Community Health Needs Assessment 2015

Sarah Bush Lincoln
Trusted Compassionate Care

BKD LLP
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.

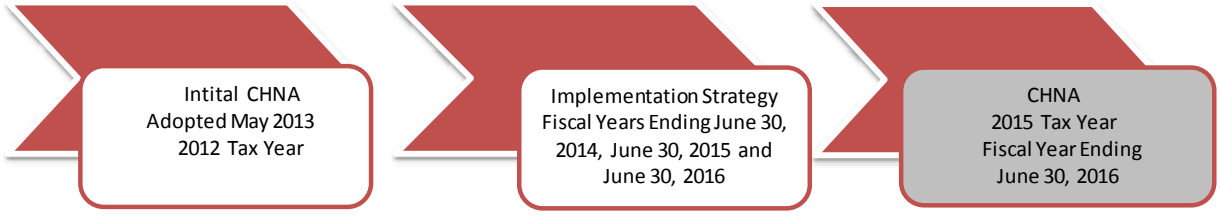
The CHNA must take into account input from persons who represent the broad interest of the community served by the hospital facility, including those with special knowledge of or expertise in public health. The hospital facility must make the CHNA widely available to the public.

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, 2014, through June 30, 2016, which was adopted by the Health Center board of directors in 2013.
- ✓ Collection and analysis of a large range of data, including demographic, socioeconomic and health statistics, health care resources and hospital data.
- ✓ Obtaining community input through:
  - 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 2015. 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 Health Center engaged **BKD, LLP** to conduct a formal CHNA. **BKD, LLP** is one of the largest CPA and advisory firms in the United States, with approximately 2,000 partners and employees in 34 offices. BKD serves more than 900 hospitals and health care systems across the country. The CHNA was conducted from July 2015 to October 2015.

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 CHNA:

- An evaluation of the impact of actions taken to address the significant health needs identified in the tax year 2013 CHNA 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 data regarding patient origin. This process is further described in *Community Served by the Hospital*.
- 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 stakeholder interviews of 25 stakeholders. Results and findings are described in *the Key Stakeholder Interview Results* 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 was first incorporated in 1970 and is a 129-bed not-for-profit, rural community health center, tax-exempt under 501(c)(3) and governed by a community-based Board of Directors. The mission of the organization is to provide exceptional care for all and to create healthy communities. It is centrally located in east central Illinois' Coles County and is the recipient of the 2011 Illinois Performance Excellence Gold Award for Achievement of Excellence, the highest performance honors in the state.

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 Management Services (HMS) -- operates Prairie Medical Pharmacy, a retail pharmacy and IV home infusion service, and Lincolnland Home Medical, a retail durable medical equipment service; 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.

SBL operates a 129-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 283 providers representing 30 specialties comprise the active and consulting medical staff. The organization employs 2,154 persons, including 139 providers, (physicians, certified registered nurse anesthetists, physician assistants and nurse practitioners). The main campus is located between Charleston and Mattoon. The primary service area is Coles County with secondary and tertiary service areas including an additional nine-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, Mattoon, Neoga, Newton, Shelbyville, Sullivan, and Toledo. 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.)

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 nine-county service area including Clark, Coles, Cumberland, Douglas, Edgar, Effingham, Jasper, Moultrie and Shelby Counties.

Over the past eight years, the program has annually reached more than 12,000 children in SBL's service area for oral health education, dental examinations for nearly 4,000 children and restorations for nearly 2,000 children. Almost half of the student population in the partnering schools qualifies for dental services.

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.

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/cordlink.

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 Almost None Curriculum
- KickStart
- Project Fit America
- Healthy Heroes Challenge
- Kidsfest
- "Make 10" Cooking Classes
- Jumpstart Camps
- Fit Girls
- Fast Reads
- Teen Cooking Classes
- Safe Sitter Classes

For more information on the programs above, please visit: http://www.sarahbush.org/your-health/healthy-communities/

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

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, 2014 – June 30, 2016, focused on five 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, 2015, 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

Action Plan 1: Develop walk-in clinic locations to improve the access to primary and acute care services.

Goal Met: Yes

In fiscal year (FY) 2014, a walk-in clinic location was built in Charleston, Illinois.

In FY 2015, the Health Center acquired primary care clinics in Shelbyville and Newton, Illinois.

In FY 2016, the Health Center is building a walk-in/primary care clinic in Tuscola, Illinois.

Action Plan 2: Develop tactics to maximize recruitment of medical staff at the Health Center.

Goal Met: Yes

The Health Center hired seven family medicine primary care providers, one pediatrician, two cardiologists, three radiologists, one dermatologist, one neurologist, one psychiatrist, one urologist and two gastroenterologists within the CHNA report period and implemented a hospitalist program, which allows the primary care providers to spend more time in their office practices.

Join With Others to Activate Healthy Choices Among Adults

Action Plan 1: Construct the Center for Healthy Living and develop programs geared at increasing physical activity for participants and develop programs developed to educate participants on healthy nutritional habits.

Goal Met: Yes

The Health Center built the Center for Healthy Living in FY 2015; there are 939 members (249 were medical patients). The other memberships were Health Center employee memberships.

Action Plan 2: Collaborate with community resources to transition participants to community-based fitness facilities.

Goal Met: In process

The Health Center has worked with Mattoon YMCA to develop a transition plan for patients once they "graduate" from the Center for Healthy Living. Medical patients can only remain in the Health Center's Center for Healthy Living for 120 days. After the medical patient has completed 120 days, SBL works with the patient to find a community-based center to continue their exercise routine.

Maximize Access to Care. Evaluate the Health Center's Current Cancer Center Program and Identify Future Needs

Action Plan 1: Develop appropriate space for the cancer center.

Goal Met: Yes

The Health Center worked with Oncology Solutions (consultant) to develop an environmental assessment and needs assessment for the cancer center.

Action Plan 2: Develop an operational plan.

Goal Met: Yes

The Health Center developed a capital and operational plan for the cancer center that includes construction of a new freestanding building on the Health Center campus, hiring of patient navigators to assist patients, clinical research coordinator, etc.

Action Plan 3: Develop marketing tactics to promote the Health Center's cancer center and the importance of preventative cancer screenings.

Goal Met: Ongoing

The Health Center highlighted cancer care within the Health Center HealthStyles magazine that is sent to homes throughout the seven-county service area.

Action Plan 4: Develop recruitment plans to ensure the appropriate provider mix to maximize access to care.

Goal Met: Yes

A study by Oncology Solutions showed that two medical oncologists and one radiation oncologist is an appropriate provider mix for the patient population. The Health Center is fully staffed at this time.

Join With Others to Activate Healthy Choices Among Adults and Build Healthy Habits in Youth

Action Plan 1: Build on the Health Center's tobacco cessation programs to address the high percentage of smokers in our service area.

Goal Met: Yes, but it will remain an ongoing focus

In FY 2015, there were 73 people enrolled in the smoking cessation classes with a 55-60% quit rate by the end of the program.

Action Plan 2: Implement a nontobacco hiring policy at the Health Center. Enhance employee health initiatives to address prevalence of smoking. Partner with area organizations to extend Health Center-implemented health initiatives with other employers.

Goal Met: Yes, but it will remain an ongoing focus

The Health Center began a nontobacco hiring policy in 2015. There is also an ongoing focus on Health Center employee health initiatives. A Health & Wellness Plan Integrator was also created to assist with wellness initiatives and health prevention for Health Center employees (goal is to reduce employee health costs while evolving to a healthier workforce).

Join With Others to Build Healthy Habits in Youth. Build on Established Health Center Oral Health Programs to Address the Need for Children's Dental Care in our Service Area

Action Plan 1: Continue to bring dental services to children through use of the mobile dental unit.

Goal Met: Yes

The Health Center partners with 70 schools in the nine-county service area to bring dental services to children with need. In FY 2015, a total of 8,161 dental treatments were performed.

Action Plan 2: Continue to focus on establishing relationships with area dentists who support the Health Center dental services.

Goal Met: Yes

The Health Center partners with seven community dentists who volunteer their time and office space to provide restorative dental care to kids in need.

Action Plan 3: Educate on the importance of preventative dental care.

Goal Met: Yes

The Health Center partners with area schools to provide oral health education to students. There is a full-time oral health educator who performs these presentations. In addition, the Health Center is actively involved at health fairs and other community events to promote the importance of proper oral hygiene.

Summary of Findings – 2015 Tax Year CHNA

The following health needs were identified based on the information gathered and analyzed through the 2015 CHNA conducted by the Health Center.

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

Identified Community 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

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 a half hour away from Effingham, Illinois and an hour away from 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 July 1, 2014, through June 30, 2015, management has identified the CHNA community to include Coles, Douglas and Cumberland Counties as each county represents greater than 5% of the total discharges and in aggregate the three counties represent 74.5% 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 5% 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 three 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
Sarah Bush Lincoln Health Center
Summary of Inpatient Discharges by Zip Code
7/1/2014 – 6/30/2015

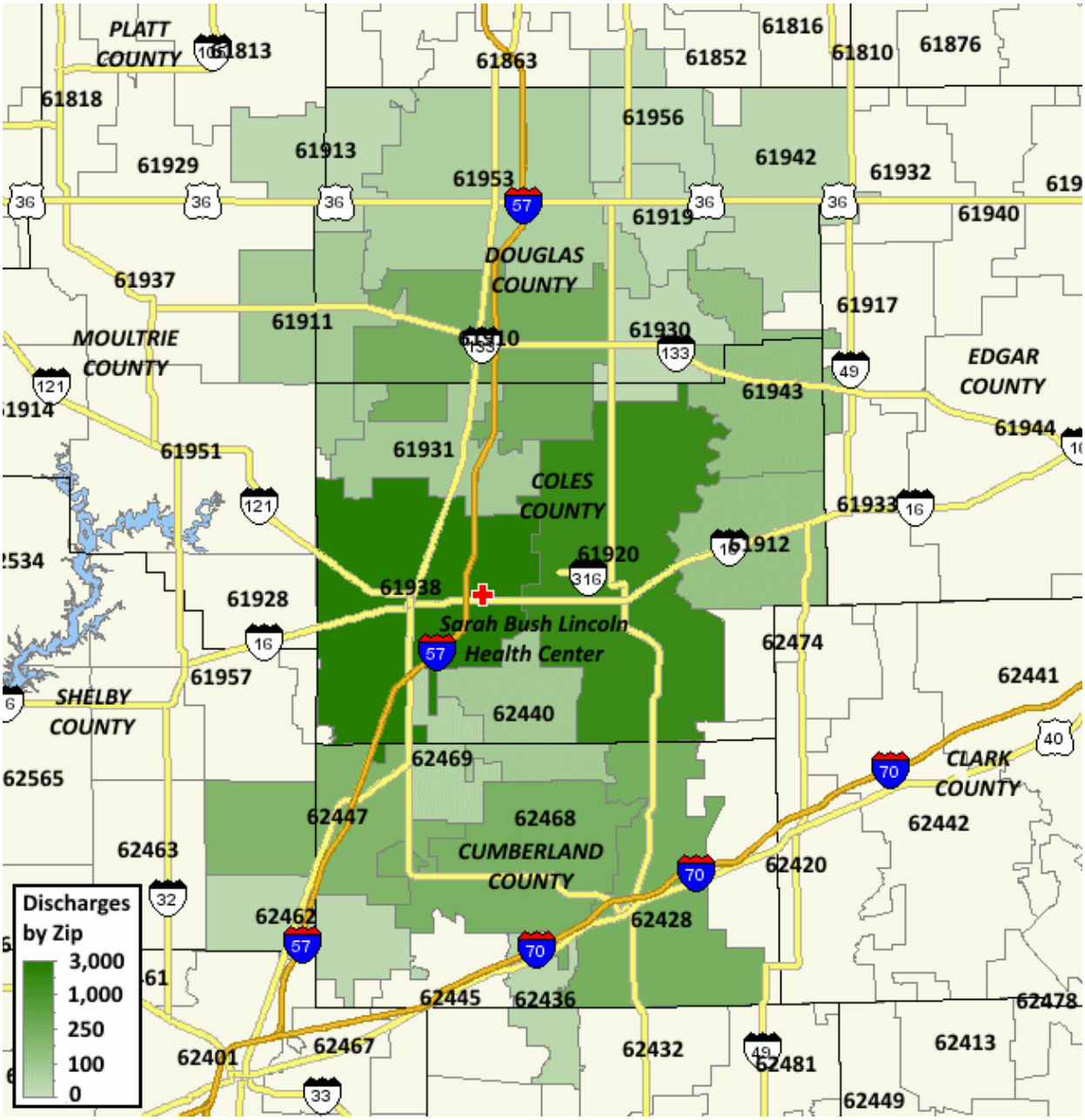
Zip Code	City	Discharges	Percent Discharges
Coles County:			
61938	Mattoon	2,703	32.9%
61920	Charleston	1,678	20.4%
61943	Oakland	141	1.7%
61912	Ashmore	127	1.5%
62440	Lerna	94	1.1%
61931	Humboldt	86	1.0%
62435	Janesville	5	0.1%
	Total Coles	4,834	58.8%
Cumberland County:			
62428	Greenup	239	2.9%
62468	Toledo	232	2.8%
62447	Neoga	198	2.4%
62469	Trilla	53	0.6%
62436	Jewett	39	0.5%
62462	Sigel	31	0.4%
	Total Cumberland	792	9.6%
Douglas County:			
61910	Arcola	247	3.0%
61911	Arthur	85	1.0%
61953	Tusola	68	0.8%
61942	Newman	30	0.4%
61930	Hindsboro	21	0.3%
61956	Villa Grove	18	0.2%
61913	Atwood	15	0.2%
61919	Camargo	13	0.2%
61941	Murdock	2	0.0%
	Total Douglas	499	6.1%
	Total Other Discharges	2,093	25.5%
	Total	8,218	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
Sarah Bush Lincoln Health Center

DEMOGRAPHIC CHARACTERISTICS

	Total Population
Coles County	53,732
Cumberland County	11,015
Douglas County	19,902
Total Service Area	84,649
Illinois	12,848,554
United States	311,536,591

	Coles	Cumberland	Douglas
Total Male Population	25,756	5,519	9,789
Total Female Population	27,976	5,496	10,113

POPULATION DISTRIBUTION

Age Distribution

Age Group	Coles	Cumberland	Douglas	Percent of Total Community	Illinois	Percent of Total IL	United States	Percent of Total US
0 - 4	2,562	706	1,366	5.47%	820,771	6.39%	20,052,112	6.44%
5 - 17	7,224	1,888	3,732	15.17%	2,265,645	17.63%	53,825,364	17.28%
18 - 24	12,376	890	1,592	17.55%	1,252,399	9.75%	31,071,264	9.97%
25 - 34	6,136	1,229	2,409	11.55%	1,778,128	13.84%	41,711,276	13.39%
35 - 44	5,362	1,293	2,376	10.67%	1,711,098	13.32%	40,874,160	13.12%
45 - 54	6,471	1,630	2,777	12.85%	1,842,487	14.34%	44,506,268	14.29%
55 - 64	5,975	1,526	2,497	11.81%	1,521,168	11.84%	37,645,104	12.08%
65+	7,626	1,853	3,153	14.92%	1,656,858	12.90%	41,851,043	13.43%
Total	**53,732**	**11,015**	**19,902**	**100%**	**12,848,554**	**100%**	**311,536,591**	**100%**

RACE

Race Distribution

Race	Coles	Cumberland	Douglas	Percent of Total Community
White Non-Hispanic	49,961	10,798	19,069	94.30%
Black Non-Hispanic	1,984	39	81	2.49%
Asian and Pacific Island Non-Hispanic	521	102	213	0.99%
All Others	1,266	76	539	2.22%
Total	**53,732**	**11,015**	**19,902**	**100%**

HISPANIC POPULATION

	Coles	Cumberland	Douglas	Percent of Total Community	Illinois	Percent of Total IL	United States	Percent of Total US
Hispanic	1,187	86	1,289	3.03%	2060706	16.04%	51,786,592	16.62%
Non-Hispanic	52,545	10,929	18,613	96.97%	10,787,848	83.96%	259,750,000	83.38%
Total	**53,732**	**11,015**	**19,902**	**100%**	**12,848,554**	**100%**	**311,536,592**	**100%**

Source: Community Commons (ACS 2008-2012 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 and illustrates different categories of race, such as white, black, Asian, other and multiple races. White non-Hispanics make up 94% 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 why transportation is one of the highest ranking needs within the community.

Exhibit 3
Sarah Bush Lincoln Health Center
Rural/Urban Population

County	Percent Urban	Percent Rural
Coles	75.71%	24.29%
Cumberland	-	100%
Douglas	38.36%	61.64%
ILLINOIS	88.49%	11.51%
UNITED STATES	80.89%	19.11%

Source: Community Commons

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 community. The following exhibits are a compilation of data that includes household per capita income, employment rates, poverty, uninsured population and educational attainment for the 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
Sarah Bush Lincoln Health Center
Per Capita Income

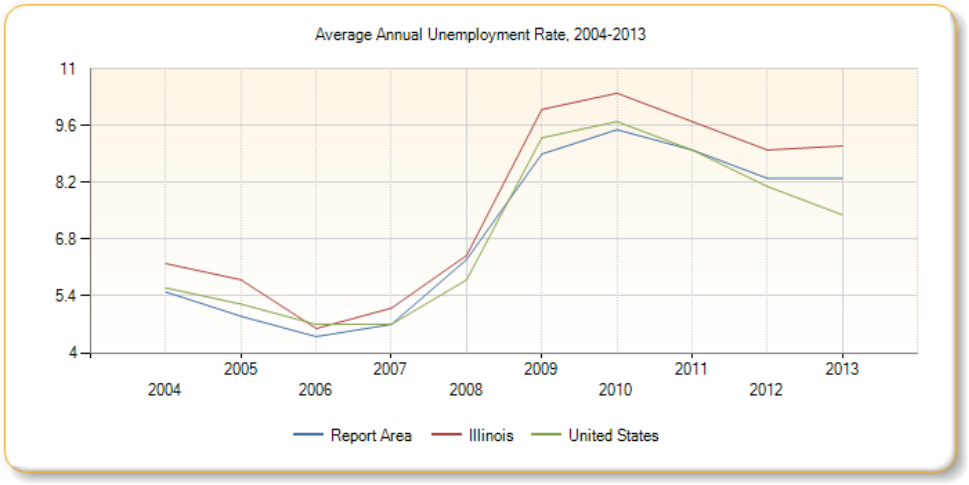
County	Total Population	Total Income ($)	Per Capita Income ($)
Coles	53,732	$ 1,180,506,752	$ 21,970
Cumberland	11,015	$ 252,817,408	$ 22,952
Douglas	19,902	$ 472,310,592	$ 23,731
ILLINOIS	12,848,554	$ 381,170,548,736	$ 29,666
UNITED STATES	311,536,608	$ 8,771,308,355,584	$ 28,154

Source: Community Commons

Unemployment Rate

Exhibit 5 presents the average annual unemployment rate from 2004 - 2013 for the community defined as the community, as well as the trend for Illinois and the United States. On average, the unemployment rate for the community is on target with the United States and lower than the state of Illinois.

Exhibit 5



Data Source: U.S. Department of Labor, Bureau of Labor Statistics. 2015 – May. Source geography: County

Poverty

Exhibit 6 presents the percentage of total population below 100% 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	Total Population	Population in Poverty	Percent Population in Poverty
Total CHNA Community	79,729	14,354	**18%**
Coles County, IL	49,249	10,829	**21.99%**
Cumberland County, IL	10,807	1,497	**13.85%**
Douglas County, IL	19,673	2,028	**10.31%**
Illinois	12,547,066	1,772,333	14.13%
United States	303,692,064	46,663,432	15.37%

Data Source: U.S. Census Bureau, American Community Survey. 2009-13. Source geography: Tract

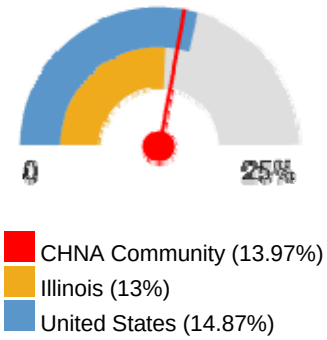
Uninsured

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 12,000 persons are uninsured in the CHNA community. Douglas County has the highest uninsured rate of 20.38%, which is most likely attributable to the high percentage of Amish population living in the county. According to the Association of Religion Data Archives, Amish Groups, undifferentiated Counties (2010), 11.82% of the population in Douglas County is Amish.

Exhibit 7	Total Population (For Whom Insurance Status is Determined)	Total Uninsured Population	Percent Uninsured Population
Total CHNA Community	83,524	11,671	**13.97%**
Coles County, IL	52,975	6,710	**12.67%**
Cumberland County, IL	10,846	946	**8.72%**
Douglas County, IL	19,703	4,015	**20.38%**
Illinois	12,668,117	1,646,762	13%
United States	306,448,480	45,569,668	14.87%

Data Source: U.S. Census Bureau, American Community Survey. 2009-13. Source geography: Tract

Percent Uninsured Population



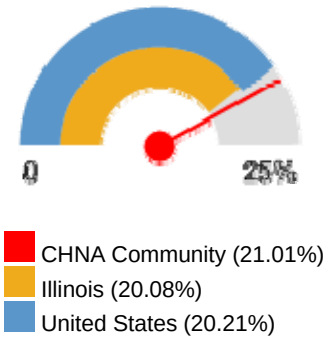
Medicaid

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	Total Population (For Whom Insurance Status is Determined)	Population With Any Health Insurance	Population Receiving Medicaid	Percent of Insured Population Receiving Medicaid
Total CHNA Community	83,524	71,853	15,098	**21.01%**
Coles County, IL	52,975	46,265	9,923	**21.45%**
Cumberland County, IL	10,846	9,900	2,207	**22.29%**
Douglas County, IL	19,703	15,688	2,968	**18.92%**
Illinois	12,668,117	11,021,355	2,212,779	20.08%
United States	306,448,480	260,878,816	52,714,280	20.21%

Data Source: U.S. Census Bureau, American Community Survey. 2009-13. Source geography: Tract

Percent of Insured Population Receiving Medicaid

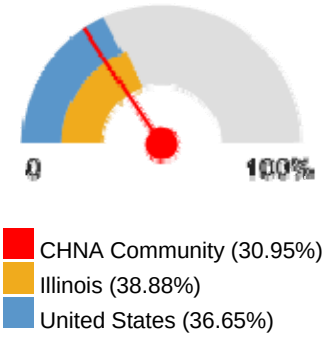


Education

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

Exhibit 9	Total Population Age 25	Population Age 25 With Associate's Degree or Higher	Percent Population Age 25 With Associate's Degree or Higher
Total CHNA Community	52,313	16,192	**30.95%**
Coles County, IL	31,570	11,056	**35.02%**
Cumberland County, IL	7,531	2,001	**26.57%**
Douglas County, IL	13,212	3,135	**23.73%**
Illinois	8,509,739	3,308,365	38.88%
United States	206,587,856	75,718,936	36.65%

Percent Population Age 25 With Associate's Degree or Higher



Data Source: U.S. Census Bureau, American Community Survey. 2009-13. Source geography: Tract

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.

Physical Environment of the Community

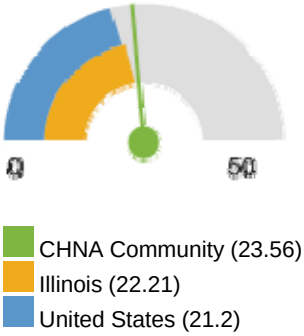
A community's health is also affected by the physical environment. A safe, clean environment that provides access to healthy food and recreational opportunities is important to maintaining and improving community health. This section will touch on a few of the elements that relate to some needs mentioned 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, 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	Total Population	Number of Establishments	Establishments, Rate per 100,000 Population
Total CHNA Community	84,901	20	**23.56**
Coles County, IL	53,873	8	**14.85**
Cumberland County, IL	11,048	3	**27.15**
Douglas County, IL	19,980	9	**45.05**
Illinois	12,830,632	2,850	22.21
United States	312,732,537	66,286	21.2

Grocery Stores, Rate (Per 100,000 Population)



Data Source: U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. 2013.
Source geography: County

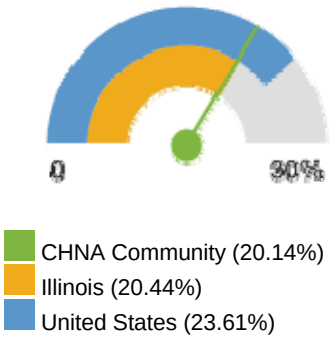
Food Access/Food Deserts

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	Total Population	Population With Low Food Access	Percent Population With Low Food Access
Total CHNA Community	84,901	17,095	**20.14%**
Coles County, IL	53,873	14,591	**27.08%**
Cumberland County, IL	11,048	92	**0.83%**
Douglas County, IL	19,980	2,412	**12.07%**
Illinois	12,830,632	2,623,048	20.44%
United States	308,745,538	72,905,540	23.61%

Data Source: U.S. Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2010. Source geography: Tract

Percent Population With Low Food Access



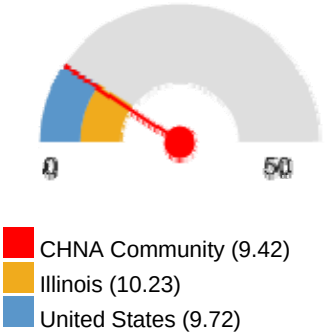
Recreation and Fitness Facility Access

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 is the only county that does not have any fitness establishments available to the residents.

Exhibit 12	Total Population	Number of Establishments	Establishments, Rate per 100,000 Population
Total CHNA Community	84,901	8	**9.42**
Coles County, IL	53,873	6	**11.14**
Cumberland County, IL	11,048	0	**0**
Douglas County, IL	19,980	2	**10.01**
Illinois	12,830,632	1,313	10.23
United States	312,732,537	30,393	9.72

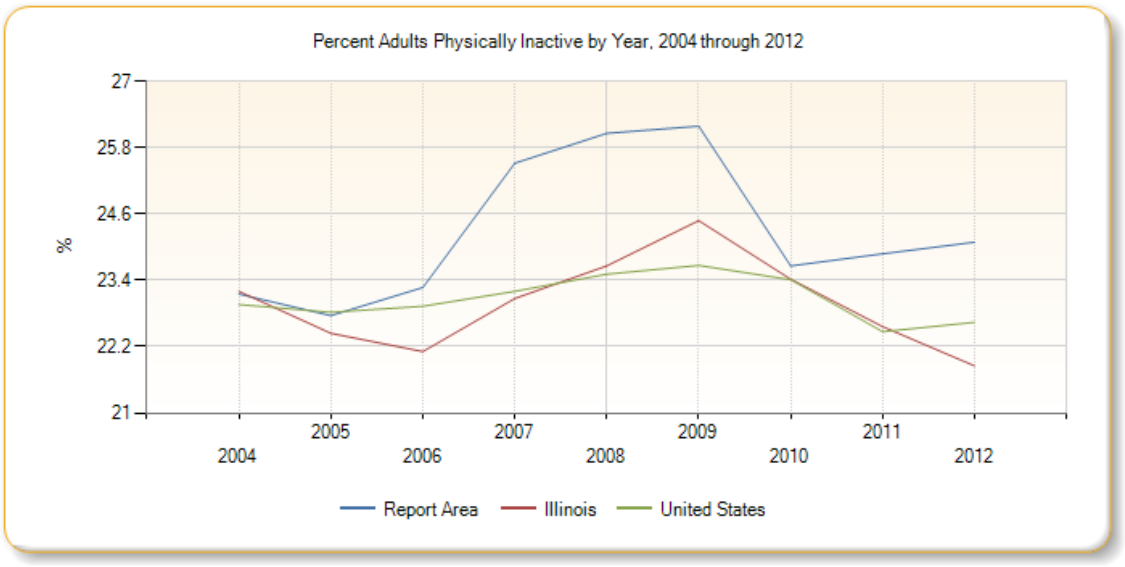
Data Source: U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES. 2013. Source geography: County

Recreation and Fitness Facilities, Rate (Per 100,000 Population)



The trend graph below (*Exhibit 13)* 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 2011 and 2012.

Exhibit 13



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 un-insurance, 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 14 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 14	Total Population, 2012	Primary Care Physicians, 2012	Primary Care Physicians, Rate per 100,000 Pop.
Total CHNA Community	84,476	35	**41.43**
Coles County, IL	53,655	28	**52.19**
Cumberland County, IL	10,968	1	**9.12**
Douglas County, IL	19,853	6	**30.22**
Illinois	12,875,255	10,168	78.97
United States	313,914,040	233,862	74.5

Data Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Area Health Resource File. 2012. Source geography: County

Lack of a Consistent Source of Primary Care

Exhibit 15 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 15	Survey Population (Adults Age 18)	Total Adults Without Any Regular Doctor	Percentage of Adults Without Any Regular Doctor
Total CHNA Community	58,444	7,013	**12%**
Coles County, IL	37,249	6,622	**17.78%**
Cumberland County, IL	no data	no data	no data
Douglas County, IL	21,195	391	**1.84%**
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 16* below shows, 100% of the residents from all counties within the CHNA community are living in a health professional shortage area.

Exhibit 16	Total Area Population	Population Living in a HPSA	Percentage of Population Living in a HPSA
Total CHNA Community	84,901	84,901	**100%**
Coles County, IL	53,873	53,873	**100%**
Cumberland County, IL	11,048	11,048	**100%**
Douglas County, IL	19,980	19,980	**100%**
Illinois	12,830,632	5,894,575	45.94%
United States	308,745,538	105,203,742	34.07%

Data Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015. Source geography: HPSA

Preventable Hospital Events

Exhibit 17 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 17	Total Medicare Part A Enrollees	Ambulatory Care Sensitive Condition Hospital Discharges	Ambulatory Care Sensitive Condition Discharge Rate
Total CHNA Community	10,713	832	**77.67**
Coles County, IL	6,574	555	**84.54**
Cumberland County, IL	1,735	110	**63.45**
Douglas County, IL	2,404	166	**69.18**
Illinois	1,420,984	92,604	65.17
United States	58,209,898	3,448,111	59.24

Data Source: Dartmouth College Institute for Health Policy, Clinical Practice, Dartmouth Atlas of Health Care. 2012. Source geography: County

Health Status of the Community

This section of the assessment reviews the health status of Coles, Cumberland and Douglas 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% 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

Lifestyle	Primary Disease Factor
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 18 reflects the leading causes of death for the community and compares the rates to the state of Illinois and the United States.

Exhibit 18
Sarah Bush Lincoln Health Center
Selected Causes of Resident Deaths: Number and Crude Rate

	Coles		Cumberland		Douglas		Illinois		United States	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Cancer	108	200.86	29	258.29	43	213.44	24,135	188.74	569,481	185.81
Heart disease	133	247.81	25	225.77	52	262.54	25,354	198.26	605,315	197.5
Ischaemic heart disease	84	156.89	14	124.63	24	119.24	15,813	123.66	390,568	127.43
Lung disease	38	70.43	8	75.86	14	68.14	5,253	41.08	137,478	44.86
Stroke	33	60.74	7	61.41	12	58.12	5,526	43.21	131,470	42.9
Unintentional injury	22	40.99	7	66.83	8	38.08	4,142	32.39	122,185	39.87
Motor vehicle	4	8.2	N/A	N/A	N/A	N/A	738	5.77	23,559	7.69
Suicide	6	11.18	N/A	N/A	N/A	N/A	1,177	9.21	37,085	12.1

Source: Community Commons 2007-2011

The table above shows leading causes of death within each county as compared to the state of Illinois and also to the United States. The crude rate is shown per 100,000 residents. The rates highlighted in yellow represent the county and corresponding leading cause of death that is greater than the state rate. As the table indicates, almost all of the leading causes of death above are greater than the Illinois rate.

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:
  - Health behaviors (nine measures)
  - Clinical care (seven measures)
  - Social and economic (nine measures)
  - 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 19*, 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 community health needs assessment 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 19.1
Sarah Bush Lincoln Health Center
County Health Rankings – Health Outcomes

		Coles County 2012	Coles County 2015	Change	Illinois 2015	Top U.S. Performers 2015
Mortality	*	66	61	↓		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)		7,842	7,443	↓	6,349	5,200
Morbidity	*	27	17	↓		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)		11%	9%	↓	15%	10%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)		4.6	3.5	↓	3.4	2.5
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)		2.8	3.1	↑	3.3	2.3
Low birth weight – Percent of live births with low birth weight (<2500 grams)		6.6%	6.9%	↑	8.4%	5.9%

* Rank out of 102 Illinois counties

Note: N/A indicates unreliable or missing data

Source: Countyhealthrankings.org

Exhibit 19.2
Sarah Bush Lincoln Health Center
County Health Rankings – Health Outcomes

		Cumberland County 2012	Cumberland County 2015	Change	Illinois 2015	Top U.S. Performers 2015
Mortality	*	81	42	↓		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)		8,287	6,756	↓	6,349	5,200
Morbidity	*	26	64	↑		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)		N/A	N/A		15%	10%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)		N/A	N/A		3.4	2.5
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)		N/A	N/A		3.3	2.3
Low birth weight – Percent of live births with low birth weight (<2500 grams)		6.6%	8.3%	↑	8.4%	5.9%

* Rank out of 102 Illinois counties

Note: N/A indicates unreliable or missing data

Source: Countyhealthrankings.org

Exhibit 19.3
Sarah Bush Lincoln Health Center
County Health Rankings – Health Outcomes

		Douglas County 2012	Douglas County 2015	Change	Illinois 2015	Top U.S. Performers 2015
Mortality	*	16	24	↑		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)		6,001	5,823	↓	6,349	5,200
Morbidity	*	4	7	↑		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)		6%	N/A		15%	10%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)		3.6	N/A		3.4	2.5
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)		2.0	1.8	↓	3.3	2.3
Low birth weight – Percent of live births with low birth weight (<2500 grams)		6.1%	6.4%	↑	8.4%	5.9%

* 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 and morbidity outcome rankings have improved while Douglas County's overall mortality and morbidity outcome rankings have declined from prior year.

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 20* 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 4% or four 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 20

Coles County:

Improvements	Challenges
Teen Birth Rate – number of births per 1,000 female population decreased from 26 to 21	Sexually Transmitted Infections – chlamydia rate per 100,000 population increased from 500 to 624
Preventable Hospital Stays – number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees decreased from 89 to 85	Primary Care Physicians – ratio of population to primary care physicians increased from 1,681:1 to 1,916:1
Some College – percent of adults with some post-secondary education increased from 60.5% to 64.6%	Mammography Screenings – percent of female Medicare enrollees ages 67 - 69 decreased from 75.2% to 67.6%
Violent Crime Rate – rate per 100,000 population decreased from 307 to 272	Children in Single-Parent Households – percent of children that live in a household headed by a single parent increased from 29% to 34%

Cumberland County:

Improvements	Challenges
Preventable Hospital Stays – number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees decreased from 84 to 63	Primary Care Physicians – ratio of population to primary care physicians increased from 10,803:1 to 10,968:1
Some College – percent of adults with some post-secondary education increased from 55.9% to 61%	Sexually Transmitted Infections – chlamydia rate per 100,000 population increased from 111 to 201
Children in Single-Parent Households – percent of children that live in a household headed by a single parent decreased from 30% to 25%	
Violent Crime Rate – rate per 100,000 population decreased from 232 to 153	

Douglas County:

Improvements	Challenges
Teen Birth Rate – number of births per 1,000 female population decreased from 39 to 30	Sexually Transmitted Infections – chlamydia rate per 100,000 population increased from 159 to 207
Preventable Hospital Stays – number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees decreased from 79 to 69	Primary Care Physicians – ratio of population to primary care physicians increased from 2,414:1 to 3,309:1
Diabetic Screening – percent of diabetic Medicare enrollees that receive HbA1c screenings increased from 85% to 93%	Mammography Screenings – percent of female Medicare enrollees ages 67 - 69 decreased from 77.4% to 67.5%
Violent Crime Rate – rate per 100,000 population decreased from 291 to 195	

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.

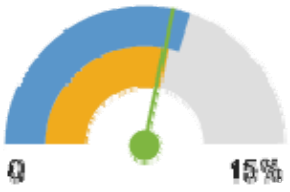
The following exhibits show a more detailed view of certain health outcomes and factors. The percentages for each county and the community as a whole are compared to the state of Illinois.

Diabetes (Adult)

Exhibit 21 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 21	Total Population Age 20	Population With Diagnosed Diabetes	Population With Diagnosed Diabetes, Crude Rate	Population With Diagnosed Diabetes, Age-Adjusted Rate
Total CHNA Community	63,416	5,803	9.15	**8.44%**
Coles County, IL	40,843	3,390	8.3	**8%**
Cumberland County, IL	8,179	916	11.2	**9.4%**
Douglas County, IL	14,394	1,497	10.4	**9%**
Illinois	9,429,505	873,757	9.27	8.67%
United States	234,058,710	23,059,940	9.85	9.11%

Percent Adults With Diagnosed Diabetes (Age-Adjusted)



CHNA Community (8.44%)
Illinois (8.67%)
United States (9.11%)

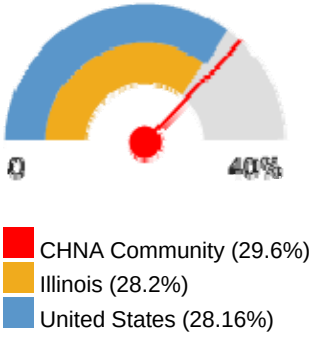
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012. Source geography: County

High Blood Pressure (Adult)

Per *Exhibit 22* below, 17,364 or 29.6% 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 less than the percentage of Illinois and the United States.

Exhibit 22	Total Population (Age 18)	Total Adults With High Blood Pressure	Percent Adults With High Blood Pressure
Total CHNA Community	67,104	17,364	**29.6%**
Coles County, IL	43,850	12,760	**29.1%**
Cumberland County, IL	8,449	no data	suppressed
Douglas County, IL	14,805	4,604	**31.1%**
Illinois	9,654,603	2,722,598	28.2%
United States	232,556,016	65,476,522	28.16%

Percent Adults with High Blood Pressure



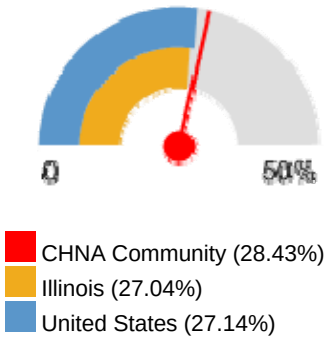
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-12. Source geography: County

Obesity

Of adults aged 20 and older, 28.43% self-report that they have a body mass index (BMI) greater than 30.0 (obese) in the community per *Exhibit 23*. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues. All three counties have a BMI percentage greater than the state rate.

Exhibit 23	Total Population Age 20	Adults With BMI > 30.0 (Obese)	Percent Adults With BMI > 30.0 (Obese)
Total CHNA Community	63,354	18,149	**28.43%**
Coles County, IL	40,823	11,308	**27.7%**
Cumberland County, IL	8,213	2,431	**28.9%**
Douglas County, IL	14,318	4,410	**30.2%**
Illinois	9,449,802	2,592,853	27.04%
United States	231,417,834	63,336,403	27.14%

Percent Adults With BMI > 30.0 (Obese)



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

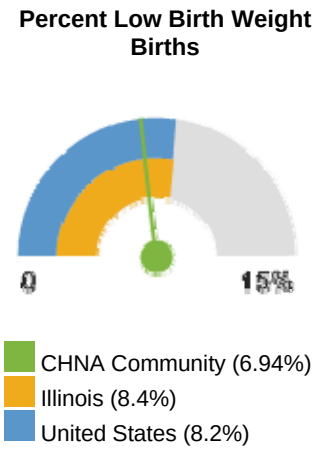
Exhibit 24	Total Population (Age 18)	Total Adults With Poor Dental Health	Percent Adults With Poor Dental Health
Total CHNA Community	66,914	7,836	suppressed
Coles County, IL	43,705	7,836	**17.93%**
Cumberland County, IL	8,428	no data	suppressed
Douglas County, IL	14,781	no data	suppressed
Illinois	9,654,603	1,418,280	14.69%
United States	235,375,690	36,842,620	15.65%

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 25 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 25	Total Live Births	Low Weight Births (Under 2500g)	Low Weight Births, Percent of Total
CHNA Community	6,860	476	**6.94%**
Coles County, IL	3,948	272	**6.9%**
Cumberland County, IL	917	76	**8.3%**
Douglas County, IL	1,995	128	**6.4%**
Illinois	1,251,656	105,139	8.4%
United States	29,300,495	2,402,641	8.2%
HP 2020 Target			<= 7.8%



Data Source: U.S. Department of Health and 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 25 key stakeholders. 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, 2013 through June 30, 2016.

Interview data was initially recorded in narrative form asking participants a series of fourteen 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.

Forty percent (10 out of 25) of the key stakeholders rated the health and quality of life in their county as "average" or "fair". Eight of the key stakeholders rated the health and quality of life as "less than average". The remaining seven stakeholders rated the health and quality of life as "good" or "very good". Key stakeholders repeatedly noted that the high rate of poverty negatively impacts the health and quality of life in the community. It was noted that the community has distinct populations which are clearly aligned with socioeconomic status. The decrease in and lack of funding for programs for the low-income and uninsured population has also had a negative impact to the health and quality of life in the community. Stakeholders noted that unhealthy habits such as smoking, lack of exercise and poor nutrition contribute to poor health in the community.

Certain key stakeholders had very positive opinions regarding youth programming conducted by SBL. They cited many youth sports and activities were making a positive change for the youth in the community. Several stakeholders noted that people are starting to make positive changes in the community regarding healthy habits.

When asked whether the health and quality of life had improved, declined or stayed the same, 14 of the 25 stakeholders expressed they thought the health and quality of life had improved over the last three years. When asked why they thought the health and quality of life had improved, key stakeholders noted that there was generally an increased awareness regarding healthy and active living among residents of the community, as well as more access to physical activity. They also attributed the improvement to continued expansion of SBL services, including more specialists and the addition of walk-in clinics. Key stakeholders had positive feelings toward the Carle Foundation Hospital adding a facility in the community.

Stakeholders who felt health and quality of life had declined stated access for residents with lower incomes was a significant issue. They also noted that more people need help today than in the past. Due to increased poverty, people need assistance in a variety of areas including housing, childcare and counseling. Many of the social services have been eliminated due to lack of funding. They also noted that it is becoming increasingly difficult for persons to understand how to access much needed social services.

Lack of mental health services in the community was also attributed to negatively impacting the health and quality of life in the community. Many key stakeholders stated there was a severe

shortage of mental health providers in the community. While there are a few services available, many who need services lack education regarding behavioral health and resist treatment due to the stigma attached to mental health conditions. Additionally, the cost associated with treatment prohibits individuals from seeking care. The stakeholders noted a significant increase in the need for mental health services for both adults and children. Lack of funding for these services and lack of providers was noted on multiple occasions.

Key stakeholders suggested family oriented programs at the schools may be a good way to communicate with many low-income families regarding health issues. Increased outreach through the schools was recommended with the possibility of having family clinic nights at schools.

"Poverty is a huge issue. People don't know where to go for help."

"SBL programs for youth are great!"

"Health care providers need to be trained in how they deal with community members who may not be middle class or upper class. There needs to be more outreach on available services to low income/uninsured individuals."

"People don't have a general awareness about how to access services. They are grasping at straws."

"Rural areas have no mental health resources."

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 noted that persons living with low-incomes or in poverty are most likely to be underserved due to lack of access to services. Lack of financial resources prevents persons with low-income from seeking medical care and it was noted that adult dental services are not available to persons with low-incomes or living in poverty. Transportation was felt to be a major barrier for persons with few financial resources. Persons who utilize Dial-a-Ride services often have to wait for days to schedule rides to medical appointments and pick-up and drop-off locations are not at the resident's door. Parents of young children need to provide car seats and the process of transporting multiple children and car seats, for some transportation options, to a pickup or drop-off site may not be realistic or safe. Persons living with low incomes also have less access to healthy food.

The elderly was also identified as a population that is faced with challenges accessing care due to limited transportation, isolation and fixed incomes.

Several of the key stakeholders noted there are language barriers and transportation barriers for the Hispanic population living in the community. Persons who work with the Hispanic population noted that due to cultural differences, the Hispanic population is unlikely to utilize any form of public

transportation. The language barrier and lack of legal status for many of these immigrant workers limits the health care services they are able to access, particularly preventative services.

"Lack of adult dental care is a critical issue, which translates to poor physical health."

"70% of kids are on free lunch program."

"Access is extremely disproportionate based on socioeconomic status."

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. The majority of the key stakeholders noted that transportation was a barrier to access to health care. Lack of funding for programs targeted at persons with low-income and the inability for persons with low-income to afford healthcare were also seen as barriers. Key stakeholders indicated that lack of employment opportunities has negatively impacted rates of poverty in the community.

It was also noted that drugs and/or alcohol were a priority over healthcare for persons dealing with substance abuse.

Lack of healthy food was stated as a barrier to improving health in the community. Access points for persons to access health food are limited and the operating hours for food pantries and farmers markets are limited and not convenient for the working poor.

"There is not a transportation option that is easy/convenient to use."

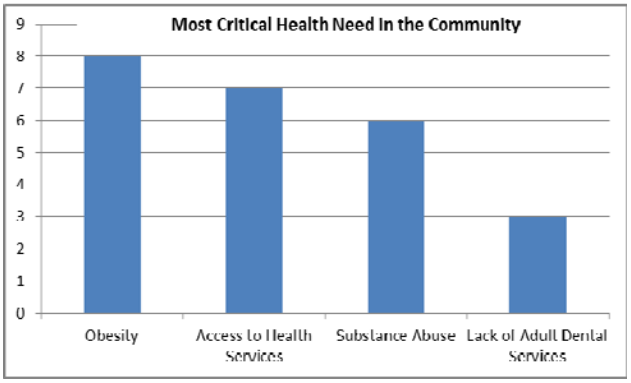
"If there was reliable bus transportation - that would alleviate a barrier. Transportation gives people a sense of security."

"The hours for food pantries and farmer's markets don't work for working poor."

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:

- Obesity
- Access to health services (including mental health services)
- Substance abuse
- Lack of adult dental services



It was also noted that heart disease, cancer and diabetes are health conditions impact the community.

"A lot of the mental health illnesses that could be treated with medication and counseling turn into persons self-medicating with drugs and alcohol."

The key stakeholders were also asked to identify the most critical issue the hospital should address over the next three to five years. Responses included:

- Continue to establish partnerships with other organizations to increase outreach.
- Increase outreach and programming to smaller communities.
- More education and awareness regarding resources and preventive programs.
- Increase mental health services and work to remove stigma surrounding mental health.
- Continue education outreach in schools.
- Continue to expand programs and services including hours and locations of clinics.
- Increase collaboration with county health departments.
- Oral health
- Obesity
- Increase outreach on how to access services and other non-health resources. Several persons noted the need for a central person to bring resources together.

"SBL, as the manager, needs to bring together and strengthen the abilities of other organizations."

"Everyone needs to have a common vision of how to support the issues."

"People don't know where to start to get resources in order to improve."

5. Feedback on Sarah Bush Lincoln's implementation strategy for July 1, 2013 through June 30, 2016.

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, 2013 through June 30, 2016 regarding access to care, the Center for Healthy Living and adult dental care.

- ***Access to Care:*** Key stakeholders were asked whether or not access to health services has improved over the last three years. The majority of the respondents (22 of 25) felt that access had improved over the last three years. The most common response to why access had improved over the last three years was opening of walk-in clinics and expansion of clinics in smaller communities. Respondents also attributed the improvement to increased awareness of the services provided by SBL due to increased communication, SBL community events and an increase in primary care doctors.

- ***Center for Healthy Living:*** Key stakeholders were asked if they were familiar with SBL's Center for Healthy Living. The Center for Healthy Living opened in early 2015 and is described on page 6 of this report. Key stakeholders had varying degrees of familiarity with the Center for Healthy Living. More than 50% of the stakeholders were familiar with the Center for Healthy Living. All stakeholders thought the concept was a great idea regardless of whether or not they were familiar with the Center for Healthy Living. Those stakeholders most familiar with the Center for Healthy Living suggested expanding the operating hours of the facility, expanding similar programing out to smaller communities and potentially offering educational sessions for WIC mothers at the through the Center for Healthy Living.

- ***Adult Dental Needs:*** SBL solicited suggestions from the key stakeholders regarding how best to address the adult dental needs of the community. The most common suggestion was collaboration with other agencies such as health departments, dental schools and agencies addressing children's dental needs. They also suggested expanding SBL's mobile dental clinic by providing evening and weekend hours for the entire family. Several of the stakeholders suggested partnering with the PAD shelter and or schools as these organizations know which families need the care.

Key Findings

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

- The community is poor and many people don't have the education or awareness on making healthy lifestyle choices.
- The decrease in social services provided by agencies, due to lack of funding, is negatively impacting those with lower financial resources and the community as a whole.
- More accessible ambulatory care is needed. Convenient hours need to be offered to patients.
- Education on health issues, preventative care and nutritional information is limited. There is a significant need for community outreach programs aimed to educate patients and those within and around the community. Many key informants suggested programs being brought to the community instead of people coming to the Health Center.
- There is a severe lack of mental and behavioral health services.
- One-third of the interviewees stated substance abuse was a critical health issue within the community.
- Obesity is seen as the most critical health issue in the community due to the overall negative impact it has on one's health.
- Increased access to adult dental services is needed. Kids get services through the school system, but adults without dental coverage have nowhere to obtain necessary dental services.
- Almost half of those interviewed (10 out of 22) stated transportation was a barrier to health. Transportation is an issue for people and prevents them from seeking care or making their appointments or receiving follow-up care.

- Lack of employment opportunities were also listed as a barrier to improving health and quality of life
- The addition of walk-in clinics is seen as positively impacting community health in a variety of ways.
- Although most interviewees thought access to care has improved over the past three years, it continues to be an issue due to transportation, cost of visit/medication and limited hours for ambulatory care services.

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
  - Access to primary care physicians
  - High cost of health care prevents needs from being met
  - Healthy lifestyle and health nutrition education
  - Access to food
  - Lack of mental health services
  - Lack of adult dental services
- Elderly
  - Transportation
  - Lack of health knowledge regarding how to access services
  - Cost of prescriptions
  - Lack of adult dental services
- Immigrant Population
  - Language barriers
  - Transportation
  - Healthy living education

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% 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% of the community= 5; >15% and <25%=4; >10% and <15%=3; >5% and <10%=2 and <5%=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 26
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 *
Lack of Access to Services	5	3	4	5	3	**20**
Healthy Behaviors/Lifestyle Choices	5	4	4	3	3	**19**
Poor Nutrition/Limited Access to Healthy Food Options	5	4	5	3	2	**19**
Lack of Dentists/Adult Services	4	3	4	5	2	**18**
Lack of Mental Health Providers/Services	5	3	4	4	2	**18**
Substance Abuse	5	4	2	5	2	**18**
Transportation	5	1	5	5	1	**17**
Lack of Health Knowledge/Education	5	1	4	4	2	**16**
Heart Disease	4	5	0	4	3	**16**
Obesity	3	5	0	5	3	**16**
Physical Inactivity	4	3	4	3	1	**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**
Adult Smoking/Tobacco Use	4	5	0	3	2	**14**
Children in Poverty/Homelessness	3	2	5	2	1	**13**
Cancer	3	5	0	2	1	**11**
Stroke	3	3	0	2	1	**9**
Lung Disease	3	3	0	2	1	**9**
Access to Exercise Opportunities	3	1	2	1	1	**8**
Children in Single-Parent Households	3	2	0	2	1	**8**
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**
Teen Birth Rate	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 26*, 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 2017-2019 will be:

- Access to Services (access to primary care and specialty services, clinic hours)
- Healthy Behaviors/Lifestyle Choices (physical activity, wellness, nutrition, tobacco use, obesity, heart disease, lung disease, exercise
- Lack of Dentists/Adult Services
- Transportation
- Uninsured/Limited Insurance (cost of healthcare/prescriptions)

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 129 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 27 summarizes hospitals available to the residents of the three counties in which the community resides. The facilities with an asterisk (*) next to their name in the table below are not located in the three-county CHNA community; however, they represent hospital facilities that are within 30 miles of Mattoon, Illinois.

Exhibit 27
Sarah Bush Lincoln Health Center
Summary of Area Hospitals and Health Centers

	Facility	Address	County
*	Shelby Memorial 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 28* provides a listing of community health centers and rural health clinics within the Health Center's community.

Exhibit 28
Sarah Bush Lincoln Health Center
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
Marshall Clinic Effingahm SC	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, Suite 39, 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)

The Health Center's CHNA community also has a number of clinics inside various retail facilities, including Walgreens and CVS. These clinics are expanding past providing only flu shots to providing checkups and treatments to a growing list of ailments.

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 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 2010 – 2015 states that the strategic health issues selected to focus on are underage binge drinking, heart disease, access to care and lung cancer.

Other Resources

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

Sarah Bush Lincoln Health Center-Priority Area	Community Resources
Access to Services	•SBL extended campus locations
Healthy Behaviors	•YMCA •County Health Departments •SBL Center for Healthy Living
Lack of Dentists	•County Health Departments
Transportation	•County Health Departments •Community Leaders
Uninsured/Limited Insurance	•Grant Funding •SBL Financial Assistance

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	185.8	18.6	200.9	15.1	
Heart Disease	197.5	19.8	247.8	50.3	Health Need
Lung Disease	44.9	4.5	70.4	25.6	Health Need
Stroke	42.9	4.3	60.7	17.8	Health Need
Unintentional Injury	39.9	4.0	41.0	1.1	
Cumberland County:					
Cancer	185.8	18.6	258.3	72.5	Health Need
Heart Disease	197.5	19.8	225.8	28.3	Health Need
Lung Disease	44.9	4.5	75.9	31.0	Health Need
Stroke	42.9	4.3	61.4	18.5	Health Need
Unintentional Injury	39.9	4.0	66.8	27.0	Health Need
Douglas County:					
Cancer	185.8	18.6	213.4	27.6	Health Need
Heart Disease	197.5	19.8	262.5	65.0	Health Need
Lung Disease	44.9	4.5	68.1	23.3	Health Need
Stroke	42.9	4.3	58.1	15.2	Health Need
Unintentional Injury	39.9	4.0	38.1	-1.8	

***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%	11.0%	-3.0%	
Adult Obesity	25.0%	7.5%	28.0%	3.0%	
Food Environment Index	8.4	3	7.1	1	
Physical Inactivity	20.0%	6.0%	23.0%	3.0%	
Access to Exercise Opportunities	92.0%	27.6%	78.0%	14.0%	
Excessive Drinking	10.0%	3.0%	14.0%	4.0%	Health Need
Alcohol-Impaired Driving Deaths	14.0%	4.2%	31.0%	17%	Health Need
Sexually Transmitted Infections	138	41	624	486	Health Need
Teen Birth Rate	20	6	21	1	
Uninsured	11.0%	3.3%	13.0%	2.0%	
Primary Care Physicians	1045	314	1916	871	Health Need
Dentists	1377	413	2148	771	Health Need
Mental Health Providers	386	116	610	224	Health Need
Preventable Hospital Stays	41	12	85	44	Health Need
Diabetic Screen Rate	90.0%	27.0%	87.0%	3.0%	
Mammography Screening	70.7%	21.2%	67.6%	3.1%	
Violent Crime Rate	59	18	272	213	Health Need
Children in Poverty	13.0%	3.9%	22.0%	9.0%	Health Need
Children in Single-Parent Households	20.0%	6.0%	34.0%	14.0%	Health Need
Cumberland County:					
Adult Smoking	14.0%	4.2%	N/A		
Adult Obesity	25.0%	7.5%	30.0%	5.0%	
Food Environment Index	8.4	3	8.6	0	
Physical Inactivity	20.0%	6.0%	29.0%	9.0%	Health Need
Access to Exercise Opportunities	92.0%	27.6%	1.0%	91.0%	Health Need
Excessive Drinking	10.0%	3.0%	N/A		
Alcohol-Impaired Driving Deaths	14.0%	4.2%	21.0%	7%	Health Need
Sexually Transmitted Infections	138	41	201	63	Health Need
Teen Birth Rate	20	6	33	13	Health Need
Uninsured	11.0%	3.3%	12.0%	1.0%	
Primary Care Physicians	1045	314	10968	9923	Health Need
Dentists	1377	413	10939	9562	Health Need
Mental Health Providers	386	116	2735	2349	Health Need
Preventable Hospital Stays	41	12	63	22	Health Need
Diabetic Screen Rate	90.0%	27.0%	88.0%	2.0%	
Mammography Screening	70.7%	21.2%	62.9%	7.8%	
Violent Crime Rate	59	18	153	94	Health Need
Children in Poverty	13.0%	3.9%	18.0%	5.0%	Health Need
Children in Single-Parent Households	20.0%	6.0%	25.0%	5.0%	
Douglas County:					
Adult Smoking	14.0%	4.2%	N/A		
Adult Obesity	25.0%	7.5%	30.0%	5.0%	
Food Environment Index	8.4	3	8.6	0	
Physical Inactivity	20.0%	6.0%	28.0%	8.0%	Health Need
Access to Exercise Opportunities	92.0%	27.6%	72.0%	20.0%	
Excessive Drinking	10.0%	3.0%	N/A		
Alcohol-Impaired Driving Deaths	14.0%	4.2%	42.0%	28%	Health Need
Sexually Transmitted Infections	138	41	207	69	Health Need
Teen Birth Rate	20	6	30	10	Health Need
Uninsured	11.0%	3.3%	16.0%	5.0%	Health Need
Primary Care Physicians	1045	314	3309	2264	Health Need
Dentists	1377	413	2210	833	Health Need
Mental Health Providers	386	116	9944	9558	Health Need
Preventable Hospital Stays	41	12	69	28	Health Need
Diabetic Screen Rate	90.0%	27.0%	93.0%	-3.0%	
Mammography Screening	70.7%	21.2%	67.5%	3.2%	
Violent Crime Rate	59	18	195	136	Health Need
Children in Poverty	13.0%	3.9%	17.0%	4.0%	Health Need
Children in Single-Parent Households	20.0%	6.0%	22.0%	2.0%	

Analysis of Primary Data - Key Informant Interviews

Poverty
Lack of Convenient Ambulatory Care
Lack of Health Knowledge/Education
Healthy Behaviors/Lifestyle Choices
Lack of Mental Health Services
Substance Abuse
Obesity
Heart Disease
Poor Nutrition/Lack of Healthy Food Options
Transportation
Shortage of Adult Dental Services
Pre-Natal Care
Uninsured
Lack of Physicians
Cost of Healthcare
Good Employment Opportunities

Issues of Uninsured Persons, Low-Income Persons and Minority/Vulnerable Populations

Population	Issues
Uninsured/Working Poor Population	Transportation Access to primary care physicians High cost of health care prevents needs from being met Healthy lifestyle and health nutrition education Access to food Lack of mental health services Lack of adult dental services
Elderly	Transportation Lack of health knowledge regarding how to access services Cost of prescriptions Lack of adult dental services
Immigrant Population	Language barriers Transportation Healthy living education

APPENDIX B

SOURCES

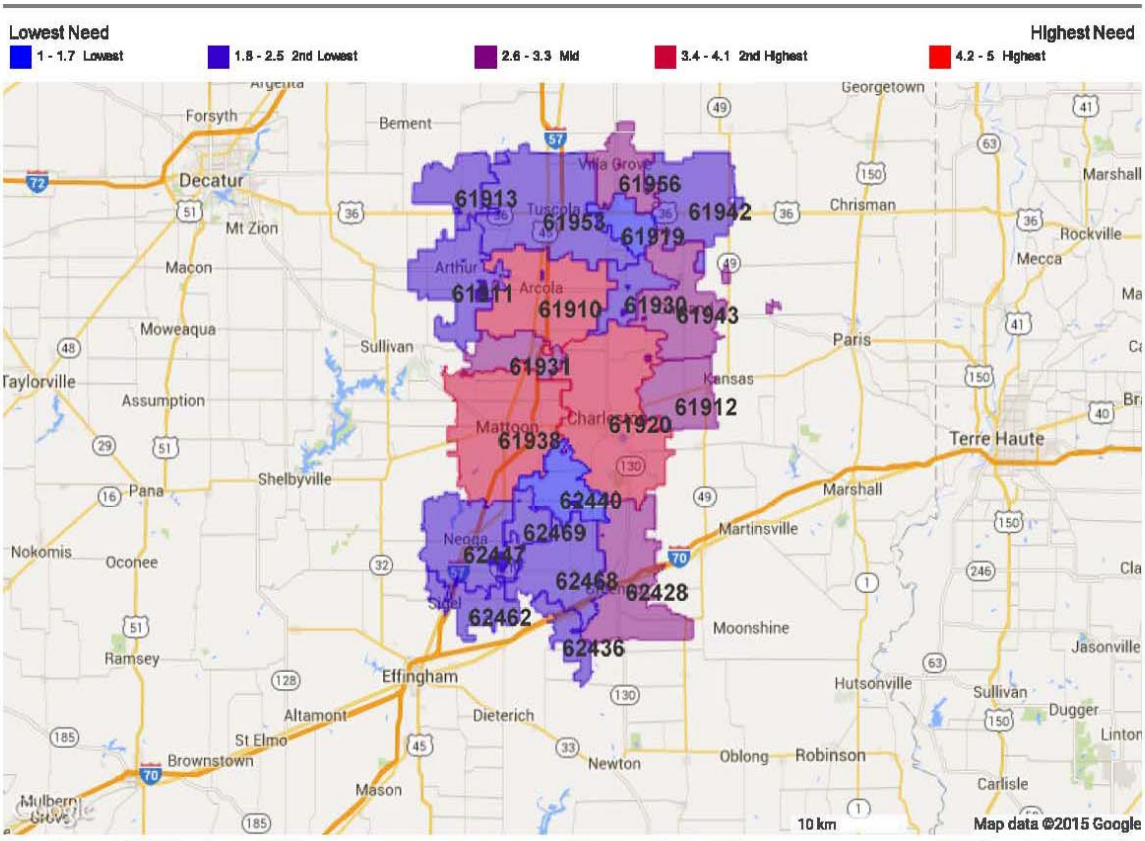
DATA TYPE	SOURCE	YEAR(S)
Discharges by Zip Code	Hospital	FY 2015
Population Estimates	The Nielson Company	2015
Demographics - Race/Ethnicity	Community Commons via American Community Survey http://www.communitycommons.org/	2015
Demographics - Income	Community Commons via American Community Survey http://www.communitycommons.org/	2009 - 2013
Unemployment	Community Commons via US Department of Labor http://www.communitycommons.org/	2015
Poverty	Community Commons via US Census Bureau, Small Areas Estimates Branch http://www.census.gov	2009 - 2013
Uninsured Status	Community Commons via US Census Bureau, Small area Helath Insurance Estimates http://www.communitycommons.org/	2009 - 2013
Medicaid	Community Commons via American Community Survey http://www.communitycommons.org/	2009 - 2013
Education	Community Commons via American Community Survey http://www.communitycommons.org/	2009 - 2013
Physical Environment - Grocery Store Access	Community Commons via US Cenus Bureau, County Business Patterns http://www.communitycommons.org/	2013
Physical Environment - Food Access/Food Deserts	Community Commons via US Department of Agriculture http://www.communitycommons.org/	2010
Physical Environment - Recreation and Fitness Facilities	Community Commons via US Cenus Bureau, County Business Patterns http://www.communitycommons.org/	2013
Physical Environment - Physically Inactive	Community Commons via US Centers for Disease control and Prevention http://www.communitycommons.org/	2012
Clinical Care - Access to Primary Care	Community Commons via US Department of Health & Human Services http://www.communitycommons.org/	2012
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 Health Professional Shortage Area	Community Commons via US Department of Health & Human Services http://www.communitycommons.org/	2015
Clinical Care - Preventable Hospital Events	Community Commons via Dartmouth College Institute for Health Policy & Clinical Practice http://www.communitycommons.org/	2012
Leading Causes of Death	Community Commons via CDC national Bital Statistics System http://www.communitycommons.org/	2007 - 2011
Health Outcomes and Factors	County Health Rankings http://www.countyhealthrankings.org/ & Community Commons http://www.communitycommons.org/	2015 & 2006 - 2012
Health Care Resources	Community Commons, CMS.gov, HRSA	

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): 2.5 / Mean(person): 3.1 CNI Score Median: 2.4 CNI Score Mode: 2,2.4,2.6

Zip Code	CNI Score	Population	City	County	State
61910	3.8	4492	Arcola	Douglas	Illinois
61911	2.4	4992	Arthur	Douglas	Illinois
61912	2.6	1102	Ashmore	Coles	Illinois
61913	2.2	1736	Atwood	Douglas	Illinois
61919	1.2	780	Camargo	Douglas	Illinois
61920	3.6	25796	Charleston	Coles	Illinois
61930	2	441	Hindsboro	Douglas	Illinois
61931	3.2	1127	Humboldt	Coles	Illinois
61938	3.6	22144	Mattoon	Coles	Illinois
61942	2	1159	Newman	Douglas	Illinois
61943	2.6	1471	Oakland	Coles	Illinois
61953	2.4	6334	Tuscola	Douglas	Illinois
61956	2.6	2958	Villa Grove	Douglas	Illinois
62428	2.6	2978	Greenup	Cumberland	Illinois
62436	2	544	Jewett	Cumberland	Illinois
62440	1.4	1280	Lerna	Coles	Illinois
62447	2.2	3649	Neoga	Cumberland	Illinois
62462	2	1203	Sigel	Shelby	Illinois
62468	2.4	2573	Toledo	Cumberland	Illinois
62469	2.4	524	Trilla	Cumberland	Illinois

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

APPENDIX D

COUNTY HEALTH RANKINGS

Sarah Bush Lincoln Health Center
County Health Rankings – Health Factors

		Coles County 2012	Coles County 2015	Change	Illinois 2015	Top Performers 2015**
Health Behaviors	*	6	3	↓		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke		10%	11%	↑	18%	14.0%
Adult obesity – Percent of adults that report a BMI >= 30		29%	28%	↓	27%	25.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)		N/A	7.1		7.8	8.4
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity		25%	23%	↓	23%	20.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity		N/A	78%		89%	92.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days		15%	14%	↓	20%	10.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement		N/A	31%		37%	14.0%
Sexually transmitted infections – Chlamydia rate per 100K population		500.0	624.0	↑	526.0	138.0
Teen birth rate – Per 1,000 female population, ages 15-19		26.0	21.0	↓	35.0	20.0
Clinical Care	*	25	56	↑		
Uninsured adults – Percent of population under age 65 without health insurance		13%	13%		15%	11%
Primary care physicians – Ratio of population to primary care physicians		1,681:1	1,916:1	↑	1,266:1	1,045:1
Dentists – Ratio of population to dentists		N/A	2,148:1		1,453:1	1,377:1
Mental health providers – Ratio of population to mental health providers		N/A	610:1		604:1	386:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees		89	85	↓	65	41
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening		87%	87%		85%	90%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening		75.2%	67.6%	↓	64.4%	70.7%
Social and Economic Factors	*	45	54	↑		
High school graduation – Percent of ninth grade cohort that graduates in 4 years		87%	85%	↓	82%	N/A
Some college – Percent of adults aged 25-44 years with some post-secondary education		60.5%	64.6%	↑	66.7%	71.0%
Unemployment – Percent of population age 16+ unemployed but seeking work		9.6%	8.8%	↓	9.2%	4.0%
Children in poverty – Percent of children under age 18 in poverty		22%	22%		21%	13.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile		N/A	5.3		4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent		29%	34%	↑	32%	20%
Social associations – Number of membership associations per 10,000 population		N/A	15.1		9.9	22.0
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)		307	272	↓	430	59.0
Injury deaths – Number of deaths due to injury per 100,000 population		N/A	53		50	50.0
Physical Environment	*	28	98	↑		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter		1.0	13.6	↑	12.5	9.5
Drinking water safety – Percentage of population exposed to water exceeding a violation limit during the past year		N/A	11%		2%	0%
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		N/A	19%		19%	9%
Driving alone to work – Percentage of the workforce that drives alone to work		N/A	76%		74%	71%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30		N/A	18%		40%	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

Sarah Bush Lincoln Health Center
County Health Rankings – Health Factors

		Cumberland County 2012	Cumberland County 2015	Change	Illinois 2015	Top Performers 2015**
Health Behaviors	*	25	32	↑		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke		N/A	N/A		18%	14%
Adult obesity – Percent of adults that report a BMI >= 30		28%	30%	↑	27%	25%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)		N/A	8.6		7.8	8.4
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity		31%	29.0%	↓	23%	20%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity		N/A	1%		89%	92%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days		N/A	N/A		20%	10%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement		N/A	21%		37%	14%
Sexually transmitted infections – Chlamydia rate per 100K population		111.0	201.0	↑	526.0	138.0
Teen birth rate – Per 1,000 female population, ages 15-19		30.0	33.0	↑	35.0	20.0
Clinical Care	*	67	55	↓		
Uninsured adults – Percent of population under age 65 without health insurance		13%	12%	↓	15%	11%
Primary care physicians – Ratio of population to primary care physicians		10,803:1	10,968:1	↑	1,266:1	1,045:1
Dentists – Ratio of population to dentists		N/A	10,939:1		1,453:1	1,377:1
Mental health providers – Ratio of population to mental health providers		N/A	2,735:1		604:1	386:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees		84	63	↓	65	41
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening		88%	88%		85%	90%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening		64.8%	62.9%	↓	64.4%	70.7%
Social and Economic Factors	*	46	51	↑		
High school graduation – Percent of ninth grade cohort that graduates in 4 years		87%	85%	↓	82%	N/A
Some college – Percent of adults age 25-44 years with some post-secondary education		55.9%	61%	↑	66.7%	71%
Unemployment – Percent of population age 16+ unemployed but seeking work		10.4%	9.7%	↓	9.2%	4%
Children in poverty – Percent of children under age 18 in poverty		18%	18%		21%	13%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile		N/A	4.0		4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent		30%	25%	↓	32%	20%
Social associations – Number of membership associations per 10,000 population		N/A	12.8		9.9	22
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)		232	153	↓	430	59
Injury deaths – Number of deaths due to injury per 100,000 population		N/A	76		50	50
Physical Environment	*	86	47	↓		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter		2.0	13.7	↑	12.5	9.5
Drinking water safety – Percentage of population exposed to water exceeding a violation limit during the past year		N/A	-		2%	-
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		N/A	10%		19%	9%
Driving alone to work – Percentage of the workforce that drives alone to work		N/A	79%		74%	71%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30		N/A	36%		40%	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*

Sarah Bush Lincoln Health Center
County Health Rankings – Health Factors

		Douglas County 2012	Douglas County 2015	Change	Illinois 2015	Top Performers 2015**
Health Behaviors	*	14	36	↑		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke		13%	N/A		18%	14.0%
Adult obesity – Percent of adults that report a BMI >= 30		30%	30%		27%	25.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)		N/A	8.6		7.8	8.4
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity		29%	28%	↓	23%	20.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity		N/A	72%		89%	92.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days		10%	N/A		20%	10.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement		N/A	42%		37%	14.0%
Sexually transmitted infections – Chlamydia rate per 100K population		159.0	207.0	↑	526.0	138.0
Teen birth rate – Per 1,000 female population, ages 15-19		39.0	30.0	↓	35.0	20.0
Clinical Care	*	52	75	↑		
Uninsured adults – Percent of population under age 65 without health insurance		16%	16%		15%	11%
Primary care physicians – Ratio of population to primary care physicians		2,414:1	3,309:1	↑	1,266:1	1,045:1
Dentists – Ratio of population to dentists		N/A	2,210:1		1,453:1	1,377:1
Mental health providers – Ratio of population to mental health providers		N/A	9,944:1		604:1	386:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees		79	69	↓	65	41
Diabetic screening – Percent of diabetic Medicare enrollees that receive HbA1c screening		85%	93%	↑	85%	90%
Mammography screening – Percent of female Medicare enrollees that receive mammography screening		77.4%	67.5%	↓	64.4%	70.7%
Social and Economic Factors	*	31	26	↓		
High school graduation – Percent of ninth grade cohort that graduates in 4 years		85%	86%	↑	82%	N/A
Some college – Percent of adults age 25-44 years with some post-secondary education		47.9%	50.3%	↑	66.7%	71.0%
Unemployment – Percent of population age 16+ unemployed but seeking work		9.3%	7.5%	↓	9.2%	4.0%
Children in poverty – Percent of children under age 18 in poverty		17%	17%		21%	13.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile		N/A	3.8		4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent		22%	22%		32%	20%
Social associations – Number of membership associations per 10,000 population		N/A	19.1		9.9	22.0
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)		291	195	↓	430	59.0
Injury deaths – Number of deaths due to injury per 100,000 population		N/A	54		50	50.0
Physical Environment	*	55	33	↓		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter		1.0	13.4	↓	12.5	9.5
Drinking water safety – Percentage of population exposed to water exceeding a violation limit during the past year		N/A	-		2%	0%
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		N/A	12%		19%	9%
Driving alone to work – Percentage of the workforce that drives alone to work		N/A	75%		74%	71%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30		N/A	35%		40%	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

KEY INFORMANT INTERVIEW

Community Health Needs Assessment for:

Interviewer's Initials: _____

Date: _____ Start Time:_____ End Time: _____

Name: _____ Title: _____

Agency/Organization: _____

# of years living in _____ County: ____ # of years in current position: ____

E-mail address: _____

Introduction: Good morning/afternoon. My name is **[interviewer's name]**. Thank you for taking time out of your busy day to speak with me. I'll try to keep our time to approximately 40 minutes, but we may find that we run over – up to 50 minutes total - once we get into the interview. **(Check to see if this is okay).**

[Name of Organization] is gathering local data as part of developing a plan to improve health and quality of life in __Coles__ County. Community input is essential to this process. A combination of surveys and key informant interviews are being used to engage community members. You have been selected for a key informant interview because of your knowledge, insight, and familiarity with the community. The themes that emerge from these interviews will be summarized and made available to the public; however, individual interviews will be kept strictly confidential.

To get us started, can you tell me briefly about the work that you and your organization do in the community?

Thank you. Next I'll be asking you a series of questions about health and quality of life in __Coles___County. As you consider these questions, 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,' while sharing the local perspectives you have from your current position and from experiences in this community.

Questions:

1. In general, how would you rate health and quality of life in __Coles___County?

2. In your opinion, has health and quality of life in ___ColesCounty improved, stayed the same, or declined over the past few years?

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

4. What other factors have contributed to the (based on answer to question 2: improvement, decline **or** to health and quality of life staying the same)?

5. What barriers, if any, exist to improving health and quality of life in Coles County?

6. In your opinion, what are the most critical health and quality of life issues in ColesCounty?

7. What needs to be done to address these issues?

8. The prior CHNA indicated the following as the most significant health needs. Is there anything that is not on the list that should be?

Access to Health Services
Cancer
Chronic Kidney Disease
Diabetes
Heart Disease & Stroke
Injury & Violence Prevention
Maternal, Infant & Child Health
Mental Health
Oral Health
Tobacco Use

What do you think is most critical health need included on the list above or other of the community?

9. 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?

Are you familiar with the association with Prairie Health Institute and SBL?

Have you utilized any of the SBL specialists? Which ones?

Are there any particular specialists who are still needed in the community?

10. Are you familiar with the Center for Healthy Living? Have you referred someone to the Center for Healthy Living? Other thoughts regarding Center for Healthy Living?

11. SBL provides dental services to youth through mobile unit. Do you have any ideas for addressing adult dental needs? Are there opportunities to collaborate with other agencies regarding addressing dental health needs?

12. Are there people or groups of people in __Coles____ County whose health or quality of life may not be as good as others? Who are these persons or groups?

13. 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?

14. What is the most important issue that the hospital should address in the next 3-5 years?

Close: Thanks so much for sharing your concerns and perspectives on these issues. The information you have provided will contribute to develop a better understanding about factors impacting health and quality of life in ___Coles____ County. Before we conclude the interview,

Is there anything you would like to add?

As a reminder, summary results will be made available by the [Name of organization] and used to develop a community-wide health improvement plan. Should you have any questions, please feel free to contact _____ at [Name of organization]. Here is his/her contact information [provide business card]. Thanks once more for your time. It's been a pleasure to meet you.

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

David Cox, Director of Foundation and Alumni, Lakeland College

Sheri Drotor, Administrator, Cumberland County Health Department

Blake Fairchild, CEO, Mattoon YMCA

Timothy Flavin, Director, MiRaza Community Center

Michael Gillespie, Professor of Sociology, Eastern Illinois University

Dr. Robert Good, Physician, Sarah Bush Lincoln Health Center

Valerie Goodwin, Disaster Program Specialist, American Red Cross

Cathy Hayden, Administrator, Clark County Health Department

Dr. Kathleen Hecksel, Psychiatrist, Sarah Bush Lincoln Health Center

Christy Hild, Principal, Mattoon Elementary School

Pamela Irwin, CEO, Central East Alcoholism & Drug Council (CEAD)

Dr. Carl Johnson, Physician, Sarah Bush Lincoln Health Center

Janet Mason, Director, Edgar County Health Department

Stephen Melega, Director, Shelby County Health Department

Amanda Minor, Administrator, Douglas County Health Department

Michael Murray, Human Services Center, Eastern Illinois University

Terra Ogle, Director of Outpatient Services, LifeLinks

Althea Pendergast, Executive Director, Hope of East Central Illinois

Shirley Sherwood, Emergency Medical Services Coordinator, Sarah Bush Lincoln Health Center

Diana Stenger, Administrator, Coles County Health Department

Suzy Tribby, Edgar County Health Department

Brent Todd, Assistant Director of Regional Medial Programs, Southern Illinois University