Memorial Medical Center
Community Health Need Assessment Implementation Strategy
FY2019: October 1, 2018 – September 30, 2019

Introduction

Memorial Health System is a not-for-profit healthcare organization located in central Illinois. It includes four hospitals: Memorial Medical Center in Sangamon County, Abraham Lincoln Memorial Hospital in Logan County; Taylorville Memorial Hospital in Christian County and Passavant Area Hospital in Morgan County. Memorial Health System also includes Mental Health Centers of Central Illinois, Memorial Physician Services and Memorial Home Services.

Community health need assessments (CHNAs) were completed in 2012, 2015 and 2018 in each of the counties where the hospitals are located. These needs assessments meet the federal health reform's Section 9007 of the Patient Protection and Affordable Care Act of March 2010 and requirements of the IRS 990 Schedule H report.

Memorial Medical Center – Sangamon County, Illinois

Memorial Medical Center (MMC), a nonprofit tertiary care hospital with 500 licensed beds, is located in the state capitol of Springfield, Ill. MMC is a teaching hospital for Southern Illinois University School of Medicine, which is adjacent to the hospital campus. MMC is a level 1 trauma center and major regional healthcare provider for central and southern Illinois, which is largely rural. Although MMC serves patients from a wide range of counties, the majority of MMC's community outreach efforts are focused on Sangamon County, where the medical center is located. Its primary service area includes Sangamon County (pop. 197,449). Sangamon County has eight federally designated medically underserved areas (MUAs). The population of Sangamon County is 80percent white, 12.8percent black, 2.2percent Hispanic, 2percent Asian and 3percent other. The median household income is $56,742. Persons age 65 and older make up 16.6 percent of Sangamon County's population, and 22.7 percent of the population is under age 18. A total of 15.2 percent of all county residents live below the federal poverty level (state average is 14 percent). This includes 13 percent of seniors, 28.6 percent of all children younger than age 6, 21.7 percent ages 6-11, and 20.6 percent ages 12-17. In FY2017, .7 percent of the patients served at MMC received patient financial assistance, 20.7 percent were on Medicaid; and 30.5 percent were covered by Medicare.

Sangamon County Identification of Priority Health Needs

Memorial Medical Center conducted a Sangamon County Community Health Need Assessment in 2018 in collaboration with HSHS St. John's Hospital, a 439 bed not-for-profit hospital and Sangamon County Department of Public Health. The Health Department used the process to meet its IPLAN requirements (Illinois Project for Local Assessment of Needs). This group collaborated on the 2015 CHNA, which was well received by the community. The two hospitals agreed to again select a joint priority and work together to address that issue following the CHNA. The two hospitals and health department also agreed that each entity would make final selection of other priorities for their organizations based on

their capacity to address the issue. The University of Illinois' Survey Research Department assisted with community surveys and focus groups throughout the assessment process.

Resources for the CHNA included Sangamon County data available through Healthy Communities Institute, which provides more than 100 health and social determinants measures specific to Sangamon County. Memorial Health System pays for that data, which are available to the community at large (www.choosememorial.org/healthycommunities). Additional secondary data was gathered from other existing community assessments and documents. Data impacting of social determinants of health were considered throughout the entire CHNA process. Primary data was gathered through a Community Advisory Committee made up of representatives that serve low income, minority and vulnerable populations. Additionally, a community survey and four focus groups were conducted by UIS Survey Research to gather community input. (Complete explanation of the CHNA process is available on Memorial Medical Center's website at www.choosememorial.org/healthycommunities.)

Defined Criteria

To help evaluate the highest priority issues, the following Defined Criteria were established:

1. Institute of Medicine Triple Aim Impact: Improve the Care of Individuals; Improve the Health of Populations; Reduce Waste, Variation and Cost
2. Magnitude of the Issue – How wide an issue is this in the community?
3. Seriousness of the Issue – How related is the issue to the mortality (deaths) of those affected?
4. Feasibility – Considering available resources to address the issue, how likely are we to make a significant impact on the issue?

Twelve categories of need with high priority issues were presented to the Community Advisory Committee:

1. Maternal, Fetal, Infant Health
   - Prenatal care
   - Infant death
   - Teen pregnancy
   - Mothers who smoke
2. Public Safety
   - Violent crime
   - Child abuse
3. Cancer
   - Lung cancer
4. Mental Health, Mental Disorders
   - Substance abuse
   - Depression in seniors
   - Access to mental health care
   - Suicide rates
5. Respiratory Disease
   - Adult asthma
   - Childhood asthma
6. Infectious Disease
   - Gonorrhea / Chlamydia rates
7. Diabetes
8. Exercise, Nutrition and Weight
   - Overweight / Obese adults
   - Childhood obesity
   - Food access / insecurity
9. Environment
   - Housing
10. Substance Abuse
    - All substances
    - Smoking
    - Death rate for drug poisoning
    - Alcoholism and opioid abuse
11. Heart Disease and Stroke
    - High blood pressure
    - Stroke
    - Cardiovascular disease disparities
12. Other Issues
    - Employment
    - Access to care
    - Dental access

Using the Defined Criteria, the Committee selected nine priorities to be included in the community forums and community survey. These nine issues in alphabetical order were:

- Asthma
- Child abuse
- Education
- Food access
- Housing
- Mental health
- Mother/Infant health
- Substance abuse – Drugs
- Violent crime

Final Selected Priorities

Following the survey, the Community Advisory Committee used information gained from the survey and additional input from the hospitals to add Access to Care to the list as a top priority. After working through the Defined Criteria, the Committee recommended the following as the most important priorities for Sangamon County:

1. Access to Care – particularly community health workers
2. Mental Health
3. Substance Abuse
4. Mother/Infant Health (particularly infant mortality)

These priorities were approved by the MHS Board's Community Benefit Committee and the MMC Board.

Non-Prioritized Significant Health Needs

The Sangamon County Community Advisory Committee and Community Health Needs Assessment identified offered input into nine significant community health needs. Memorial Medical selected the four final priorities identified above to address in FY19-FY21. The priorities that were not selected follow.

1. Housing – Housing is not a core competency of the hospital, and there are a number of other organizations already addressing this issue in the community. The Community Advisory Committee did not recommend that the hospitals select this a final priority.
2. Violent Crime – The hospital does not have the expertise to address this issue directly or the resources to lead an initiative, although it does work with both individuals and organizations on issues of individual and public safety.
3. Education – The Community Advisory Committee recommended that the hospitals focus on other initiatives which are a higher priority.
4. Food Access – This issue is being addressed through numerous other agencies and community resources.
5. Child Abuse – Issues of child abuse are dealt with on an individual basis in the hospital emergency department, Memorial Physician Services and Memorial Behavioral Health. However, the hospital does not have the expertise to address this issue on a community-wide basis.
6. Asthma – This issue was not a high priority in the community survey or for the Community Advisory Committee. Memorial chose to address other, higher-priority issues.

The MMC 2019 Implementation Strategy was approved by the MMC Board on Nov. 14, 2018.

FY2019 Implementation Strategy

PRIORITY 1:	ACCESS TO CARE
Reasons for priority selection	During the 2018 Sangamon County Community Health Needs Assessment community survey, Access to Care was the top issue residents identified as something that would improve the health of Sangamon County. The CHNA Community Advisory Committee also recommended Access to Care as a top final priority.

Goal 1: Improve access to health through a neighborhood-based community health worker program.	
Target Population	Residents living in the Enos Park and Pillsbury Mills neighborhood. An additional neighborhood may be added in FY20.
Objective	Offer community health worker programs to help residents in identified neighborhoods improve their health by addressing social determinants of health and barriers to accessing care.

Strategy Selected: Access to Care, a priority of the FY15 CHNA, was addressed in FY16-FY18 by implementing a successful community health worker (CHW) program in a specific neighborhood with poor health and socioeconomic indicators. Program outcomes were so strong the program will continue in FY19-FY21. In addition to the Enos Park neighborhood, a program will begin in FY19 in Pillsbury Mills. An additional neighborhood may be added to the program in FY20.

Commitment of Resources: Memorial Medical Center commits to joint funding of this project with HSHS St. John's Hospital as well as administrative leadership for the steering committee.

Collaborative Partners: HSHS St. John's Hospital, SIU School of Medicine's Center for Family Medicine federally qualified health center, Enos Park Neighborhood Improvement Association, Pillsbury Mills Neighborhood Association, Springfield Police Department, Mental Health Centers of Central Illinois, Springfield Urban League Head Start, and a range of community social service agencies, community police officers and local residents.

Activity	Timeline	Anticipated Results
1. Continue Access to Health program in Enos Park.	FY2019	• Steering Committee continues to monitor project objectives and outcomes • Work with Managed Medicaid to collaborate around providing services for clients • Continue neighborhood advisory group.
2. Expand Access to Health program to Pillsbury Mills neighborhood. Explore establishing the program in an additional neighborhood.	FY2019	• Establish relationship with the Pillsbury Mills Neighborhood Association. • Work with residents to identify unique needs of the neighborhood. Conduct a photo survey to identify neighborhood assets, gaps and

		challenges to health from the residents' perspective. • Establish neighborhood advisory council. • Implement community health worker program in Pillsbury Mills. • Work with additional neighborhood association in zip code 67203 to explore establishing the program. Confirm by Q2 whether this neighborhood will participate.
3. Expand local providers' alliance and offer educational/training opportunities.	FY2019	• By Q2 identify additional social service agencies who serve Enos Park and Pillsbury Mills neighborhoods. • By Q4, offer at least two educational/training opportunities on topics relevant to addressing health access or social determinants of health.
4. Create annual impact statement for the Access to Health Collaborative.	Q1 FY2020	• By Q1 of FY20, complete program impact statement for FY19. • Share outcomes with neighborhoods, community partners and hospital leadership.
5. Create program logic model	Completed by Q3 FY2019	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• FY19: Track number of clients enrolled in CHW programs; track Number who have medical homes and access to physicians, dental care and mental health services. • Address social determinants of health issues for individual clients. • Work with each neighborhood to identify and address specific priorities that affect the health of their neighborhood.	
Long term indicators & source	• Increase the number of participating residents who have a medical home, measured by patient medical records. • Participating residents will decrease their use of hospital emergency departments for non-emergent care and decrease hospitalizations for ambulatory sensitive conditions, measured by hospital electronic medical records and SIU records from community health workers. • Increase health outcomes and quality of life for program participants, measured by self-sufficiency scale.	

Goal 2: Support education of physicians through financial and in-kind support of Southern Illinois University School of Medicine	
Target Population	People living in central and southern Illinois
Objective	Increase access to health care services in central and southern Illinois by providing ongoing support for SIU School of Medicine for the education of new physicians (nearly half select primary care for their residencies).

Strategy Selected: Educating new physicians is vital to maintaining access to care for people living in central and southern Illinois. Memorial Medical Center serves as a teaching hospital for SIU School of Medicine and provides significant financial and in-kind support for the education and graduation of new physicians, many of whom enter primary care practices. Healthy People 2020 Access to Health Services (AHS) objectives:

- AHS-3: Increase the proportion of persons with a usual primary care provider
- AHS-4: Increase the number of practicing primary care providers

Commitment of Resources: Memorial commits a grant for academic support, in-kind support by providing office, clinic and classroom space, and staff to support the work necessary to be a teaching hospital.

Collaborative Partners: Southern Illinois University School of Medicine

Activity	Timeline	Anticipated Results
1. Provide financial support for training of new physicians	FY2019	SIU School of Medicine has operating support for educating new physicians
2. Employ medical residents and fellows to facilitate completion of residencies and fellowships.	FY2019	Medical residents and fellows students complete post-medical school training
3. Provide state-of-the art clinical simulation and surgical skills laboratories as well as classroom space.	FY2019	Students, residents and fellows receive hands-on experiential education in simulation laboratories that offer top quality education in medical procedures they may encounter as physicians.
4. Provide physical facilities for faculty offices, clinics and classrooms.	FY2019	SIU School of Medicine has necessary space for programs and staff.

MEASURES: What will we measure to know the program is making a difference?

Short term indicators & source	• Number of medical students on MMC campus, measured by MMC/SIU records. • Number of medical residencies measured by MMC/SIU records. • Number of residents and fellows who complete their residencies or fellowships, measured by MMC/SIU records. • Number of student who receive education in the clinical simulation, surgical skills labs, and other education programs

	offered at the Memorial Center for Learning and Innovation, measured by MCLI usage records. • Square footage of office, clinic and classroom space provided by MMC, measured by MMC records.
Long term indicators & source	• Number of medical students on MMC campus • Number of medical residencies • Number of residents and fellows who complete their residencies or fellowships • Number of student who receive education in the clinical simulation and surgical skills labs

Goal 3: Increase access to exercise and health improvement opportunities by supporting the construction of a new downtown YMCA in Springfield, pending successful completion of fundraising by the Y.

Target Population	Residents of the east and north sides of Springfield (zip codes 62710, 62702 and 62703) which are areas of the community that are the most challenged by social determinants of health than other zip codes in Springfield and Sangamon County.
Objective	Increase access to top quality and affordable exercise opportunities.

Strategy Selected:

The 85,000 square foot replacement YMCA facility will replace the aging downtown facility. The improved facility will provide opportunities for increased access to exercise programs, including aquatic programs, for downtown, north and east side residents. The new YMCA facility will also promote economic development in the medical district and Enos Park neighborhood. The groundbreaking for this project is scheduled for June 2019.

Commitment of Resources: Memorial commits up to $10.6 million in funding for the building of a new facility, pending other successful fundraising by the YMCA that allows construction of the new facility to succeed.

Collaborative Partners: Springfield YMCA, Enos Park Neighborhood Association, O'Shea Builders

Activity	Timeline	Anticipated Results
1. Groundbreaking	Summer 2019	• New building is started
2. Building commences	Into 2020	• Building proceeds
3. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.

MEASURES: What will we measure to know the program is making a difference?	
Short term indicators & source	• Fundraising is successful and construction begins in FY19.
Long term indicators & source	• New YMCA facility opens.

	• YMCA increase opportunities healthy living and exercise options for residents living in zip codes 62701, 62702 or 62703. Membership from those zip codes is expected to grow by 30 percent.

PRIORITY 2:	**MENTAL HEALTH**
Reasons for priority selection	During the 2018 Sangamon County Community Health Needs Assessment, mental health was the second-highest ranked issue in the community survey and was a final recommendation from the Community Advisory Committee as a top priority. Mental illness is very common in the community but is hidden and has many stigmas. It is a significant contributing problem to many other health and social determinant issues, including substance abuse, crime, child abuse, poor health, education, housing, homelessness, unemployment, suicide and early deaths. Sangamon County has very high rates of pediatric and adult emergency department usage and hospitalizations. Healthy People 2020 goals for Mental Health & Mental Disorders (MHMD) • MDHD-6 Increase the proportion of children with mental health problems who receive treatment • MDHD-9 Increase the proportion of adults with mental health disorders who receive treatment • MDHD-10 Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders

Goal 1: Support the Children's MOSAIC project in Springfield schools.	
Target Population	Children in Sangamon County.
Objective	To increase the number of child-serving sites with the capacity to conduct social/emotional screening and to provide mental health services on-site in order to identify children in distress and to increase access to intervention. The screening and early intervention efforts are provided in Springfield Public Schools, physician practices and the community.

Strategy Selected: The Children's MOSAIC Project is a community collaborative transforming the landscape of children's mental health care by moving services out of the clinic and into the community. Under this transformed system of care, children are identified earlier and are quickly engaged in appropriate services and supports in schools, primary care offices, and in the community. Behavioral health integration into schools and primary care practices has been shown to be effective in early identification and treatment of children at risk.

Commitment of Resources: Memorial Medical Center will help expand and secure the MOSAIC program by providing financial support for the MOSAIC treatment team in Springfield School District 186, including one high school.

Collaborative Partners: Memorial will collaborate with Memorial Behavioral Health, Springfield School District 186, SIU School of Medicine, area primary care physicians, area social service providers, United Way of Central Illinois, the Community Foundation of the Land of Lincoln, and University of Illinois Springfield.

Activity	Timeline	Anticipated Results
1. Add one new school to increase number of sites within Springfield Public Schools.	FY2019	• Increased number of school sites with integrated behavioral health services in Springfield Public Schools. It is anticipated a new site will include a high school
2. Participate in targeted neighborhood community worker activities	FY2019	• Increased early identification and intervention within targeted communities
3. Provide ongoing program evaluation of MOSAIC's impact.	FY2019	• Develop a standardized data collection plan for consistent outcomes and targets across all MOSAIC school sites of care. • Design, implementation, and distribution of MOSAIC scorecards for each MOSAIC school on an annual basis.
4. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• # of Springfield Public Schools sites providing on-site behavioral health intervention • # of client contacts • # of direct client care hours • # of students referred to services • # of students engaged in MOSAIC services • Source: MOSAIC data collection tool, Electronic Health Record, SAEBRS screening reports, school records	
Long term indicators & source	• Increase attendance • Decrease behavior-related office referrals • Increase # of students successfully graduating from MOSAIC • Increase daily living functioning scores • Decrease problem behavior scores • Source: Ohio Youth Scales, functioning assessment tool, school records, Electronic Health Record	

Goal 2: Provide support for Memorial Behavioral Health to collaborate on the new Community Outreach and Engagement Team (Co-ET) model to respond to crisis calls with SIU Medicine and the Springfield Police Department.

Target Population	High-risk individuals with mental health and addiction issues, homelessness, law enforcement involvement and other trauma and social stressors
Objective	To develop and implement a liaison program between behavioral health, law enforcement organizations, and homeless programs which focuses on engagement and linkage of high risk, high need individuals who have poor or no behavioral health connection. This program will be based on intensive care coordination models and the Sequential Intercept Model to advance community-based solutions and decriminalize responses to people with mental health and/or substance use disorders.

Strategy Selected: Every day across the country law enforcement officers respond to disturbances or crises involving a child, youth or adult with mental illness. Some of these individuals may have multiple contacts with police, multiple incarcerations for petty offences, unstable or no housing, poverty and other and multiple co-morbidities of addiction, mental illness and other chronic health conditions. Research shows that that community collaboration for responding to such issues using a Sequential Intercept Model provides improved outcomes for decriminalizing individuals with these issues, helping them increase access to needed services rather than being referred to the criminal justice system. There is also a wide body of research showing the effectiveness of assertive care coordination and outreach in reducing recidivism and unnecessary hospitalizations. This MBH staff member will be embedded in a number of community settings including the homeless shelter, jail, and Springfield Police Department so as to better build trust with and engage those high-risk individuals. This position will be the liaison to the homeless shelters/programs, court service and law enforcement including the specialty courts, jail, and the police. This position will be able to co-respond with police for those individuals who are identified as frequently involved with law enforcement. These outreach programs have showed effectiveness in reducing, arrests, incarceration, police contacts and negative outcomes, and emergency department and hospital visits.

Commitment of Resources: Memorial Medical Center will provide financial support for the addition of an outreach liaison staff position at Memorial Behavioral Health. This liaison will provide early identification and intervention at the embedded sites of identified high risk individuals, work with the Community Health Workers, the homeless providers, and law enforcement to provide community identification and intervention to improve behavioral health access and treatment.

Collaborative Partners: Memorial Medical Center will collaborate with Memorial Behavioral Health leadership; Gerry Castles, SPD LEARN and Neighborhood Police Officer Sergeant; Mike Torchia, Court Services Director; the Recovery and other specialty courts; Erica Smith, director of Helping Hands homeless shelter; Tracey Smith, DNP, director of population health integration and community outreach, SIU Medicine; Kari Wolf, MD, Chair of SIU Psychiatry; leaders of SIU Center for Family Medicine federally qualified health center; and other local social service providers, churches, and Neighborhood Improvement Associations, as appropriate.

Activity	Timeline	Anticipated Results
3. Establish steering committee with partners	Q1 FY19	• Defining and getting commitment from identified steering committee. • Support, guidance and oversite of progress

		• Defined project timelines and project outcomes Partner collaboration and commitment
4. Develop timeline, plan and other necessary documentation such as outcomes tracking, a job description, process for "ride alongs" with police, coordination with other programs, sustainability.	Q1 FY19	• Project Plan • Job description/responsibilities • Outcomes identified and defined Behavioral health functioning tool selected
5. Creation of MOUs with Helping Hands, SPD and Court Services	Q2 FY19	Signed MOUs
6. Hire the liaison and implement and establish the processes, tools, and documentation for the liaison	Q2/Q3 FY19	• Liaison hired and trained • Processes and tools established Documentation processes established
7. Begin implementation of program	Q3/Q4 FY19	• The number of referrals • The # of clients served and types of intervention. .
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source Sources of Information could include: SPD Crisis Intervention sheets, SIUCFM and MBH documentation.		• # of co-responder visits • # of clients served • # of clients engaged in behavioral health services • # of clients connected to PCP services • # and list of community partners on steering committee • Data collection plan Implementation plan/process flow
Long term indicators & source Sources of information will include MBH tracking sheets, Court Services/Jail data, and hospital data		• Decrease incarceration among people with mental illness • Decrease homelessness among people with mental illness • Decrease ED and Hospital visits • Increase behavioral health functioning

Goal 3: Continue offering Mental Health First Aid training in Sangamon, Logan, Morgan and Christian counties	
Target Population	Community at large
Objective	Step in early to stop the trajectory of issues that lead to mental health issues and the need for psychiatric intervention by providing community education to

	improve mental health literacy, early identification, peer intervention, and referral of community members to available resources if needed.

Strategy Selected: Mental Health First Aid (MHFA) is an evidence-based program that offers a five-day intensive training session to community members to become certified MHFA trainers. These certified trainers in turn go out in the community to provide an eight-hour education session to community members such as teachers, police, first responders, churches, youth leaders and others to teach them how to identify mental health issues, how to refer people to resources, and encourage community support of those struggling with issues that may contribute to mental illness. The Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency that leads public health efforts to advance the behavioral health of the nation, endorses MHFA and recently established grant funding for MHFA as part of the President's initiative to increase access to mental health services. MHFA is on the National Registry of Evidence Based Practices (NREPP). All interventions on the registry have been independently assessed and rated for quality of research and readiness for dissemination. MHFA has been shown to increase understanding of mental health disorders, knowledge of available resources, and confidence in and likelihood to help and individual in distress,

Commitment of Resources: MHFA was a program initiated in response to the 2015 CHNA priority of mental health, which was also a final priority of the 2018 CHNA. The MHFA program will continue to be offered to both the community at large and healthcare workers. Memorial Medical Center's Organization Learning Department will oversee the MHFA program. This includes communication about the program, maintaining contact with the network of certified MHFA instructors in Sangamon, Christian, Logan and Morgan counties; overseeing online registration portal for MHFA classes, and ordering program materials.

Collaborative Partners: Abraham Lincoln Memorial Hospital, Passavant Area Hospital, Taylorville Memorial Hospital, Memorial Behavioral Health, Sangamon County Department of Public Health, and area social service providers.

Activity	Timeline	Anticipated Results
1. MHFA Coordinator will maintain contact with MHFA certified trainers and assist trainers with program registrations via an online website.	FY2019	Certified MHFA instructors both within MHS and in other community organizations will have support for MHFA promotion, program registration and access to program materials.
2. Promote the program to communities in Sangamon, Logan, Morgan and Christian counties.	FY2019	MMC will create a communication plan to promote MHFA in Sangamon, Christian, Logan and Morgan counties to create awareness of and promote available MHFA courses in their communities.
3. Hold at minimum three MHFA community trainings by certified MHFA instructors in	FY2019	Increased number of individuals in each community trained as mental health first aiders.

each county, for a total of 12 courses.		
4. Create program logic model	Completed by Q3	Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Creation of a communication plan for FY19. • Number of MHS-sponsored community training events • Number of overall community MHFA trainings. • Source: MHFA data collection tool	
Long term indicators & source	• Among instructors and first aiders, increases in: mental health literacy, awareness of available resources, and confidence in assisting individuals in distress • Source: MHFA data collection tool.	

Goal 4: Support Girls on the Run of Central Illinois to help participants learn critical life skills to increase their personal confidence in who they are.	
Target Population	Girls grades three through eight.
Objective	Girls will increase their personal confidence and gain skills to manage emotions and resolve conflict.

Strategy Selected: Girls on the Run is a positive youth development program designed to intentionally teach life skills. PYD programs use the "5 Cs" to measure impact on life skills which include confidence, competence, caring, character and connection. The curriculum teaches skills for girls to build their personal confidence, manage their emotions and resolve conflicts. This program reaches approximately 1,000 girls annually in central Illinois.

Commitment of Resources: MMC will provide $11,500 to support Girls on the Run of Central Illinois. This includes program support and scholarships for low-income girls, with additional support for CPR training for coaches and printing of program materials.

Collaborative Partners: Memorial Health System's three affiliate hospitals also support Girls on the Run, along dozens of schools, the YMCA and other organizations.

Activity	Timeline	Anticipated Results
1. Girls participate in a 10-week GOTR program, focusing on; two sessions offered annually	Fall 2018 and spring 2019	• 60% or more of participants will increase in personal confidence
2. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.

MEASURES: What will we measure to know the program is making a difference?	
Short term indicators & source	• Coach evaluations will include measures of increases in their team's confidence during the 10-week program. • Parent evaluations will include whether their daughter increased her personal confidence during the 10-week session.
Long term indicators & source	• Coach evaluations will include measures of increases in their team's confidence during the 10-week program. • Parent evaluations will include whether their daughter increased her personal confidence during the 10-week session.

PRIORITY 3: SUBSTANCE ABUSE	
Reasons for priority selection	During the 2018 Sangamon County Community Health Needs Assessment, substance abuse was the top-ranked issue in the community survey and was a final recommendation from the Community Advisory Committee as a top priority. Substance abuse was noted as a significant contributing problem to many other health and social determinant issues, including mental health issues, crime, child abuse, poor health, education, housing, homelessness, unemployment, accidents, DUIs, suicide and early deaths. Is a drain on available community resources and affects everyone, either directly or indirectly.

Goal 1: Memorial Health System will develop a system-wide initiative to combat opiod abuse.	
Target Population	All patients provided care within Memorial Health System Healthcare providers within the community.
Objective	MHS will develop a system-wide initiative to reduce unnecessary clinical use of opioids and risk of addiction for patients treated at MHS hospitals, Memorial Physician Services, Memorial Home Services and Memorial Behavioral Health. Additionally, MHS will work with other community healthcare providers on standardizing opiod prescription policies, medication management agreements and increasing awareness of alternative treatments.
Strategy Selected: Using guidelines developed by the Centers for Disease Control and Intermountain Healthcare, Memorial Health System is putting structures in order to develop strategies to address clinical opioid use, among other key factors surrounding the opioid epidemic. An Opioid Stewardship Steering Committee has been formed to create a system-wide strategy to standardize opioid stewardship efforts. This effort is being led by Jennifer Harris, Administrator, Perioperative Services and Tamar Kutz, Administrator, Ambulatory Operations. The group is comprised of key leaders across the system and will oversee the work of four different subgroups focused on: Inpatient Compliance and Operations, Workforce Management, Drug Control & Diversion, and Ambulatory Operations/ Community Partnerships.	

Additionally, MHS will collaborate with other community healthcare providers on reviewing protocols across various physician practices and hospitals, including Southern Illinois University School of Medicine, Springfield Clinic, HSHS Medical Group, local law enforcement, and other community partners.

Commitment of Resources: The Opioid Stewardship Steering Committee is comprised of the following individuals: Kim Bourne, President and CEO, Taylorville Memorial Hospital; Dolan Dalpoas, President and CEO, Abraham Lincoln Memorial Hospital; Harry Schmidt, President and CEO, Passavant Area Hospital; Raj Govindaiah, MD, Senior Vice President and Chief Medical Officer; Marsha Prater, Senior Vice President and Chief Nursing Officer; Jay Roszhart, Vice President, Ambulatory Networks and Clinical Integration; Todd Roberts, Vice President, Quality and Safety; Linda Jones, Vice President, Operations and Administration; Bob Scott, Vice President, Human Resources; Drew Early, Vice President, Operations, Emergency Medical Services; Evan Davis, Administrator, Ortho and Neurosciences; Jan Gambach, System Administrator, Behavioral Health; Tamar Kutz, Administrator, Ambulatory Networks; and Jennifer Harris, Administrator, Perioperative Services.

Collaborative Partners: Memorial Medical Center, Abraham Lincoln Memorial Hospital, Passavant Area Hospital, Taylorville Memorial Hospital, Memorial Physician Services, Memorial Home Services and Memorial Behavioral Health. Community partners include SIU School of Medicine, HSHS Medical Group, Springfield Clinic, and local law enforcement agencies.

Activity	Timeline	Anticipated Results
1. Development of charter and goals for Opioid Stewardship Steering Committee	Q1	• Systemized strategy around opioid stewardship throughout Memorial Health System
2. Inpatient Compliance and Operations for Opioid Stewardship	Q1-Q4	• Address Joint Commission standards around pain and compliance
3. Ambulatory Operations and Community Partnerships	Q1-Q4	• Standardized Opioid Prescription Policy with partners • Increase usage of Medication Management agreements • Increase awareness of complementary and alternative treatments
4. Workforce Management	Q1-Q4	• Create a policy and program as it relates to opportunities around workforce management
5. Drug Control and Diversion	Q1-Q4	• Development of opportunities through drug diversion prevention audit
6. In FY19, MHS will participate in the Sangamon County Opioid Task Force convened by Sangamon County Department of Public Health	Q1-Q4	• Serve on the Education Committee of the Sangamon County Opioid Task Force. • Keep leadership of MHS opioid initiative apprised of work being done by the task force, which includes law enforcement, courts, pharmacies, public health, schools, mental health and others.

7. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.
8. Development of Program Measures	Completed by Q3	• Data collection plan
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Usage of Medication Management Agreement by prescribing providers for patients prescribed an opiate prescription. • Usage of Prescription Monitoring Program Site by prescribing providers. • Increased understanding of risks associated with opioid prescriptions by both patients and providers	
Long term indicators & source	Program measures to be fully identified by FY19 Q3.	

Goal 2: MHS will engage in a system-wide initiative to expand access to substance abuse treatment.		
Target Population	Community members who are dealing with a substance abuse issue.	
Objective	To develop a strategy to expand substance abuse treatment by creating a system of care that will provide a full continuum of care and treatment options to people in central Illinois.	
Strategy Selected: MHS, along with collaborative partners, will design and implement an integrated, treatment approach to treating co-occurring behavioral health and substance use disorders. According to the 2017 National Survey of Substance Abuse Treatment services, about 37% of individuals in Illinois seeking substance use disorder treatment have been diagnosed as having a co-occurring mental and substance use disorder. The Substance Abuse and Mental Health Services Administration (SAMHSA) supports an integrated treatment approach along a continuum of care. An integrated treatment approach has shown to lower costs and lead to better outcomes. **Commitment of Resources**: MHS Substance Use Treatment Steering Committee is comprised of Jay Roszhart, Vice President, Ambulatory Networks and Clinical Integration; Jan Gambach, System Administrator, Behavioral Health; Kari Wolf, MD, Chair of Department of Psychiatry, SIU Medicine; Tamar Kutz, Administrator, Ambulatory Operations; Emily Ebert, Director of Finance, MBH; Heather Sweet, Manager, Behavioral Health Performance Management; and Jeanette Hoelzer, Behavioral Health Consultant. Additional workgroups comprised of affiliate hospitals and local community treatment agencies will be convened as needed during strategic implementation. **Collaborative Partners:** Memorial Medical Center, Abraham Lincoln Memorial Hospital, Passavant Area Hospital, Taylorville Memorial Hospital, Memorial Physician Services, Memorial Behavioral Health, SIU School of Medicine, SIU Department of Psychiatry, and area social service and substance abuse treatment providers.		
Activity	**Timeline**	**Anticipated Results**

1. Engage a system-wide steering team, including medical leadership from SIU and other local stakeholders	Q1	• Develop a core committee to work across the region in creating a system-wide treatment approach
2. Identify best practice care continuums that allow for full integration and coordination of care	Q1	• Evidence-based practices for alcohol and opioid use in detoxification, integrated co-occurring treatment models, and medication assisted treatment
3. Conduct regional gap analysis in substance use treatment	Q2-Q3	• Regional maps identifying locations of current substance use treatment resources
4. Develop action items to advance regional capacity	Q3-Q4	• Create multiple and seamless, best-practice, pathways of care from identification of a substance abuse problem, through acute treatment, recovery and aftercare to prevent relapse
5. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Development of regional gap analysis/neighborhood maps • Development of integrated co-occurring treatment model with optimal treatment pathways • Source: MHS system-wide continuum of care model	
Long term indicators & source	• Increase access to substance abuse treatment • Decrease substance use disorder overdoses • Decrease substance use presentations in emergency departments • Source: Electronic health records	

PRIORITY 4:	**MOTHER/INFANT HEALTH**
Reasons for priority selection	During the 2018 Sangamon County Community Health Needs Assessment, the issue of mother/infant health was a top concern for the Community Advisory Committee. Sangamon County has traditionally had a higher than average number of pre-term births, low birth weights and infant mortality rate. Mother/infant health has been identified as a top concern by multiple community organizations, including Springfield's two federally qualified health centers and various social service agencies. In addition an extensive community assessment by Sangamon Success identified it as a top priority and worked with community partners to initiate the creation of the Nurse Family Partnership Program with SIU Center for Family Medicine FQHC.

Goal 1: Support the Nurse-Family Partnership Program.	
Target Population	Low-income women during their first pregnancy who live in Sangamon County.
Objective	Help women achieve a health pregnancy and birth, and support for newborns birth-2 years to have a healthy start.

Strategy Selected: The Nurse-Family Partnership is a national, evidence-based program. It empowers vulnerable first-time moms to transform their lives and create better futures for themselves and their babies. Research shows the program succeeds at its most important goals: keeping children healthy and safe and improving the lives of moms and babies by having specially trained nurses regularly visit young, first-time moms-to-be, starting early in the pregnancy, continuing through the child's second birthday. The program was a top recommendation of needs assessment work completed by Sangamon Success, a Continuum of Learning initiative started in 2015, to help less advantaged children in our community acquire the skills they need for long-term success.

Commitment of Resources: Memorial committed $500,000 over three years (March 2017-March 2020) and participates on the Community Advisory Board.

Collaborative Partners: SIU Center for Family Medicine FQHC, HSHS St. John's Hospital, Community Foundation for the Land of Lincoln, SIU Foundation

Activity	Timeline	Anticipated Results
1. Work toward goal of reaching 100 families.	Complete by March 2020	• 100 first-time low-income mothers will achieve support for healthy pregnancies and care for their babies.
2. Evaluate local program's effectiveness.	Complete by March 2020	• Evaluate program's impact and outcomes to determine whether the program was effective in Sangamon County.
3. Create program logic model	Completed by FY19 Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.

MEASURES: What will we measure to know the program is making a difference?

Short term indicators & source	• Number of families served • Number of low birthweights • Number of preterm births • Measures provided by SIU Family Medicine
Long term indicators & source	• Overall outcomes will determine whether to continue program funding.

Goal 2: Explore the issue of infant mortality, particularly accidental asphyxiation.	
Target Population	Parents, grandparents and caregivers of infants from birth-12 months old.

Objective	Decrease Sangamon County's infant mortality rate by identifying and addressing issues contributing to accidental asphyxiation of infants from birth to 12 months of age.

Strategy Selected: Sangamon County has higher-than average rates of infant mortality. Information obtained from the Sangamon County coroner during the 2018 Community Health Needs Assessment identified that of 27 infants deaths (birth-12 months) from July 2012-May 2016. Accidental asphyxiation was the leading cause of death, killing 16 infants. The 2018 CHNA Community Advisory Committee strongly supported that infant mortality/accidental asphyxiation be a final priority that the hospitals should address.

Commitment of Resources: Memorial, along with HSHS St. John's Hospital and Sangamon County Department of Public Health, will lead a collaboration to explore the issue and identify resources needed to address the issue.

Collaborative Partners: HSHS St. John's Hospital, Sangamon County Department of Community Resources, SIU Center for Family Medicine FQHC, Nurse Family Partnership, Sangamon County Coroner

Activity	Timeline	Anticipated Results
1. Meet with Sangamon County Coroner	Q1	• Identify current rates of all infant deaths vs. accidental asphyxiation.
2. Meet with Nurse Family Partnership and Center for Family Medicine FQHC	Q2	• Identify relevant issues in the population served by the NFP and FQHC that might contribute to infant accidental asphyxiation.
3. Identify local organizations serving expectant mothers and infants birth to 12 months of age.	Q3	• Identify relevant issues in the population they serve • Identify any existing programs that are address parent/caregiver information or infant safety programs.
4. Develop priorities and strategies to address the issue	Q4	• Identify key partners • Identify resources • Create collaborative action plan.
3. Create program logic model	Completed by Q3	• Logic model will provide overview of program inputs, outputs and expected outcomes/program impacts.

MEASURES: What will we measure to know the program is making a difference?

Short term indicators & source	• Establish baseline measure of infant deaths based on records from the Sangamon County Coroner. • Identify all existing programs that address the issue of infant mortality. • Create action plan.
Long term indicators & source	• Reduction in infant deaths due to accidental asphyxiation based on coroner's records.