

## Case Study

# Access to Care Plus Measurable Community Improvement



### At-A-Glance

Market Segment:  
Health System

Service Area:  
Sangamon County, IL

Population: 197,499

Solution: HCI Platform

Most Used Features:  
Zip Code & Census Tract  
Level Data

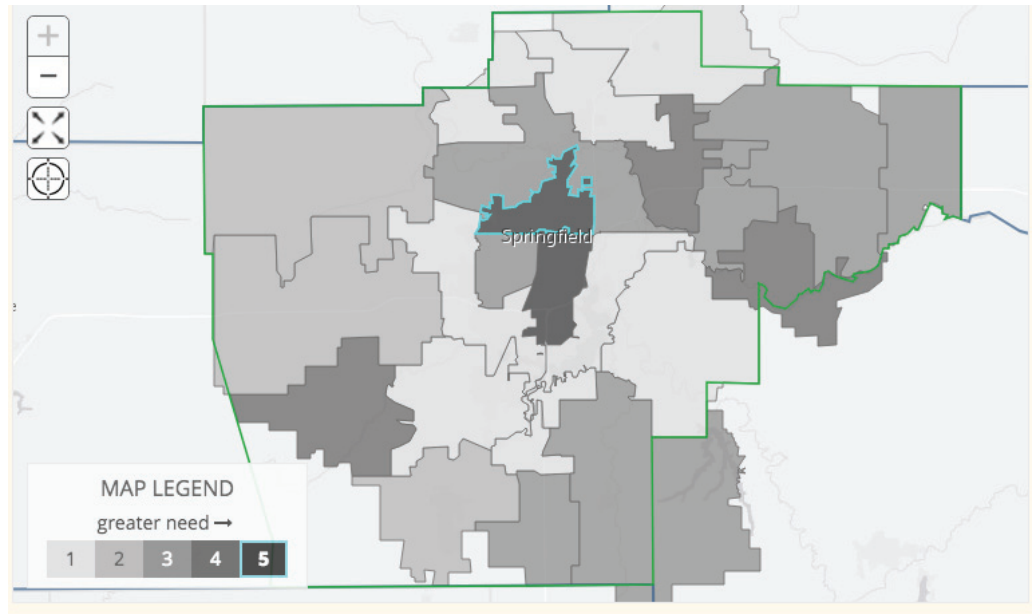
On the ground community intervention transforms healthcare access for rural, underserved population.

Memorial Medical Center (MMC) is located in Sangamon County – a predominately rural and agricultural county in central Illinois with a population of 197,499. Sangamon County includes the City of Springfield (117,000) as well as eight federally designated medically underserved areas. This case study documents the steps that MMC took to transform healthcare access for local residents.

### Know Your Community: Geographic Disparities in Access to Care and Unmet Non-Medical Needs

The collaborative CHNA effort between Memorial Medical Center and HSHS St. John's Hospital, plus Sangamon County Department of Public Health expanded primary and secondary data collection to best identify community health priorities. The resulting CHNA report utilized the Conduent Healthy Communities Institute (HCI) platform analytics and incorporated 150 health and socioeconomic indicators from two dozen sources and findings from the 2013 Sangamon County Citizens Survey. Especially striking, in the county, 11.3% of residents did not have health coverage, 37.8% earned less than \$15,000 per year, and 20.9% of residents were economically insecure about their family's health care. Five community forums, a community survey, and four focus groups rounded out the primary data collection.

### SocioNeeds Index



**Memorial Medical Center's Community Health Needs Assessment:**  
[www.choosememorial.org/Community-Health-Needs-Assessment](http://www.choosememorial.org/Community-Health-Needs-Assessment)

Learn more about Memorial Medical Center through their Community Needs Assessment (CHNA) report.

MMC and SJH's jointly selected access to care to address collaboratively. In addition, MMC prioritized mental health and obesity as key priorities. To develop a targeted and data-driven implementation strategy, the two hospitals leveraged HCI's proprietary SocioNeeds Index to map and identify areas of greatest socioeconomic need by zip code. Zip code 62702 stood out. Alongside high emergency departments utilization for ambulatory sensitive conditions, the zip code has a poverty rate of 53%, compared to 18% city-wide and 14% countywide. The Enos Park neighborhood within zip code 62702 is located between the two collaborating hospital campuses. Further research into census tract data for this neighborhood identified socioeconomic risk factors such as a high number of single parent families and transportation issues. The neighborhood also had issues with drug abuse and a large transient population. Due to a well-organized and active neighborhood association, Enos Park's ability to transform was feasible. In the past, the association had reduced crime through partnership with community policing programs, addressed blighted properties, supported the local elementary school, and improved street lighting and parks.

### **Listen to the Community : The Role of Community Health Workers**

Through a series of focus groups, residents of Enos Park, MMC, and SJH together identified that social service providers are not aware of available community resources or how to refer their clients to those resources. Also, many residents did not trust or know how to access healthcare services. Collaboratively, a plan for a jointly-funded community health worker (CHW) program through the SIU Center for Family Medicine, a federally qualified health center, was developed.

### **Transform the Community: Community Health Workers Benefit Enos Park Residents and Springfield Health Care System**

"The first two years have been remarkably successful," said project director Tracey Smith, DNP, Director of Population Health Integration and Community Outreach at SIU HealthCare. "We have focused on building trust in the neighborhood. We not only met our initial goals to make our clients self-sufficient, but we also addressed other needs, such as housing and referrals to social service agencies."

## The CHW clinic now has an 81% show rate and high level of billing by the primary care providers and mental health specialists so that it is becoming income-generating.



Contact us for  
more information:  
[communityhealth@conduent.com](mailto:communityhealth@conduent.com)

[www.conduent.com/  
community-population-health](http://www.conduent.com/community-population-health)

The three-year \$500,000 CHW program holistically addressed access to services and health improvement. It has successfully met years one and two goals for resident enrollment, primary care provider engagement, reducing emergency room utilization, and increasing community outreach. The program impacted over 1,000 people, 300 of whom enrolled in the CHW program. After the first year, nearly 20% of Enos Park residents obtained increased access to care, including dental, primary care, and mental health services. After the second year, improved access expanded to 38% of residents.

By the end of year one, there was a 38% reduction in unnecessary emergency department visits. Of participants, 100% selected a primary medical home (an increase of 51%) and 100% enrolled in health insurance (an increase of 56%).

### Expanded and Sustainable Services

The CHW clinic now has an 81% show rate and high level of billing by the primary care providers and mental health specialists so that it is becoming income-generating. The CHW clinic has expanded its hours from twice to six times per month due to demand. Also, a new clinic modeled after the successful CHW clinic was established at SIU Center for Family Medicine which now operates at high capacity.

### Positive non-Medical Impacts

Beyond access to care, self-sufficiency measures have increased: employment, income, and housing safety have improved significantly. The Springfield Police Department has seen a 22% reduction in calls over the past two years and an 89% reduction in repeat 9-1-1 calls. Additionally, recidivism dropped to 0% by the end of year two compared to 25.5% reported in year one.

### Growing Financial Support

Since inception and due to its success, the program received financial support from Friends of Memorial and the MidWest Dairy Council to expand the outreach efforts. Year three will see an expansion of current programs and an aim to decrease the number of super utilizers who depend on emergency departments rather than primary care. A grant from the United Way of Central Illinois is now funding a similar CHW project in the Brandon Court neighborhood on Springfield's east side, in collaboration with Central Counties Health Center FQHC and the employment of three more CHWs.