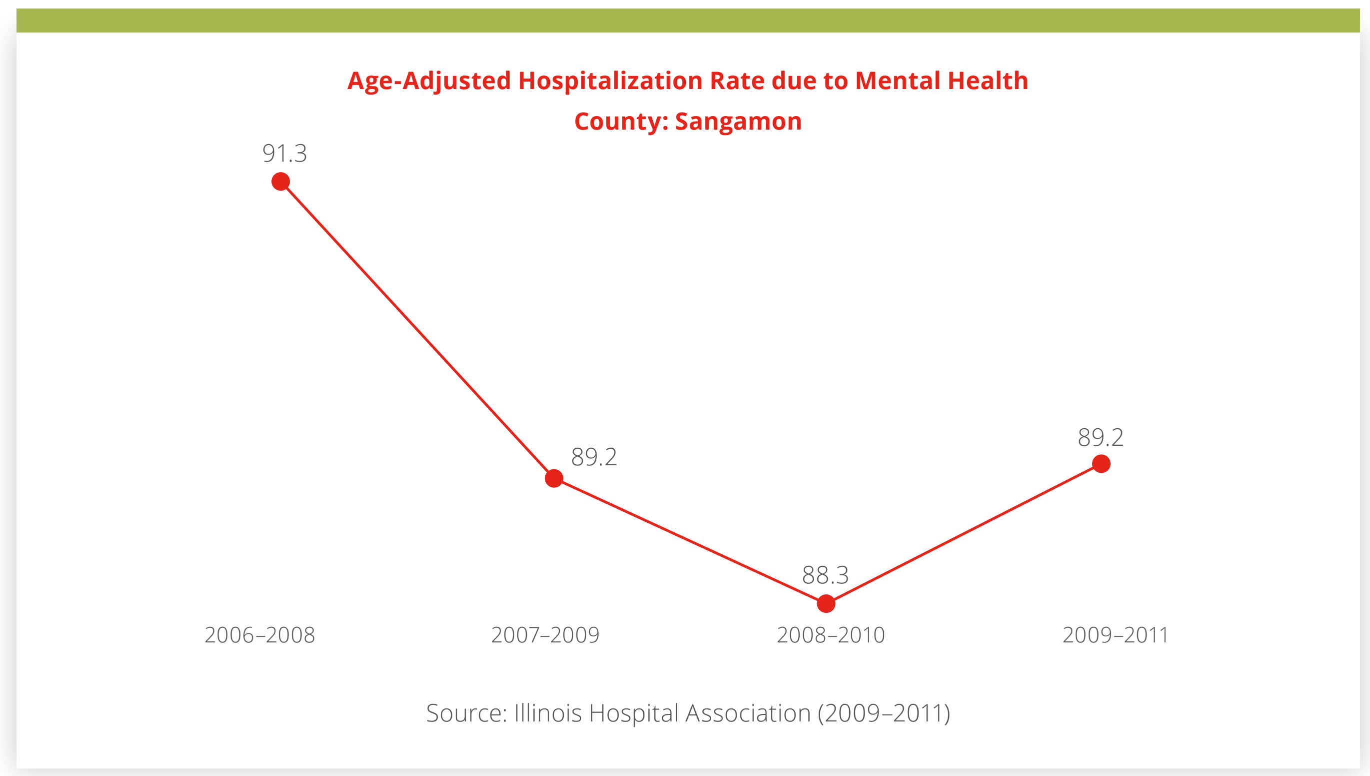
Memorial Health Priority: Mental Health

The below sections will provide deeper insight into the chosen priorities, as well as those that were not chosen as final priorities. While many were not chosen as final priorities, MH is committed to meeting the needs of our communities and will continue to collaborate with community partners to help address the needs identified in this assessment.

Mental/Behavioral Health

Following disparities in economy and education, access to mental health services was the next highest-ranked health indicator. Many community members also considered homeless issues and access to behavioral health services (including substance use) as closely related to this indicator, which, if combined, would result in an even higher score. (It was also noted, in relation to mental health and its connection to homelessness, that there is a need for safe and affordable housing advocacy and education in the community.) The COVID-19 pandemic has had a significant impact on mental health, which was already identified as a top concern pre-pandemic.

Compared to Illinois counties, Sangamon County has 89.3 hospitalizations due to mental health per 10,000 in populations 18 years and older. This ranks in the worst 25% of Illinois counties.



Source: Illinois Hospital Association (2009–2011)

While there are barriers to accessing mental healthcare for the broad community, such as cost and stigma, those who are marginalized face increased barriers, some of which are included below.

- There is a higher risk for people of color of being affected by the stigma of mental health from employers, the justice system and more.
- There is a lack of culturally competent care, diverse providers and services rendered in the primary language of many community members.
- Providers and the healthcare system are met with skepticism and deemed as untrustworthy.
- Mental health contributes to many of the social determinants of health, but is difficult to prioritize over other needs, such as food and shelter.

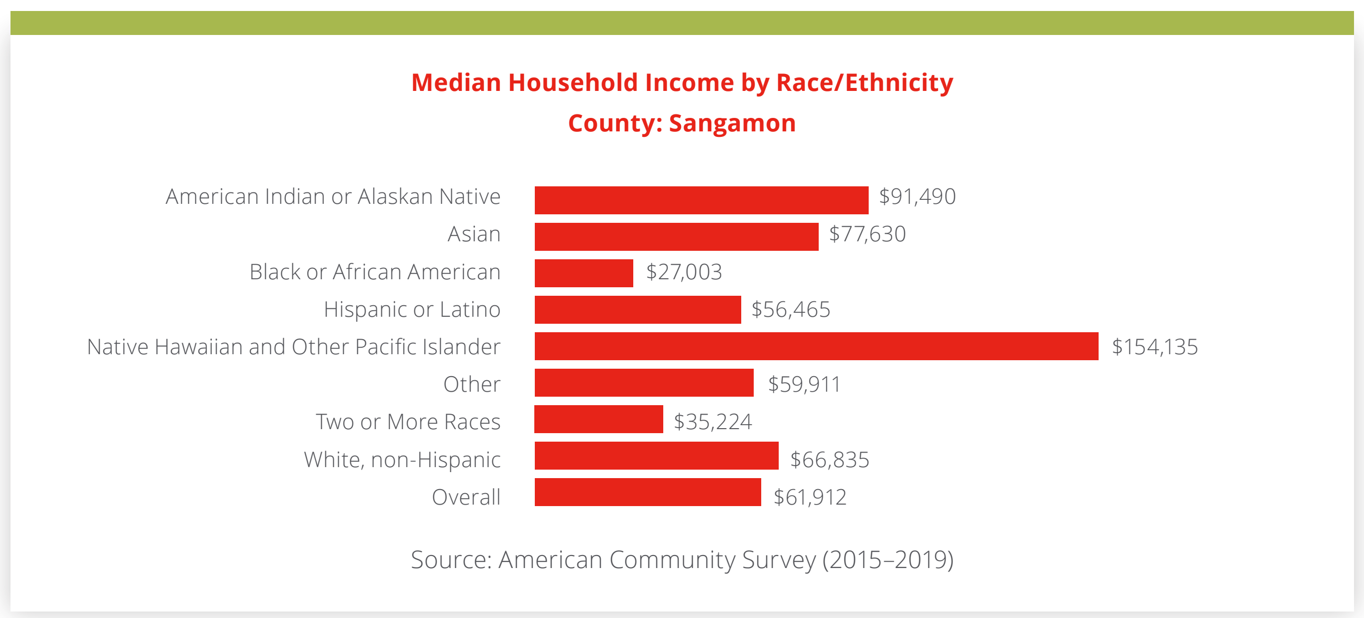
An additional common theme from community focus group/interview feedback is that people are unclear when to seek mental healthcare. Many people rely on their faith leaders to guide them through mental health issues and there was a strong sense of need to equip faith leaders for this role, as well as to help the community understand when mental healthcare is necessary.

Memorial Behavioral Health, a Memorial Health affiliate, is well-positioned to help address these community needs and was considered when assessing our ability to make an impact for this priority.

Variations of mental health were identified as the highest priorities in the CHNAs for each county where a Memorial Health hospital is located. Community Health leaders across the system have committed to making mental health a priority and using our combined resources to make a regional impact for this priority area. Strategies for our approach will be outlined in our CHIPs.

Economic Disparities

This was the highest ranked priority throughout our community focus groups/interviews. Black or African American households are earning 40% of the income of White households. According to Governing Magazine, Springfield ranks the worst for severe disparities in White and Black household incomes – more so than any other metro area in the entire country.



Source: American Community Survey (2015–2019)

Disparities in economy were strongly related to disparities in education by community members. As one of the largest private employers in the county, we have potential to make an impact in this area in a way that we cannot in the education sector. We recognize, however, that education, including job training, must be a key component of addressing these disparities. Additionally, significant disparities exist for children, seniors and those who have been disabled. A portion of the feedback from the community focus groups/interviews in Sangamon and Macon counties, regarding this indicator, included the below statements:

- "Disparities in economy are disturbing, but not shocking to us – we're living it every day."
- "Generational poverty, it's not just regular poverty, it's hopelessness embedded in the community, social and monetary wealth. There is no safety net of support if everyone's in that same boat."
- "This same data goes back for decades…"
- "Why does it take data to validate the experience we've been trying to tell you we're living?"

Access to Health

While access to health can be difficult to define, it continues to be centered as a top priority amongst community members. In the 2018 CHNA, access to health was not listed as a health indicator; however, it came up frequently among the CAC and survey respondents' open comments. During the 2021 CHNA process, we approached this as a major contributing factor, but did not include it on our list of indicators. We again saw community members organically indicate the importance of access to health. When community focus group/interview participants were asked to submit their top priorities, force-ranked via chat box or email, we continued to receive responses including access to health as their top choice. Community members independently identified the following as some of the barriers to accessing healthcare:

- Lack of insurance, particularly for families with mixed-immigration status
- Lack of culturally competent, diverse providers and those who speak their primary language
- Transportation
- Housing and safe living conditions, including lack of kitchens, heating and cooling, and landlord accessibility
- Economic instability
- Food insecurity

With existing infrastructure and collaboration between SIU, SJH and SMH around this priority, we hope to continue making an impact in our efforts to increase access to health.

PRIORITIES NOT SELECTED

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

Access to Behavioral Health Services

Access to behavioral health services will be addressed as part of our comprehensive approach to mental/behavioral health. This includes substance use. While this was seen as a community need, it was widely viewed as a result of mental health issues and disparities in economy and was not highly prioritized in our final list.

Affordable Housing

Affordable housing is a health indicator for which healthcare professionals are not the experts or thought leaders. Recognizing that, and considering the defined criteria for CHNA priorities, we cannot make a meaningful impact in this area at this time. We will, however, consider advocacy and education around this issue as part of our mental health strategy.

Disparities in Education

Disparities in education were a highly ranked priority by community members. This was so closely related to disparities in economy that we deeply considered how both relate to each other and what can be done to address both. Being that we, as healthcare providers, are not in the education space, but are one of the largest private employers, we chose to prioritize disparities in economy instead of education.

Food Access

Food insecurity and access to safe and healthy foods became a top priority early in the pandemic. Many organizations are committed to this mission and are effectively combatting hunger in Sangamon County. While the need is great and we anticipate partnering with the leaders in this work as we consider access to health, we decided to focus our efforts on priorities not being as widely addressed.

Homeless Issues

Homelessness in Sangamon County has been, and continues to be, a serious problem. Homeless issues were ranked low in comparison to other health indicators, due to being considered a part of mental health challenges. We will continue efforts to address homelessness in the community through our mental health strategies and will partner with community organizations working to address this issue.

Other Health Indicators

Additional health indicators are in need of being addressed in our community; however, they were not ranked highly by the CAC and, therefore, have not been prioritized for our CHIP. These indicators include maternal/infant health, obesity, senior health, tobacco use, unemployment, unmanaged chronic conditions, utility and rental assistance and violence. Strategies to address these and other unselected priorities may be present in our final CHIP, as they relate to the final health priorities.

SECTION IV—POTENTIAL RESOURCES

RESOURCES & PARTNERS

Gaps, assets, collaborative partnerships and existing work for each of the final priorities will be explored with the CAC and members of the organizations who participated in the community focus groups/interviews. The result of these discussions will inform, and be included in, the Sangamon County CHIP. Below are some examples of existing or potential partnerships that can be leveraged to address the final priorities selected.

Economic Disparities

- Continue collaborative meetings occurring between Sangamon County Growth Alliance, the Springfield Black Chamber of Commerce and Memorial Health.
- Pursue opportunities to partner through the Community Foundation for the Land of Lincoln's NEXT10 Project.
- Explore opportunities to promote connection between community and Lincoln Land Workforce Alliance.
- Support workforce development and pipeline programs in existence: SIU's P4, Simon Youth Academy, Springfield Urban League Workforce & Economic Division, NAACP Back-to-School/Stay-in-School program and more.

Mental/Behavioral Health

- Support faith leaders who are already playing a role in addressing mental health needs of marginalized communities.
- Continue support of Memorial Behavioral Health's comprehensive mental health services and capitalize on eagerness to partner on this priority.
- Collaborate on the Homelessness Strategic Planning Initiative organized by the Heartland Continuum of Care.
- Enlist the help of the Community Health Round Table to assist with advocacy and awareness around housing.

Access to Health

- Support Community Health Worker programs through SIU Access to Health program and the Springfield Immigrant Advocacy Network.
- Opportunity to increase provider diversity through Economic Disparities initiatives.

Additionally, there are more than 100 social service agencies and resources who can contribute to addressing the health needs of Sangamon County. Several of these organizations are identified in this CHNA report and will be integral partners to the work of addressing the health needs of our community.

SECTION V—2018 CHNA/CHIP

2018 CHNA/CHIP EVALUATION OF IMPACT

SMH, SJH and SCDPH also collaborated on the 2018 CHNA. SMH selected its own priorities to address over the following three years. Priorities selected by SMH were Access to Care, Mental Health, Substance Use and Mother/Infant Health. The CHIP was used as a guide for updating our annual Measures of Success internally. The Community Benefit Committee of the MH Board of Directors reviewed annual outcomes to meet the strategic plan goal to "achieve 100% of approved Community Benefit targets." Highlights and expenses were shared annually in the Memorial Health Annual Report. The COVID-19 pandemic slowed progress in meeting our goals; however, we continued to make strides in addressing these priorities, as well as responding to COVID-19 and meeting the healthcare needs of our community. Throughout MH, more than 80,000 masks were delivered to more than 70 community-based organizations.

Access to Care

The jointly funded Access to Care program, a partnership between SJH and SMH administered by SIU School of Medicine, continues to provide support and resources to those residing in the Pillsbury Mills and Enos Park neighborhoods. An impact statement for this program will be available in November 2021. Funding was also provided to the Springfield Immigrant Advocacy Network, which has increased access to dental/vision care, community-specific dietary needs, rental assistance and strategic planning for capacity building. Kumler United Methodist Church continues to receive funding to administer prescription assistance programs to those who have trouble accessing their medications. This program provides access to an average of 40 prescriptions each month. In addition to our Community Health Worker programs, SMH provides over $40 million of support to SIU School of Medicine annually to ensure their ability to continue to care for central Illinois. This support comes in the form of financial contributions and provision of office and simulation space, as well as medical education for residents and fellows. Over the last CHNA/CHIP cycle, $10.4 million was also provided to the YMCA to support the construction of a new downtown facility to promote healthy living and provide access to wellness and exercise.

Mental Health

Prior to the COVID-19 pandemic, Mental Health First Aid was offered throughout the community. Nearly 150 community members in Sangamon County were trained to recognize signs of mental and emotional distress. SMH also provided funding to the Children's MOSAIC Project, including expansion to Jefferson Middle School. The MOSAIC Project is an innovative program created to transform the way mental health services are provided to children in Springfield. Co-responder Engagement Team, or CoET, has been funded by SMH through Memorial Behavioral Health to provide mental health professionals as co-responders to crises. CoET team members are often called on to be dispatched alongside local law enforcement, but can also be engaged through any means to help individuals access mental healthcare when they need it. This program is intended to help those struggling with mental illness in an effort to decrease homelessness and incarceration rates. The program has been widely viewed as a positive asset in our community. Girls on the Run support was an additional part of our mental health strategy. In the last sponsored event prior to the pandemic, 740 participants participated and 90% of coaches and parents/guardians "agreed" or "strongly agreed" that because of participating in GOTR, their participating child was more confident. Memorial Behavioral Health staffs and supports the Behavioral Health Access to Care Hotline across all service areas, including Sangamon County, which includes the Farm Family Line, COVID-19 Emotional Support Line and the National Suicide Prevention Hotline.

Substance Use

Representatives from SMH are currently participating on the Recovery-Oriented Systems of Care (ROSC) Council through the Family Guidance Center. SMH representatives have maintained roles on this, as well as other opioid and substance use task forces through the county health department and SIU. Involvement in one of these committees led to the creation and distribution of a brochure addressing substance use and treatment seeking to be used by care providers. SMH participated in internal work throughout MH to address opioid prescriptions and usage within our institution. This work is ongoing. Finally, we participated on the Community Advisory Committee for the Safety and Justice Challenge planning grant to establish ways to provide sobering units and detox services to individuals as a means to avoid incarceration.

Mother/Infant Health

SMH participated in a joint press conference to raise awareness around infant safe sleep alongside SJH, SCDPH and DCFS during Safe Sleep Month. SMH and SJH jointly funded the Nurse Family Partnership program through SIU, which consists of home-visiting nurses for women who are first-time mothers, at risk and who are pregnant or have recently delivered. While this program had positive outcomes, including 89% of mothers with term births, 69% attempted breastfeeding and 36% reduction in smoking, the program proved to be restrictive and not cost-effective. The program was not funded past the initial three-year commitment. Focus groups were held with community members of diverse identities to better understand the barriers with safe sleep for infants. The COVID-19 pandemic adversely affected progress following these focus groups. Finally, SMH participated in the Sangamon HEART workgroup, resulting from the Sangamon Success report, and has begun to address the need of better referral connections between families and providers for home-visiting programs and children aged 0–3.

THE 2021 CHNA Report and Final Priorities were adopted by the Community Benefit Committee of the Memorial Health Board of Directors on July 23, 2021.

The CHNA is made widely available on our website, as well as through press releases, social media and presentations. If you are interested in copies of this assessment or have additional questions, please direct inquiries to CommunityHealth@mhsil.com.

SECTION VI—Appendices

FOCUS GROUP PRESENTATION

Presenters

Bill Dart, Assistant Director of Public Health
Sangamon County Department of Public Health

Becky Gabany, System Director of Community Engagement
Memorial Health System / Memorial Medical Center

Lingling Liu, Equity, Diversity and Inclusion Program Coordinator
Memorial Health System / Memorial Medical Center

Kimberly Luz, Division Director of Community Outreach
HSHS Illinois / HSHS St. John's Hospital

NOTE TO PARTICIPANTS: we will be recording this presentation and discussion

Goals

Goal One: Data Review

Goal Two: Breakout Room Discussion

- Today, we would like to learn from you.
- You do not have to speak unless you wish to.
- Facilitators will be taking notes; but your name will NOT be recorded with anything you say.
- All opinions and voices will be respected and every idea will be noted.

Goal Three: Ranking

- Today, we would like you to rank your top three health priorities from the following list.

Seven Priority Areas & Three Major Contributing Factors

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

Major Contributing Factors

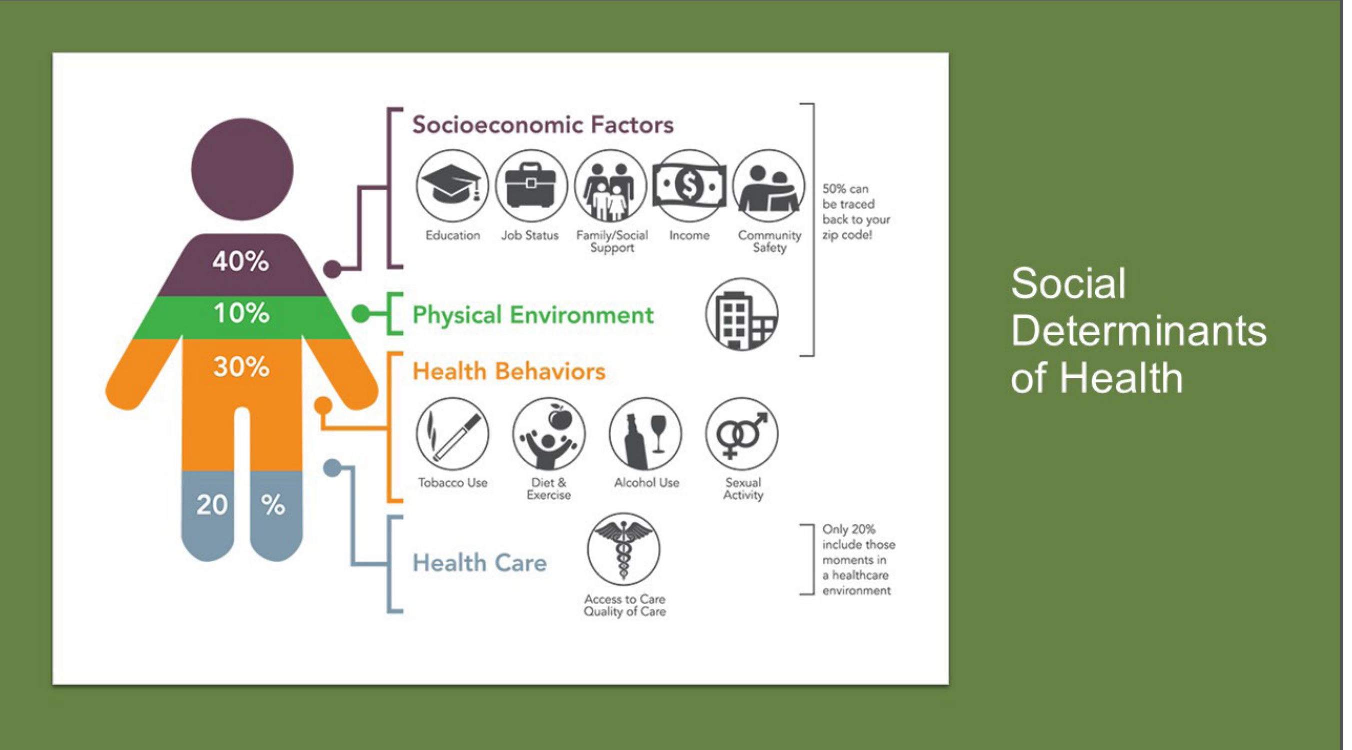
1. Access to Health and Healthcare
2. Social Determinants of Health
3. Racial Inequities and Inequalities

Access to Health and Healthcare Barriers

Structural
- Availability
- How Organized
- Transportation

Financial
- Insurance Coverage
- Reimbursement Levels
- Public Support

Personal
- Acceptability
- Cultural
- Language
- Attitudes
- Education / Income



Equality

The assumption is that **everyone benefits from the same supports**. This is equal treatment.

Equity

Everyone gets the supports they need (this is the concept of "affirmative action"), thus producing equity.

Justice

All 3 can see the game without supports or accommodations because **the cause(s) of the inequity was addressed**. The systemic barrier has been removed.

Breakout Session One: Mental and Behavioral Health

- How do these issues impact you?
- How do these issues impact those you know?
- What is one thing we could do to improve these issues?

Mental Health

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

People identified the following reasons as access barriers:

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

Behavioral Health

Drug and alcohol use is on the rise.

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

Breakout Session Two: Disparities in Education, Economy, and Food Security

How do these issues impact you?

How do these issues impact those you know?

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

Disparities in Economy

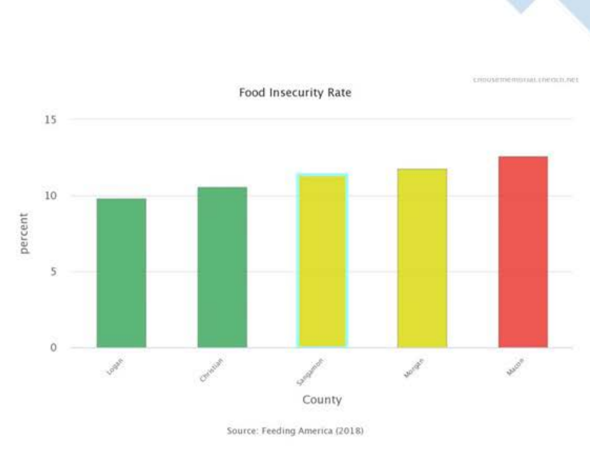
- Sangamon county scores in the lowest quartile for children living in poverty.
- And the second lowest quartile for families living in poverty.
- We are higher than the state and nation for persons with a disability living in poverty.
- Black and African American seniors over 65 are twice as likely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

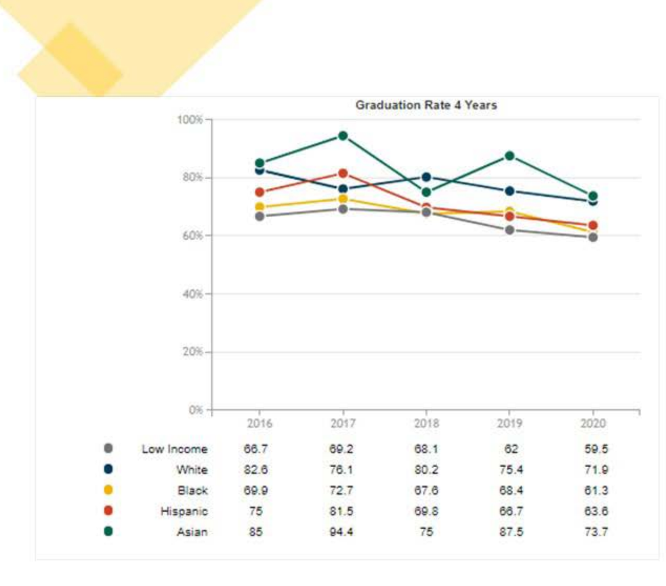
Poverty by Race

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

Food Access

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





	2016	2017	2018	2019	2020
Low Income	66.7	69.2	68.1	62	59.5
White	82.6	76.1	80.2	75.4	71.9
Black	69.9	72.7	67.6	68.4	61.3
Hispanic	75	81.5	69.8	66.7	63.6
Asian	85	94.4	75	87.5	73.7

Disparities in Education

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

Breakout Session Three: Homelessness and Affordable Housing

How do these issues impact you?

How do these issues impact those you know?

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

Homelessness

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

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

Affordable Housing

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

Rank your top three priorities.

1 = Highest

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

Data Sources

- Townhall Charts: 2019 Census Bureau
- Illinois Department of Public Health: 2018
- 2019 IHA COMPdata
- Springfield District 186
- American Community Survey
- Feeding America: 2018
- Sangamon County 2019 Citizen's Survey
- Illinois Kids Count 2020
- 2019 County Health Rankings
- National Council for Behavioral Health
- State of Homelessness 2020

COMMUNITY FEEDBACK

SANGAMON—ISLAMIC SOCIETY OF GREATER SPRINGFIELD

Access to Behavioral Health/Mental Health

- Language is an incredible barrier to finding a provider, even with translators.
- Due to many different dialects, translation can fail.
- Hard to open up to family because of stigma, though it's easier to talk to friends than professionals.
- Cultural lack of interest and encouragement to go into mental health field for work.
- Lack of knowledge in how to access mental health care.
- When there are cases of abuse, care providers may understand trauma, but not their culture.
- Stigma stems from needing to trust God and simply not be depressed. "Not having enough faith in God." Adds guilt.
- If advice comes from outside the culture, it is often dismissed.
- Because community is small, word spreads quickly about familial issues.
- Substance use not a major issue due to cultural and religious practices.
- Solutions
    - Training an Imam may help those seeking counseling.
    - Of note: Group is wanting to establish a free healthcare clinic.

Disparities in Economy, Education, Food Access

- Education not really an issue – very rare to not finish high school and college.
- For some, working in the family business may be the priority. Women are encouraged to marry and may be frowned upon for going to college away from home.
- Poverty is a problem for those who have many children. Lack of knowledge from parents may impact children.
- Medicaid support exists, but uncertainty around how to access.
- The community is united and also segregated. (Pakastani, Yemeni, etc.)
- Solutions
    - Information on Medicaid could help.
    - Outreach from persons within the community to the community.

Affordable Housing/Homeless Issues

- Not a big problem for this community. Perpetual charity is an Islamic concept. Community believes in sharing familial care.
- General feeling of not facing a lot of discrimination unless you're on Medicaid. Then viewed as poor and unreliable.

SANGAMON—WARD 2 ALDERMAN SHAWN GREGORY

Access to Behavioral Health/Mental Health

- Many not working traditional jobs so don't have access to insurance.
- Lack of activities to keep young people busy, leads to behavioral health issues.
- Talked about more now within Black community.
- Drinking alcohol contributing to depression.
- Mental health affected by stability, many folks living below poverty line without stability.
- Solutions
  - Push resources through grassroots organizations.
  - Need to reach folks who don't go through usual channels.

Disparities in Economy, Education, Food Access

- Generating own incomes due to being unable to get traditional jobs.
- Even with good resumes, jobs are not hired for.
- People living in houses without windows sets tone for young people feeling capable of overcoming the situation.
- It's hard to be anything different than what you are exposed to.
- Debt is an issue – families would rather buy their kids something nice so they won't get made fun of because they can't afford to pay the other bills anyways.
- We assume people know what to do with insurance once they get it.
- Kids taking care of siblings while parents work hinders education.
- Once education issues are noticed, students are already so far behind.
- Solutions
  - Be more visible in the community, be proximate.
  - Use our networks to make an impact.
  - Free dental clinics.
  - DARE programs back in schools.

Affordable Housing/Homeless Issues

- Rent takes up all your money.
- Issues with no working kitchens, broken windows, doorless, partial electricity, etc.
- Landlords unavailable or being unengaged from nearby communities.
- Many don't have a situation that allows for cooking a meal.
- Credit may not be good, but paying rent consistently.
- Solutions
  - Banks to consider loans for renters who pay more rent than a mortgage.
  - Hold property owners accountable.

BLACK CHAMBER OF COMMERCE

Access to Behavioral Health/Mental Health

- Limited access due to low income and lack of information on when to seek therapy.
- Lack of trust both ways, which lead to inaccurate diagnosis and over medication.
- Stigma—can be prayed away or due to lack of discipline.
- Mental health among senior citizens is concerning due to isolation.
- Solutions
  - Mental health professionals with law enforcement to assist with mental illness situations.
  - Destigmatize.
  - Meet folks where they are, mental health and behavioral health services need to be provided hand-in-hand and consider generational trauma.
  - Education on mental/behavioral health symptoms, PTSD and evaluation tools.
  - Trauma-informed therapy.
  - Telehealth therapy to maintain confidentiality.

Disparities in Economy, Education, Food Access

- Lack of access to technology and internet; bandwidth is also an issue when you have 3-4 kids online learning at the same time.
- Lack of access to child care, leading to absenteeism.
- Hunger is a bigger issue than seen. Transportation/work causes barrier to accessing. Hunger exacerbates education, job performance, etc.
- Lack of grocery stores in some areas. Only Dollar General.
- Lack of blue collar jobs, and jobs for kids in the summer.
- Access to food banks can be socially unacceptable.
- Access to affordable quality glasses.
- Solutions
  - Home visits to figure out reasons for absenteeism, promote understanding and accountability.
  - Career pipeline at hospitals to support minoritized populations getting into the field.
  - NAACP “back to school, stay in school” program. 98% graduation rate.

Affordable Housing/Homeless Issues

- Food and housing are basic needs.
- Understand causes of homelessness. They need to be heard.
- White saviorism—telling folks what they need vs. listening and helping.
- Homelessness will likely worsen.
- High rates of renting vs. owning.
- Solutions
  - Financial stability programs, assistance with home ownership, stable income.
  - Provide multifamily homes before homelessness.

RACE HEALTH AND EQUITY PARTNERSHIP, KENNIEBREW FORUM

Access to Behavioral Health/Mental Health

- Trauma impacts health and health behaviors.
- Mental and physical health are just health as a whole.
- Solutions
    - Sharing mental health experiences between providers and patients to break down stigma and silos.
    - Universal mental health screening.
    - Insurance coverage.
    - Assess how BIPOC patients are treated from front door to treatment room.
    - Empower patients.
    - Church programs on mental health to break stigma.
    - Trauma-informed care training for physicians, including racial trauma.
    - Promote provider diversity by addressing education disparity.
    - Program for regular check in on seniors.
    - Build trust in each contact is key.
    - Free mental health healing circles.
    - Tutorials on how to navigate mental health in Sangamon County for BIPOC individuals.
    - Mental health services at each school.

Disparities in Economy, Education, Food Access

- Economic inequality is a huge issue.
- To impact health we need to be in the non-health sector.
- Commit to fully funding solutions. Hire and pay BIPOC well to implement the solutions.
- Budget is policy. Need HSHS and Memorial senior leaders to get behind and support budget.
- Commitment from centers of White power—government, healthcare, education to do and fund the work. Money backing the talk and action.
- Partnerships in advocacy.
- Solutions
    - Black business owners bridge food desert needs.
    - Improve access to job market for folks without computers. Introduce folks to trades that provide good living wages.
    - Scholarship application coaching.
    - Must end poverty so that folks can focus on long-term planning vs. what is on fire today.
    - Inform parents and students on opportunities post HS.
    - Healthcare and schools collaborate on career pipeline.
    - Needs assessment for kids who suffer from absenteeism and create solutions accordingly.
    - No one left behind attitude vs. we are doing all we can.
    - Listen to folks who need assistance. Offer opportunities for them to lead the work.
    - Programs to meet students who are not ready for college.

- Minimum basic income for all that's enough to live with dignity.
- Increase diversity in student and faculty at college of nursing.
- Comprehensive approach that involves everyone (government, school, healthcare, businesses, etc.).
- Acknowledge poverty as societal failure as a result of systemic deficiency and dysfunction.

Affordable Housing/Homeless Issues

- Housing segregation leading to health disparity between zip codes. 11th St. in Springfield is a distinct line.
- Elected officials/local government contribute to inequities.
- Solutions
    - Accessible homeownership for POC.
    - Employers help support housing for employees, livable wage.
    - Safe housing is health.
    - Board members and leaders in healthcare employ power to remove barriers.
    - Regulations must require landlord registration and routine rental property inspection. Persecute predatory lenders. From landlord friendly to tenant friendly.
    - Have a voice on the zoning board.
    - Hospitals can help build housing.
    - Recognize differences in how BIPOC communities manage housing and thrive.
    - Early education in finances.
    - Serve the people where THEY are.
    - Banking programs that promote responsibility.
    - Job training and support.
    - Work with the Springfield Housing Authority to change the misdemeanor/felony restrictions on housing. This is prohibitive to accessing safe and affordable housing and we have the power to change it in our local housing authority.
    - Invest in under-resourced communities to support a feeling of value.
    - Better social services and funding without negative stigma.
    - Rent protection policies.

THE PHOENIX CENTER

Access to Behavioral Health/Mental Health

- Folks are anti-LGBTQQ or not educated in LGBTQQ issues. Lack of understanding and insensitive.
- Mental health and primary care are biggest barriers. Lack of access for transgender individuals. Very few services for hormone replacement therapy. There is no therapist who understands transgender issues.
- Private insurance through employment doesn't cover transgender issues.
- Higher tobacco use, higher rates of obesity, substance use.
- Solutions
    - Planned Parenthood provides hormone replacement therapy.
    - Medicaid covers hormone replacement therapy. Private insurance needs to include also.
    - Culturally competent therapists.

Disparities in Economy, Education, Food Access

- High dropout rates among LGBTQ students due to bullying and lack of acceptance among educators, co-workers and family.
- Homelessness are due to family disowning them for their identity. Additional issues like home isolation, emotional abuse, etc.
- All SDoH are tied with LGBTQ issues especially with anti-acceptance and isolation.
- Solutions
    - Awareness and education among health providers.
    - Shed light on issues and eliminate barriers by sharing insights from the LGBTQQ community.
    - Trainings through the Phoenix Center for healthcare workers.
    - Disconnect between religious-based service organizations and LGBTQ individuals.
    - Wait-list at the Phoenix Center in the transitional program.

Affordable Housing/Homelessness Issues

- Minimal options for housing and shelters for LGBTQ folks. Harassment and unfair treatment happen often.
- Difficulties getting employment and accessing homeless shelters.
- Solutions
    - Helping Hands does a good job. Contact Ministries are accepting but there are issues afterwards usually.
    - Create more housing for LGBTQ folks.
    - Increase local data collection for LGBTQ community—Molly Lamb, Citizen Survey.
    - Increase ally-ship and understanding.
    - Increase education reach through hospitals and larger organizations.

AIWO, ASIAN INDIAN WOMEN'S ORGANIZATION

Access to Behavioral Health/Mental Health

- Social isolation has caused issues.
- The mentees of the Outlet have a hard time with abuse and neglect.
- Mental health is not an issue just for poor people, rampant in all groups.
- Parents need to assume responsibility and support the kids and have dedicated family time.
- Parents need to invest time in their family.
- Technology is taking over our lives.
- The Outlet changed its focus to addressing food insecurity and ensuring that families had a meal a day.
- Mentees were having a hard time due to the loss of in-person school.
- Access and availability to mental health services is important.
- Education about the taboos of mental illness is very important.
- Abuse of prescription drugs is rampant.
- Are there community health workers to help people?

Disparities in Economy, Education, Food Access

- The disparity of people living in the area is eye opening.
- The community is highly segregated.
- Look at the differences in finances and resources in Springfield District 186 and Chatham.
- More advocacy with lawmakers and government.
- Access is often divided by the schools and aldermen.
- Something needs to be done with jobs.
- The community as a whole suffers when the most disadvantaged are not supported.
- Education about how deep the problem goes and how systemic the problems are.

Affordable Housing/Homelessness Issues

- Leaders in the community need to stand up for a facility to replace the failed one on 11th Street.
- People need to be more globally minded and have leaders who will break down walls, physical and psychological.

MAYOR LANGFELDER & CITY COUNCIL

Access to Behavioral Health/Mental Health

- Behavioral health and mental health is a taboo subject.
- How you grew up determines whether you take the medicine or seek care.
- Tax revenues from marijuana are great but you are seeing an escalation in usage by young people especially with edibles alcohol too.
- Drug treatment facilities have been gutted from state and federal levels.

Disparities in Economy, Education, Food Access

- Gun violence is being perpetuated by those who are not living on the east side but are living in other areas to remain safe.
- Chronic absenteeism in school.
- Subsidies and pandemic dollars provided by the government during the pandemic is making it hard to get people back into the workforce.
- Like mental health issues, people are afraid to discuss their needs.
- Larger families are living together in smaller spaces.

Affordable Housing/Homelessness Issues

- Holistic approach needed with transitional and wraparound services.
- Emergency shelter or more supportive transitional housing.
- Organizations involved with the homeless initiative are stretched.
- Create partnerships to improve access and referrals.

SANGAMON COUNTY—EASTSIDE NEIGHBORHOODS

Access to Behavioral Health/Mental Health

- Mental health is not talked about in the homes. Parents and youth need resources to guide conversation.
- Access to culturally competent providers is limited.
- Seniors are living in isolation and don't have anyone around to help them.
- People don't know when to access mental healthcare; awareness of when to access care.
- Help people understand mental health is an illness like the cold.

Disparities in Economy, Education, Food Access

- We see young Black men with aspirations but don't know how to seek out workforce development, leadership skills, mentorship opportunities and career opportunities.
- The Black population overwhelmingly makes less than White population.
- Solutions
  - First, we need to acknowledge the health disparities (as the healthcare community is doing through this assessment) then raise awareness that they do exist.
  - If a youth steals a car at 15, they have a stamp on their record for life. We need to help that youth turn things around rather than label them a criminal for the rest of their life.

Affordable Housing/Homelessness Issues

- Once eviction moratoriums lift people will owe a lot of back rent.
- Families are choosing between paying rent and food for their children.
- Too many slumlords who don't even live in the county. We need stronger landlord laws and a landlord registry.

SANGAMON COUNTY—CITIZEN'S CLUB

Access to Behavioral Health/Mental Health

- Need more sober living opportunities.
- Even with insurance, mental health access is limited by providers.
- Lack of minority providers.
- Use telehealth and telemedicine more; it allows someone to seek care without the stigma and fear of being seen going to the counselor.
- Need more school-based early intervention.
- Marijuana use in teens is a big concern now that it is legal.
- Resources
    - o Gateway Foundation
- Solutions:
    - o People access ER and priority care for mental and behavioral health. So we need to make it easier to transition from ER to recovery and treatment.

Disparities in Economy, Education, Food Access

- We need to stop calling public transportation to grocery stores a 'resource.' It is but for a mother with four children taking three busses to get groceries; that is not a resource.
- There is a lack of diversity in our teachers; and a gap between administration and teachers.
- How can we address chronic absenteeism disproportionately impacting our minority students.
- We need to be better equipped to deal with students with behavior issues.
- Solutions
    - o WIC nurses used to go to the home; now parents have to go to the health department.
    - o Hospitals provide mobile markets to communities using their commercial grade kitchens.

Affordable Housing/Homelessness Issues

- Landlords don't even live in the same county or state.
- Illinois is not a landlord friendly state.
- Opportunities
    - o Work with HUD/Housing authority:
        - Strict criminal laws
    - o Hospitals collaborate with Habitat and churches to renovate homes; not just build new homes.
    - o Some shelters have more structure and services than others; how can we rotate services to all shelters.

SANGAMON COUNTY—MINISTERIAL ALLIANCE

Access to Behavioral Health/Mental Health

- People with substance use disorder do not need to be incarcerated.
- The solution is relationships.

Disparities in Economy, Education, Food Access

- Access is largely based on education. Disparity in education and poor academic health outcomes means poor access.
- Trust and relationship building to improve education.
- Need more training opportunities for workforce development and training.
- Need more pipeline programs in schools.
- Breakdown in the family—how do we motivate parents?

Affordable Housing/Homelessness Issues

- The shelters don't work together.
- Helping Hands has housed more than 42 people since April. They are doing amazing work.
- Our churches through the ministerial alliance are very willing to volunteer and work with you on any solutions.

CALL FOR ACTION

Dear community members,

Your participation in the recent community health needs assessment meetings and focus groups was instrumental in helping Memorial Medical Center, HSHS St. John's Hospital, and Sangamon County Department of Public Health identify top health priorities for the Community Health Needs Assessment (CHNA) and Illinois Project for Local Assessment of Need (IPLAN).

Based on your input, our organizations identified the following health priorities for inclusion in a Community Health Improvement Plan (CHIP). While slightly different, there are similarities in each of our final priorities and opportunity for collaboration as we work together toward a healthier Sangamon County.

St. John's and Memorial Medical Center: CHNA Priorities

1. Disparities in Economy
2. Mental and Behavioral Health Services
3. Access to Health

Sangamon County Department of Public Health: IPLAN Priorities

1. Access to Mental & Behavioral Health Services
2. Housing Safety
3. Access to Health
4. Chronic Conditions: Education and Resources

We would like to invite you as representatives from your organizations to join us once again on July 14, 2021: 11:30am to 1pm as we begin to develop a plan outlining steps we will take to address the identified health needs over the next several years. A Zoom invite will be sent to you later today.

During this meeting, we will:

- Identify assets and gaps to addressing the priorities listed above.
- Identify resources available to us in meeting the identified needs.
- Identify existing programs, initiatives, and coalitions addressing the identified needs.
- Identify goals and strategies to move toward health improvement.
- Develop a shared vision and strategic plan to address the identified needs.

Please let us know if you or someone from your organization is available to join us and other community stakeholders in developing the Community Health Improvement Plan (CHIP). We hope the final product is a document all our organizations can use and reference as we journey together toward a healthier Sangamon County.

Please do not hesitate to reach out to us with any questions or further discussion.

Sincerely,

Kim Luz
Division Director Community Outreach
HSHS St. John's Hospital

Kim.luz@hshs.org

Becky Gabany
System Director Community Engagement
Springfield Memorial Hospital

Gabany.Becky@mhsil.com

Gail O'Neill
Public Health Director
Sangamon County
Department of Public Health
Gail.ONeill@co.sangamon.il.us

SANGAMON COUNTY FOCUS GROUP OVERALL SCORES FOR FORCE-RANKING

- 176—Disparities in Economy
- 168—Disparities in Education
- 142—Access to Mental Health Services
- 129—Safe and Affordable Housing
- 91—Food Access
- 62—Homeless Issues
- 60—Access to Behavioral Health Services