



Logan County

ILLINOIS

Community Health
Implementation Plan

2022
-24



Contents

- Executive Summary 3
- Introduction to Memorial Health 4
- Introduction to Lincoln Memorial Hospital 5
- Community Health Factors 7
- Section I—Communities Served and Demographics 10**
 - General Information 10
 - Population 10
 - Education and Healthcare Resources 11
 - Economics 12
 - Equity 13
- Section II—CHNA Process, Criteria Used and Final Priorities 14**
 - Assessment Process 14
 - Internal Advisory Council (IAC) 14
 - Community Advisory Council (CAC) Invitees 15
 - Community Focus Groups/Interviews 15
 - Internal Community Health Leaders 16
 - Criteria for Determining Need 16
- Section III—Significant Health Needs 17**
 - Selected Priorities 17
 - Priorities Not Selected 19
- Section IV—CHIP Development 20**
- Section V—Goals, Strategies and Potential Programs 21**
 - Goals 21
 - Strategies 21
 - System Priority: MENTAL HEALTH 22
 - Community Health Programming 23
 - Awareness Campaign 24
 - County-Level Coalitions 25
 - Hospital Interventions 26
 - Internal Equity, Diversity and Inclusion 27





EXECUTIVE SUMMARY

In 2021, Lincoln Memorial Hospital (LMH) completed a Community Health Needs Assessment (CHNA) for Logan County, Illinois. This report is the accompanying FY22-24 Community Health Implementation Plan (CHIP) that outlines steps LMH intends to take during this three-year cycle to address the priorities set forth in the CHNA, as required of nonprofit hospitals by the Affordable Care Act of 2010.

As an affiliate of Memorial Health (MH), LMH worked with four other affiliate hospitals to produce the overall CHNA and CHIP, but completed its Logan County assessment and plan independently from those hospitals in collaboration with local community partners. Final priorities selected by LMH are listed below.

- Youth Mental Health (Mental health was approved as a priority across the health system.)
- Obesity
- Substance Use

In order to narrow down potential projects and initiatives to address the final priorities, Community Health leaders used community input, internal input and strategic considerations to develop the CHIP. Access to health, the social determinants of health and racial inequities and inequalities were considered in all parts of the process as well.

Recognizing that initiatives often address multiple priorities, these plans have been organized into broader strategies that will be employed to address the priorities of the CHNA, as listed below.

1. Provide ownership/oversight and primary support for community health programs.
2. Develop and implement county-level awareness campaigns related to final CHNA priorities.
3. Be an active participant and key partner within established/formal county-level community health coalitions to implement agreed upon action plans and track metrics and outcomes.
4. Position the hospital as a hub for hospital-based community health interventions.
5. Develop and implement an Equity, Diversity and Inclusion structure and strategic plan which addresses disparities and provides meaningful support for patients, colleagues and the community.

The Memorial Health Board of Directors Community Benefit Committee approved the FY22-24 Community Health Implementation Plan on Oct. 29, 2021. Approval was also received from the Lincoln Memorial Hospital board of directors. This report is available online at [memorial.health/about-us/community/community-health-needs-assessment/](https://www.memorial.health/about-us/community/community-health-needs-assessment/) or by contacting MH Community Health at communityhealth@mhsil.com.



INTRODUCTION

MEMORIAL HEALTH

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

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

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

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

FY22-24 Final Priorities

Decatur Memorial Hospital

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

Jacksonville Memorial Hospital

- 1. Mental Health
- 2. Obesity
- 3. Cancers

Lincoln Memorial Hospital

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

Springfield Memorial Hospital

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

Taylorville Memorial Hospital

- 1. Mental Health
- 2. Obesity
- 3. Lung Health

Memorial Health Priority Mental Health



Our Mission

Why we exist:

To improve lives and build stronger communities through better health

Our Vision

What we aspire to be:

To be the health partner of choice



INTRODUCTION TO LINCOLN MEMORIAL HOSPITAL

LMH is a 25-bed, not-for-profit, community-based rural critical access hospital affiliated with Memorial Health. LMH is located in Lincoln, Illinois, approximately 30 miles northeast of the state capital of Springfield. LMH serves the people and communities of Logan and eastern Mason counties.

LMH offers a full range of general (secondary) hospital inpatient and outpatient care on-site, including general acute care, observation, swing bed services, obstetrics and gynecology, surgical services, emergency medicine and special procedures. Ancillary and support services offered at LMH include laboratory, radiology, pharmacy, clinical dietetics, diabetes self-management education, cardiology, sleep studies, physical therapy, speech-language pathology, occupational therapy, respiratory therapy and cardiopulmonary rehabilitation. Tertiary care, including psychiatric services, when appropriate and required, is provided through affiliation agreements with other providers, including other Memorial Health affiliate hospitals. LMH nursing teams were among the first in the state to be granted Pathway to Excellence designation by the American Nurses Credentialing Center.

LMH is accredited by The Joint Commission and is a member of the American Hospital Association, the Illinois Hospital Association and Vizient. As a nonprofit community hospital, Lincoln Memorial Hospital provides millions of dollars in community support each year, both for its patients and in support of community partnerships. During the past three years, that support has totaled more than \$17 million.

COVID-19 AND COMMUNITY HEALTH

On the afternoon of Saturday, March 14, 2020, MH leaders gathered with their peers from other local healthcare organizations at a news conference announcing that Springfield Memorial Hospital was treating the first known patient hospitalized with COVID-19 in central Illinois. MH mobilized its Hospital Incident Command System (HICS). Incident Command protocols are intended to provide short-term leadership during a crisis, such as a severe weather event or an accident that brings a rush of injured patients to the hospital. Usually, Incident Command teams are only mobilized for a few hours or days. But the team handling the COVID-19 response quickly became the longest-running Incident Command in Memorial history.

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

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

Equity, Diversity and Inclusion *Pledge*



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

Our Values

Safety

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

Integrity

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

Quality

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

Stewardship

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



COMMUNITY HEALTH FACTORS

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

ACCESS TO HEALTH AND HEALTHCARE

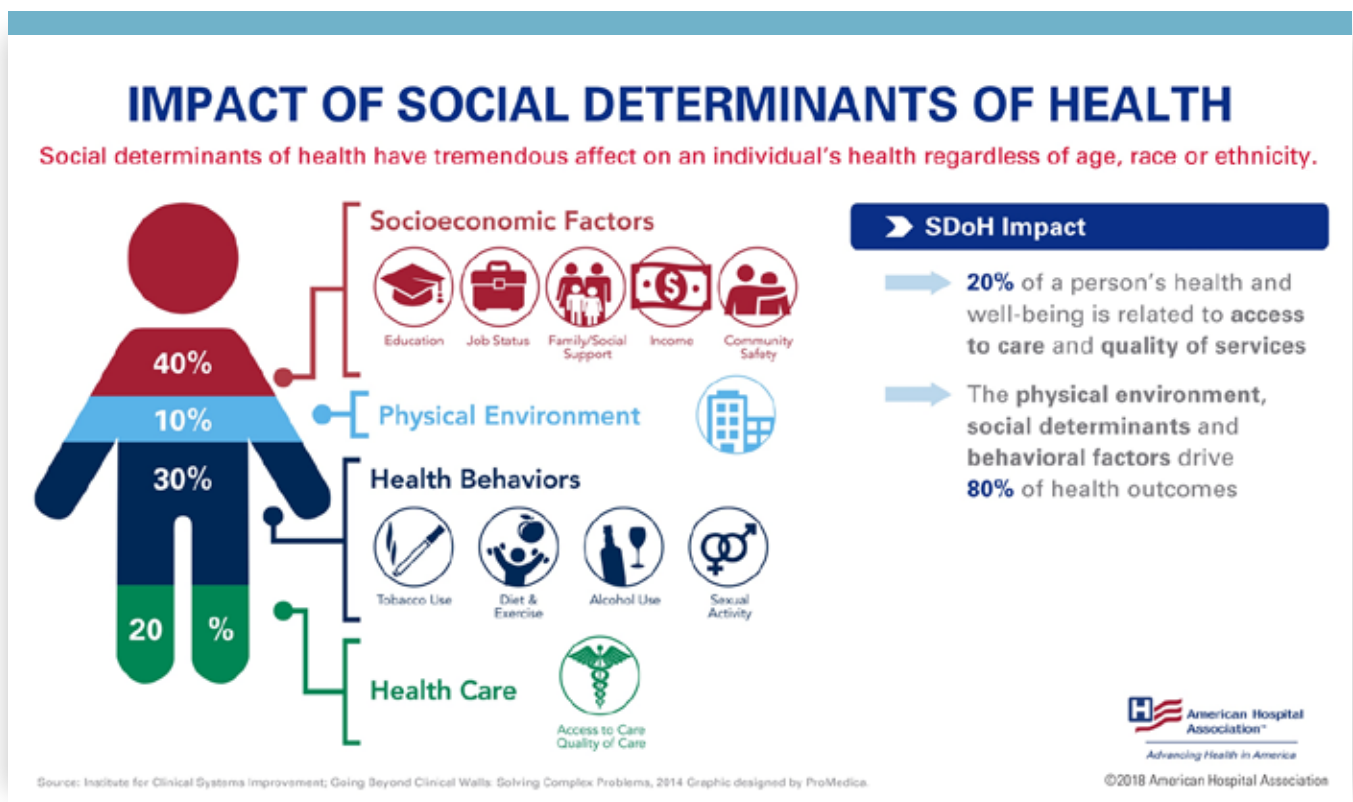
Access to health and healthcare is a multilayered contributing factor including structural, financial and personal components. The presence of facilities, availability of providers, hours of operation and access via public transportation all have a significant impact on access to health and healthcare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

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

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

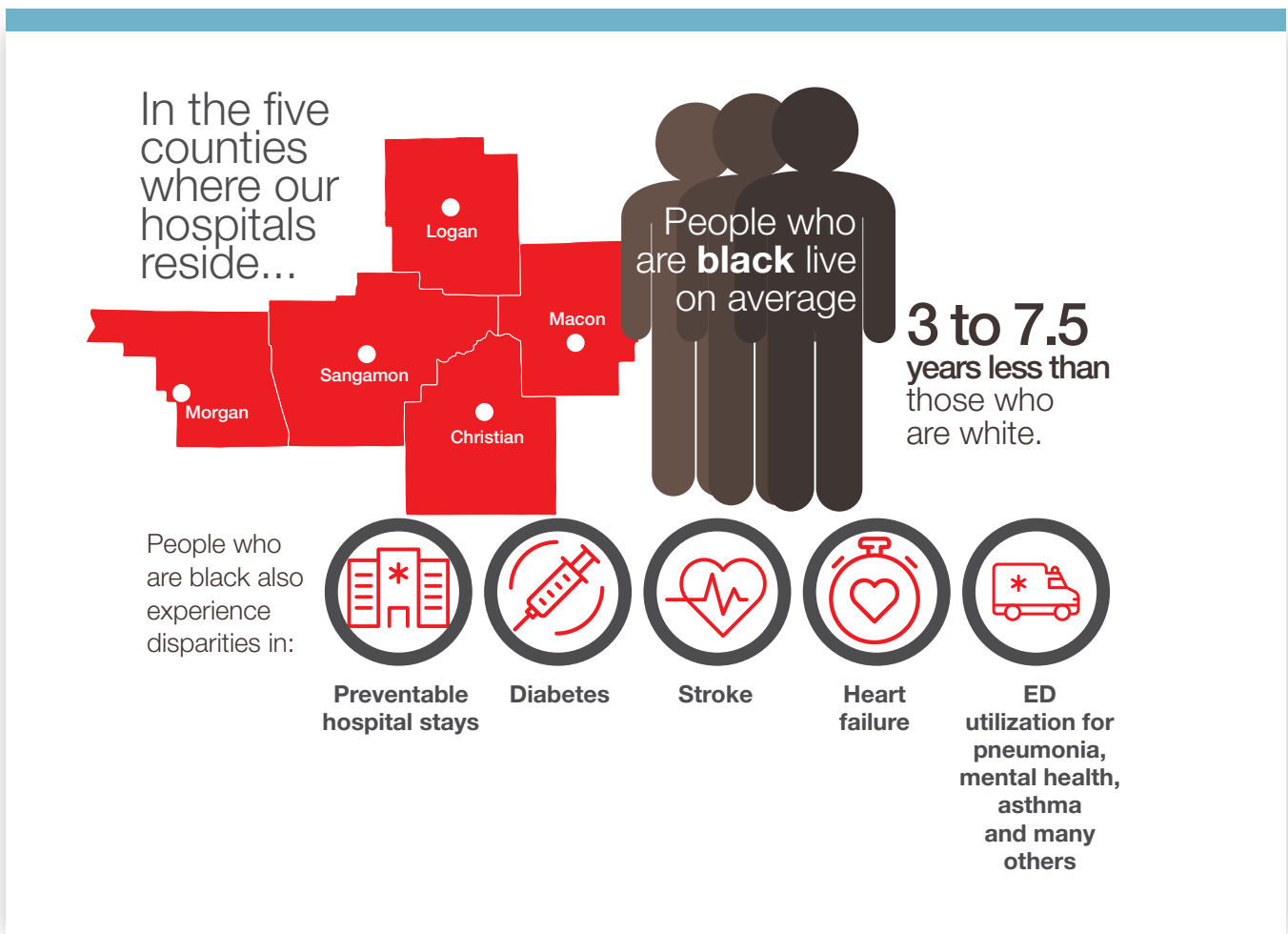
SOCIAL DETERMINANTS OF HEALTH

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



RACIAL INEQUITY AND INEQUALITY

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



SECTION I—COMMUNITIES SERVED & DEMOGRAPHICS

GENERAL INFORMATION

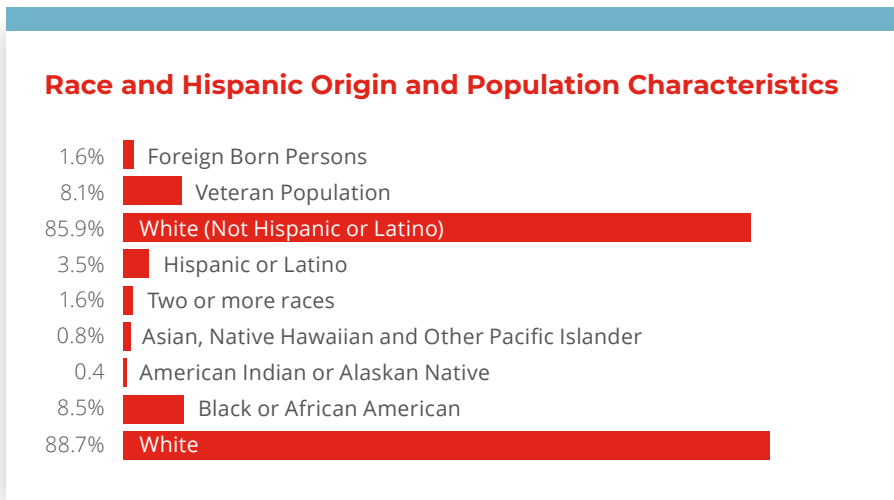
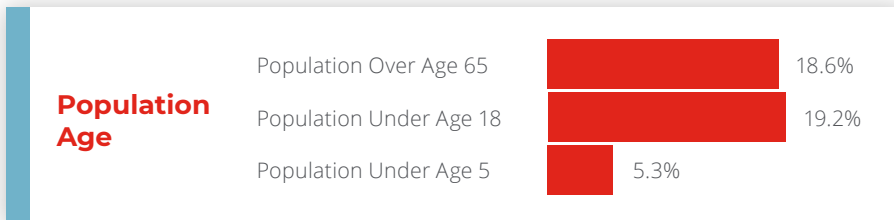
LMH is located in Lincoln, Illinois, near the center of the state. Lincoln is the county seat. Logan County is largely rural and agricultural, with healthcare, small businesses and mining being the largest employers. The majority of patients served by LMH come from Lincoln and surrounding areas. Lincoln is where the hospital focuses most of its community engagement and community health initiatives, due to its population density and resources for collaborative partnerships.

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



POPULATION

The population of Logan County is 28,925 and the largest urban setting in Logan County is Lincoln, with a population of 13,202.





EDUCATION AND HEALTHCARE RESOURCES

LMH is the only hospital located in the primary service area of Logan County. Lincoln is also home to a private liberal arts college, a Christian university and graduate seminary. A community college based 38 miles away in Normal, Illinois, also offers classes locally.

Many patients come to LMH annually for quality specialty care and surgery that is not available in their community. In addition to LMH, other Logan County healthcare resources include:

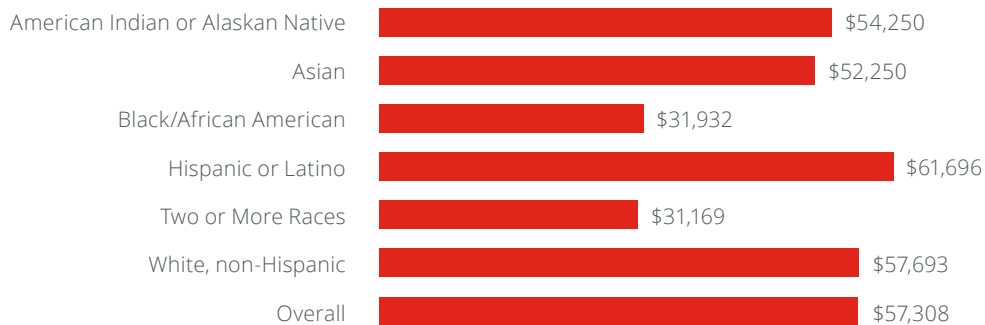
- Hospice care
- Logan County Department of Public Health
- Memorial Home Medical Supply
- Memorial Care
- SIU Center for Family Medicine, FQHC – Federally Qualified Health Center
- Springfield Clinic

ECONOMICS

ALICE (Asset Limited, Income Constrained, Employed) is a way of defining and understanding financial hardship faced by households that earn above the federal poverty line (FPL), but not enough to afford a “bare bones” household budget. In Illinois, 12% of households live below the FPL and an additional 23% qualify as ALICE. Logan County has 34% of households living below the FPL or qualifying as ALICE.

Median Household Income by Race/Ethnicity

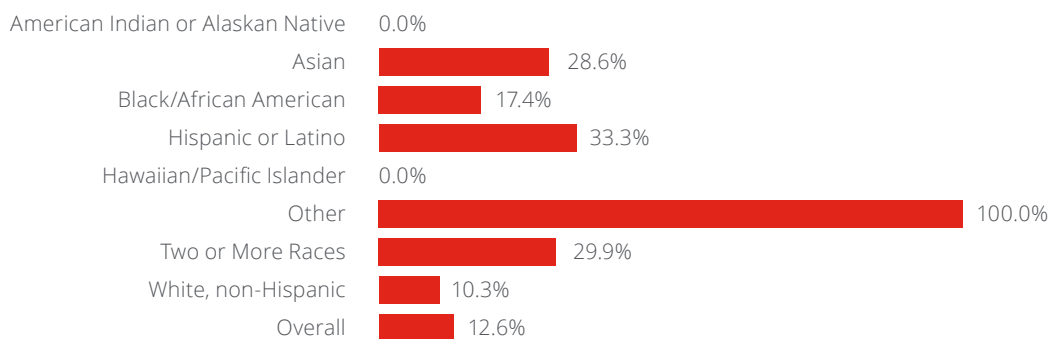
County: Logan



Source: American Community Survey (2015–2019)

Children Living Below the Poverty Level by Race/Ethnicity

County: Logan



Source: American Community Survey (2015–2019)

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

Racial/ethnic residential segregation refers to the degree to which two or more groups live separately from one another in a geographic area. Although most overt discriminatory policies and practices, such as separate schools or seating on public transportation based on race, have been illegal for decades, segregation caused by structural, institutional and individual racism still exists in many parts of the country. The removal of discriminatory policies and practices has impacted institutional and individual acts of overt racism, but has had little effect on structural racism, like residential segregation, resulting in lingering structural inequalities. Residential segregation is a key determinant of racial differences in socioeconomic mobility and, additionally, can create social and physical risks in residential environments that adversely affect health. The residential segregation index is unavailable for Logan County, indicating unreliable or missing data. While prison populations are not included in residential segregation indexes, it is important to note that Logan County is home to a women's multilevel security prison, the Logan Correctional Center, which houses approximately 1,000 inmates, as well as a minimum-security prison, Lincoln Correctional Center, which also has a capacity of approximately 1,000. Within the two facilities, 56% of inmates are people of color.

56% of inmates at the Logan and Lincoln Correctional Centers are people of color.

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

Logan County's 2018 overall SVI score is 0.2271. A score of 0.2271 indicates a low level of vulnerability.

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

In Logan County, the zip codes estimated with the highest socioeconomic need are 62656, 61723 and 62635.

SECTION II – CHNA PROCESS, CRITERIA USED & FINAL PRIORITIES

ASSESSMENT PROCESS

Lincoln Memorial Hospital collaborated with the Logan County Department of Public Health (LCDPH) to complete the FY21 Community Health Needs Assessment. As part of the CHNA process, an extensive secondary data review was completed. In addition to individual health indicators, the three major contributing factors described earlier in this report – social determinants of health, access to health and racial inequity and inequalities – were identified as playing a role in outcomes across many of the health indicators. Primary data was gathered through community focus groups and a community-wide survey, as well as input from the LMH Community Health Collaborative Advisory Board. These groups were asked to force-rank community health indicators by highest priority while considering the Criteria for Determining Need. They were additionally asked to consider capacity and local desire to address the issue, existing interventions and whether the issue was a root cause of other problems. They were also asked to share insight on how these priorities are experienced within the community and what the hospital might do to address them. Internal Advisory Councils and the Community Health team reviewed and analyzed feedback from the process and recommended final priorities to the Memorial Health Board of Directors Community Benefit Committee for approval. The general process steps illustrated below were used to conduct the CHNA. Members of key participant groups are also listed below.



INTERNAL ADVISORY COUNCIL (IAC)

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

- Community Action Partnership of Central Illinois
- Lincoln Area YMCA
- Lincoln Community High School
- Lincoln Economic Advancement and Development
- Lincoln Elementary School District 27
- Lincoln Memorial Hospital
- Lincoln Memorial Foundation
- Lincoln Park District
- Lincoln Police Department
- Logan County Department of Public Health
- Logan County Regional Planning Commission
- Memorial Behavioral Health
- Memorial Medical Group
- Private Businesses



COMMUNITY ADVISORY COUNCIL (CAC) INVITEES

Charter: The Logan County CAC will review primary and secondary data in order to assist in identifying high-priority health needs in Logan County.

- Center for Youth and Family Solutions*
- Chestnut Health Systems
- Christian Child Care
- Community Action Partnership of Central Illinois*
- Community Child Care Connection*
- Department of Children and Family Services*
- EPIC*
- Gateway Foundation
- Heartland Community College
- Land of Lincoln Workforce Alliance*
- Lincoln Arts Institute
- Lincoln Community High School
- Lincoln Fire Department
- Lincoln Memorial Hospital
- Lincoln Park District
- Lincoln Police Department/DARE
- Lincoln/Logan Crimestoppers*
- Lincoln/Logan Food Pantry*
- Logan County Board
- Logan County Department of Public Health*
- Logan County Probation*
- Memorial Behavioral Health*
- Moksha Center
- Moms Who Care*
- Salvation Army*
- SIU Center for Family Medicine*
- SIU School of Medicine, FQHC*
- United Way of Logan County*

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

COMMUNITY FOCUS GROUPS/INTERVIEWS

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

- College students
- Lincoln Police Department
- Lincoln College recognized student organizations
- Department of Children and Family Services*
- Tri-County Special Education Association*
- Elementary and high school staff
- Churches
- Behavioral Health consultants*
- Lincoln Memorial Hospital clinical staff
- City of Lincoln aldermen
- City of Lincoln Diversity and Inclusion Coalition*
- Lincoln Community High School students
- Center for Youth and Family Solutions*

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

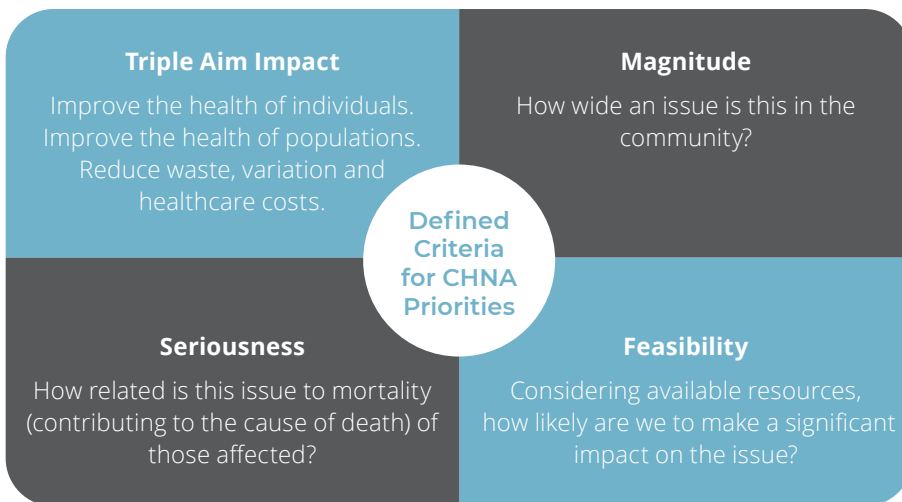
INTERNAL COMMUNITY HEALTH LEADERS

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

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

CRITERIA FOR DETERMINING NEED

The following criteria were used by MH affiliates during the 2015 and 2018 CHNA processes for determining significant need, and were used again during the 2021 CHNA. Additionally, capacity and local desire to address the issue, existing interventions and whether the issue was a root cause of other problems were considered.



SECTION III—SIGNIFICANT HEALTH NEEDS

SELECTED PRIORITIES

Lincoln Memorial Hospital

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

Memorial Health Priority: Mental Health

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

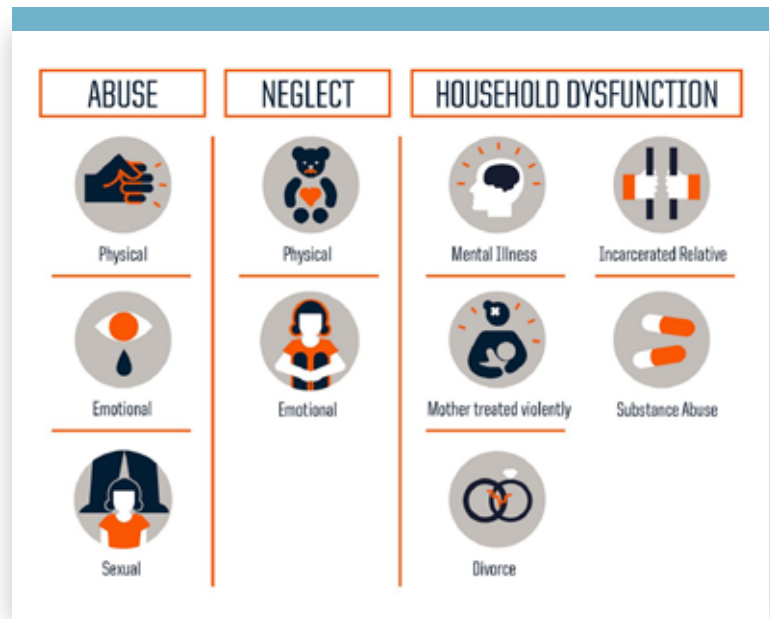
Youth Mental Health

The Illinois Youth Survey shows that Logan County youth have higher rates of anxiety, depression and suicide contemplation than their counterparts statewide. In addition, bullying and bias-based bullying is higher in Logan County than state averages.

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

We recognize several causal factors that may be contributing to this poor health outcome including poverty and adverse childhood experiences (ACEs). As part of the community survey, we specifically asked respondents to identify any ACEs that they or a member of their household had experienced. The most common responses included sexual abuse, domestic violence and mental illness inside the home.

While the mental health provider rate in Logan County is improving, there are only 22 providers in Logan County, creating a ratio of 1 provider to 1,315 residents. The rate is significantly lower than the Illinois and national rates. However, provider rates reflect just one barrier to achieving mental health. We also found transportation, copays and stigma as significant barriers to addressing mental health concerns.

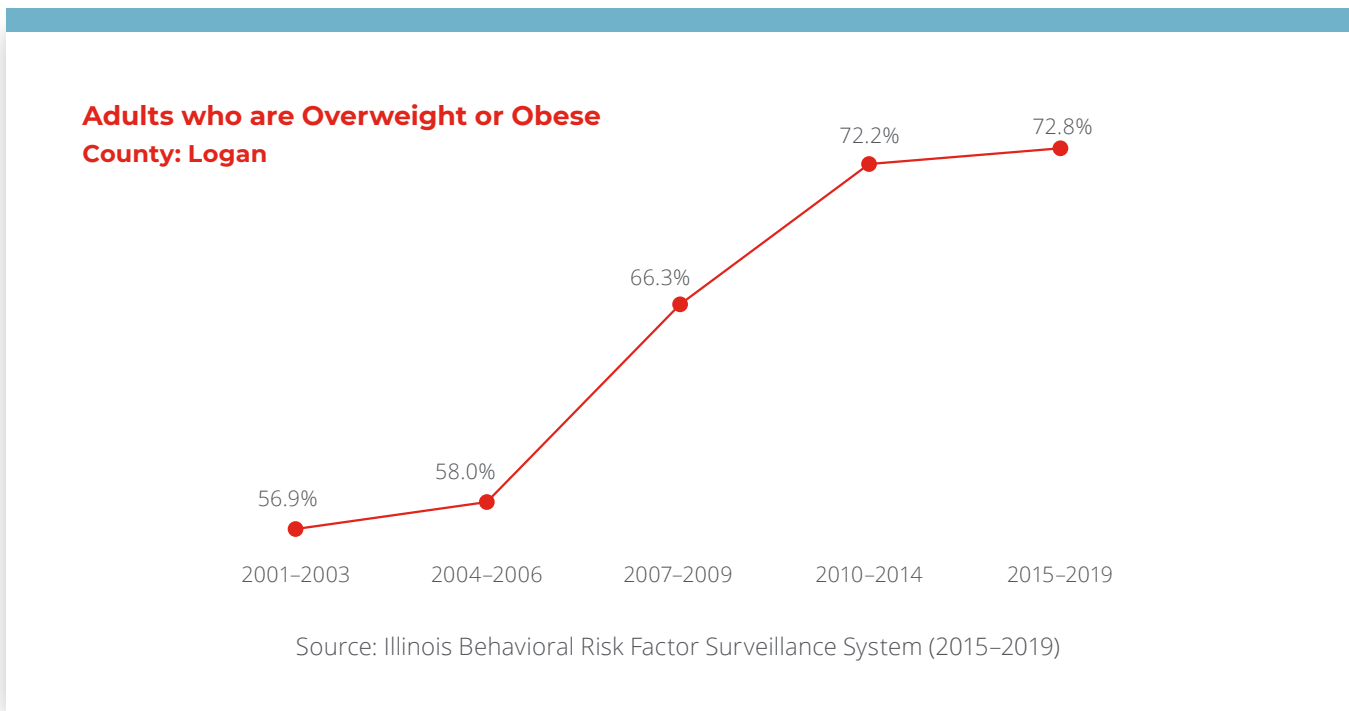


Variations of mental health were identified as the highest priorities in the CHNAs for each county where a Memorial Health hospital is located. Community Health leaders across the system have committed to making mental health a priority and using our combined resources to make a regional impact for this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



Obesity

Well over half (72.2%) of Logan County adults are overweight and 43.4% are obese. A total of 72.8% are overweight or obese. These rates have been increasing and are higher than state and national rates. Obesity is an indicator of the overall health and lifestyle of a community. Obesity increases the risk of many diseases and health conditions, including heart disease, type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, respiratory problems and osteoarthritis. Losing weight and maintaining a healthy weight help to prevent and control these diseases. Being obese also carries significant economic costs due to increased healthcare spending and lost earnings and can have a negative impact on mental health.



We recognize that several local factors contribute to this poor health outcome, including low fruit and vegetable consumption, lack of adult physical activity, lack of access to physical activity opportunities and low breastfeeding rates/duration, as well as local poverty, which creates food insecurity, homes that lack a kitchen, dependence on convenience foods and less cooking. We recognize that obesity is a root cause for cancers, diabetes and hypertension, which can lead to heart disease and stroke.



Substance Use

Logan County reports the highest value in the Memorial Health service area for binge drinking. Twenty-three percent (23%) of Logan County adults reported binge drinking. Binge drinking is a common pattern of excessive alcohol use in the United States. Binge drinking can be dangerous and may result in vomiting, loss of sensory perception and blackouts. The prevalence of binge drinking among men is twice that of women. In Logan County the highest prevalence of substance use was disproportionately among white men who were mostly uninsured.

In addition, it was found that binge drinkers are 14 times more likely to report alcohol-impaired driving than non-binge drinkers. In Logan County, 46.7% of motor vehicle mortality involved alcohol.

Alcohol use is associated with a variety of negative health and safety outcomes, including alcohol-related traffic accidents and other injuries, employment problems, legal difficulties, financial loss, family disputes and other interpersonal problems. The rate of alcohol motor vehicle mortality is higher than state and national average. Forty-one percent (41%) of high school seniors reported trying alcohol at least once in the past year and approximately 50 youth visited the Emergency Department as a result of alcohol.

PRIORITIES NOT SELECTED

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

Diabetes

Diabetes was not chosen as a priority. LMH has existing services in place to address diabetes, specifically Diabetes Self-Management Education. Obesity, a chosen priority, is recognized as a risk factor for type 2 diabetes and will be addressed as a final priority.

Fruit and Vegetable Consumption

Fruit and vegetable consumption was not selected specifically as a priority due to its contribution to healthy weight (obesity). Therefore, interventions to encourage increased fruit and vegetable consumption will be incorporated into the community health improvement plan.

Heart Disease/Stroke

Heart disease/stroke was not chosen as a priority in recognition that obesity is a root cause of heart disease, high blood pressure and stroke.

Low Mental Health Provider Rate

Low mental health provider rate was not chosen as a specific priority due to a lack of control over significantly improving this rate. When addressing youth mental health as a priority, improving access to mental health services will be incorporated into interventions.

Lung Cancer

Smoking tobacco is the leading cause of lung cancer. In addressing substance use, a chosen priority, we will recognize the importance of avoiding tobacco/vaping. Likewise, obesity, another chosen priority, is recognized as a risk factor for cancers.

Senior Mental Health

Senior mental health was not chosen as a specific priority and instead LMH will focus on the importance of prevention in young children in an effort to improve mental health across the life course. Further, LMH has existing services in place to address senior mental health, specifically Senior Life Solutions.

Other Health Indicators

Additional health indicators are in need of being addressed in our community; however, they were not ranked highly by the CAC/community feedback and, therefore, have not been prioritized for our CHIP. Strategies to address these and other unselected priorities may be present in our final CHIP, as they relate to the final health priorities



SECTION IV – CHIP DEVELOPMENT

The CHIP was developed with the input of the community, internal Memorial Health stakeholders and additional strategic considerations. Community Health leaders worked to balance these plans to be both broad and specific. It is important to be flexible and allow room for change as community partnerships evolve, while also being explicit and direct regarding MH’s commitment to address the priorities of the community. After reviewing current Community Health work and the desires of the community, goals were established for each priority and broad strategies were developed to help meet those goals. Within the strategy templates, detailed information is included regarding which priorities the strategy addresses, resources we will commit, potential impacts, measures we can report on, community partnerships and more.

Community Input

- Several meetings have been held with community partners and organizations working to address the final priority areas. Through these meetings, gaps were identified that could serve as potential projects or initiatives.
- Meetings were held with the CHNA collaborative partners to identify areas for collaboration.
- Many ideas were garnered through the CHNA process. Notes from these events were analyzed for trends and ideas that address these priorities.

Internal Input

- Community Health leaders spend much of their time in the community, working alongside those who have been engaged in work around the final priorities for years. Community Health leaders’ insight and expertise was relied on as the CHIP was developed.
- Members of the Internal Advisory Committees were consulted at various points to discuss general budget expectations, internal operations considerations and overall guidance and input.

Strategic Plans and Commitments

- Memorial Health’s new strategic plan, Destination 2025, was reviewed and considered to be a guiding document as Memorial Health deepens its commitment to community health.
- Evolving work around equity, diversity and inclusion helped shape and prioritize strategies and potential projects Memorial Health will engage in. Organizations who are conducting their work in an anti-oppressive and inclusive way are prioritized for partnership.
- Current community health work was inventoried, as well as those projects and initiatives MH has committed to in the coming years. This work was incorporated into our CHIPs where the work was applicable to addressing the final priorities.

Complexity and Intersectionality

As input was sought on the development of the CHIP, it was apparent that many initiatives and programs address multiple final priorities. It is also clear these priorities intersect in many ways and the interventions needed will often intersect as well. For these reasons, broader strategies were defined and detailed strategy templates were developed to highlight anticipated work, resources and outcomes. Within those strategy templates are some of the potential projects to collaborate on, as well as which priorities those projects and strategies address. It is also recognized that this CHIP is developed, for this three-year cycle, during a global pandemic in which community needs and ways to address them are changing rapidly. For these reasons, the terms “potential programs” are used within the strategy templates to indicate work already being collaborated on, or intended to, so long as the current needs and plans continue during this CHIP cycle.



SECTION V—GOALS, STRATEGIES & POTENTIAL PROGRAMS

GOALS

Each of the final priority areas have a corresponding goal. The strategies employed are intended to help meet these goals.

Youth Mental Health

- To encourage and increase protective factors and health behaviors that help prevent the onset of a diagnosable mental health disorder and reduce risk factors that can lead to the development of a mental disorder.

Obesity

- To reduce overweight and obesity.

Substance Use

- To provide substance use prevention activities, reduce substance use disorder, improve harm reduction efforts and increase opportunity for treatment and recovery.

System Priority: Mental Health

- To improve mental health in Christian, Logan, Macon, Morgan and Sangamon counties.

STRATEGIES

Multiple strategies will be employed to meet the aspirational goals previously outlined. Included in the strategy templates are the following details:

- The potential programs that will be pursued as part of the strategy
- The anticipated impact of the potential programs
- The resources the hospital will dedicate to those potential programs
- The community partners we intend to collaborate with for potential programs
- The social determinants of health that the strategy and potential programs help address
- The final priorities which will be addressed through the strategy and potential programs
- Any related inequities identified
- Whether this strategy will provide support to low-income and disadvantaged communities
- Outcomes we can measure and report on annually and in our next CHNA

The CHIP strategies are listed below and are detailed within the subsequent strategy templates.

1. Provide ownership/oversight and primary support for community health programs.
2. Develop and implement county-level awareness campaigns related to final CHNA priorities.
3. Be an active participant and key partner within established/formal county-level community health coalitions to implement agreed upon action plans and track metrics and outcomes.
4. Position the hospital as a hub for hospital-based community health interventions.
5. Develop and implement an Equity, Diversity and Inclusion structure and strategic plan which addresses disparities and provides meaningful support for patients, colleagues and the community.

Every year, Memorial Health contributes millions of dollars in patient financial assistance and government-sponsored health care subsidies. You can find more details about these contributions in the Community Benefit Annual Reports on the Memorial Health website. Memorial will continue to provide these community benefits, in addition to the strategies outlined in this implementation plan.



STRATEGY TEMPLATES WITH POTENTIAL PROGRAMS

System Priority: MENTAL HEALTH

STRATEGY	Take a regional, collective-impact approach to selected interventions related to improving mental wellness in counties where Memorial Health hospitals reside.	
POTENTIAL PROGRAMS	<ul style="list-style-type: none"> • Awareness Campaign • Trauma-Informed Care training • Memorial Behavioral Health Community Committee participation • Emergency Department hand offs for Substance Use Disorder treatment 	
ANTICIPATED IMPACT	<ul style="list-style-type: none"> • Decreased stigma around mental wellness and seeking care. • Increased community residents seeking mental healthcare. • Community partners approaching their work in a trauma-informed way. • Increased connection to Substance Use Disorder treatment. • Improved collaboration and greater impact between Memorial Behavioral Health and MH hospitals. 	
HOSPITAL RESOURCES	<input checked="" type="checkbox"/> Colleague Time <input checked="" type="checkbox"/> Marketing <input checked="" type="checkbox"/> Financial Support <input checked="" type="checkbox"/> Printing/Supplies	<input checked="" type="checkbox"/> Meeting Space/Virtual Platform <input checked="" type="checkbox"/> Consultant/Expert <input checked="" type="checkbox"/> Other Support
COMMUNITY PARTNERS	Memorial Behavioral Health, others as appropriate	
AREA(S) OF IMPACT Social Determinants of Health	<input checked="" type="checkbox"/> Healthy Behaviors <input type="checkbox"/> Social/Economic Factors	<input checked="" type="checkbox"/> Clinical Care <input type="checkbox"/> Physical Environment
TARGETED PRIORITY(IES)	<input checked="" type="checkbox"/> Mental Health	
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	Many people of marginalized identities expressed barriers to seeking and accessing mental healthcare during the CHNA process. These needs will be centered in our interventions.	
Does this strategy provide support to low-income and disadvantaged communities	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
OUTCOME MEASURE	<ul style="list-style-type: none"> • Awareness campaign developed and implemented. • Number of organizations reached through campaign. • Usage data from 988 hotline. • Trauma-Informed Care training options evaluated, plan developed and executed. • Number of participants. • Tracked metrics from participants. • Number of meetings Community Health leaders attend on MBH Community Committee. • Reduced readmissions to EDs for SUD. • Impacts reported from work on MBH Community Committee. 	



Community Health Programming

STRATEGY	Provide ownership/oversight and primary support for community health programs.								
POTENTIAL PROGRAMS	<ul style="list-style-type: none"> • Breastfeeding Support • Weekly Walking Group • Healthy You 								
ANTICIPATED IMPACT	<ul style="list-style-type: none"> • Reduced chronic disease over time. • Reduced overweight and obese in participating individuals. • Increased physical activity and fitness. • Improved mental health and overall health outcomes. • Increased infant health and resilience. • Lower childhood obesity rates over time. • Increased breastfeeding duration. 								
HOSPITAL RESOURCES	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input checked="" type="checkbox"/> Colleague Time</td> <td style="width: 50%; border: none;"><input checked="" type="checkbox"/> Meeting Space/Virtual Platform</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Marketing</td> <td style="border: none;"><input checked="" type="checkbox"/> Consultant/Expert</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Financial Support</td> <td style="border: none;"><input checked="" type="checkbox"/> Other Support</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Printing/Supplies</td> <td style="border: none;"></td> </tr> </table>	<input checked="" type="checkbox"/> Colleague Time	<input checked="" type="checkbox"/> Meeting Space/Virtual Platform	<input checked="" type="checkbox"/> Marketing	<input checked="" type="checkbox"/> Consultant/Expert	<input checked="" type="checkbox"/> Financial Support	<input checked="" type="checkbox"/> Other Support	<input checked="" type="checkbox"/> Printing/Supplies	
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<input checked="" type="checkbox"/> Financial Support	<input checked="" type="checkbox"/> Other Support								
<input checked="" type="checkbox"/> Printing/Supplies									
COMMUNITY PARTNERS									
AREA(S) OF IMPACT Social Determinants of Health	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input checked="" type="checkbox"/> Healthy Behaviors</td> <td style="width: 50%; border: none;"><input checked="" type="checkbox"/> Clinical Care</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Social/Economic Factors</td> <td style="border: none;"><input type="checkbox"/> Physical Environment</td> </tr> </table>	<input checked="" type="checkbox"/> Healthy Behaviors	<input checked="" type="checkbox"/> Clinical Care	<input type="checkbox"/> Social/Economic Factors	<input type="checkbox"/> Physical Environment				
<input checked="" type="checkbox"/> Healthy Behaviors	<input checked="" type="checkbox"/> Clinical Care								
<input type="checkbox"/> Social/Economic Factors	<input type="checkbox"/> Physical Environment								
TARGETED PRIORITY(IES)	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Youth Mental Health</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Substance Use</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Obesity</td> <td style="border: none;"></td> </tr> </table>	<input type="checkbox"/> Youth Mental Health	<input type="checkbox"/> Substance Use	<input checked="" type="checkbox"/> Obesity					
<input type="checkbox"/> Youth Mental Health	<input type="checkbox"/> Substance Use								
<input checked="" type="checkbox"/> Obesity									
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	Community-based social support interventions have been shown to increase physical activity among adults in socio-economically disadvantaged neighborhoods. National breastfeeding rates are disproportionately low among adolescents, as well as those who are African American.								
Does this strategy provide support to low-income and disadvantaged communities	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
OUTCOME MEASURE	<ul style="list-style-type: none"> • Develop and implement weekly walking group for community members. • Number of participants. • Healthy You program launched. • Reductions in overweight and obesity among Healthy You enrolled clients. • Number of enrolled clients. • 24-hour breastfeeding support hotline maintained and available to the community. • At least 36 breastfeeding support group sessions offered annually with access to a certified lactation consultant. • Demonstrated increase in breastfeeding knowledge and duration, as well as meaningful peer support in pre- and post-surveys of breastfeeding support group participants. 								



Awareness Campaign

STRATEGY	Develop and implement county-level awareness campaigns related to final CHNA priorities.								
POTENTIAL PROGRAMS	<ul style="list-style-type: none"> • Substance Use Awareness Campaign • Mental Health Awareness Campaign 								
ANTICIPATED IMPACT	<ul style="list-style-type: none"> • Increased availability of information regarding substance use resources. • More residents connected to substance use treatment. • Increased availability of information regarding mental health resources. • Improved mental health among connected individuals. 								
HOSPITAL RESOURCES	<table border="0"> <tr> <td><input checked="" type="checkbox"/> Colleague Time</td> <td><input type="checkbox"/> Meeting Space/Virtual Platform</td> </tr> <tr> <td><input checked="" type="checkbox"/> Marketing</td> <td><input type="checkbox"/> Consultant/Expert</td> </tr> <tr> <td><input type="checkbox"/> Financial Support</td> <td><input type="checkbox"/> Other Support</td> </tr> <tr> <td><input checked="" type="checkbox"/> Printing/Supplies</td> <td></td> </tr> </table>	<input checked="" type="checkbox"/> Colleague Time	<input type="checkbox"/> Meeting Space/Virtual Platform	<input checked="" type="checkbox"/> Marketing	<input type="checkbox"/> Consultant/Expert	<input type="checkbox"/> Financial Support	<input type="checkbox"/> Other Support	<input checked="" type="checkbox"/> Printing/Supplies	
<input checked="" type="checkbox"/> Colleague Time	<input type="checkbox"/> Meeting Space/Virtual Platform								
<input checked="" type="checkbox"/> Marketing	<input type="checkbox"/> Consultant/Expert								
<input type="checkbox"/> Financial Support	<input type="checkbox"/> Other Support								
<input checked="" type="checkbox"/> Printing/Supplies									
COMMUNITY PARTNERS									
AREA(S) OF IMPACT Social Determinants of Health	<table border="0"> <tr> <td><input checked="" type="checkbox"/> Healthy Behaviors</td> <td><input checked="" type="checkbox"/> Clinical Care</td> </tr> <tr> <td><input type="checkbox"/> Social/Economic Factors</td> <td><input type="checkbox"/> Physical Environment</td> </tr> </table>	<input checked="" type="checkbox"/> Healthy Behaviors	<input checked="" type="checkbox"/> Clinical Care	<input type="checkbox"/> Social/Economic Factors	<input type="checkbox"/> Physical Environment				
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<input checked="" type="checkbox"/> Youth Mental Health	<input checked="" type="checkbox"/> Substance Use								
<input type="checkbox"/> Obesity									
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	Men who are white, with no insurance or Medicaid, ages 25-44, disproportionately present to the Emergency Department at a higher rate for substance use issues (not alcohol).								
Does this strategy provide support to low-income and disadvantaged communities	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
OUTCOME MEASURE	<ul style="list-style-type: none"> • Inventory of mental health resources compiled for county. • Inventory of substance use treatment resources compiled for county. • Campaign and/or education developed and shared regarding mental health and substance use treatment resources. • Number of persons/units/organizations reached. • Number of referrals to mental health services. • Report on metrics as defined by the awareness campaigns. 								



County-Level Coalitions

STRATEGY	Be an active participant and key partner within established/formal county-level community health coalitions to implement agreed upon action plans and track metrics and outcomes.								
POTENTIAL PROGRAMS	<ul style="list-style-type: none"> Lincoln Community Health Collaborative 								
ANTICIPATED IMPACT	<ul style="list-style-type: none"> Resources provided for what the community needs, as requested by those already doing the work. Partnership and collaboration increased between organizations and residents. More opportunities to be active. Innovation around supporting the Social Determinants of Health and increasing equity. 								
HOSPITAL RESOURCES	<table border="0"> <tr> <td><input checked="" type="checkbox"/> Colleague Time</td> <td><input checked="" type="checkbox"/> Meeting Space/Virtual Platform</td> </tr> <tr> <td><input checked="" type="checkbox"/> Marketing</td> <td><input checked="" type="checkbox"/> Consultant/Expert</td> </tr> <tr> <td><input checked="" type="checkbox"/> Financial Support</td> <td><input checked="" type="checkbox"/> Other Support</td> </tr> <tr> <td><input checked="" type="checkbox"/> Printing/Supplies</td> <td></td> </tr> </table>	<input checked="" type="checkbox"/> Colleague Time	<input checked="" type="checkbox"/> Meeting Space/Virtual Platform	<input checked="" type="checkbox"/> Marketing	<input checked="" type="checkbox"/> Consultant/Expert	<input checked="" type="checkbox"/> Financial Support	<input checked="" type="checkbox"/> Other Support	<input checked="" type="checkbox"/> Printing/Supplies	
<input checked="" type="checkbox"/> Colleague Time	<input checked="" type="checkbox"/> Meeting Space/Virtual Platform								
<input checked="" type="checkbox"/> Marketing	<input checked="" type="checkbox"/> Consultant/Expert								
<input checked="" type="checkbox"/> Financial Support	<input checked="" type="checkbox"/> Other Support								
<input checked="" type="checkbox"/> Printing/Supplies									
COMMUNITY PARTNERS	Lincoln Community Health Collaborative								
AREA(S) OF IMPACT Social Determinants of Health	<table border="0"> <tr> <td><input checked="" type="checkbox"/> Healthy Behaviors</td> <td><input checked="" type="checkbox"/> Clinical Care</td> </tr> <tr> <td><input checked="" type="checkbox"/> Social/Economic Factors</td> <td><input checked="" type="checkbox"/> Physical Environment</td> </tr> </table>	<input checked="" type="checkbox"/> Healthy Behaviors	<input checked="" type="checkbox"/> Clinical Care	<input checked="" type="checkbox"/> Social/Economic Factors	<input checked="" type="checkbox"/> Physical Environment				
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<input checked="" type="checkbox"/> Youth Mental Health	<input type="checkbox"/> Substance Use								
<input checked="" type="checkbox"/> Obesity									
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?									
Does this strategy provide support to low-income and disadvantaged communities	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
OUTCOME MEASURE	<ul style="list-style-type: none"> Number of persons served. Report on agreed-upon metrics for defined projects. Number of new partnerships and interventions implemented. 								



Hospital Interventions

STRATEGY	Position the hospital as a hub for hospital-based community health interventions.	
POTENTIAL PROGRAMS	<ul style="list-style-type: none"> • Naloxone in Emergency Department • Community Support Team • Bicycle-Friendly Designation 	
ANTICIPATED IMPACT	<ul style="list-style-type: none"> • Fewer deaths as a result of opioid overdose. • Increased access to Naloxone for opioid users. • Increased knowledge of appropriate overdose response. • Improved overall and mental health outcomes. • Strong cycling culture created that welcomes and celebrates biking for transportation, well-being or fun. • Provide an example to the community of how to obtain bicycle-friendly designations. 	
HOSPITAL RESOURCES	<input checked="" type="checkbox"/> Colleague Time <input checked="" type="checkbox"/> Marketing <input checked="" type="checkbox"/> Financial Support <input checked="" type="checkbox"/> Printing/Supplies	<input checked="" type="checkbox"/> Meeting Space/Virtual Platform <input checked="" type="checkbox"/> Consultant/Expert <input checked="" type="checkbox"/> Other Support
COMMUNITY PARTNERS		
AREA(S) OF IMPACT Social Determinants of Health	<input checked="" type="checkbox"/> Healthy Behaviors <input type="checkbox"/> Social/Economic Factors	<input checked="" type="checkbox"/> Clinical Care <input type="checkbox"/> Physical Environment
TARGETED PRIORITY(IES)	<input checked="" type="checkbox"/> Youth Mental Health <input checked="" type="checkbox"/> Obesity	<input checked="" type="checkbox"/> Substance Use
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	A community that supports and promotes active transportation can indirectly support low-income individuals with a safe, low-cost transportation opportunity.	
Does this strategy provide support to low-income and disadvantaged communities	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
OUTCOME MEASURE	<ul style="list-style-type: none"> • Initiative developed and executed to provide Naloxone in the Emergency Department. • Baseline established for rate of prescribing/providing access to Naloxone. • Application for LMH submitted to the League of American Bicyclists and approved. • Community Bike event held annually. • Number of participants served through Community Support Team. • Develop and implement a Community Support Team program for youth presenting to the Emergency Department. 	



Internal Equity, Diversity and Inclusion

STRATEGY	Develop and implement an Equity, Diversity and Inclusion structure and strategic plan which addresses disparities and provides meaningful support for patients, colleagues and the community.	
POTENTIAL PROGRAMS	<ul style="list-style-type: none"> • EDI Strategic Planning 	
ANTICIPATED IMPACT	<ul style="list-style-type: none"> • Increased diversity and inclusion among MH workforce. • Improved patient outcomes. • Stronger relationships between MH and the communities we serve. • Culturally appropriate services, resources and interventions provided to the community. 	
HOSPITAL RESOURCES	<input checked="" type="checkbox"/> Colleague Time <input checked="" type="checkbox"/> Marketing <input checked="" type="checkbox"/> Financial Support <input checked="" type="checkbox"/> Printing/Supplies	<input checked="" type="checkbox"/> Meeting Space/Virtual Platform <input checked="" type="checkbox"/> Consultant/Expert <input checked="" type="checkbox"/> Other Support
COMMUNITY PARTNERS	Korn Ferry, MH Coalition Development Team (CDT), various community organizations who participated in the CHNA process and are serving marginalized members of the community.	
AREA(S) OF IMPACT Social Determinants of Health	<input type="checkbox"/> Healthy Behaviors <input checked="" type="checkbox"/> Social/Economic Factors	<input checked="" type="checkbox"/> Clinical Care <input type="checkbox"/> Physical Environment
TARGETED PRIORITY(IES)	<input checked="" type="checkbox"/> Mental Health <input checked="" type="checkbox"/> Obesity	<input checked="" type="checkbox"/> Substance Use
IDENTIFIED INEQUITY(IES) If applicable, how are they being addressed?	People who identify or are typically identified with non-dominant dimensions of diversity experience emotional trauma, reduced employment and worse health outcomes than those who are typically identified by the dominant dimensions of diversity.	
Does this strategy provide support to low-income and disadvantaged communities	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
OUTCOME MEASURE	<ul style="list-style-type: none"> • Comprehensive gap analysis completed. • Strategic plan developed with recommended strategies in implementation. • Metrics tracked related to diverse identities. • Continued commitment of resources to EDI work. • Annual report provided on progress and barriers. • Patient experience and colleague survey scores (stratified). 	

THE FY22-24 CHIP Report and Final Priorities were adopted by the Community Benefit Committee of the Memorial Health Board of Directors on Oct. 29, 2021.

The CHNA and CHIP is made widely available on the MH website, as well as through press releases, social media and presentations. Updates regarding this CHIP will be published in the MH Annual Report and posted on the website. If you are interested in copies of this report or have additional questions, please direct inquiries to communityhealth@mhsil.com.

