Community Health Needs Assessment 2018

Sarah Bush Lincoln

Trusted Compassionate Care

BKD CPAs & Advisors

Contents

Introduction

Internal Revenue Code (IRC) Section 501(r) requires health care organizations to assess the health needs of their communities and adopt implementation strategies to address identified needs. Per IRC Section 501(r), a byproduct of the *Affordable Care Act*, to comply with federal tax-exemption requirements, a tax-exempt hospital facility must:

- ✓ Conduct a community health needs assessment (CHNA) every three years.
- ✓ Adopt an implementation strategy to meet the community health needs identified through the assessment.
- ✓ Report how it is addressing the needs identified in the CHNA and a description of needs that are not being addressed with the reasons why such needs are not being addressed.

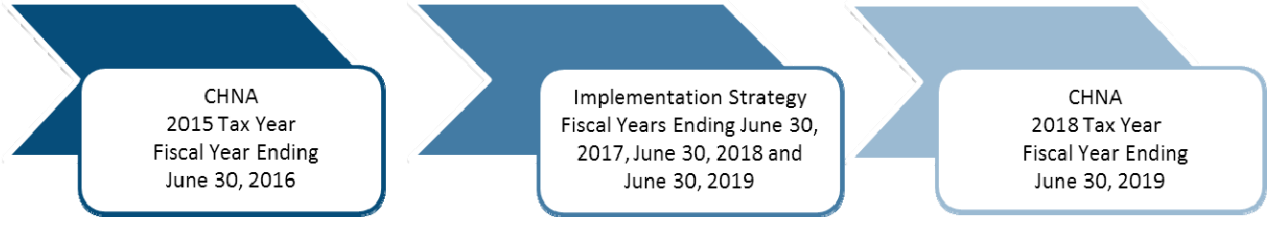
The CHNA must take into account input from persons who represent the broad interest of the community served by the hospital facility, including those with special knowledge of or expertise in public health. The hospital facility must make the CHNA widely available to the public.

This CHNA, which describes both a process and a document, is intended to document Sarah Bush Lincoln Health Center's (SBL or Health Center) compliance with IRC Section 501(r). Health needs of the community have been identified and prioritized so that the Health Center may adopt an implementation strategy to address specific needs of the community.

The *process* involved:

- ✓ A comprehensive evaluation of the implementation strategy for fiscal years ending June 30, 2017, through June 30, 2019, which was adopted by the Health Center board of directors in 2015.
- ✓ Collection and analysis of a large range of data, including demographic, socioeconomic and health statistics, health care resources and hospital data.
- ✓ Interviews with key stakeholders who represent a) broad interests of the community, b) populations of need or c) persons with specialized knowledge in public health.

This *document* is a summary of all the available evidence collected during the CHNA conducted in tax year 2018. It will serve as a compliance document, as well as a resource, until the next assessment cycle. Both the *process* and *document* serve as the basis for prioritizing the community's health needs and will aid in planning to meet those needs.



Summary of Community Health Needs Assessment

The purpose of the CHNA is to understand the unique health needs of the community served by the Health Center and to document compliance with new federal laws outlined above.

The Hospital engaged **BKD, LLP** (BKD) to conduct a formal community health needs assessment. BKD is one of the largest CPA and advisory firms in the United States, with approximately 2,400 partners and employees in 34 offices. BKD serves more than 1,000 hospitals and health care systems across the country. The community health needs assessment was conducted from July 2018 through October 2018.

Based on current literature and other guidance from the treasury and the IRS, the following steps were conducted as part of the Health Center's community health needs assessment:

- ✓ An evaluation of the impact of actions taken to address the significant health needs identified in the prior community health needs assessment was completed and an implementation strategy scorecard was prepared to understand the effectiveness of the Health Center's current strategies and programs.
- ✓ The "community" served by the Health Center was defined by utilizing inpatient and outpatient data regarding patient origin. This process is further described in Community Served by the Health Center.
- ✓ Population demographics and socioeconomic characteristics of the community were gathered and reported utilizing various third parties (see references in Appendices). The health status of the community was then reviewed. Information on the leading causes of death and morbidity information was analyzed in conjunction with health outcomes and factors reported for the community by CountyHealthrankings.org. Health factors with significant opportunity for improvement were noted.
- ✓ Community input was provided through key informant interviews. Results and findings are described in the Key Informant section of this report.
- ✓ Information gathered in the above steps was analyzed and reviewed to identify health issues of uninsured persons, low-income persons and minority groups and the community as a whole. Health needs were ranked utilizing a weighting method that weighs 1) the size of the problem, 2) the seriousness of the problem, 3) the impact of the issues on vulnerable populations, 4) the prevalence of common themes and 5) how important the issue is to the community.
- ✓ An inventory of health care facilities and other community resources potentially available to address the significant health needs identified through the CHNA was prepared and collaborative efforts were identified.

Health needs were then prioritized taking into account the perceived degree of influence the Health Center has to impact the need and the health needs impact on overall health for the community. Information gaps identified during the prioritization process have been reported.

General Description of the Health Center

Sarah Bush Lincoln Health Center (SBL) is one of four corporations organized under the not-for-profit parent corporation of Sarah Bush Lincoln Health System (SBLHS.) The other corporations are Sarah Bush Lincoln Health Foundation (SBLHF) — serves as the fundraising arm of the organization to generate philanthropic support for programs and services; and Sarah Bush Lincoln Captive Insurance, Ltd. — a wholly owned subsidiary providing primary general and professional liability coverage to SBLHS; and Sarah Bush Lincoln Practice Acquisition, Inc.

SBL was first incorporated in 1970 and is tax-exempt under 501(c)(3) and governed by a community-based Board of Directors. The main campus is centrally located between Charleston and Mattoon, in east-central Illinois. The primary service area is Coles County with secondary service areas including an additional eight-county region. Home health and hospice services cover an expanded region of 10 additional counties. SBL operates provider clinics in Arcola, Arthur, Casey, Charleston, Effingham, Martinsville, Mattoon, Neoga, Newton, Shelbyville, Sullivan, Toledo and Tuscola. Other facilities include offices for home health, hospice, laboratory, durable medical equipment services and Healthy Communities programs, *e.g.*, I Sing the Body Electric and SBL Dental Services, etc.

Accredited by The Joint Commission, the nation's oldest and largest standards-setting and accrediting body in healthcare, The Health Center operates a 145-bed acute care facility and provides 24-hour health services to patients of all ages (newborn/neonate, pediatric, adolescent, adult and geriatric). A total of 408 providers representing 33 specialties comprise the active and consulting medical staff. Employing about 2,420 area residents, the Health Center promotes a culture of excellence and safety through continuing personal and professional growth.

Mission Statement

Sarah Bush Lincoln will provide exceptional care for all and create healthy communities.

Vision Statement

Sarah Bush Lincoln will be the leading community health system in the nation.

Our Values

As members of the Sarah Bush Lincoln Health System, we commit to the following values:

Integrity
To be honest, trustworthy and consistent in our words.

Respect
To recognize the intrinsic value and dignity of all individuals.

Compassion
To respond to the feelings and needs of each person with kindness, concern and empathy.

Excellence
To hold ourselves to the highest standards in all we do.

Leadership
To envision possibilities, seek opportunities, advocate and act to meet community needs.

Stewardship
To hold ourselves accountable for the responsible use of resources.

Innovation
To think and act in new ways to achieve greatness.

Partnership
To learn from and work with our community through collaboration and cooperation.

Significant Community Benefit Programs

Dental Services and Mobile Dental Clinic: Sarah Bush Lincoln Dental Services (SBL Dental) is a collaborative community effort that provides dental care at no cost to families who qualify.

The staff consists of dental hygienists, dental assistants and staff and volunteer dentists. The program serves a seven-county service area including Coles, Cumberland, Douglas, Effingham, Jasper, Moultrie and Shelby Counties.

Each year, the program reaches nearly 3,000 children in SBL's service area for oral health education, diagnostic and preventive dental care and surgical and restorative dental care.

In an effort to remove transportation barriers, the SBL Dental team visits schools where cleanings and screenings are performed. The child is dismissed from class to receive the services. If further oral care is needed, it is delivered in SBL's mobile clinic at the school. In addition, a fixed site was established where kids can come and get a healthy smile.

Community Online Research Directory (CORD): CORD is a comprehensive database stocked with current information about agencies and programs offering services focusing on physical, mental, emotional and social needs, www.sarahbush.org/cord/.

Healthy Kids Education: The Health Center's Healthy Kids Education is all about bringing awareness to families about childhood obesity and promoting healthy lifestyle choices. The following programs are offered by the Health Center:

- 5-2-1-0 Curriculum
- KickStart
- Project Fit America
- KidsFest
- Fit-Girls
- Fast Reads
- Teen Cooking Classes
- Body Electric
- Parent & Child Cooking Classes
- Races for All Paces

For more information on the programs above, please visit:
https://www.sarahbush.org/healthycommunities/.

Center for Healthy Living: The Health Center opened the Center for Healthy Living in 2015 to achieve the following goals:

- Enhance quality of life
- Manage chronic conditions
- Prevent avoidable hospitalizations
- Delay onset or reoccurrence of symptoms
- Support and help achieve individual goals
- Behavior modification
- Achieve a consistent fitness program
- Transition to a long-term community-based exercise program, including a YMCA membership at the Center for Healthy Living

Regular exercise is fundamental in chronic illness management, weight loss and overall health maintenance. It boosts immune systems, relieves stress, helps regulate blood pressure, cholesterol and blood sugar, increases lung capacity and metabolism and a whole host of other benefits.

Through the 120-day Healthy Living Medical Exercise program, participants receive a custom-designed exercise and lifestyle program to help them achieve their goals and manage chronic illness.

The exercise program is tailored to their limitations and goals, with options and tools to make meaningful, positive changes. The overreaching goal is to instill lifelong healthy behaviors that foster independence and encourage participants to transition to a long-term community-based exercise program.

Evaluation of Prior Implementation Strategy

The implementation strategy for fiscal years ending June 30, 2017 – June 30, 2019, focused on four strategies to address identified health needs. Action plans for each of the strategies are summarized below. Based on the Health Center's evaluation for the fiscal year ending June 30, 2019, the Health Center has either met their goals or is still in the process of meeting their goals for each strategy listed.

Maximize Access to Care: Increase Access to Health Care Services by Enhancing Recruitment and Retention Efforts.

Goal Met: Yes

Sarah Bush Lincoln continued to increase access to health care services through our recruitment and retention initiatives as well as by increasing access points to receive care. Sarah Bush Lincoln partnered with a seven-physician orthopedic medical group to further improve access to care in our southern service area. In addition, in FY18, SBL recruited 14 additional providers to join our employed medical staff during the fiscal year. These providers include the following specialties: pediatrics, orthopedics, hospital medicine, psychiatry, family practice, emergency medicine, among others.

Join With Others to Activate Healthy Choices throughout the Community

Goal Met: Yes

In September 2017, Sarah Bush Lincoln partnered with the Mattoon Area Family YMCA (YMCA) to further improve the health of our community. The Center for Healthy Living (CFHL) (which was built in FY 15) increased access to health and fitness facilities in our community through new membership options with the YMCA.

Address the Lack of Mental Health Providers/Services

Goal Met: Ongoing progress

Sarah Bush Lincoln (SBL) offers a continuum of behavioral health programs for adults and adolescents, including inpatient services, outpatient counseling and employee assistance program. In FY18, SBL expanded our mental health services by adding additional providers to our program to help address the growing mental health needs in our community. Our mental health team now includes: two Licensed Clinical Professional Counselors, two Licensed Clinical Social Workers, three Advanced Practice Nurses and four Psychiatrists. In an effort to further meet the mental health demand, in April 2018, Sarah Bush Lincoln contracted with Regroup to provide Tele-psychiatry services to patients in our outpatient psychiatry clinic.

Address Oral Health Needs in our Community

Goal Met: Yes

In FY 18, Sarah Bush Lincoln provided preventative, restorative and surgical dental care to pediatric patients in our nine-county service area through our partnership with 66 local school districts. These partnerships provided us the opportunity to meet the dental needs of nearly 3,000 children in our community.

In addition, Sarah Bush Lincoln is committed to addressing the adult dental needs in our community. Through partnerships with local dentists, SBL provides monetary vouchers to adult dental patients who require emergency dental care.

Summary of Findings – 2018 Tax Year CHNA

The following health needs were identified based on the information gathered and analyzed through the 2018 CHNA conducted by the Health Center.

These needs have been prioritized based on information gathered through the CHNA.

Identified Community Health Needs

1. Poor Nutrition/Limited Access to Healthy Food Options
2. Lack of Mental Health Providers/Services
3. Substance Abuse
4. Obesity
5. Lack of Access to Services
6. Lack of Dentists/Adult Services

7. Healthy Behaviors/Lifestyle Choices
8. Transportation
9. Physical Inactivity
10. Heart Disease
11. Cost of Health Care/Prescriptions
12. Lack of Primary Care Physicians/Hours
13. Uninsured/Limited Insurance
14. Lack of Health Knowledge/Education
15. Adult Smoking/Tobacco Use
16. Children in Poverty/Homelessness
17. Cancer
18. Lung Disease
19. Access to Exercise Opportunities
20. Stroke
21. Children in Single-Parent Households
22. Teen Birth Rate
23. Need for Pre-Natal Care
24. Preventable Hospital Stays
25. Sexually Transmitted Infections
26. Violet Crime Rate
27. Excessive Drinking/Alcohol-Impaired Drinking Deaths

These identified community health needs are discussed in greater detail later in this report.

Community Served by the Health Center

The Health Center is located in the city of Mattoon, Illinois in Coles County. Mattoon is approximately 30 minutes north of Effingham, Illinois and an hour south of Champaign, Illinois. Mattoon is only accessible by secondary roads.

Defined Community

A community is defined as the geographic area from which a significant number of the patients utilizing hospital services reside. While the CHNA considers other types of health care providers, the Health Center is the single largest provider of acute care services. For this reason, the utilization of hospital services provides the clearest definition of the community.

Based on the patient origin of acute care inpatient discharges from January 1, 2016, through December 31, 2016, management has identified the CHNA community to include Coles, Douglas, Clark and Cumberland Counties as each county represents greater than 4.5 percent of the total discharges and in aggregate the four counties represent 79.9 percent of the total discharges. These counties are listed in *Exhibit 1* (Community) with corresponding demographic information in the following exhibits.

Secondary data for certain counties included in the secondary service area has not been included in the CHNA report as discharges for each individual county is less than 4.5 percent of total discharges. The socioeconomic characteristics, physical environment, clinical care, health status and health outcomes for these counties are similar to those indicated in the data for the four counties identified as the CHNA community. Primary data was obtained for these counties through key stakeholder interviews with representatives from each county's health department.

Exhibit 1
Summary of Inpatient Discharges by Zip Code
1/1/2016 - 12/31/2016

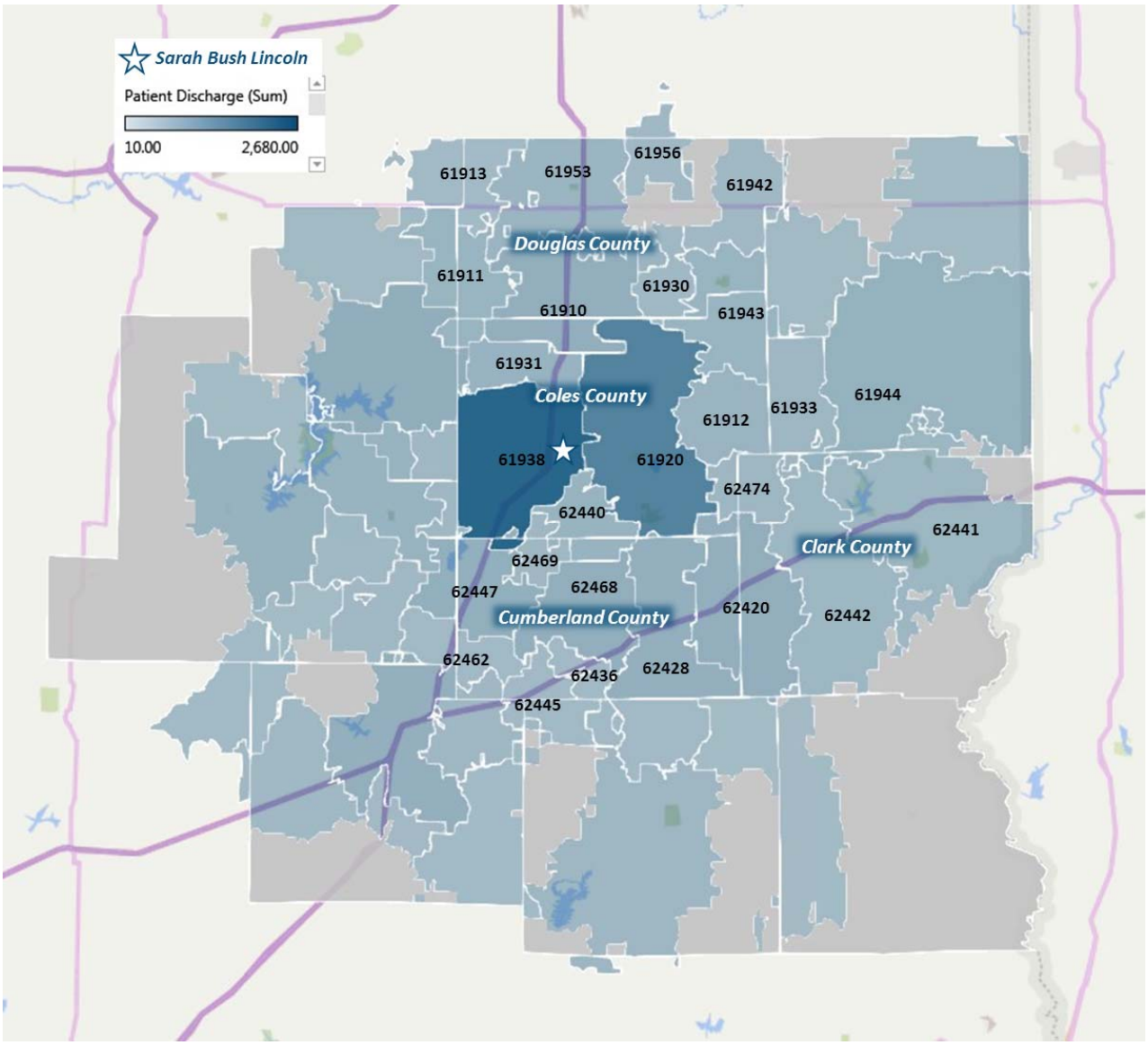
Zip Code	City	Discharges	Percent Discharges
Coles County:			
61938	Mattoon	2,680	33.2%
61920	Charleston	1,681	20.8%
61943	Oakland	100	1.2%
61912	Ashmore	105	1.3%
62440	Lerna	109	1.4%
61931	Humboldt	133	1.6%
62435	Janesville	2	0.0%
	Total Coles	4,810	59.6%
Cumberland County:			
62428	Greenup	207	2.6%
62468	Toledo	230	2.8%
62447	Neoga	216	2.7%
62469	Trilla	36	0.4%
62436	Jewett	20	0.2%
62462	Sigel	22	0.3%
	Total Cumberland	731	9.1%
Douglas County:			
61910	Arcola	225	2.8%
61911	Arthur	100	1.2%
61953	Tusola	85	1.1%
61942	Newman	32	0.4%
61930	Hindsboro	32	0.4%
61956	Villa Grove	25	0.3%
61913	Atwood	14	0.2%
61919	Camargo	4	0.0%
61941	Murdock	2	0.0%
	Total Douglas	519	6.4%
Clark County:			
62420	Casey	227	2.8%
62442	Martinsville	56	0.7%
62441	Marshall	54	0.7%
62474	Westfield	51	0.6%
62477	West Union	3	0.0%
62478	West York	2	0.0%
	Total Clark	393	4.9%
	Total Other Discharges	1,620	20.1%
	Total	8,073	100.0%

Source: Sarah Bush Lincoln Health Center

Community Details

Identification and Description of Geographical Community

The following map geographically illustrates the Health Center's community by showing the community zip codes shaded by number of inpatient discharges. The map below displays the Health Center's geographic relationship to the community, as well as significant roads and highways.



Community Population and Demographics

The U.S. Bureau of Census has compiled population and demographic data. *Exhibit 2* below shows the total population of the community. It also provides the breakout of the community between the male and female population, age distribution, race/ethnicity and the Hispanic population.

Exhibit 2
Demographic Snapshot

DEMOGRAPHIC CHARACTERISTICS

	Total Population		Coles	Cumberland	Douglas	Clark
Coles County	52,802	Total Male Population	25,466	5,473	9,743	7,840
Cumberland County	10,890	Total Female Population	27,336	5,417	10,027	8,249
Douglas County	19,770					
Clark County	16,089	Illinois	12,851,684			
Total Service Area	99,551	United States	318,558,162			

POPULATION DISTRIBUTION

Age Group	Coles	Cumberland	Douglas	Clark	Percent of Total Community	Illinois	Percent of Total IL	United States	Percent of Total US
0 - 4	2,460	654	1,295	965	5.40%	790,205	6.15%	19,866,960	6.24%
5 - 17	7,066	1,849	3,719	2,692	15.40%	2,200,424	17.12%	53,745,478	16.87%
18 - 24	10,668	811	1,621	1,257	14.42%	1,242,771	9.67%	31,296,577	9.82%
25 - 34	6,884	1,240	2,353	1,786	12.32%	1,780,279	13.85%	43,397,907	13.62%
35 - 44	5,358	1,283	2,426	1,858	10.97%	1,672,366	13.01%	40,548,400	12.73%
45 - 54	6,026	1,497	2,491	2,322	12.39%	1,768,455	13.76%	43,460,466	13.64%
55 - 64	6,384	1,597	2,663	2,195	12.90%	1,613,087	12.55%	40,061,742	12.58%
65+	7,956	1,959	3,202	3,014	16.20%	1,784,097	13.88%	46,180,632	14.50%
Total	**52,802**	**10,890**	**19,770**	**16,089**	**100%**	**12,851,684**	**100%**	**318,558,162**	**100%**

RACE DISTRIBUTION

Race	Coles	Cumberland	Douglas	Clark	Percent of Total Community
White Non-Hispanic	49,104	10,709	19,096	15,646	94.98%
Black Non-Hispanic	1,940	20	58	72	2.10%
Asian and Pacific Island Non-Hispanic	701	53	135	80	0.97%
All Others	1,057	108	481	291	1.95%
Total	**52,802**	**10,890**	**19,770**	**16,089**	**100%**

HISPANIC POPULATION

	Coles	Cumberland	Douglas	Clark	Percent of Total Community	Illinois	Percent of Total IL	United States	Percent of Total US
Hispanic	1,224	155	1,399	227	3.02%	2,136,474	16.62%	55,199,107	17.33%
Non-Hispanic	51,578	10,735	18,371	15,862	96.98%	10,715,210	83.38%	263,359,055	82.67%
Total	**52,802**	**10,890**	**19,770**	**16,089**	**100%**	**12,851,684**	**100%**	**318,558,162**	**100%**

Source: Community Commons (ACS 2012-2016 data sets)

While the relative age of the community population can impact community health needs, so can the ethnicity and race of a population. The population of the community by race illustrates different categories of race, such as white, black, Asian, other and multiple races. White (including Hispanic and non-Hispanic) makes up 95 percent of the community.

Exhibit 3 reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban. This table helps to understand how access to care can be limited.

Exhibit 3
Rural/Urban Population

County	Percent Urban	Percent Rural
Coles	75.71%	24.29%
Cumberland	-	100%
Douglas	38.36%	61.64%
Clark	40.46%	59.54%
Total Community	54.39%	45.61%
ILLINOIS	88.49%	11.51%
UNITED STATES	80.89%	19.11%

Source: Community Commons (2010)

Socioeconomic Characteristics of the Community

The socioeconomic characteristics of a geographic area influence the way residents access health care services and perceive the need for health care services within society. The economic status of an area may be assessed by examining multiple variables within the CHNA community. The following exhibits are a compilation of data that includes household per capita income, unemployment rates, poverty, uninsured population and educational attainment for the CHNA community. These standard measures will be used to compare the socioeconomic status of the community to the state of Illinois and the United States.

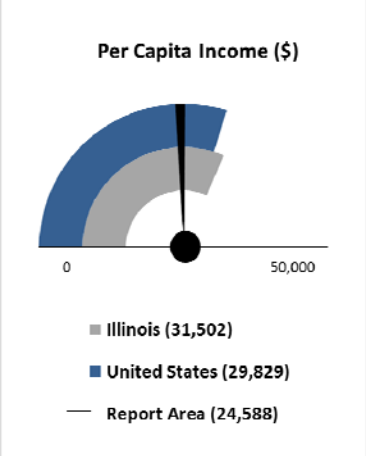
Income and Employment

Exhibit 4 presents the per capita income for the CHNA community. This includes all reported income from wages and salaries, as well as income from self-employment, interest or dividends, public assistance, retirement and other sources. The per capita income in this exhibit is the average (mean) income computed for every man, woman and child in the specified area. None of the counties within the community have a per capita income that is above the state of Illinois.

Exhibit 4
Per Capita Income

County	Total Population	Total Income ($)	Per Capita Income ($)
Coles	52,802	$ 1,264,280,200	**$ 23,943**
Cumberland	10,890	$ 248,143,000	**22,786**
Douglas	19,770	$ 520,120,900	**26,308**
Clark	16,089	$ 415,185,900	**25,805**
Total Community	99,551	2,447,730,000	**$ 24,588**
ILLINOIS	12,851,684	$ 404,855,436,100	**$ 31,502**
UNITED STATES	318,558,162	$ 9,502,305,741,900	**$ 29,829**

Source: Community Commons (2012 - 2016)



Unemployment Rate

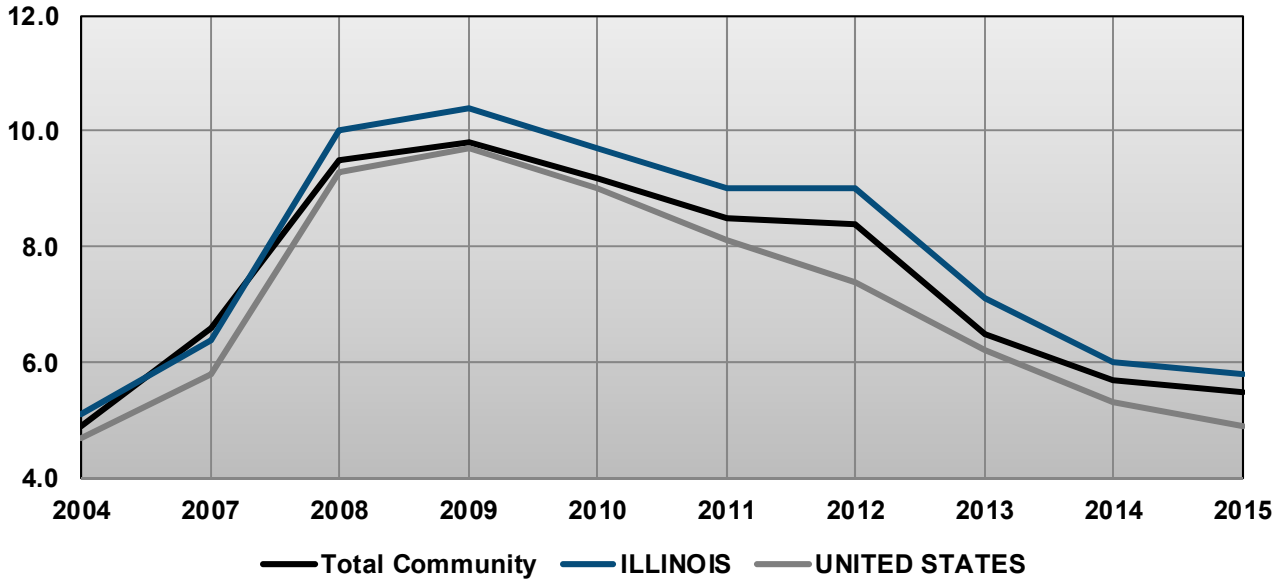
Exhibit 5 and 5a present the average annual unemployment rate from 2007 – 2016 for the area defined as the community, as well as the trend for Illinois and the United States. On average, the unemployment rate for the community is slightly higher than the United States and lower than the state of Illinois.

Exhibit 5
Average Annual Unemployment Rate (%)

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Coles	4.6	6.3	8.9	9.8	9.4	8.8	8.8	6.8	6.1	5.8
Cumberland	5.4	7.3	9.6	9.2	8.6	7.8	7.8	5.9	5.3	5.1
Douglas	4.5	6.0	8.5	8.8	8.1	7.2	7.0	5.9	4.9	4.7
Clark	5.9	8.1	12.8	11.7	10.4	9.6	9.3	7.1	6.2	5.8
Total Community	4.9	6.6	9.5	9.8	9.2	8.5	8.4	6.5	5.7	5.5
ILLINOIS	5.1	6.4	10.0	10.4	9.7	9.0	9.0	7.1	6.0	5.8
UNITED STATES	4.7	5.8	9.3	9.7	9.0	8.1	7.4	6.2	5.3	4.9

Data Source: US Department of Labor, Bureau of Labor Statistics

Exhibit 5a
Average Annual Unemployment Rate 2007 - 2016



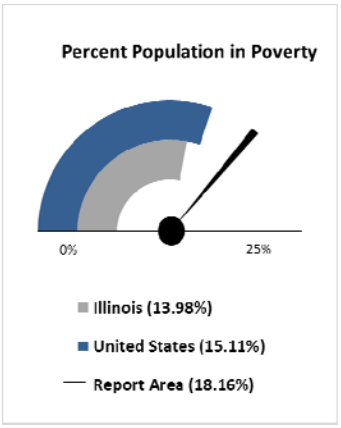
Data Source: U.S. Department of Labor, Bureau of Labor Statistics. 2018 – June. Source geography: County

Poverty

Exhibit 6 presents the percentage of total population below 100 percent Federal Poverty Level (FPL). Poverty is a key driver of health status and is relevant because poverty creates barriers to access, including health services, healthy food choices and other factors that contribute to poor health. Coles County poverty rate is almost double the state of Illinois.

Exhibit 6
Per Capita Income

	Total Population	Population in Poverty	Percent Population in Poverty
Coles County, IL	48,934	10,711	**21.89%**
Cumberland County, IL	10,737	1,747	**16.27%**
Douglas County, IL	19,555	2,223	**11.37%**
Clark County, IL	15,804	2,576	**16.30%**
Total Community	95,030	17,257	**18.16%**
ILLINOIS	12,548,538	1,753,731	13.98%
UNITED STATES	310,629,645	46,932,225	15.11%



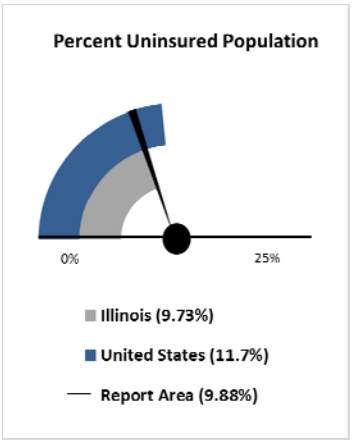
Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract.
**Note: Populations may not match between data charts due to differing data sources.*

Uninsured

Exhibit 7 reports the percentage of the total civilian non-institutionalized population without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to health care access, including regular primary care, specialty care and other health services that contribute to poor health status. Nearly 10,000 persons are uninsured in the CHNA community.

Exhibit 7
Per Capita Income

	Total Population (For Whom Insurance Status is Determined)	Total Uninsured Population	Percent Uninsured Population
Coles County, IL	52,114	4,840	**9.29%**
Cumberland County, IL	10,761	669	**6.22%**
Douglas County, IL	19,607	2,934	**14.96%**
Clark County, IL	15,855	1,268	**8.00%**
Total Community	98,337	9,711	**9.88%**
ILLINOIS	12,671,738	1,233,486	9.73%
UNITED STATES	313,576,137	36,700,246	11.70%



Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
**Note: Populations may not match between data charts due to differing data sources.*

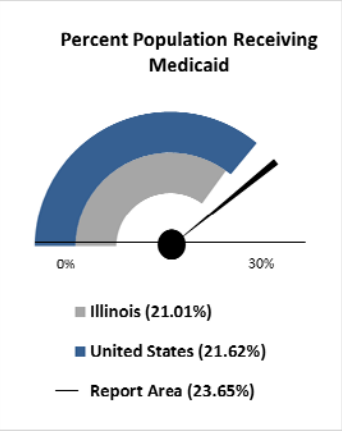
Medicaid

The Medicaid indicator reports the percentage of the population with insurance enrolled in Medicaid (or other means-tested public health insurance). This is relevant because it assesses vulnerable populations, which are more likely to have multiple health access, health status and social support needs; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment. *Exhibit 8* shows Douglas County is the only county within the CHNA community to rank favorably compared to the state of Illinois.

Exhibit 8
Percent of Insured Population Receiving Medicaid

	Total Population (For Whom Insurance Status is Determined)	Population with Any Health Insurance	Population Receiving Medicaid	Percent of Insured Population Receiving Medicaid
Coles County, IL	52,114	47,274	11,008	**23.29%**
Cumberland County, IL	10,761	10,092	2,572	**25.49%**
Douglas County, IL	19,607	16,673	3,227	**19.35%**
Clark County, IL	15,855	14,587	4,152	**28.46%**
Total Community	98,337	88,626	20,959	**23.65%**
ILLINOIS	12,671,738	11,438,252	2,403,086	21.01%
UNITED STATES	313,576,137	276,875,891	59,874,221	21.62%

Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract
**Note: Populations may not match between data charts due to differing data sources.*



Education

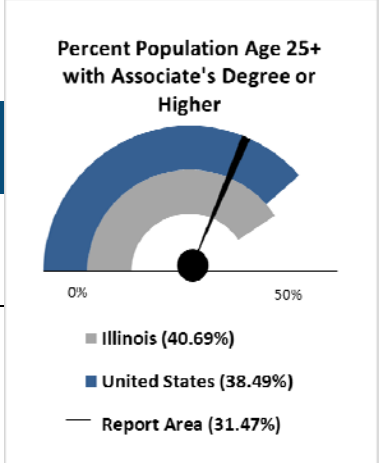
Exhibit 9 presents the population with an Associate's level degree or higher in each county versus Illinois and the United States.

Education levels obtained by community residents may impact the local economy. Higher levels of education generally lead to higher wages, less unemployment and job stability. These factors may indirectly influence community health. As noted in *Exhibit 9*, the percent of residents within the CHNA community obtaining an Associate's degree or higher is below the state percentage.

Exhibit 9
Educational Attainment of Population Age 25 and Older

	Total Population Age 25	Population Age 25 with Associate's Degree or Higher	Percent Population Age 25 with Associate's Degree of Higher
Coles County, IL	32,608	11,645	**35.71%**
Cumberland County, IL	7,576	1,987	**26.23%**
Douglas County, IL	13,135	3,534	**26.91%**
Clark County, IL	11,175	3,130	**28.01%**
Total Community	64,494	20,296	**31.47%**
ILLINOIS	8,618,284	3,506,690	40.69%
UNITED STATES	213,649,147	82,237,511	38.49%

Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract



Physical Environment of the Community

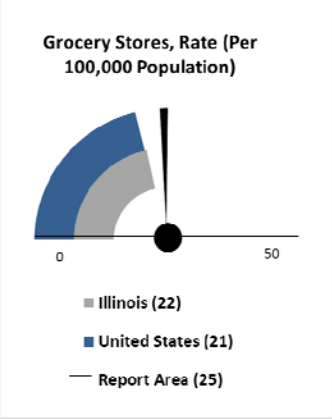
A community's health is also affected by the physical environment. A safe, clean environment that provides access to healthy food and recreational opportunities is important to maintaining and improving community health. This section will touch on a few of the elements that relate to some needs mentioned throughout the report.

Grocery Store Access

Exhibit 10 reports the number of grocery stores per 100,000-population. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods, fresh fruits and vegetables, and fresh and prepared meats, such as fish and poultry. Included are delicatessen-type establishments. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded. This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors.

Exhibit 10
Grocery Store Access

	Total Population	Number of Establishments	Establishments, Rate per 100,000 Population
Coles County, IL	53,873	9	**16.71**
Cumberland County, IL	11,048	2	**18.10**
Douglas County, IL	19,980	11	**55.06**
Clark County, IL	16,335	3	**18.37**
Total Community	101,236	25	**24.69**
ILLINOIS	12,830,632	2,770	21.59
UNITED STATES	308,745,538	65,399	21.18



Data Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016. Source geography: ZCTA

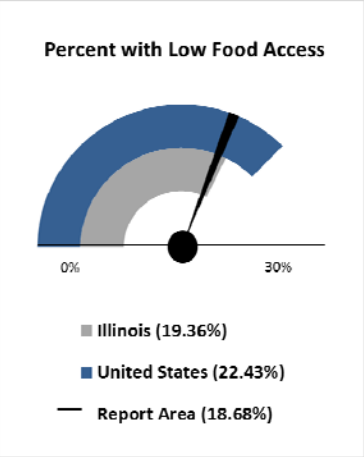
Food Access/Food Deserts

This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as a low-income census tract where a substantial number or share of residents has low access to a supermarket or large grocery stores. The information in *Exhibit 11* below is relevant because it highlights populations and geographies facing food insecurity.

Exhibit 11
Population with Low Food Access

	Total Population	Population With Low Food Access	Percent Population With Low Food Access
Coles County, IL	53,873	14,805	**27.48%**
Cumberland County, IL	11,048	-	**0.00%**
Douglas County, IL	19,980	2,348	**11.75%**
Clark County, IL	16,335	1,756	**10.75%**
Total Community	101,236	18,909	**18.68%**
ILLINOIS	12,830,632	2,483,877	19.36%
UNITED STATES	308,745,538	69,266,771	22.43%

Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015. Source geography: Tract



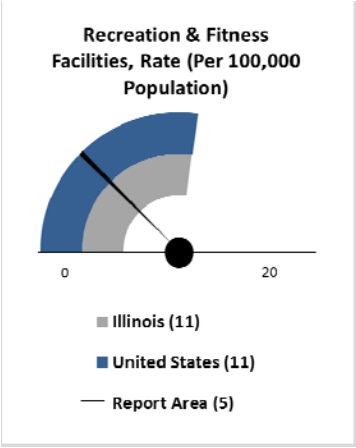
Recreation and Fitness Facility Access

This indicator reports the number per 100,000-population of recreation and fitness facilities as defined by North American Industry Classification System (NAICS) Code 713940. It is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors. *Exhibit 12* shows that Cumberland County and Clark County are the only counties that do not have any fitness establishments available to the residents.

Exhibit 12
Recreation and Fitness Facility Access

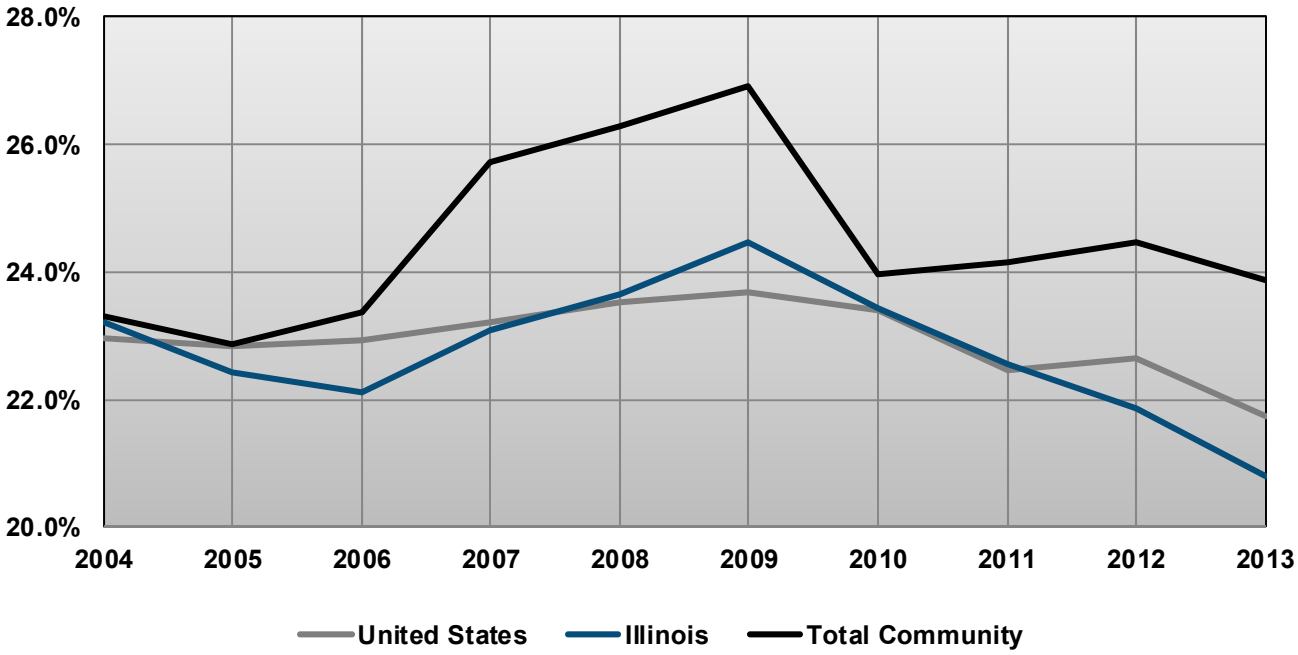
	Total Population	Number of Establishments	Establishments, Rate per 100,000 Population
Coles County, IL	53,873	4	**7.42**
Cumberland County, IL	11,048	-	**-**
Douglas County, IL	19,980	1	**5.01**
Clark County, IL	16,335	-	**-**
Total Community	101,236	5	**4.94**
ILLINOIS	12,830,632	1,402	**10.93**
UNITED STATES	308,745,538	33,980	**11.01**

Data Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016. Source geography: ZCTA



The trend graph below (*Exhibit 12a)* shows the percentage of adults who are physically inactive by year for the community and compared to Illinois and the United States. Since 2004, the CHNA community has had a higher percentage of adults who are physically inactive compared to both the state of Illinois and the United States. Although the trend saw a decrease in 2009, the percentage of adults physically inactive within the community has slightly increased between 2010 and 2012.

Exhibit 12a
Percent Adults Physically Inactive by Year, 2004 - 2013



Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012. Source geography: County

Clinical Care of the Community

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians, the rate of uninsured, financial hardship, transportation barriers, cultural competency and coverage limitations affect access.

Rates of morbidity, mortality and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions.

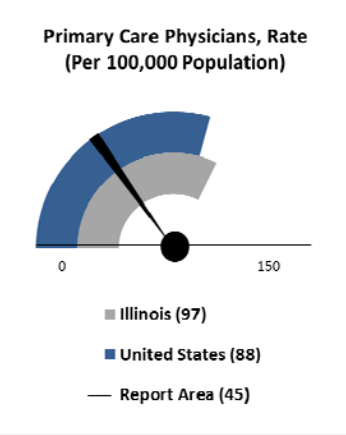
Access to Primary Care

Exhibit 13 shows the number of primary care physicians per 100,000-population. Doctors classified as "primary care physicians" by the American Medical Association include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Exhibit 13
Access to Primary Care

	Total Population, 2014	Primary Care Physicians, 2014	Primary Care Physicians, Rate per 100,000 Population
Coles County, IL	53,320	34	**63.77**
Cumberland County, IL	10,833	-	-
Douglas County, IL	19,889	5	**25.14**
Clark County, IL	16,180	6	**37.08**
Total Community	100,222	45	**44.90**
ILLINOIS	12,880,580	12,477	**96.87**
UNITED STATES	318,857,056	279,871	**87.77**

Data Source: US Department of Health Human Services, Health Resources and Services Administration, Area Health Resource File. 2014. Source geography: County



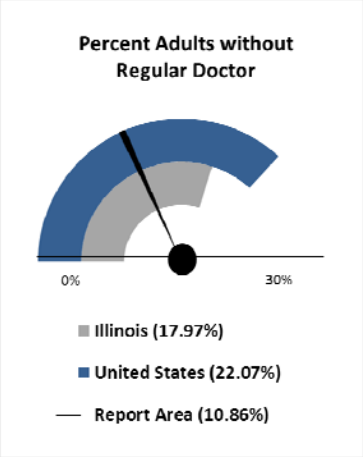
Lack of a Consistent Source of Primary Care

Exhibit 14 reports the percentage of adults aged 18 and older who self-report that they do not have at least one person who they think of as their personal doctor or health care provider. This indicator is relevant because access to regular primary care is important to preventing major health issues and emergency department visits.

Exhibit 14
Lack of a Consistent Source of Primary Care

	Survey Population (Adults Age 18)	Total Adults Without Any Regular Doctor	Percent Adults Without Any Regular Doctor
Coles County, IL	37,249	6,622	**17.78%**
Cumberland County, IL	N/A	N/A	**N/A**
Douglas County, IL	21,195	391	**1.84%**
Clark County, IL	8,604	268	**3.11%**
Total Community	67,048	7,281	**10.86%**
ILLINOIS	9,702,848	1,743,367	**17.97%**
UNITED STATES	236,884,668	52,290,932	**22.07%**

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County



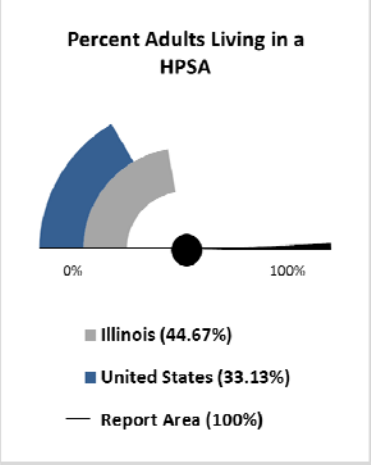
Population Living in a Health Professional Shortage Area

This indicator reports the percentage of the population that is living in a geographic area designated as a Health Professional Shortage Area (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. As *Exhibit 15* shows, 100 percent of the residents from all counties within the CHNA community are living in a health professional shortage area.

Exhibit 15
Population Living in a Health Professional Shortage Area (HPSA)

	Total Area Population	Population Living in a HPSA	Percentage of Population Living in a HPSA
Coles County, IL	53,873	53,873	**100.00%**
Cumberland County, IL	11,048	11,048	**100.00%**
Douglas County, IL	19,980	19,980	**100.00%**
Clark County, IL	16,335	16,335	**100.00%**
Total Community	101,236	101,236	**100.00%**
ILLINOIS	12,830,632	5,731,457	**44.67%**
UNITED STATES	308,745,538	102,289,607	**33.13%**

Data Source: US Department of Health Human Services, Health Resources and Services Administration, Health Resources and Services Administration. April 2016. Source geography: HPSA



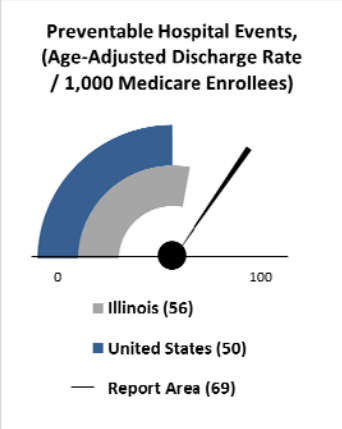
Preventable Hospital Events

Exhibit 16 reports the discharge rate (per 1,000 Medicare enrollees) for conditions that are ambulatory care sensitive (ACS). ACS conditions include pneumonia, dehydration, asthma, diabetes and other conditions which could have been prevented if adequate primary care resources were available and accessed by those patients. This indicator is relevant because analysis of ACS discharges allows demonstrating a possible "return on investment" from interventions that reduce admissions (for example, for uninsured or Medicaid patients) through better access to primary care resources.

Exhibit 16
Preventable Hospital Events

	Total Medicare Part A Enrollees	Ambulatory Care Sensitive Condition Hospital Discharges	Ambulatory Care Sensitive Condition Discharge Rate
Coles County, IL	5,518	436	**79.0**
Cumberland County, IL	1,558	96	**61.6**
Douglas County, IL	2,079	121	**58.2**
Clark County, IL	2,495	156	**62.5**
Total Community	11,650	809	**69.4**
ILLINOIS	1,330,462	74,243	**55.8**
UNITED STATES	29,649,023	1,479,545	**49.9**

Data Source: Dartmouth College Institute for Health Policy Clinical Practice, Dartmouth Atlas of Health Care. 2014. Source geography: County



Health Status of the Community

This section of the assessment reviews the health status of Coles, Cumberland, Douglas and Clark County residents. As in the previous section, comparisons are provided with the state of Illinois and the United States. This in-depth assessment of the mortality and morbidity data, health outcomes, health factors and mental health indicators of the county residents that make up the CHNA community will enable the Health Center to identify priority health issues related to the health status of its residents.

Good health can be defined as a state of physical, mental and social well-being, rather than the absence of disease or infirmity. According to *Healthy People 2020*, the national health objectives released by the U.S. Department of Health and Human Services, individual health is closely linked to community health. Community health, which includes both the physical and social environment in which individuals live, work and play, is profoundly affected by the collective behaviors, attitudes and beliefs of everyone who lives in the community. Healthy people are among a community's most essential resources.

Numerous factors have a significant impact on an individual's health status: lifestyle and behavior, human biology, environmental and socioeconomic conditions, as well as access to adequate and appropriate health care and medical services.

Studies by the American Society of Internal Medicine conclude that up to 70 percent of an individual's health status is directly attributable to personal lifestyle decisions and attitudes. Persons who do not smoke, drink in moderation (if at all), use automobile seat belts (car seats for infants and small children), maintain a nutritious low-fat, high-fiber diet, reduce excess stress in daily living and exercise regularly have a significantly greater potential of avoiding debilitating diseases, infirmities and premature death.

The interrelationship among lifestyle/behavior, personal health attitude and poor health status is gaining recognition and acceptance by both the general public and health care providers. Some examples of lifestyle/behavior and related health care problems include the following:

Lifestyle	*Primary Disease Factor*
Smoking	Lung cancer Cardiovascular disease Emphysema Chronic bronchitis
Alcohol/drug abuse	Cirrhosis of liver Motor vehicle crashes Unintentional injuries Malnutrition Suicide Homicide Mental illness
Poor nutrition	Obesity Digestive disease Depression
Driving at excessive speeds	Trauma Motor vehicle crashes
Lack of exercise	Cardiovascular disease Depression
Overstressed	Mental illness Alcohol/drug abuse Cardiovascular disease

Health problems should be examined in terms of morbidity as well as mortality. Morbidity is defined as the incidence of illness or injury, and mortality is defined as the incidence of death. Such information provides useful indicators of health status trends and permits an assessment of the impact of changes in health services on a resident population during an established period of time. Community attention and health care resources may then be directed to those areas of greatest impact and concern.

Leading Causes of Death and Health Outcomes

Exhibit 17 reflects the leading causes of death for the community and compares the rates to the state of Illinois and the United States.

Exhibit 17
Selected Causes of Resident Deaths: Age-Adjusted Death Rate (Per 100,000 Pop.)

	Coles	Cumberland	Douglas	Clark	Illinois	United States	HP 2020 Target
Cancer	188.6	181.3	167.3	188.0	104.16	160.9	<= 160.6
Coronary Heart disease	109.2	83.6	63.6	124.5	54.4	99.6	<= 103.4
Lung disease	58.9	41.4	48.7	58.1	11.72	41.3	N/A
Stroke	36.9	42.1	39.5	53.3	37.7	36.9	<= 33.8
Unintentional injury	39.1	32.4	47.5	50.7	33.7	41.9	<= 36.0

Source: Community Commons 2012-2016; Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

The table above shows leading causes of death within each county as compared to the state of Illinois, the United States, and the target rates for Healthy People 2020 (HP 2020). The rates shown in green font represent the counties and corresponding leading causes of death that are less than the HP 2020 target rate. The rates shown in green highlight represent the counties and corresponding leading causes of death that are less than the state of Illinois. All of the other rates are higher than the HP 2020 target and/or the State of Illinois rates. As the table indicates, almost all of the leading causes of death are greater than both the HP 2020 targets and the state of Illinois.

Health Outcomes and Factors

An analysis of various health outcomes and factors for a particular community can, if improved, help make the community a healthier place to live, learn, work and play. A better understanding of the factors that affect the health of the community will assist with how to improve the community's habits, culture and environment. This portion of the CHNA utilizes information from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project, a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

The County Health Rankings model is grounded in the belief that programs and policies implemented at the local, state and federal levels have an impact on the variety of factors that, in turn, determine the health outcomes for communities across the nation. The model provides a ranking method that ranks all 50 states and the counties within each state, based on the measurement of two types of health outcomes for each county: how long people live (mortality) and how healthy people feel (morbidity). These outcomes are the result of a collection of health factors and are influenced by programs and policies at the local, state and federal levels.

Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, *e.g.*, 1 or 2, are considered to be the "healthiest." Counties are ranked relative to the health of other counties in the same state on the following summary measures:

- ✓ Health outcomes – rankings are based on an equal weighting of one length of life (mortality) measure and four quality of life (morbidity) measures.
- ✓ Health factors – rankings are based on weighted scores of four types of factors:
  - o Health behaviors (nine measures)
  - o Clinical care (seven measures)
  - o Social and economic (nine measures)
  - o Physical environment (five measures)

A more detailed discussion about the ranking system, data sources and measures, data quality and calculating scores and ranks can be found at the website for County Health Rankings (www.countyhealthrankings.org).

As seen in *Exhibits 18,* the relative health status of each county within the community will be compared to the state of Illinois as well as to a national benchmark. The current year information is compared to the health outcomes reported on the prior CHNA and the change in measures is indicated. A better understanding of the factors that affect the health of the community will assist with how to improve the community's habits, culture and environment.

Exhibit 18.1
County Health Rankings – Health Outcomes

		Coles County 2015	Coles County 2018	Illinois 2018	Top U.S. Performers 2018
Mortality	*	**61**	**48**		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)		7,443	7,200	6,300	5,300
Morbidity	*	**17**	**92**		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)		9%	18%	17%	12%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)		3.5	4.5	3.8	3.0
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)		3.1	4.0	3.5	3.1
Low birth weight – Percent of live births with low birth weight (<2500 grams)		6.9%	7.0%	8.0%	6.0%

* Rank out of 102 Illinois counties
Note: N/A indicates unreliable or missing data
Source: Countyhealthrankings.org

Exhibit 18.2
County Health Rankings – Health Outcomes

		Cumberland County 2015	Cumberland County 2018	Illinois 2018	Top U.S. Performers 2018
Mortality	*	**42**	**17**		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)		6,756	5,700	6,300	5,300
Morbidity	*	**64**	**71**		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)		N/A	15%	17%	12%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)		N/A	3.9	3.8	3.0
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)		N/A	3.7	3.5	3.1
Low birth weight – Percent of live births with low birth weight (<2500 grams)		6.6%	8.0%	8.0%	6.0%

* Rank out of 102 Illinois counties
Note: N/A indicates unreliable or missing data
Source: Countyhealthrankings.org

Exhibit 18.3
County Health Rankings – Health Outcomes

		Douglas County 2015	Douglas County 2018	Illinois 2018	Top U.S. Performers 2018
Mortality	*	**24**	**25**		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)		5,823	6,300	6,300	5,300
Morbidity	*	**7**	**42**		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)		N/A	15%	17%	12%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)		N/A	3.9	3.8	3.0
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)		1.8	3.6	3.5	3.1
Low birth weight – Percent of live births with low birth weight (<2500 grams)		6.4%	7.0%	8.0%	6.0%

* Rank out of 102 Illinois counties
Note: N/A indicates unreliable or missing data
Source: Countyhealthrankings.org

Exhibit 18.4
County Health Rankings – Health Outcomes

		Clark County 2015	Clark County 2018	Illinois 2018	Top U.S. Performers 2018
Mortality	*	**79**	**82**		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)		8,266	8,300	6,300	5,300
Morbidity	*	**55**	**66**		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)		N/A	16%	17%	12%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)		N/A	4.0	3.8	3.0
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)		N/A	3.8	3.5	3.1
Low birth weight – Percent of live births with low birth weight (<2500 grams)		7.9%	8.0%	8.0%	6.0%

* Rank out of 102 Illinois counties
Note: N/A indicates unreliable or missing data
Source: Countyhealthrankings.org

The above tables show Coles County's overall mortality has improved since the last assessment while overall morbidity has drastically declined. Cumberland County also saw an improvement in overall mortality, while it and the remaining counties saw an overall decrease in morbidity.

A number of different health factors shape a community's health outcomes. The County Health Rankings model includes four types of health factors: health behaviors, clinical care, social and economic and the physical environment. The following summary shows some of the major improvements from prior year to current year and challenges faced by each county in the Health Center's community. The improvements/challenges shown below in *Exhibits 19* were determined using a process of comparing the rankings of each county's health outcomes in the current year to the rankings in the prior year. If the current year rankings showed an improvement or decline of 3 percent or three points, they were included in the charts below. Please refer to Appendix D for the full list of health factor findings and comparisons between prior year information reported and current year information.

Exhibit 19.1
Coles County, IL

Improvements	Challenges
Teen Birth Rate - number of births per 1,000 female population decreased from 21 to 18	Adult Smoking - adults report smoking at least 100 cigarettes and currently smoke increased from 11% to 19%
Alcohol-Impaired Driving Deaths - percentage of driving deaths with alcohol involvement decreased from 31% to 24%	Excessive Drinking - percent of adults that report excessive drinking in the past 30 days increased from 14% to 21%
Uninsured Adults - percent of population under age 65 without health insurance has decreased from 13% to 6%	Sexually Transmitted Infections - chlamydia rate per 100K population increased from 624 to 701.4
Violent Crime Rate - rate per 100,000 population decreased from 272 to 228	

Exhibit 19.2
Cumberland County, IL

Improvements	Challenges
Physical Inactivity - percent of adults age 20 and over reporting no leisure time physical activity decreased from 29% to 24%	Alcohol-Impaired Driving Deaths - percentage of driving deaths with alcohol involvement increased from 21% to 29%
Teen Birth Rate - per 1,000 female population, ages 15-19 decreased from 33 to 23	Sexually Transmitted Infections - chlamydia rate per 100K population increased from 201 to 212.3
Uninsured Adults - percent of population under age 65 without health insurance decreased from 12% to 6%	Preventable Hospital Stays - hospitalization rate for ambulatory-care sensative conditions per 1,000 Medicare enrollees increased from 63 to 75
High School Graduation - percent of ninth grade cohort that graduates in 4 years increased from 85% to 96%	Some College - percent of adults age 25-44 years with some post-secondary education decreased from 61% to 56%

Exhibit 19.3
Douglas County, IL

Improvements	Challenges
Physical Inactivity - percent of adults age 20 and over reporting no leisure time physical activity decreased from 28% to 25%	Violent Crime Rate - rate per 100,000 population increased from 195 to 251
Alcohol-Impaired Driving Deaths - percentage of driving deaths with alcohol involvement decreased from 42% to 35%	Injury Deaths - number of deaths due to injury per 100,000 population increased from 54 to 63
Sexually Transmitted Infections - chlamydia rate per 100K population decreased from 207 to 170.9	Children in Single-Parent Households - Percent of children that live in household headed by single parent increased from 22% to 25%
Teen Birth Rate - per 1,000 female population, ages 15-19 decreased from 30 to 22	Mental Health Providers - ratio of population to mental health providers increased from 9,944:1 to 19,630:1

Exhibit 19.4
Clark County, IL

Improvements	Challenges
Alcohol-Impaired Driving Deaths - percentage of driving deaths with alcohol involvement decreased from 42% to 5%	Adult Obesity - percent of adults that report a BMI >= 30 increased from 30% to 33%
Sexually Transmitted Infections - chlamydia rate per 100K population decreased from 207 to 166.9	Access to Exercise Opportunities - percentage of population with adequate access to locations for physical activity decreased from 72% to 62%
Uninsured Adults - percent of population under age 65 without health insurance decreased from 16% to 5%	Dentists - ratio of population to dentists increased from 2,210:1 to 7,970:1
Mental Health Providers - ratio of population to mental health providers decreased from 9,944:1 to 3,980:1	Children in Single-Parent Households - Percent of children that live in household headed by single parent increased from 22% to 33%

As can be seen from the summarized tables above, there are numerous areas of the community that have room for improvement when compared to the state statistics; however, there are also significant improvements made within each county from the prior year CHNA report.

The following exhibits show a more detailed view of certain health outcomes and factors. The percentages for each county and the community as a whole are compared to the state of Illinois and also the United States.

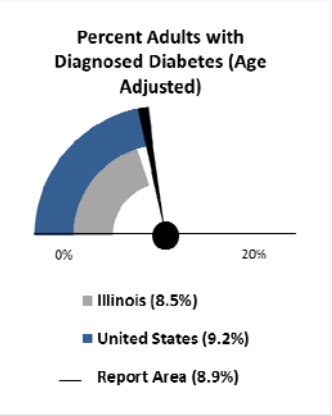
Diabetes (Adult)

Exhibit 20 reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Exhibit 20
Population with Diagnosed Diabetes

	Total Population Age 20	Population With Diagnosed Diabetes	Population With Diagnosed Diabetes, Crude Rate	Population With Diagnosed Diabetes, Age-Adjusted Rate
Coles County, IL	40,730	3,625	8.9	**8.5%**
Cumberland County, IL	8,135	903	11.1	**9.2%**
Douglas County, IL	14,361	1,551	10.8	**9.3%**
Clark County, IL	12,183	1,401	11.5	**9.5%**
Total Community	75,409	7,480	9.9	**8.9%**
ILLINOIS	9,507,158	864,658	9.1	8.5%
UNITED STATES	236,919,508	23,685,417	10.0	9.2%

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013.



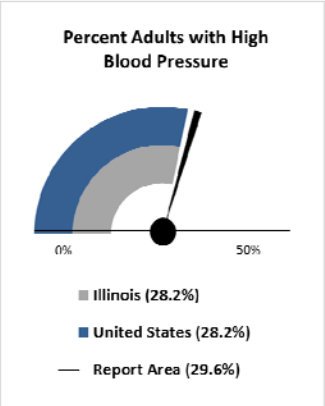
High Blood Pressure (Adult)

Per *Exhibit 21* below, 17,364 or 29.6 percent of adults aged 18 and older have ever been told by a doctor that they have high blood pressure or hypertension. The community percentage of high blood pressure among adults is higher than the percentage of Illinois and the United States.

Exhibit 21
Population with High Blood Pressure

	Total Population (Age 18)	Total Adults With High Blood Pressure	Percent Adults With High Blood Pressure
Coles County, IL	43,850	12,760	**29.1%**
Cumberland County, IL	8,449	N/A	**N/A**
Douglas County, IL	14,805	4,604	**31.1%**
Clark County, IL	12,657	N/A	**N/A**
Total Community	79,761	17,364	**29.6%**
ILLINOIS	9,654,603	2,722,598	28.2%
UNITED STATES	232,556,016	65,476,522	28.2%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health Human Services, Health Indicators Warehouse. 2006-12. Source geography: County

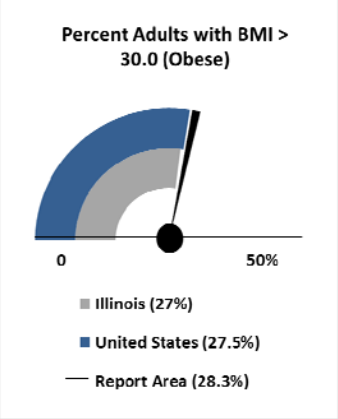


Obesity

Of adults aged 20 and older, 28 percent self-report that they have a body mass index (BMI) greater than 30.0 (obese) in the community per *Exhibit 22*. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues. Of the four counties, Coles and Cumberland County have BMI percentages less than the state rate.

Exhibit 22
Population with Obesity

	Total Population (Age 20+)	Adults With BMI > 30.0 (Obese)	Percent Adults With BMI > 30.0 (Obese)
Coles County, IL	40,882	10,752	**26.3%**
Cumberland County, IL	8,126	2,259	**26.9%**
Douglas County, IL	14,321	4,368	**29.9%**
Clark County, IL	12,128	3,966	**32.1%**
Total Community	75,457	21,345	**28.3%**
ILLINOIS	9,511,847	2,600,939	27%
UNITED STATES	234,188,203	64,884,915	27.5%



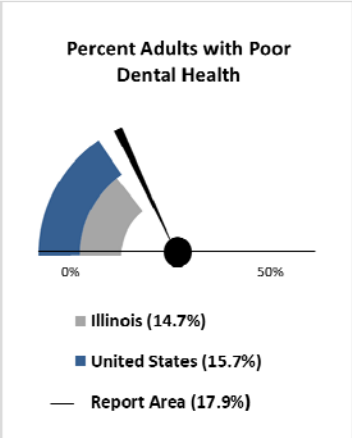
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013. Source geography: County

Poor Dental Health

This indicator is relevant because it indicates lack of access to dental care and/or social barriers to utilization of dental services. *Exhibit 24* shows that of the information available, Coles County has a higher percentage of adults with poor dental health than the state. During the key stakeholder interviews, many of the key stakeholders stated that more adult dental health services and options are needed and consider it one of the most critical health needs within the community.

Exhibit 23
Population with Poor Dental Health

	Total Population (Age 18)	Total Adults With Poor Dental Health	Percent Adults With Poor Dental Health
Coles County, IL	43,705	7,836	**17.9%**
Cumberland County, IL	8,428	No data	**N/A**
Douglas County, IL	14,781	No data	**N/A**
Clark County, IL	12,656	No data	**N/A**
Total Community	79,570	7,836	**17.9%**
ILLINOIS	9,654,603	1,418,280	14.7%
UNITED STATES	235,375,690	36,842,620	15.7%



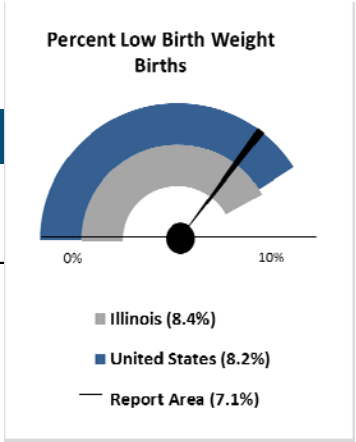
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10. Source geography: County

Low Birth Weight

Exhibit 24 reports the percentage of total births that are low birth weight (under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Exhibit 24
Population with Low Birth Weight

	Total Live Births	Low Weight Births (Under 2500g)	Low Weight Births, Percent of Total
Coles County, IL	3,948	272	**6.9%**
Cumberland County, IL	917	76	**8.3%**
Douglas County, IL	1,995	128	**6.4%**
Clark County, IL	1,281	101	**7.9%**
Total Community	8,141	577	**7.1%**
Illinois	1,251,656	105,139	8.4%
United States	29,300,495	2,402,641	8.2%



Data Source: US Department of Health Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2006-12. Source geography: County

Community Input – Key Stakeholder Interviews

Interviewing key stakeholders (community members who represent the broad interest of the community, persons representing vulnerable populations or persons with knowledge of or expertise in public health) is a technique employed to assess public perceptions of the county's health status and unmet needs. These interviews are intended to ascertain opinions among individuals likely to be knowledgeable about the community and influential over the opinions of others about health concerns in the community.

Methodology

Interviews were performed with 16 key stakeholders in August 2018. Stakeholders were determined based on a) their specialized knowledge or expertise in public health, b) their affiliation with local government, schools and industry or c) their involvement with underserved and minority populations.

All interviews were conducted by BKD personnel. Participants provided comments on the following issues:

- ✓ Health and quality of life for residents of the primary community
- ✓ Underserved populations and communities of need
- ✓ Barriers to improving health and quality of life for residents of the community
- ✓ Opinions regarding the important health issues that affect community residents and the types of services that are important for addressing these issues

Feedback was also solicited regarding certain action plans related to SBL's implementation strategy for July 1, 2016 through June 30, 2019.

Interview data was initially recorded in narrative form asking participants a series of 13 questions. Please refer to *Appendix E* for a copy of the interview instrument. This technique does not provide a quantitative analysis of the stakeholders' opinions but reveals community input for some of the factors affecting the views and sentiments about overall health and quality of life within the community.

Key Stakeholder Profiles

Key stakeholders from the community (see *Appendix E* for a list of key stakeholders) worked for the following types of organizations and agencies:

- ✓ Sarah Bush Lincoln Health Center
- ✓ Social service agencies
- ✓ Local school systems and universities
- ✓ Public health agencies
- ✓ Other medical providers
- ✓ Community centers

Key Stakeholder Interview Results

The questions on the interview instrument are grouped into five major categories for discussion. The interview questions for each key stakeholder were identical. A summary of the stakeholders' responses by each of the categories follows. Paraphrased quotes are included to reflect some commonly held opinions and direct quotes are employed to emphasize strong feelings associated with the statements. This section of the report summarizes what the key stakeholders said without assessing the credibility of their comments.

1. General opinions regarding health and quality of life in the community

The key stakeholders were asked to rate the health and quality of life in their respective county. They were also asked to provide their opinion whether the health and quality of life had improved, declined or stayed the same over the past few years. Lastly, key stakeholders were asked to provide support for their answers.

Approximately 63 percent (10 out of 16) of the key stakeholders rated the health and quality of life in their county as "average" or "fair." One of the respondents rated the health and quality of life as "below average." The remaining five stakeholders rated the health and quality of life as "good" or "above average" in the community. The key stakeholders indicated that certain populations with lower social economic status continued to struggle with having access to health care services and understanding and making healthy choices related to nutrition and physical activity and exercise. In addition, the many of the respondents indicated that that they had seen worsening substance abuse in their community.

When asked whether the health and quality of life had improved, declined or stayed the same, approximately 70 percent (12 of the 16) of the stakeholders expressed that the health and quality of life of the community had stay "about the same" in the past years. One of the key stakeholders thought the health and quality of life had declined in the past three years. The remaining three respondents believed that health and quality of life had improved over the last three years.

When asked why they thought the health and quality of life had "remained about the same," the key stakeholders indicated that the health organizations are primarily focusing on only treating illnesses of the individual versus focusing on more preventative care and the overall health (including social and mental health) of the individual. Changing the mindset of focusing on preventative care and the overall health of the community should help avoid chronic illnesses that have a detrimental impact to an individual's quality of life. In addition, many of the stakeholders indicated that some in the community are struggling with increasing health care costs for medical services and drugs, mental health services and trouble navigating the Medicare, Medicaid and insurance marketplace to obtain affordable care. Several of the respondents indicated that no improvement in the incidence of chronic illnesses including diabetes and heart disease has been seen in past three years.

Many of the key stakeholders felt that the opening of additional walk-in clinics by SBL has significantly helped with access to physician services within the community in the past three years; however, care after hours can still be an issue as the clinics are typically only open during business hours. Also, the health resources of the community have been expanded by SBL with the opening of the regional cancer center and heart center and has played a role in improving access for these services in the community. In addition, increased awareness of healthy lifestyles with proper nutrition and physical activity has helped the community quality of life and health, which has been driven by resources offered by SBL and other community organizations.

Increasing substance abuse was mentioned in many of the comments of the respondents as a worsening issue in the community. In addition, the lack of mental health services was also attributed to negatively impacting the health and quality of life in the community. Many key stakeholders stated there was a significant shortage of mental health providers in the community. While there are a few mental health resources in the community available, many of the individuals who need services lack education regarding behavioral health and resist treatment due to the stigma attached to mental health conditions.

"If individuals work outside of the county, it can be hard for these individuals and their kids to have access to the walk-in clinics after hours."

"Substance abuse and the related arrests have increased in the past several years."

"With drug abuse, the community does not have the facilities to address these issues. Individuals typically will have to seek treatment in larger cities. There are some resources in the community but they are not currently adequate."

"The health care community needs to have a change of mindset from the treating of chronic illnesses to the prevention of these illnesses with healthy lifestyles."

"Sarah Bush Lincoln has added a lot of resources for the community, including the Center for Healthy Living and partnerships with the YMCA to increase enrollment."

2. Underserved populations and communities of need

Key stakeholders were asked to provide their opinions regarding specific populations or groups of people whose health or quality of life may not be as good as others. BKD also asked the key stakeholders to provide their opinions as to why they thought these populations were underserved or in need. BKD asked each key stakeholder to consider the specific populations they serve or those with which they usually work.

Respondents indicated four main areas of need: low income, elderly, those with substance abuse concerns and minority populations.

Almost all key stakeholders indicated that individuals in poverty or the working poor are most likely to be underserved due to lack of access to services. These individuals are more likely to use the emergency room as primary care versus having access primary care physicians. High health care and drug costs can cause individuals to avoid seeking treatment for their illness until their situation worsens. Working poor individuals often cannot afford quality healthcare coverage and may not qualify for Medicaid assistance and other low income programs that address improving access to health care as they do not meet the low income thresholds for these programs. Transportation is still a barrier for persons with few financial resources but has seen some improvement with the limited public transportation options.

The elderly population of the community are underserved for a variety of reasons including isolation due to families moving out of the area, fixed incomes and limited of transportation options. Home health options for these individuals can be limited due to the cost of such care and limited coverage for these services by insurance, Medicare and Medicaid.

Individuals who are struggling with substance abuse are typically struggling with reliable housing are focused on food, safety and shelter and are not focused on seeking consistent treatment and primary health care. Many of these individuals lack the ability to take care of themselves.

African American populations within the community can have a lack of trust for medical services and physicians in the community. Participation in this community by the health care community and physicians could possibly overcome these trust issues. In addition, the Latino population in the community continues to struggle with language and transportation barriers that limits the population's access for preventative health care services.

"Underinsured individuals typically will wait to seek care and cannot pay when they do seek care."

"The low social economic status population, including homeless and people who live in public housing, is growing."

"Mentally ill individuals, especially with the substance abuse increasing, lack the ability to take care of themselves."

"Home bound elderly is a hidden need when their children no longer live in the area and can no longer help."

3. Barriers

The key stakeholders were asked what barriers or problems keep community residents from obtaining necessary health services and improving health in their community. Responses from the key informants include a significant shortage of mental health resources including treatment options for individuals with substance abuse. Low income, uninsured and underinsured are populations in the community that have are unable to afford primary and preventative health care services. Key stakeholders noted that transportation was a barrier to access to health care even though this issue has improved in the past three years with the opening of walk-in clinics and some limited public transportation options. Cost and the availability of dental providers is also a barrier for dental services in the community. Lack of affordable healthy food options and access to affordable medications are limited for low income, uninsured and underinsured individuals. Food pantries and other community organizations that provided healthy foods and education are lacking funding for programs that target these individuals.

"The current public transportation option needs to be more frequent and easier to obtain rides."

"Not everyone can afford preventative dental care and only seek treatment for major issues. Medicaid will not cover these services."

"The area does not have enough mental health providers. One provider has a six month wait list. Typically, someone will only get help if already in crisis."

4. Most important health and quality of life issues

Key stakeholders were asked to provide their opinion as to the most critical health and quality of life issues facing the county. The issues identified most frequently were:

- Substance abuse
- Access to health services, including mental health services
- Lack of adult dental services
- Obesity (including lack of affordable health foods and physical inactivity)

Several respondents noted that heart and lung disease, cancer and diabetes are health conditions that impact the community.

The key stakeholders were also asked what opportunities they see for community groups to partner together to address health needs in the community. Responses included:

- A more collaborative approach to addressing the health care needs in the community is needed. More can be accomplished together than organizations working alone.
- More regular communication and meetings are needed to discuss approaches and what each resource in the community can do to address the health needs.
- Better communication and community partnerships will be more effective and reach more people. Partnerships are more efficient with limited resources and lack of funding.
- County health departments and SBL can work together more on community needs assessments and addressing those community health needs with regular communication and community roundtables.
- The community already has a healthy community's advisory board that has community partners that is primarily focused on children issues. This model be used for addressing adult health needs as well.
- Schools, churches and other religious organizations in the community can be engaged more in addressing the health needs and wellness issues of the community.

"Within our smaller community, communication and collaboration can be done better with SBL and other resources in the community."

"There are lots of opportunities to partner together and address health needs of the community rather than each organization working alone. Working together will go further and reach more people than going it alone."

"The hospital and health departments in the community need to provide more programs and collaborate more often."

5. Feedback on Sarah Bush Lincoln's implementation strategy for July 1, 2016 through June 30, 2019.

In an effort to evaluate the effectiveness of SBL's current implementation strategy, several questions were asked related to specific priorities and action plans included in the implementation strategy for July 1, 2016 through June 30, 2019, regarding the identified needs in the prior CHNA.

Access to Care: Key stakeholders were asked whether or not access to health services has improved in the last three years. The majority of respondents (11 of 16) responded that they felt access had improved over the past three years. The most common response for the reason of this improvement was the expansion of the walk-in clinics in the different areas of the community that were underserved. However, a number of the key stakeholders felt that the mental health providers and resources, including treatment for substance abuse, had not seen improvement. In addition, some felt transportation is still a barrier for some of the population to seek health care services.

Healthy Behaviors/Lifestyle Choices: Many of the respondents indicated that efforts are being made by SBL and other community organizations on educational events and health fairs on the importance of healthy behaviors and lifestyle choices as a means to avoid potential chronic illness including diabetes and heart disease. However, several of the key stakeholders indicated that education did not make an impact for many to make healthy changes in their lifestyle. In addition, affordability of healthy food options and the resulting poor nutrition is still an issue for individuals who have a low social economic status. Several respondents indicated that the resources offered are not available to some in the community in need due to transportation issues.

Dental Needs: In their responses, several of the key stakeholders indicated that child dental services has seen some improvement in the past three years with the mobile dental trucks and dental clinics. However, the majority of the respondents felt that dental services for adults is still a significant need in the community as there are currently too few dental providers and resources. An expansion of SBL's mobile dental clinic services including more consistent visits and expansion of hours could help meet this community need.

Key Findings

A summary of themes and key findings provided by the key informants follows:

- Education on healthy behaviors, lifestyle choices and other pertinent health issues has increased in the past three years through efforts by SBL and other community organizations. However, low income, elderly and minority target populations have issues accessing this education due to transportation, language and cultural issues. Several of the key stakeholders indicated that programs being brought to the community members in need instead of people coming to the health center (including through technology options) could improve education efforts.

- Accessible healthy food options that are affordable and physical activity and exercise remain an issue for many in the community.

- Obesity and related chronic illnesses are still seen as major critical health issue in the community due to the overall negative impact it has on an individual's health.

- There is a significant lack of mental and behavioral health services in the community, including treatment options for substance abuse.

- Approximately 63 percent of the respondents (10 of 16) stated that substance abuse was a critical health issue within the community.

- Although tobacco use has seen a decrease in recent years, users of e-cigarettes and vaping, especially in the teenage population, has seen a significant increase in the same time period.

- Expansion of the walk-in clinics has increased access to primary physician services in the past three years. However, difficulty in navigating the health care system, increasing health care and drug costs and limited transportation options are still barriers in the community in accessing these services.

- Increased access to adult dental services is needed in the community. Children are able to get services through the mobile dental bus or dental clinics; however, there is still a shortage of adult dental services and resources.

- A more collaborative approach with SBL, county health departments and other community organizations on the assessing and addressing the health needs of the community can help reach more people in the community than organizations working alone. Regular communication, meetings and/or community roundtables with these partnerships is needed to keep track of progress on these issues.

Health Issues of Vulnerable Populations

According to Dignity Health's Community Need Index (see Appendices), the Health Center's community has a moderate level of need. The CNI score is an average of five different barrier scores that measure socioeconomic indicators of each community (income, cultural, education, insurance and housing). The zip codes that have the highest need in the community are 61910 (Arcola), 61920 (Charleston), 61931 (Humboldt) and 61938 (Mattoon).

Certain key stakeholders were selected due to their positions working with low-income and uninsured populations. Several key stakeholders were selected due to their work with minority populations. Based on information obtained through key stakeholder interviews and the community health survey, the following populations are considered to be vulnerable or underserved in the community and the identified needs are listed:

- Uninsured/Working Poor Population
  - Transportation
  - High cost of health care prevents needs from being met
  - Healthy lifestyle and health and nutrition education and choices
  - Access to affordable healthy food
  - Lack of mental health services, including treatment for substance abuse
  - Lack of adult dental services
- Elderly
  - Transportation
  - Lack of health knowledge and health care system in regarding how to access services
  - Cost of prescriptions
  - Lack of mental health services
  - Lack of adult dental services
- Immigrant Population
  - Language and Cultural barriers
  - Transportation
  - Lack of health knowledge and health care system in regarding how to access services
  - Healthy lifestyle and health and nutrition education and choices
  - Lack of mental health serves and stigma of seeking these services

Information Gaps

This assessment was designed to provide a comprehensive and broad picture of the health in the overall community served by the Health Center; however, there may be a number of medical conditions that are not specifically addressed in this report due to various factors, including but not limited to, publically available information or limited community input.

In addition, certain population groups might not be identifiable or might not be represented in numbers sufficient for independent analysis. Examples include homeless, institutionalized persons, undocumented residents and members of certain ethnic groups who do not speak English or Spanish. Efforts were made to obtain input from these specific populations through key stakeholder interviews.

Prioritization of Identified Health Needs

Priority setting is a required step in the community benefit planning process. The IRS regulations indicate that the CHNA must provide a prioritized description of the community health needs identified through the CHNA and include a description of the process and criteria used in prioritizing the health needs.

Using findings obtained through the collection of primary and secondary data, the Health Center completed an analysis of these inputs (see *Appendices*) to identify community health needs. The following data was analyzed to identify health needs for the community:

Leading Causes of Death

Leading causes of death for the community and the death rates for the leading causes of death for each county within the Health Center's CHNA community were compared to U.S. adjusted death rates. Causes of death in which the county rate compared unfavorably to the U.S. adjusted death rate resulted in a health need for the Health Center CHNA community.

Health Outcomes and Factors

An analysis of the County Health Rankings health outcomes and factors data was prepared for each county within the SBL's CHNA community. County rates and measurements for health behaviors, clinical care, social and economic factors and the physical environment were compared to state benchmarks. County rankings in which the county rate compared unfavorably (by greater than 30 percent of the national benchmark) resulted in an identified health need.

Primary Data

Health needs identified through key informant interviews were included as health needs. Needs for vulnerable populations were separately reported on the analysis in order to facilitate the prioritization process.

Health Needs of Vulnerable Populations

Health needs of vulnerable populations were included for ranking purposes.

To facilitate prioritization of identified health needs, a ranking process was used. Health needs were ranked based on the following five factors. Each factor received a score between 0 and 5.

1) **How many people are affected by the issue or size of the issue?** For this factor, ratings were based on the percentage of the community who are impacted by the identified need. The following scale was utilized: >25 percent of the community = 5; >15 percent and <25 percent = 4; >10 percent and <15 percent = 3; >5 percent and <10 percent=2 and <5 percent = 1.

2) **What are the consequences of not addressing this problem?** Identified health needs which have a high death rate or have a high impact on chronic diseases received a higher rating.

3) **The impact of the problem on vulnerable populations.** Needs identified which pertained to vulnerable populations were rated for this factor.

4) **How important the problem is to the community.** Needs identified through community interviews and/or focus groups were rated for this factor.

5) **Prevalence of common themes.** The rating for this factor was determined by how many sources of data (leading causes of death, primary causes for inpatient hospitalization, health outcomes and factors and primary data) identified the need.

Each need was ranked based on the five prioritization metrics. As a result, the following summary list of needs was identified:

Exhibit 25
Sarah Bush Lincoln Health Center
Prioritization of Health Needs

	How Many People Are Affected by the Issue?	What Are the Consequences of Not Addressing This Problem?	What is the Impact on Vulnerable Populations?	How Important is it to the Community?	How Many Sources Identified the Need?	Total Score *
Poor Nutrition/Limited Access to Healthy Food Options	5	4	4	4	3	**20**
Lack of Mental Health Providers/Services	5	4	4	4	3	**20**
Substance Abuse	5	4	4	5	2	**20**
Obesity	4	5	4	4	3	**20**
Lack of Access to Services	4	3	4	4	3	**18**
Lack of Dentists/Adult Services	4	3	4	4	3	**18**
Healthy Behaviors/Lifestyle Choices	4	4	4	3	2	**17**
Transportation	5	1	5	4	1	**16**
Physical Inactivity	4	3	4	4	1	**16**
Heart Disease	4	5	0	3	3	**15**
Cost of Healthcare/Prescriptions	4	2	5	3	1	**15**
Lack of Primary Care Physicians/Hours	4	2	3	3	2	**14**
Uninsured/Limited Insurance	4	1	4	3	2	**14**
Lack of Health Knowledge/Education	3	1	4	3	2	**13**
Adult Smoking/Tobacco Use	3	5	0	3	2	**13**
Children in Poverty/Homelessness	3	2	5	2	1	**13**
Cancer	3	5	0	2	1	**11**
Lung Disease	3	3	1	2	1	**10**
Access to Exercise Opportunities	3	2	3	1	1	**10**
Stroke	3	3	0	2	1	**9**
Children in Single-Parent Households	3	2	1	2	1	**9**
Teen Birth Rate	3	1	1	1	1	**7**
Need for Pre-Natal Care	2	2	0	1	1	**6**
Preventable Hospital Stays	2	2	0	1	1	**6**
Sexually Transmitted Infections	3	1	0	1	1	**6**
Violent Crime Rate	2	1	0	1	1	**5**
Excessive Drinking/Alcohol-Impaired Drinking Deaths	2	1	0	1	1	**5**

*Highest potential score = 25

Management's Prioritization Process

For the health needs prioritization process, the Health Center engaged a hospital leadership team to review the most significant health needs reported the prior CHNA, as well as in *Exhibit 25*, using the following criteria:

- ✓ Current area of hospital focus
- ✓ Established relationships with community partners to address the health need
- ✓ Organizational capacity and existing infrastructure to address the health need

Based on the criteria outlined above, the leadership team utilized a priority matrix to determine areas of focus. As a result of the priority setting process, the identified priority areas that will be addressed through the Health Center's Implementation Strategy for fiscal years 2019 – 2021 will be:

- Poor Nutrition/Limited Access to Healthy Food Options
- Lack of Mental Health Providers/Services and Substance Abuse
- Lack of Access to Services
- Lack of Dentists and Oral Health Services

The Health Center's next steps include developing an implementation strategy to address these priority areas.

Resources Available to Address Significant Health Needs

Health Care Resources

The availability of health care resources is a critical component to the health of a county's residents and a measure of the soundness of the area's health care delivery system. An adequate number of health care facilities and health care providers are vital for sustaining a community's health status. Fewer health care facilities and health care providers can impact the timely delivery of services. A limited supply of health resources, especially providers, results in the limited capacity of the health care delivery system to absorb charity and indigent care as there are fewer providers upon which to distribute the burden of indigent care.

Hospitals

The Health Center has 145 acute beds and is the only hospital facility located within the CHNA community. Residents of the community also take advantage of services provided by hospitals in neighboring counties, as well as services offered by other facilities and providers.

Exhibit 26 summarizes hospitals available to the residents of the four counties in which the community resides. The facilities in the table below are not located in the four-county CHNA community; however, they represent hospital facilities that are within 30 miles of Mattoon, Illinois.

Exhibit 26
Summary of Area Hospitals and Health Centers

Facility	Address	County
HSHS Good Shepherd Hospital	200 South Cedar Street Shelbyville, IL 62565	Shelby
St. Anthony's Memorial Hospital	503 North Maple Street Effingham, IL 62401	Effingham

Source: US Hospital Finder

Other Health Care Facilities

Short-term acute care hospital services are not the only health services available to members of the Health Center's community. *Exhibit 27* provides a listing of community health centers and rural health clinics within the Health Center's community.

Exhibit 27
Summary of Rural Health Centers & FQHC's

Facility	Facility Type	Address	County
Atwood Rural Health Clinic	Rural Health Clinic	108 South Main Street, Atwood, IL 61913	Douglas
Carle Clinic Tuscola	Rural Health Clinic	301 East Southline Road, Tuscola, IL 61953	Douglas
Springfield Clinic	Rural Health Clinic	223 East Sixth Street, Neoga, IL 62447	Cumberland
Neoga Clinic	Rural Health Clinic	650 Oak Avenue, Neoga, IL 62447	Cumberland
Mattoon Medical Center	Federally Qualified Health Center	700 Broadway Avenue East, Mantoon, IL 61938	Coles
Cumberland County Health Care Center	Federally Qualified Health Center	302 North Mill Street, Greenup IL 62428	Cumberland
Charleston Medical Center	Federally Qualified Health Center	415 18th Street, Charleston, IL 61920	Coles

Source: CMS.gov, Heath Resources & Services Administration (HRSA)

Physicians

The Health Center regularly monitors physician supply and demand. The key informant interviews indicated the need for specialists in the following areas:

- Psychiatrists
- Pediatricians
- Neonatal

Health Departments

Each county with the Health Center's CHNA community has a county health department: Coles County Health Department, Cumberland County Health Department, Clark County Health Department and Douglas County Health Department.

The above mentioned health departments offer a large array of services to patients, including assessments and screenings, as well as education in order to help them take a proactive approach toward monitoring and developing their health status. Some of these services include well child exams, family planning (birth control), prenatal care (not offered in all counties), Women, Infants & Children food program (WIC), bloodwork, emergency preparedness, HIV and STD screenings, diabetes screening and counseling, immunizations, environmental health information and dental clinic (Douglas County only) as well as much more.

These services are provided by trained medical providers such as physicians, ARNPs, RNs, LPNs, registered dieticians, certified nutritionists, etc. These providers adhere to the guidelines set forth by the Department of Public Health's Public Health Practice Reference, ensuring care is provided at the highest possible professional standard.

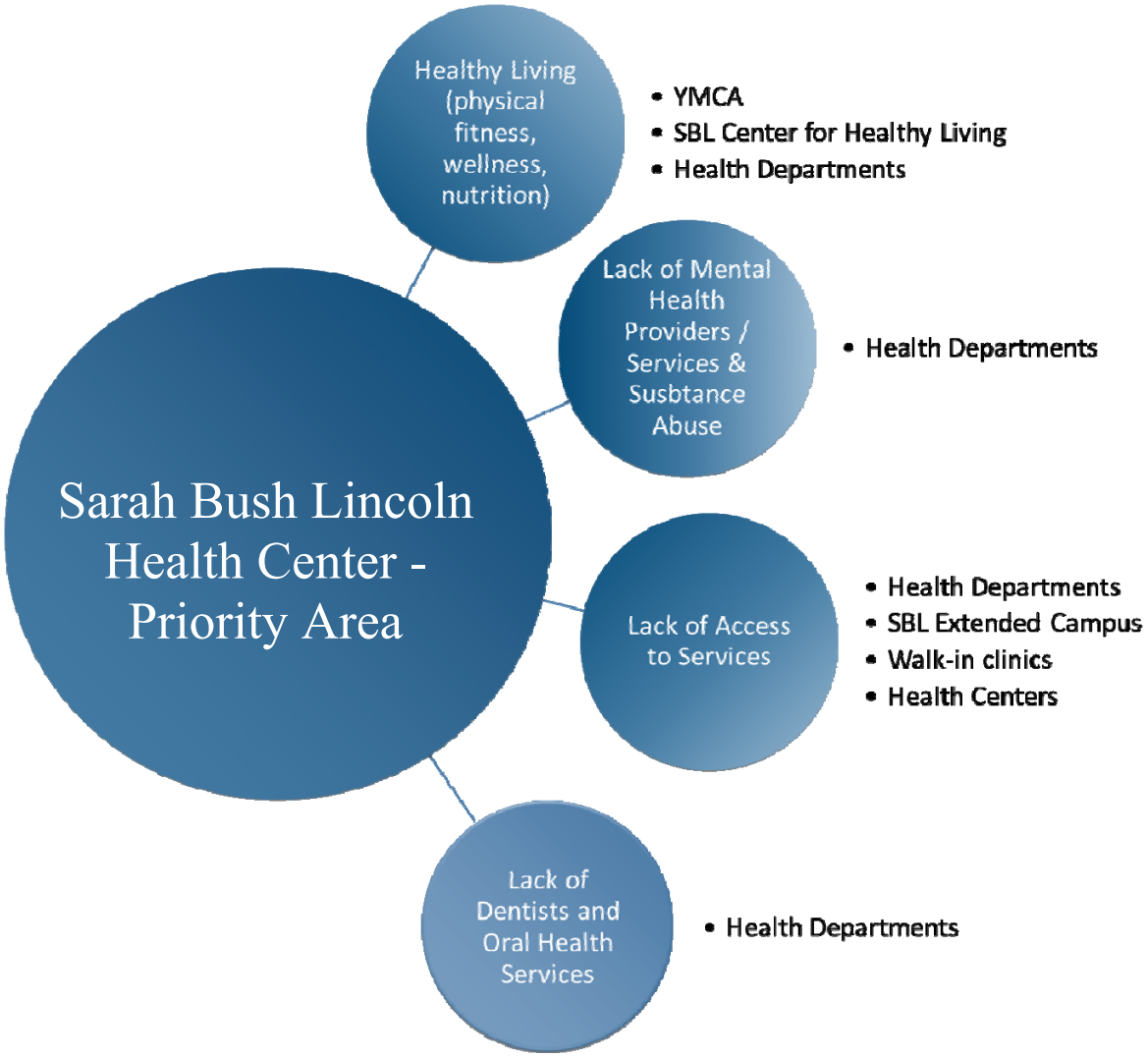
Many of the services are covered by Medicare, Medicaid and other insurances. In the case individuals are uninsured or their insurance doesn't pay for the service, the majority of the services are offered on a sliding fee scale basis.

Every health department in Illinois must complete an IPLAN, which stands for the Illinois Project for Local Assessment of Needs. The IPLAN is a community health assessment and planning process that is conducted every five years by local health jurisdictions in Illinois. The essential elements of IPLAN are an organizational capacity assessment, a community health needs assessment and a community health plan, focusing on a minimum of three priority health problems.

The Coles County Health Department IPLAN for 2015 – 2020 states that the strategic health issues selected to focus on are access to care, mental health (including substance abuse) and cancer.

Other Resources

SBL has identified other resources in the community available to address the prioritized area selected by the Health Center.



APPENDICES

APPENDIX A

ANALYSIS OF DATA

Sarah Bush Lincoln Health Center
Analysis of CHNA Data

Analysis of Health Status-Leading Causes of Death

		(A)		(B)	
	U.S. Crude Rates	10% of U.S. Crude Rate	County Rate	County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Coles County:					
Cancer	185.3	18.5	224.4	39.1	Health Need
Heart Disease	194.2	19.4	252.3	58.1	Health Need
Lung Disease	47.0	4.7	70.8	23.8	Health Need
Stroke	42.2	4.2	46.7	4.5	Health Need
Unintentional Injury	44.1	4.4	40.3	-3.8	
Cumberland County:					
Cancer	185.3	18.5	249.6	64.3	Health Need
Heart Disease	194.2	19.4	207.3	13.1	
Lung Disease	47.0	4.7	60.5	13.5	Health Need
Stroke	42.2	4.2	62.4	20.2	Health Need
Unintentional Injury	44.1	4.4	42.2	-1.9	
Douglas County:					
Cancer	185.3	18.5	218.0	32.7	Health Need
Heart Disease	194.2	19.4	227.1	32.9	Health Need
Lung Disease	47.0	4.7	65.6	18.6	Health Need
Stroke	42.2	4.2	54.5	12.3	Health Need
Unintentional Injury	44.1	4.4	50.5	6.4	Health Need
Clark County:					
Cancer	185.3	18.5	264.6	79.3	Health Need
Heart Disease	194.2	19.4	304.4	110.2	Health Need
Lung Disease	47.0	4.7	88.2	41.2	Health Need
Stroke	42.2	4.2	79.5	37.3	Health Need
Unintentional Injury	44.1	4.4	55.8	11.7	Health Need

***The crude rate is shown per 100,000 residents. Please refer to Exhibit 18 for more information.

Analysis of Health Outcomes and Factors

	National Benchmark	(A) 30% of National Benchmark	County Rate	(B) County Rate Less National Benchmark	If (B)>(A), then "Health Need"
Coles County:					
Adult Smoking	14.0%	4.2%	19.0%	5.0%	Health Need
Adult Obesity	26.0%	7.8%	29.0%	3.0%	
Food Environment Index	8.6	3	7.3	1	
Physical Inactivity	20.0%	6.0%	24.0%	4.0%	
Access to Exercise Opportunities	91.0%	27.3%	79.0%	12.0%	
Excessive Drinking	13.0%	3.9%	21.0%	8.0%	Health Need
Alcohol-Impaired Driving Deaths	13.0%	3.9%	24.0%	11%	Health Need
Sexually Transmitted Infections	145	44	701	556	Health Need
Teen Birth Rate	15	5	18	3	
Uninsured	6.0%	1.8%	6.0%	0.0%	
Primary Care Physicians	1030	309	1310	280	
Dentists	1280	384	2090	810	Health Need
Mental Health Providers	330	99	550	220	Health Need
Preventable Hospital Stays	32	10	87	55	Health Need
Diabetic Screen Rate	91.0%	27.3%	87.0%	4.0%	
Mammography Screening	71.0%	21.3%	63.0%	8.0%	
Violent Crime Rate	62	19	228	166	Health Need
Children in Poverty	12.0%	3.6%	21.0%	9.0%	Health Need
Children in Single-Parent Households	20.0%	6.0%	36.0%	16.0%	Health Need
Cumberland County:					
Adult Smoking	14.0%	4.2%	17.0%		
Adult Obesity	26.0%	7.8%	29.0%	3.0%	
Food Environment Index	8.6	3	N/A		
Physical Inactivity	20.0%	6.0%	24.0%	4.0%	
Access to Exercise Opportunities	91.0%	27.3%	2.0%	89.0%	Health Need
Excessive Drinking	13.0%	3.9%	20.0%		
Alcohol-Impaired Driving Deaths	13.0%	3.9%	29.0%	16%	Health Need
Sexually Transmitted Infections	145	44	212	67	Health Need
Teen Birth Rate	15	5	23	8	Health Need
Uninsured	6.0%	1.8%	6.0%	0.0%	
Primary Care Physicians	1030	309	N/A		
Dentists	1280	384	10860	9580	Health Need
Mental Health Providers	330	99	2170	1840	Health Need
Preventable Hospital Stays	32	10	75	43	Health Need
Diabetic Screen Rate	91.0%	27.3%	84.0%	7.0%	
Mammography Screening	71.0%	21.3%	62.0%	9.0%	
Violent Crime Rate	62	19	191	129	Health Need
Children in Poverty	12.0%	3.6%	17.0%	5.0%	Health Need
Children in Single-Parent Households	20.0%	6.0%	27.0%	7.0%	Health Need

Analysis of Health Outcomes and Factors

	National Benchmark	(A) 30% of National Benchmark	County Rate	(B) County Rate Less National Benchmark	If (B)>(A), then "Health Need"
Douglas County:					
Adult Smoking	14.0%	4.2%	16.0%		
Adult Obesity	26.0%	7.8%	29.0%	3.0%	
Food Environment Index	8.6	3	8.8	0	
Physical Inactivity	20.0%	6.0%	25.0%	5.0%	
Access to Exercise Opportunities	91.0%	27.3%	72.0%	19.0%	
Excessive Drinking	13.0%	3.9%	21.0%		
Alcohol-Impaired Driving Deaths	13.0%	3.9%	35.0%	22%	Health Need
Sexually Transmitted Infections	145	44	171	26	
Teen Birth Rate	15	5	22	7	Health Need
Uninsured	6.0%	1.8%	9.0%	3.0%	Health Need
Primary Care Physicians	1030	309	3960	2930	Health Need
Dentists	1280	384	1780	500	Health Need
Mental Health Providers	330	99	19630	19300	Health Need
Preventable Hospital Stays	32	10	54	22	Health Need
Diabetic Screen Rate	91.0%	27.3%	89.0%	2.0%	
Mammography Screening	71.0%	21.3%	64.0%	7.0%	
Violent Crime Rate	62	19	251	189	Health Need
Children in Poverty	12.0%	3.6%	14.0%	2.0%	
Children in Single-Parent Households	20.0%	6.0%	25.0%	5.0%	
Clark County:					
Adult Smoking	14.0%	4.2%	17.0%		
Adult Obesity	26.0%	7.8%	33.0%	7.0%	
Food Environment Index	8.6	3	8.3	0	
Physical Inactivity	20.0%	6.0%	27.0%	7.0%	Health Need
Access to Exercise Opportunities	91.0%	27.3%	62.0%	29.0%	Health Need
Excessive Drinking	13.0%	3.9%	20.0%		
Alcohol-Impaired Driving Deaths	13.0%	3.9%	5.0%	-8%	
Sexually Transmitted Infections	145	44	167	22	
Teen Birth Rate	15	5	32	17	Health Need
Uninsured	6.0%	1.8%	5.0%	-1.0%	
Primary Care Physicians	1030	309	2660	1630	Health Need
Dentists	1280	384	7970	6690	Health Need
Mental Health Providers	330	99	3980	3650	Health Need
Preventable Hospital Stays	32	10	58	26	Health Need
Diabetic Screen Rate	91.0%	27.3%	86.0%	5.0%	
Mammography Screening	71.0%	21.3%	56.0%	15.0%	
Violent Crime Rate	62	19	269	207	Health Need
Children in Poverty	12.0%	3.6%	18.0%	6.0%	Health Need
Children in Single-Parent Households	20.0%	6.0%	33.0%	13.0%	Health Need

APPENDIX B

SOURCES

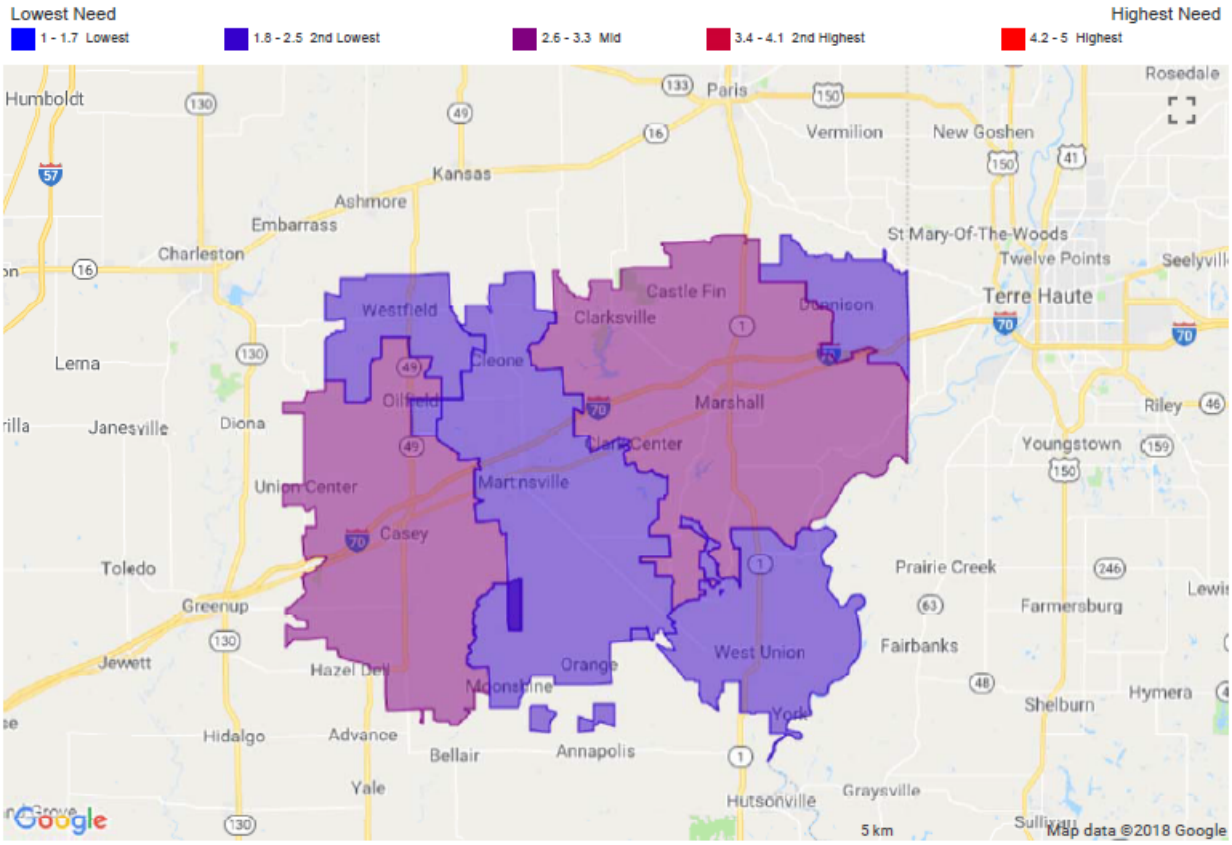
DATA TYPE	SOURCE	YEAR(S)
Discharges by Zip Code	Hospital	FY 2018
Community Details: Population & Demographics	U.S. Census Bureau, American Community Survey http://factfinder.census.gov	2012-2016
Community Details: Urban/Rural Population	U.S. Census Bureau, American Community Survey http://factfinder.census.gov	2010
Socioeconomic Characteristics: Income	U.S. Census Bureau, American Community Survey http://factfinder.census.gov	2012 - 2016
Socioeconomic Characteristics: Unemployment	Community Commons via US Department of Labor, Bureau of Labor Statistics http://www.communitycommons.org/	2015
Socioeconomic Characteristics: Poverty	U.S. Census Bureau, American Community Survey http://factfinder.census.gov	2012 - 2016
Socioeconomic Characteristics: Uninsured	U.S. Census Bureau, American Community Survey http://factfinder.census.gov	2012 - 2016
Socioeconomic Characteristics: Medicaid	Community Commons via U.S. Census Bureau, American Community Survey http://www.communitycommons.org/	2012 - 2016
Socioeconomic Characteristics: Education	U.S. Census Bureau, American Community Survey http://factfinder.census.gov	2012 - 2016
Physical Environment - Grocery Store Access	Community Commons via US Cenus Bureau, County Business Patterns http://www.communitycommons.org/	2016
Physical Environment - Food Access/Food Deserts	Community Commons via US Department of Agriculture http://www.communitycommons.org/	2015
Physical Environment - Recreation and Fitness Facilities	Community Commons via US Cenus Bureau, County Business Patterns http://www.communitycommons.org/	2016
Physical Environment - Physically Inactive	Community Commons via US Centers for Disease control and Prevention http://www.communitycommons.org/	2013
Clinical Care - Access to Primary Care	Community Commons via US Department of Health & Human Services http://www.communitycommons.org/	2014
Clinical Care - Lack of a Consistent Source of Primary Care	Community Commons via US Department of Health & Human Services http://www.communitycommons.org/	2011 - 2012
Clinical Care - Population Living in a Shortage Area	Community Commons via US Department of Health & Human Services http://www.communitycommons.org/	2016
Clinical Care - Preventable Hospital Events	Community Commons via Dartmouth College Institute for Health Policy & Clinical Practice http://www.communitycommons.org/	2014
Leading Causes of Death	Community Commons via CDC national Bital Statistics System http://www.communitycommons.org/	2012 - 2016
Health Outcomes and Factors	County Health Rankings http://www.countyhealthrankings.org/ & Community Commons http://www.communitycommons.org/	2015 & 2018
Health Care Resources: Hospitals	US Hospital Finder http://www.ushospitalfinder.com/	2018
Health Care Resources: Community Health Centers	Community Commons, CMS.gov, HRSA	2018
Zip Codes with Highest CNI	Dignity Health Community Needs Index http://cni.chw-interactive.org/	2018

APPENDIX C

DIGNITY HEALTH COMMUNITY NEED INDEX

(CNI) REPORT

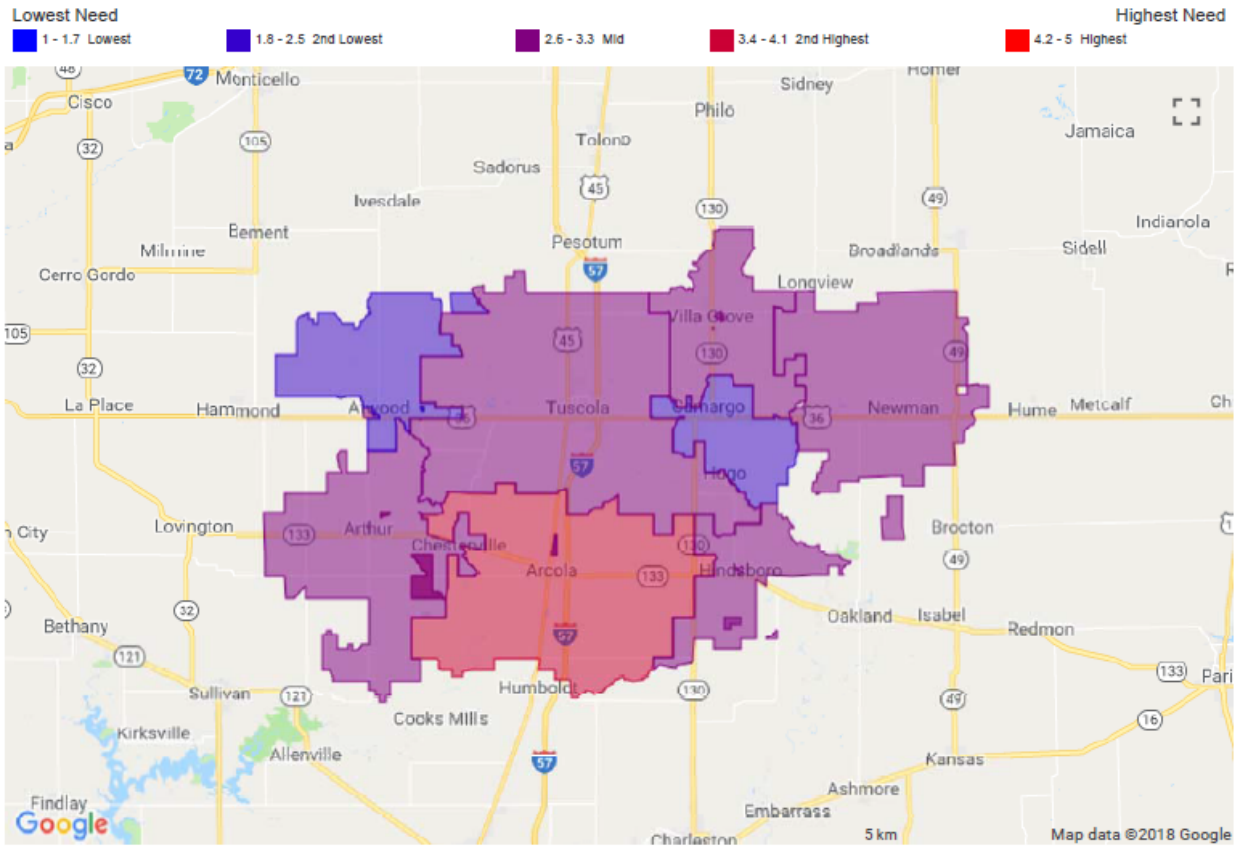
Map of Community Needs Index Scores for CHNA Community Based on Dignity Health's Community Need Index (CNI)



Mean(zipcode): 2.4 / Mean(person): 2.7 | CNI Score Median: 2.3 | CNI Score Mode: 2.2

Zip Code	CNI Score	Population	City	County	State
62420	2.8	4444	Casey	Clark	Illinois
62423	2.2	722	Dennison	Clark	Illinois
62441	3	7351	Marshall	Clark	Illinois
62442	2.4	2292	Martinsville	Clark	Illinois
62474	2.2	828	Westfield	Clark	Illinois
62477	1.8	899	West Union	Clark	Illinois

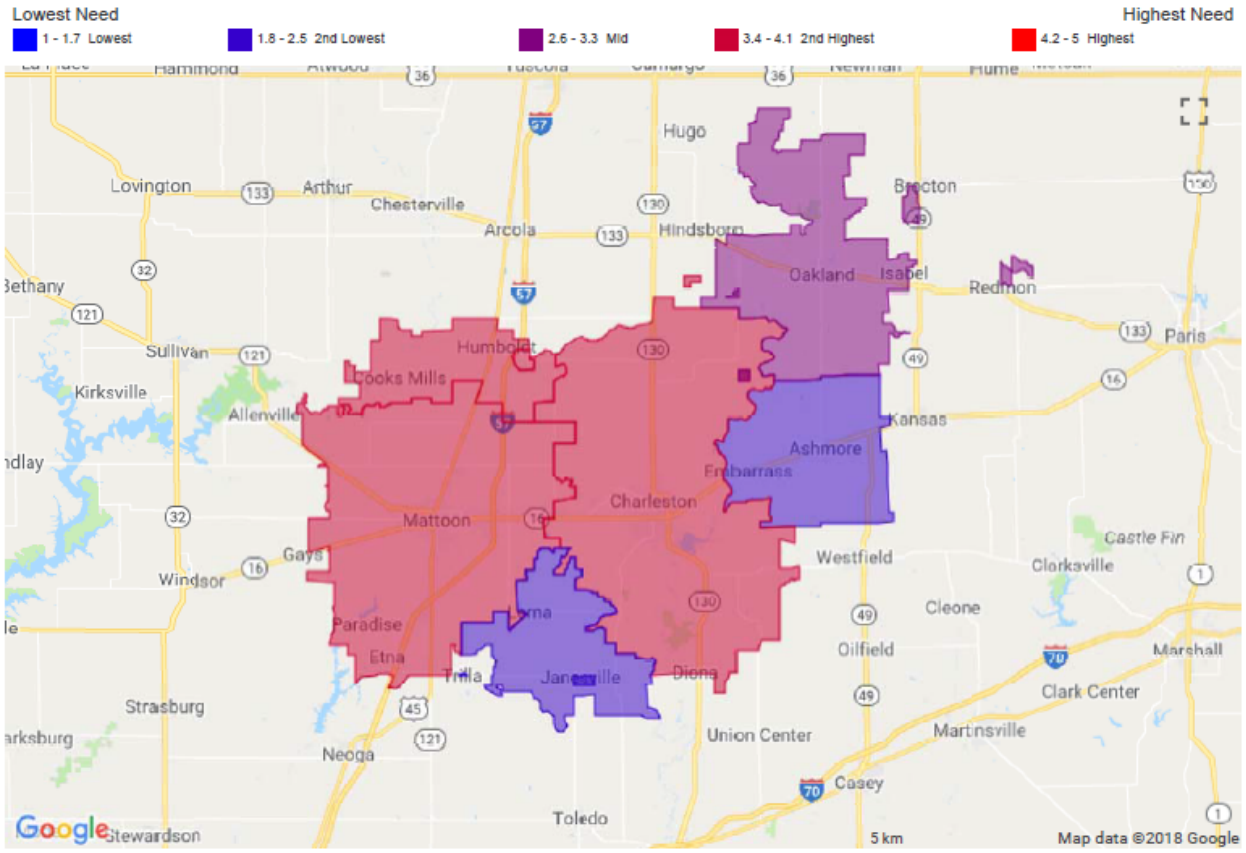
Source: http://cni.chw-interactive.org



Mean(zipcode): 2.7 / Mean(person): 2.9 CNI Score Median: 2.6 CNI Score Mode: 2.6

Zip Code	CNI Score	Population	City	County	State
61910	3.6	4506	Arcola	Douglas	Illinois
61911	2.6	4640	Arthur	Douglas	Illinois
61913	2.2	1667	Atwood	Douglas	Illinois
61919	1.8	801	Camargo	Douglas	Illinois
61930	2.8	428	Hindsboro	Douglas	Illinois
61942	2.6	1133	Newman	Douglas	Illinois
61953	3	6171	Tuscola	Douglas	Illinois
61956	2.6	2908	Villa Grove	Douglas	Illinois

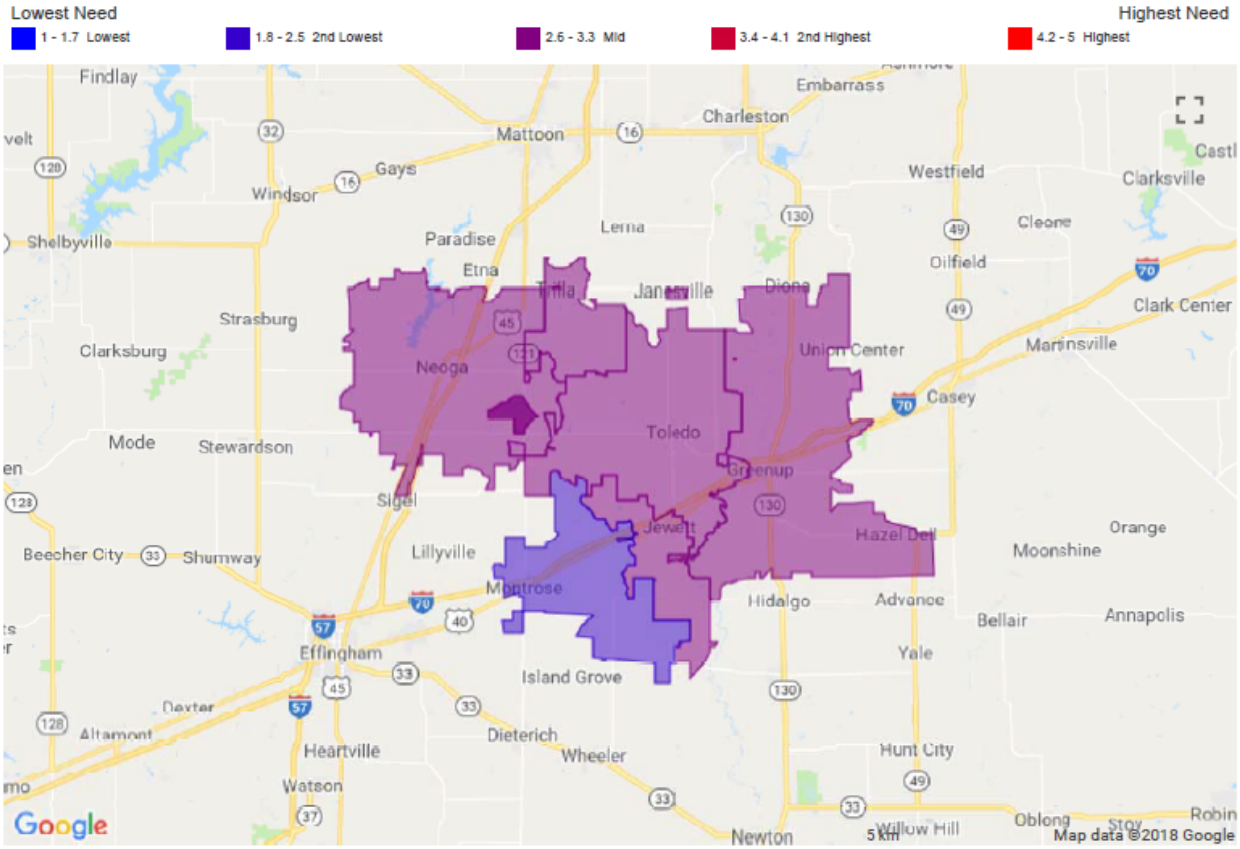
Source: http://cni.chw-interactive.org



Mean(zipcode): 3 / Mean(person): 3.6 CNI Score Median: 3.3 CNI Score Mode: None

Zip Code	CNI Score	Population	City	County	State
61912	2.2	1233	Ashmore	Coles	Illinois
61920	3.8	24726	Charleston	Coles	Illinois
61931	3.4	1153	Humboldt	Coles	Illinois
61938	3.6	21653	Mattoon	Coles	Illinois
61943	3.2	1456	Oakland	Coles	Illinois
62440	1.8	1274	Lerna	Coles	Illinois

Source: http://cni.chw-interactive.org



Mean(zipcode): 2.8 / Mean(person): 2.9 | CNI Score Median: 2.8 | CNI Score Mode: 2.8

Zip Code	CNI Score	Population	City	County	State
62428	3.2	2936	Greenup	Cumberland	Illinois
62436	2.8	548	Jewett	Cumberland	Illinois
62445	2	1005	Montrose	Cumberland	Illinois
62447	3	3466	Neoga	Cumberland	Illinois
62468	2.8	2573	Toledo	Cumberland	Illinois
62469	2.8	489	Trilla	Cumberland	Illinois

Source: http://cni.chw-interactive.org

APPENDIX D

COUNTY HEALTH RANKINGS

County Health Rankings – Health Factors

		Coles County 2015	Coles County 2018	Illinois 2018	Top Performers 2018**
Health Behaviors	*	**3**	**90**		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke		11%	19.0%	16.0%	14.0%
Adult obesity – Percent of adults that report a BMI >= 30		28%	29.0%	28.0%	26.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)		7.1	7.3	8.7	8.6
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity		23%	24.0%	22.0%	20.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity		78%	79.0%	91.0%	91.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days		14%	21.0%	21.0%	13.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement		31%	24.0%	33.0%	13.0%
Sexually transmitted infections – Chlamydia rate per 100K population		624.0	701.4	540.4	145.1
Teen birth rate – Per 1,000 female population, ages 15-19		21.0	18.0	26.0	15.0
Clinical Care	*	**56**	**49**		
Uninsured adults – Percent of population under age 65 without health insurance		13%	6.0%	8.0%	6%
Primary care physicians – Ratio of population to primary care physicians		1,916:1	1,310:1	1,240:1	1,030:1
Dentists – Ratio of population to dentists		2,148:1	2,090:1	1,330:1	1,280:1
Mental health providers – Ratio of population to mental health providers		610:1	550:1	530:1	330:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees		85	87.0	55.0	35
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening		87%	87.0%	86.0%	91%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening		67.6%	63.0%	64.0%	71.0%
Social and Economic Factors	*	**54**	**46**		
High school graduation – Percent of ninth grade cohort that graduates in 4 years		85%	91.0%	86.0%	95%
Some college – Percent of adults aged 25-44 years with some post-secondary education		64.6%	66.0%	68.0%	72.0%
Unemployment – Percent of population age 16+ unemployed but seeking work		8.8%	5.9%	5.9%	3.2%
Children in poverty – Percent of children under age 18 in poverty		22%	21.0%	18.0%	12.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile		5.3	5.2	5.0	3.7
Children in single-parent households – Percent of children that live in household headed by single parent		34%	36.0%	32.0%	20%
Social associations – Number of membership associations per 10,000 population		15.1	13.7	9.8	22.1
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)		272	228.0	388.0	62.0
Injury deaths – Number of deaths due to injury per 100,000 population		53	53	56.0	55.0
Physical Environment	*	**98**	**20**		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter		13.6	10.4	10.5	6.7
Drinking water safety – Percentage of population exposed to water exceeding a violation limit during the past year		11%	N/A	N/A	N/A
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities		19%	16.0%	18.0%	9%
Driving alone to work – Percentage of the workforce that drives alone to work		76%	77.0%	73.0%	72%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes		18%	18%	40.0%	15%

* Rank out of 102 Illinois counties
** 90th percentile, i.e., only 10% are better

Note: N/A indicates unreliable or missing data
Source: Countyhealthrankings.org

County Health Rankings – Health Factors

		Cumberland County 2015	Cumberland County 2018	Illinois 2018	Top Performers 2018**
Health Behaviors	*	**32**	**56**		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke		N/A	17.0%	16.0%	14.0%
Adult obesity – Percent of adults that report a BMI >= 30		30%	29.0%	28.0%	26.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)		8.6	N/A	8.7	8.6
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity		29.0%	24.0%	22.0%	20.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity		1%	2.0%	91.0%	91.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days		N/A	20.0%	21.0%	13.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement		21%	29.0%	33.0%	13.0%
Sexually transmitted infections – Chlamydia rate per 100K population		201.0	212.3	540.4	145.1
Teen birth rate – Per 1,000 female population, ages 15-19		33.0	23.0	26.0	15.0
Clinical Care	*	**55**	**65**		
Uninsured adults – Percent of population under age 65 without health insurance		12%	6.0%	8.0%	6%
Primary care physicians – Ratio of population to primary care physicians		10,968:1	N/A	1,240:1	1,030:1
Dentists – Ratio of population to dentists		10,939:1	10,860:1	1,330:1	1,280:1
Mental health providers – Ratio of population to mental health providers		2,735:1	2,170:1	530:1	330:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees		63	75.0	55.0	35
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening		88%	84.0%	86.0%	91%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening		62.9%	62.0%	64.0%	71.0%
Social and Economic Factors	*	**51**	**18**		
High school graduation – Percent of ninth grade cohort that graduates in 4 years		85%	96.0%	86.0%	95%
Some college – Percent of adults age 25-44 years with some post-secondary education		61%	56.0%	68.0%	72.0%
Unemployment – Percent of population age 16+ unemployed but seeking work		9.7%	5.2%	5.9%	3.2%
Children in poverty – Percent of children under age 18 in poverty		18%	17.0%	18.0%	12.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile		4.0	4.2	5.0	3.7
Children in single-parent households – Percent of children that live in household headed by single parent		25%	27.0%	32.0%	20%
Social associations – Number of membership associations per 10,000 population		12.8	11.9	9.8	22.1
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)		153	191.0	388.0	62.0
Injury deaths – Number of deaths due to injury per 100,000 population		76	51.0	56.0	55.0
Physical Environment	*	**47**	**36**		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter		13.7	10.4	10.5	6.7
Drinking water safety – Percentage of population exposed to water exceeding a violation limit during the past year		-	-	N/A	N/A
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities		10%	10%	18.0%	9%
Driving alone to work – Percentage of the workforce that drives alone to work		79%	84.0%	73.0%	72%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes		36%	33.0%	40.0%	15%

* Rank out of 102 Illinois counties

** 90th percentile, i.e., only 10% are better

Note: N/A indicates unreliable or missing data

Source: *Countyhealthrankings.org*

County Health Rankings – Health Factors

		Douglas County 2015	Douglas County 2018	Illinois 2018	Top Performers 2018**
Health Behaviors	*	**36**	**34**		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke		N/A	16.0%	16.0%	14.0%
Adult obesity – Percent of adults that report a BMI >= 30		30%	29.0%	28.0%	26.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)		8.6	8.8	8.7	8.6
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity		28%	25.0%	22.0%	20.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity		72%	72.0%	91.0%	91.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days		N/A	21.0%	21.0%	13.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement		42%	35.0%	33.0%	13.0%
Sexually transmitted infections – Chlamydia rate per 100K population		207.0	170.9	540.4	145.1
Teen birth rate – Per 1,000 female population, ages 15-19		30.0	22.0	26.0	15.0
Clinical Care	*	**75**	**94**		
Uninsured adults – Percent of population under age 65 without health insurance		16%	9.0%	8.0%	6%
Primary care physicians – Ratio of population to primary care physicians		3,309:1	3,960:1	1,240:1	1,030:1
Dentists – Ratio of population to dentists		2,210:1	1,780:1	1,330:1	1,280:1
Mental health providers – Ratio of population to mental health providers		9,944:1	19,630:1	530:1	330:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees		69	54.0	55.0	35
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening		93%	89.0%	86.0%	91%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening		67.5%	64.0%	64.0%	71.0%
Social and Economic Factors	*	**26**	**13**		
High school graduation – Percent of ninth grade cohort that graduates in 4 years		86%	94.0%	86.0%	95%
Some college – Percent of adults age 25-44 years with some post-secondary education		50.3%	53.0%	68.0%	72.0%
Unemployment – Percent of population age 16+ unemployed but seeking work		7.5%	4.7%	5.9%	3.2%
Children in poverty – Percent of children under age 18 in poverty		17%	14.0%	18.0%	12.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile		3.8	4.0	5.0	3.7
Children in single-parent households – Percent of children that live in household headed by single parent		22%	25.0%	32.0%	20%
Social associations – Number of membership associations per 10,000 population		19.1	17.7	9.8	22.1
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)		195	251.0	388.0	62.0
Injury deaths – Number of deaths due to injury per 100,000 population		54	63.0	56.0	55.0
Physical Environment	*	**33**	**17**		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter		13.4	10.5	10.5	6.7
Drinking water safety – Percentage of population exposed to water exceeding a violation limit during the past year		-	-	N/A	N/A
Severe housing problems – Percentage of household with at least 1 of 4 housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities		12%	13.0%	18.0%	9%
Driving alone to work – Percentage of the workforce that drives alone to work		75%	76.0%	73.0%	72%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes		35%	36.0%	40.0%	15%

* Rank out of 102 Illinois counties
** 90th percentile, i.e., only 10% are better

Note: N/A indicates unreliable or missing data
Source: *Countyhealthrankings.org*

County Health Rankings – Health Factors

		Clark County 2015	Clark County 2018	Illinois 2018	Top Performers 2018**
Health Behaviors	*	**36**	**66**		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke		N/A	17.0%	16.0%	14.0%
Adult obesity – Percent of adults that report a BMI >= 30		30%	33.0%	28.0%	26.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)		8.6	8.3	8.7	8.6
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity		28%	27.0%	22.0%	20.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity		72%	62.0%	91.0%	91.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days		N/A	20.0%	21.0%	13.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement		42%	5.0%	33.0%	13.0%
Sexually transmitted infections – Chlamydia rate per 100K population		207.0	166.9	540.4	145.1
Teen birth rate – Per 1,000 female population, ages 15-19		30.0	32.0	26.0	15.0
Clinical Care	*	**75**	**54**		
Uninsured adults – Percent of population under age 65 without health insurance		16%	5.0%	8.0%	6%
Primary care physicians – Ratio of population to primary care physicians		3,309:1	2,660:1	1,240:1	1,030:1
Dentists – Ratio of population to dentists		2,210:1	7,970:1	1,330:1	1,280:1
Mental health providers – Ratio of population to mental health providers		9,944:1	3,980:1	530:1	330:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees		69	58.0	55.0	35
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening		93%	86.0%	86.0%	91%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening		67.5%	56.0%	64.0%	71.0%
Social and Economic Factors	*	**26**	**44**		
High school graduation – Percent of ninth grade cohort that graduates in 4 years		86%	85.0%	86.0%	95%
Some college – Percent of adults age 25-44 years with some post-secondary education		50.3%	62.0%	68.0%	72.0%
Unemployment – Percent of population age 16+ unemployed but seeking work		7.5%	5.9%	5.9%	3.2%
Children in poverty – Percent of children under age 18 in poverty		17%	18.0%	18.0%	12.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile		3.8	3.9	5.0	3.7
Children in single-parent households – Percent of children that live in household headed by single parent		22%	33.0%	32.0%	20%
Social associations – Number of membership associations per 10,000 population		19.1	23.8	9.8	22.1
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)		195	269.0	388.0	62.0
Injury deaths – Number of deaths due to injury per 100,000 population		54	83.0	56.0	55.0
Physical Environment	*	**33**	**12**		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter		13.4	10.5	10.5	6.7
Drinking water safety – Percentage of population exposed to water exceeding a violation limit during the past year		-	-	N/A	N/A
Severe housing problems – Percentage of household with at least 1 of 4 housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities		12%	9.0%	18.0%	9%
Driving alone to work – Percentage of the workforce that drives alone to work		75%	81.0%	73.0%	72%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes		35%	28.0%	40.0%	15%

* Rank out of 102 Illinois counties
** 90th percentile, i.e., only 10% are better

Note: N/A indicates unreliable or missing data
Source: *Countyhealthrankings.org*

APPENDIX E

KEY STAKEHOLDER INTERVIEW PROTOCOL

& ACKNOWLEDGEMENTS

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)
COMMUNITY INTERVIEW QUESTIONS
August 7, 2018

The Community Health Needs Assessment (CHNA) was added under the Affordable Care Act (ACA) and is an IRS requirement for hospitals to explicitly and publicly demonstrate community benefit by conducting a community health needs assessment, as well as, adopting an implementation strategy to meet the identified needs.

While this is an IRS requirement the hospital administration is first and foremost committed to identifying and addressing the top healthcare needs in Coles County and surrounding communities. Sarah Bush Lincoln has retained BKD, an external audit and consulting firm, to assist in conducting a Community Health Needs Assessment.

The first phase of a Community Health Needs Assessment includes interviewing key informants in the healthcare community who represent the broad interest of the community, populations of need, or persons with specialized knowledge in public health. You have been identified as on such person and we again greatly appreciate you taking time to help identify and address the top healthcare needs of the community.

From the June 30, 2016 CHNA, the following were identified as the most significant health needs:

1. Lack of Access to Services
2. Healthy Behaviors/Lifestyle Choices
3. Poor Nutrition/Limited Access to Healthy Food Options
4. Lack of Dentists/Adult Services
5. Lack of Mental Health Providers/Services
6. Substance Abuse
7. Transportation
8. Lack of Health Knowledge/Education
9. Heart Disease
10. Obesity
11. Physical Inactivity
12. Cost of Health Care/Prescriptions
13. Lack of Primary Care Physicians/Hours
14. Uninsured/Limited Insurance
15. Adult Smoking/Tobacco Use

Please keep in mind the broad definition of "health" adopted by the World Health Organization: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

The themes that emerge from these interviews will be summarized and made available to the public; however, individual interviews will be kept **confidential**.

Name:
Organization/Title:
# of years living in the community:

# of years in current position:
Were you involved in the June 30, 2016 CHNA process:

1) Update on prior CHNA:
    a. Do these remain an issue?
    b. Have you seen changes directly related to these identified need?
    c. Is there anything that is not on the list that should be?

2) In general, how would you rate health and quality of life in the community?

3) How do you feel health in the community has changed in past three years (improved, declined, same)?

4) Why do you think it has (based on the answer from the previous question: improved, declined, or stayed the same)?

5) Most critical areas of health in area?
    a. What barriers exist?
    b. What can be done to address issues?

6) Are there groups in the community with lower health or quality of life? Who are these groups?

7) Do you think access to Health Services has improved over the last 3 years? Why or why not? What needs to be done to improve access to health services in the community?

8) Are there people or groups of people who have a more difficult time obtaining necessary/preventive medical services? If so, who are these persons or groups? Why do you think they have a more difficult time? What can be done to improve the situation?

9) Do you think there are health resources missing in the community? If so, can you please provide some examples?

10) What community initiatives are you aware of that are focused on addressing health and quality of life in our community?

11) What opportunities do you see for community groups to partner together to address health needs in our service area?

12) What are your thoughts or perception of how the Hospital is doing servicing the health and quality of life needs?

13) Anything else you would like to add for the Community Health Needs Assessment?

Key Stakeholders

Thank you to the following individuals who participated in our key informant interview process:

Debbie Albin, Catholic Charities

Lynette Ashmore, Outpatient Behavioral Health Program, LifeLinks

Laura Bollan, Director of Healthy Communities, Sarah Bush Lincoln Health Center

Eric Davidson, EIU Health Counseling Services

Sheri Drotor, Administrator, Cumberland County Health Department

Bill Duey, Executive Director, Fit 2 Serve

Blake Fairchild, Executive Director, Mattoon YMCA

Michael Gillespie, Professor of Sociology, Eastern Illinois University

Janet Mason, Administrator, Edgar County Health Department

Amanda Minor, Administrator, Douglas County Health Department

Teressa Perdieu, Executive Director, CEAD Council

Eric Roa, Juvenile Officer, Charleston Police Department

Gloria Speark, Director of Environmental Health, Coles County Health Department

Amanda Standerfer, Director, Program Services, Lumpkin Foundation

Diana Stenger, Administrator, Coles County Health Department

Suzan Tribby, Assistant Administrator, Edgar County Health Department