Memorial Medical Center
Community Health Need Assessment Implementation Strategy
FY2016 October 1, 2015 – September 30, 2016

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 2015 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 Health System hospital also completed need assessments in 2012.

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. 198,997). Sangamon County has eight federally designated medically underserved areas (MUAs). The population of Sangamon County is 83.4% white, 12.2% black and 4.4% other. The median household income is $55,449. Persons age 65 and older make up 15% of Sangamon County's population, which is higher than the state average of 13.5%. A total of 14.2% of all county residents live below the federal poverty level, including 21.8% of all children and 6.3% of seniors. In FY2014, 1.8 percent of the patients served at MMC received uninsured/underinsured charity care assistance; 16.4percent of patients were on Medicaid; and 29.9 percent were covered by Medicare.

Sangamon County Identification of Priority Health Needs

Memorial Medical Center conducted a Sangamon County Community Health Need Assessment in 2015 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). Southern Illinois University School of Medicine's Department of Community Health and Service and the University of Illinois' Survey Research Department assisted throughout the assessment process.

From the inception of the CHNA planning process the two hospitals agreed that they would select one joint priority and work together to address that issue. 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.

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. Primary data was gathered through a Community Advisory Committee made up of representatives that serve low income, minority and vulnerable populations. Additionally a series of five public forums and a written community survey gathered community input. (Complete explanation of the CHNA process is available on Memorial Medical Center's website.)

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 high priority issues were presented to the CHNA Community Advisory Committee:

1. Access to Care
2. Asthma
3. Cardiovascular Disease
4. Child Abuse
5. Dental Care
6. Diabetes
7. Food Insecurity
8. Infant Mortality/Mother-Infant Issues
9. Mental Health
10. Overweight/Obesity
11. Sexually Transmitted Diseases: Chlamydia and Gonorrhea
12. Violent Crime

Using the Defined Criteria, the Committee selected nine priorities to be included in the community forums and community survey. The items not ranking as high and left off of the survey were Infant Mortality/Mother-Infant Issues, Sexually Transmitted Diseases and Violent Crime.

The University of Illinois at Springfield's Survey Research office analyzed results of five community forums and community survey, which was completed by 781 individuals. The survey results in ranked order were:

1. Mental Health
2. Child Abuse
3. Overweight/Obesity
4. Access to Care
5. Heart disease
6. Diabetes
7. Dental Care
8. Food Insecurity
9. Asthma

Priorities Not Selected by Memorial Medical Center

Memorial presented the nine priorities from the community survey to an Internal Advisory Committee. This group used the Defined Criteria to help select final priorities. Those not selected were:

1. Child Abuse – Considering feasibility, this issue is not a core competency for our hospital to address. Memorial will participate on community initiatives to address this issue, but is not positioned to lead such an initiative.
2. Heart/Cardiovascular Disease – Memorial is already very involved in addressing cardiovascular issues, both within its patient population in the community at large. Data shows that cardiovascular indicators for Sangamon County are gradually improving over time. Memorial will continue to address cardiovascular issues, but it was felt that a focus on obesity might be a way to address a significant contributing factor.
3. Diabetes is a significant issue in Sangamon County and impacts many people. But, like cardiovascular disease, it was determined that selecting obesity as a priority than diabetes would be a way to address a significant contributing factor.
4. Dental Care did not rank high in feasibility for Memorial, either in expertise or resources. The community does have a Federally Qualified Health Center that offers dental services.
5. Food Insecurity did not rank as high a priority for the hospital to address as the other issues. It was felt that it would be more feasible to address this through a broader community collaborative.
6. Asthma, although an important issue, did not rank as high using the defined criteria as did the other selected priorities

Memorial Medical Center's Final Selected Priorities

Following review of input from the Community Advisory Committee, community forums, the community survey, and Memorial's Internal Advisory Team, Memorial Medical Center selected three priorities to address in its implementation strategy over the next three years, from FY2016-FY2018. These priorities are:

1. Access to Care – This is a joint priority with HSHS St. John's Hospital, and the two hospitals are developing a joint initiative to address access to care in vulnerable neighborhood.
2. Mental Health [In addition to goals specific to MMC, the four Memorial Health System Hospitals have a collaborative program to address this priority.]
3. Obesity [In addition to goals specific to MMC, the four Memorial Health System Hospitals have a collaborative program to address this priority.]

FY2016 IMPLEMENTATION STRATEGY

PRIORITY 1:	**ACCESS TO CARE**
Reasons for priority selection	Memorial Medical Center's 2015 community health need assessment identified access to care as a top priority through its community survey, community forums, advisory groups and data collection.

Goal 1: Improve access to health care in Springfield's Enos Park neighborhood	
Target Population	Residents of Enos Park Neighborhood
Objective	Create a community health worker program to help Enos Park neighborhood residents increase access to health care, in collaboration with HSHS St. John's Hospital and SIU Center for Family Medicine federally qualified health center.

Strategy Selected: Increasing access to care was one of the priorities of the community health need assessment. Research into neighborhood-specific data show that health outcomes and social determinants of health for people living in the Enos Park area of Springfield are an issue. Additional focus groups held for Enos Park residents and social service providers highlighted areas of need, including issues that may be addressed by a community health worker program to work with individuals living in Enos Park.

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, Mental Health Centers of Central Illinois, MOSAIC, McClernand Elementary School, and a range of community social service agencies, community police officers and local residents

Activity	Timeline	Anticipated Results
1. Develop the organizational structure for the Enos Park Access Project.	Oct. 2015 Dec. 2015 Aug. 2016	• Finalize memorandum of understanding, mission statement and expectations for the project steering committee. • Set measurable objectives for the program. • Produce an annual impact statement.
2. Develop the Community Health Worker Program	Aug. 2015 Sept. 2015 Dec. 2015 Feb. 2016	• Identify hiring agency and budget, develop job description, office location, and hire CHW coordinator • Identify training requirements. • Gather hospital data on ED utilization and admissions; establish baseline measures • Begin identifying and seeing clients
3. Create Enos Park Access Advisory Council	Nov. 2015 Dec. 2015 Jan. 2016	• Identify council membership, including residents, social service providers, community police officers and others • Draft charter for the council • Create organizational structure. • Identify meeting schedule and location and hold meetings

4. Create Enos Park Providers Alliance	Nov. 2015 Dec. 2015 Jan. 2016	• Identify alliance membership of social service providers in the neighborhood • Draft charter for the council • Create organizational structure. • Identify meeting schedule and location and hold meetings
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Program builds meaningful connections between community residents and social service providers located within Enos Park; measured by surveys of Advisory Council, Providers Alliance and number of new clients due to increased visibility. • Program identifies Enos Park residents who will participate in CHW program and increases their access to medical, mental health and other services; measures to be determined during the first quarter of the program. • Program collaborates with the MOSAIC mental health project's social worker at McClernand Elementary School in Enos Park; measured by referrals between the two programs.	
Long term indicators & source	• Increase the number of participating Enos Park 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 health records. • Increase health outcomes and quality of life for program participants; measure to be determined.	

Goal 2: Increase access to children's mental health services through the MOSAIC Mental Health Initiative in Enos Park	
Target Population	Children attending McClernand Elementary school and/or living in the Enos Park neighborhood and their families.
Objective	To increase access to mental health screening, intervention and educational services through provision of these services at McClernand Elementary School, homes, and other sites in the Enos Park Neighborhood. [NOTE: Memorial Medical Center has additional objectives for the community-wide MOSAIC project under the Mental Health Priority]

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 a target neighborhood. 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 and HSHS St. John's Hospital will help expand and secure the MOSAIC program by providing financial support for screening and engagement activities and for a behavioral health consultant (BHC) at McClernand Elementary School. The BHC will provide early identification and intervention at the school and work with the Community Health Worker to provide

other community identification and intervention to improve behavioral health access.

Collaborative Partners: Memorial and St. John's will collaborate with Mental Health Centers of Central Illinois, School District 186 and in particular McClernand Elementary School, SIU School of Medicine, area primary care providers, area social service providers, Enos Park Neighborhood Improvement Association, United Way of Central Illinois, the Community Foundation for the Land of Lincoln and the University of Illinois Springfield.

Activity	Timeline	Anticipated Results
1. Add one new school clinician to increase number of sites within Springfield Public Schools.	9/30/16	Increased number of school sites with MOSAIC services in Springfield Public Schools.
2. Provide screening of children at McClernand Elementary School.	9/30/16	Increased number of children receiving a social/emotional screen.
3. Provide behavioral health consultant to serve McClernand Elementary School and Enos Park neighborhood.	9/30/16	Increased number of children receiving mental health intervention in school and community settings.
4. Provide education on healthy social/emotional development and parenting.	9/30/16	Increased number of parents/caregivers receiving education on healthy social/emotional development and parenting.

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

Short term indicators & source	• Number of children receiving social/emotional screening. • Percentage of children receiving elevated screens. • Number of parent/caregivers receiving education on social/emotional development and parenting. • Source: MOSAIC records, Electronic Health Record, school records.
Long term indicators & source	• Number of children and/or families receiving intervention. • Source: MOSAIC records and measures from University of Illinois at Springfield's Survey Research Department

Goal 3: 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	Oct. 2015-Sept. 2016	SIU School of Medicine has operating support for educating new physicians
2. Employ medical residents and fellows to facilitate completion of residencies and fellowships.	Oct. 2015-Sept. 2016	Medical students complete and graduate medical school
3. Provide state-of-the art clinical simulation and surgical skills laboratories as well as classroom space.	Oct. 2015-Sept. 2016	Students 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.	Oct. 2015-Sept. 2016	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 supported by MMC, 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 and surgical skills labs, measured by MMC/SIU 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 supported by MMC • 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 4: Support Southern Illinois University School of Medicine's Center for Family and Community Medicine Federally Qualified Health Center (FQHC).

Target Population	**Underserved and uninsured residents of Sangamon County.**
Objective	**Increase convenient access to primary care health services for target population.**

Strategy Selected: The Affordable Care Act (ACA) is shifting the healthcare industry focus to primary and preventative care and on expanding coverage to millions of people through Medicaid expansion and enrollment through private health care exchanges. Part of the Medicaid expansion now allows coverage to individuals and families making up to 133% of the federal poverty level of income. A primary objective of the ACA is to increase convenient access to care for patients through FQHCs and other clinics. These

facilities can become the patient's medical home, and will in turn reduce the strain on hospital emergency rooms and decrease health care costs.

Commitment of Resources: Memorial Medical Center will provide financial support of The SIU Family and Community Medicine FQHC including the expansion of its existing clinic facility by 30,315 sq. ft. The current facility features 33 exam rooms and two procedure rooms with a staff of 43 licensed professionals (including 23 FCM physician and midlevel providers, pharmacy, dietary and mental health providers) who support the administration of the FQHC's 30 residents. It is estimated the FQHC will reach 50,000 visits this year, serving a total of 19,000 patients. SIU FCM is also actively working with Mental Health Centers of Central Illinois to integrate behavioral health into primary care, an integral component of health care. The Residency Program has a strong desire to remain at this location given its FQHC designation. This expansion will position the FQHC to serve a growing number of underserved and underserved patients.

Collaborative Partners: SIU Center for Family Medicine

Activity	Timeline	Anticipated Results
1. Provide financial support for operation of FQHC.	Oct. 2015	FQHC providing access to underserved and uninsured residents of Sangamon County.
2. Initiate construction of 30,315 sq. ft., $16,259,000 clinic expansion.	April 2016	Facility expansion project initiated.
3. Recruit additional FQHC health care providers.	Sept. 2016	Execution of plan to expand FQHC provider capacity under way.

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

Short term indicators & source	• Number of physician and mid-level providers at end of FY2016 = 23. • Number of individual patients served in FY2016 = 19,000. • Number of patient visits in FY2016 = 50,000. • Facility construction on-time and on-budget.
Long term indicators & source	• Number of physician and mid-level providers at end of FY2018 = 31. • Number of individual patients served in FY2018 = 22,000. • Number of patient visits in FY2018 = 70,000. • Facility expansion project completed on-time and on-budget.

Goal 5: Support Kumler Outreach Ministries pharmaceutical assistance program

Target Population	Low-income insured or uninsured people without access to prescription medications, or who cannot afford the co-pay for the medication.
Objective	Increase access to necessary prescription medications regardless for people who cannot afford to pay for prescription medications

Strategy Selected: Access to necessary pharmaceutical medications is important to treat diagnosed conditions. People who cannot afford their prescription medication experience adverse health outcomes, may rely on receiving care through repeated visits to hospital emergency departments and may experience preventable hospitalizations for conditions that could have been treated with the proper medications. Support for Kumler Outreach Ministries' program helps this program provide prescription medication for people who otherwise would not be able to obtain required medications.

Commitment of Resources: $24,000 in support for FY16

Collaborative Partners: Kumler Outreach Ministries

Activity	Timeline	Anticipated Results
1. Provide monthly funding of $2000 for 12 months	Oct. 2015-Sept. 2016	Financial support will help Kumler assist at least 750 clients in FY16.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	Assist 750 people; measured by report from Kumler	
Long term indicators & source	Program assists those in need to receive necessary prescription medications, as measured by Kumler	

PRIORITY 2:	**MENTAL HEALTH**
Reasons for priority selection	Mental Health was identified by the community as the top priority in the community health need assessment. Community data shows very high rates of emergency department utilization and hospitalization for both adult and pediatric populations. 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: MOSAIC Project	
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: In addition to the expansion of the MOSAIC project at McClernand Elementary School within the Enos Park Access to Care initiative in collaboration with St. John's Hospital, (listed under Access to Care priority), Memorial Medical Center will help expand and secure the MOSAIC program by providing financial support for the project coordinator, expansion of behavioral health consultants into new schools and primary care physician practices, and to provide training to the primary care physicians and behavioral health consultants on behavioral health integrated care.

Collaborative Partners: Memorial will collaborate with Mental Health Centers of Central Illinois, SIU School of Medicine, local school districts, area primary care physicians, area social service providers, United Way of Central Illinois, the Community Foundation of the Land of Lincoln and the University of Illinois Springfield		
Activity	**Timeline**	**Anticipated Results**
1. Support the MOSAIC project coordinator position until sustainable or other funding is secured.	Through 9/30/16	Plan to fully sustain position with more permanent funding will be developed.
2. Add one new school clinician to increase number of sites within Springfield Public Schools.	9/30/16	Increased number of school sites with MOSAIC services in Springfield Public Schools.
3. Sustain current MOSAIC school based clinicians until sustainable or other funding is secured.	Through 9/30/16	Plan to fully sustain position with more permanent funding will be developed.
4. Add one new clinician to primary care sites.	9/30/16	Increased number of behavioral health consultants within primary care sites.
5. Provide training in the integrated care model to new clinicians based in primary care practices.	9/30/16	Increased number of clinicians trained in the integrated care model.
6. Provide screening of children at the additional schools and physician offices.	9/30/16	Increased number of children receiving a social/ emotional screen.
7. Provide ongoing program evaluation of MOSAIC's impact.	9/30/16	Completion of annual report of MOSAIC results to the community.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Number of sites providing social/emotional screens and on-site intervention. • Number of primary care clinicians trained in the integrated health model. • Number of children receiving social/emotional screening. • Source: MOSAIC records, Electronic Health Record, school records.	
Long term indicators & source	• Number of children receiving on-site intervention. • Source: MOSAIC records	

Goal 2: Implement 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: Memorial Medical Center will commit funding to bring a trainer from the national program to Springfield to train up to 30 local community members. Memorial will provide the conference center, promotion of the event, required materials and provide funding for an ongoing program coordinator and tracking of results.

Collaborative Partners: Memorial will collaborate with Mental Health Centers of Central Illinois, Abraham Lincoln Memorial Hospital, Passavant Area Hospital, Taylorville Memorial Hospital, SIU School of Medicine, local school districts, area social service providers and the University of Illinois Springfield.

Activity	Timeline	Anticipated Results
1. Reserve date and facility for Mental Health First Aid program.	12/2015	Date for Mental Health First Aid instructor training identified. Trainer and facility reserved.
2. Provide promotional materials to partners for potential individuals to become certified MHFA trainers.	By 6/2016	Partners will be aware of opportunity to receive MHFA instructor training.
3.. Hold MHFA instructor training	By 9/2016	Complete training of up to 30 individuals in central Illinois to become certified MHFA instructors.
4. Promote the program to communities in Sangamon, Logan, Morgan and Christian counties and begin to schedule communication education events.	9/2016	Local school districts and community organizations will be aware of the availability of MHFA training events for the community by certified MHFA trainers.
5. Hold at minimum 1 MHFA community trainings by certified MHFA instructors in each of the communities.	9/2016	Increase number of individuals in each community trained as mental health first aiders.

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

Short term indicators & source	• Number of individuals becoming certified trainers from MHS sponsored certification training • Number of MHS sponsored community training events • Number of community members trained as mental health first aiders • 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: Survey of community members trained as instructors and first aiders.

Goal 3: Increase access to psychiatric care by increasing the number of inpatient psychiatric beds at Memorial Medical Center		
Target Population	Adults with Mental Health & Mental Disorders (MHMD) in Sangamon, Christian, Logan and Morgan Counties.	
Objective	Expand access to acute mental health treatment by increasing the inpatient psychiatric beds capacity in the community by at least 4 beds.	
Strategy Selected: A shortage of adult inpatient psychiatric beds exists in the community. Patients in psychiatric crisis are being held in area emergency rooms and jails for extended periods of time waiting for a bed to become available for treatment. **Commitment of Resources**: Space, construction, staffing and programming costs. **Collaborative partners:** Memorial Medical Center will partner with SIU School of Medicine Department of Psychiatry and Memorial Physician Services Vine Street Clinic to expand the current inpatient psychiatric bed capacity.		
Activity	**Timeline**	**Anticipated Results**
1. Complete preliminary space planning and incorporate into approved capital and operating budgets.	Oct. 2015	Preliminary space planning completed, incorporated into approved budget, timeline established.
2. Initiate construction of inpatient psychiatric beds.	Sept. 2016	Construction milestones achieved.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	Increased bed capacity construction milestones achieved. Source: MMC Facilities Planning Data	
Long term indicators & source	Increased numbers of inpatient acute psychiatric patients receive service in 12 months after expansion vs. 12 months before expansion. Source: MMC Census Data	

PRIORITY 3:	**OBESITY**
Reasons for priority selection	Memorial Medical Center's 2015 community health need assessment identified obesity as a top priority through its community survey, community forums, advisory groups and data collection.

Goal 1: Expand access to the Memorial Weight Loss and Wellness Center program (MWLWC)	
Target Population	Adults who are overweight who live in Sangamon, Logan, Christian and Morgan Counties

Objective	Expand access to the Memorial Weight Loss and Wellness Center by developing strategy to implement the program at Abraham Lincoln Memorial Hospital (Logan County); Passavant Area Hospital (Morgan County) and Taylorville Memorial Hospital (Christian County)

Strategy Selected:

Healthy People 2020 goals highlight the need for increased intervention by physicians with patients in the areas of nutrition and weight status (NWS).

- NWS-6.1: Increase the proportion of physician office visits made by patients with a diagnosis of cardiovascular disease, diabetes, or hyperlipidemia that include counseling or education related to diet and nutrition. (Baseline: 20.8 percent of physician visits in 2007; Target = 22.9 percent/10 percent improvement)
- NWS-6.2: Increase the proportion of physician office visits made by adult patients who are obese that include counseling or education related to weight reduction, nutrition or physical activity. (Baseline: 28.9 percent of physician visits in 2007; Target = 31.8 percent/10 percent improvement)

Memorial's Weight Loss and Wellness Center is based on the nationally recognized, evidence-based model of Geisinger Health System. Memorial's program includes a medical (non-surgical) weight loss program; accredited bariatric surgery program; diabetes services; outpatient nutrition services; and fitness. It provides physicians a comprehensive resource to refer their patients to for individualized counseling and education. There is no other program offering this specialized approach in central Illinois.

Commitment of Resources: Memorial Medical Center will provide leadership and staff for assessing expansion of the program, develop the business plan, create implementation strategies, train staff, and provide resources and promotional support.

Collaborative Partners: Abraham Lincoln Memorial Hospital, Passavant Area Hospital, Taylorville Memorial Hospital, Memorial Physician Services, Springfield Clinic, SIU School of Medicine, Springfield YMCA, Mental Health Centers of Central Illinois

Activity	Timeline	Anticipated Results
1. MWLWC will collaborate with ALMH to establish staffing and space requirements for program expansion to ALMH and complete staff training and implementation of protocols and processes.	Sept 2016	• Staffing and space will be secured for implementation of MWLWC at ALMH. • ALMH staff will be trained to implement MWLWC programming at affiliate location.
2. MWLWC will collaborate with ALMH to implement communication and marketing plan and launch program	Sept 2016	• Referring physicians in the Lincoln area will refer patients to the MWLWC at ALMH • Increase awareness of the new service to residents of Logan County. • ALMH will begin seeing MWLWC patients at ALMH.
3. MWLWC will collaborate with Passavant to determine staffing, space and physician involvement for program expansion to Passavant and complete staff training and	Sept 2016	Staffing, space and physician involvement will be secured for implementation of MWLWC at Passavant. Passavant staff will be trained to implement MWLWC programming at affiliate location.

implementation of protocols and processes.		
4. MWLWC will collaborate with Passavant to develop communication and marketing plan	Sept 2016	• Increase awareness of referring physicians and community members in Morgan County about the new MWLWC services at Passavant. • Target FY17 for program launch.
5. MWLWC will collaborate with TMH to complete a feasibility study for MWLWC at TMH	Sept 2016	• Decision will be made whether MHS will develop MWLWC at TMH.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• MWLWC program development and implementation at ALMH. • MWLWC program development at Passavant. • Decision of MWLWC at TMH made.	
Long term indicators & source	• Medical weight loss patients who complete at least 6 months of programming, on average, will achieve 5% weight loss. • Bariatric surgical patients will achieve, on average, 45% excess weight loss at one year post-op. • MWLWC at ALMH will achieve 40 physician referrals in year 2 (FY17) and 50 in year 3 (FY18). • MWLWC at Passavant will achieve 40 physician referrals in year 3 (FY18).	

Goal 2: At Memorial Medical Center, add a pediatric component to Memorial's Weight Loss and Wellness Center.	
Target Population	Children and adolescents ages 2-18
Objective	Expand the success of the Weight Loss and Wellness Center to address the needs of pediatric patients.

Strategy Selected: Healthy People 2020 goals highlight the need for physicians to address the nutrition and weight status (NWS) issues of pediatric patients.

- NWS-6.3: Increase the proportion of physician visits made by all children or adult patients that include counseling about nutrition or diet.
- NWS-10.4: Reduce the proportion of children and adolescents aged 2 to 19 years who are considered obese. (Baseline: 16.1 percent were considered obese in 2005-2008; Target = 9.4 percent, a 10 percent improvement)

Memorial's Weight Loss and Wellness Center is based on the nationally recognized, evidence-based model of Geisinger Health System. Memorial's program includes a medical (non-surgical) weight loss program; accredited bariatric surgery program; diabetes services; outpatient nutrition services; and fitness. It provides physicians a comprehensive resource to refer their patients to for individualized counseling and education. Since its inception in 2013, the program has focused on adults. There is no pediatric program offering this comprehensive approach in central Illinois, and physicians and community members are requesting the addition of this service.

Commitment of Resources: Memorial Medical Center will provide leadership, staff, and financial support for assessing expansion of the program, developing the business plan, the facility for the program and training of staff.

Collaborative Partners: Springfield Clinic, Memorial Physician Services, SIU School of Medicine, Springfield YMCA, Mental Health Centers of Central Illinois		
Activity	**Timeline**	**Anticipated Results**
1. MWLWC will establish staffing, space and physician involvement, protocols and processes for pediatric program development	Sept 2016	• Staffing, space and physician involvement will be secured for pediatric programming. • Standard pediatric program protocols and processes will be implemented
2. MWLWC will develop program materials and communication plan and launch the pediatric program	Sept 2016	• Referring physicians and community members in the MMC service area will have knowledge of the new pediatric services offered under MWLWC. • Begin seeing pediatric patients at MWLWC.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	Program implemented and begins seeing pediatric patients.	
Long term indicators & source	Program will serve 100 families by the end of FY18.	

Goal 3: Memorial Medical Center and YMCA of Springfield will collaborate to establish the Center for Disease Control's National Diabetes Prevention Program in Springfield.

Target Population	Residents of Springfield and Sangamon County
Objective	Memorial Weight Loss and Wellness Center's Diabetes Services and the Springfield YMCA will partner to attain a CDC-recognized Diabetes Prevention Program through the process identified by the American Association of Diabetes Educators (AADE).

Strategy Selected: The CDC-led National Diabetes Prevention Program is an evidence-based lifestyle change program for preventing type 2 diabetes. The year-long program helps participants make real lifestyle changes such as eating healthier, including physical activity into their daily lives, and improving problem-solving and coping skills. This proven program can help people with prediabetes and/or at risk for type 2 diabetes make achievable and realistic lifestyle changes and cut their risk of developing type 2 diabetes by 58 percent.

Commitment of Resources: MMC's AADE-certified Diabetes Services program will lead the initiative and have staff complete required training. A $23,500 grant from Memorial Medical Center Foundation is helping with expenses for creation of the program and the application process.

Collaborative Partners: YMCA of Springfield, IL

Activity	**Timeline**	**Anticipated Results**
1. YMCA to determine 1-2 appropriate staff for training. YMCA and MMC meet to determine roles in the partnership. Appropriate staff complete AADE Lifestyle Coach Training.	Aug.-Nov. 2015	• Partnership roles identified. • Appropriate staff members receive training.
2. Memorial/YMCA will submit application for CDC Pending Status. Initial cohort groups will start the program.	Jan.-Sept. 2016	• Application submitted • Cohorts formed, program starts to be offered.

3. Memorial/YMCA will collect data for submission as a CDC Recognized National Diabetes Prevention Program.	Jan. 2016-Dec. 2017	• Data collected.
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Staff are trained and program begun (precertification status).	
Long term indicators & source	• CDC-certified program is established and implemented. • Program participants demonstrate documented lifestyle changes.	

Goal 4: Support YMCA Healthier Communities Initiative		
Target Population	Residents of Springfield and Sangamon County	
Objective	Support YMCA of Springfield's efforts to create a community coalition to address obesity by enhancing the role of policy, systems and environmental changes to ensure that healthy living options are within reach of the people who live in the Springfield-area community.	
Strategy Selected: In 224 communities across the nation, YMCAs are working with other community leaders to form community coalitions focused on an intentional effort to ensure that healthy living is within reach of the people who live in those communities. To date, communities participating in this type of initiative have influenced more than 35,900 community-level changes that have impacted up to 65 million people across the nation. The Springfield YMCA is working to establish such a coalition in our community. **Commitment of Resources**: MMC will commit up to $50,000 in FY2016, will participate on the coalition task force and support program initiatives. **Collaborative Partners:** To be determined		
Activity	**Timeline**	**Anticipated Results**
1. Establish Springfield Community Coalition	March 2016	• Recruit 6-8 community coalition members • Initial meeting of coalition members to identify priority issues that will address areas of need in the Springfield area community
MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	• Initial meeting of coalition and identifying areas of need in the Springfield area community, measured by Springfield YMCA.	
Long term indicators & source	• Begin policy and systems change at the community-level that directly impact the ability of community residents to lead a healthy lifestyle; measured by Community Coalition, Springfield YMCA.	

Goal 5: Support Girls on the Run of Central Illinois	
Target Population	Girls in grades 3-8 and their families
Objective	The goal of the program is to unleash confidence through accomplishment while establishing a lifetime appreciation of health and fitness.
Strategy Selected: Girls on the Run is a transformational physical activity based positive youth development program (PA-PYD) for girls in 3rd-8th grade. We teach life skills through dynamic,	

interactive lessons and running games. The program culminates with the girls being physically and emotionally prepared to complete a celebratory 5k running event.

Commitment of Resources: Memorial Medical Center provides $12,500 in cash and in-kind support for Girls on the Run. This includes program support, scholarships for low-income girls, coverage at race-day events by SportsCare professionals, and printing of program materials.

Collaborative Partnerships: Memorial Health System's three affiliate hospitals also support Girls on the Run, along with 45 schools, the Springfield YMCA, YMCA of Christian County, Springfield Park District and HeathLink

Activity	Timeline	Anticipated Results
1. Offer program to at least 1,000 girls in central Illinois during the 2015-2016 school year. [NOTE: Ensure the target is one you will hit.]	Oct. 2015-Sept. 2016	1,000 girls will participate in the 2015-16 school year program.
2. Encourage community health and physical fitness through family member participation in the end-of-season 5k event.	Oct. 2015-Sept. 2016	A total of 600 community members and families of the program girls will complete either the fall or spring the 5k events.

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

Short term indicators & source	As a result of the Girls on the Run program season and 5k race event, 75% or more of GOTR participants and their families will report that the program positively impacted their attitude toward exercise. Measurement: GOTR survey of participants and their families.
Long term indicators & source	Continued growth of the program and reaching new schools/communities due to the demand for positive and physically active programming for girls. Expected increase in the number of schools and participants served will be 10% over the next 3-4 years. Measurement: GOTR program records

Goal 6: Support genH Kids community garden and programming at MacArthur Park Apartments Outreach Center & Community Garden

Target Population	Low-income children and families in the MacArthur Park apartment complex in Springfield, IL
Objective	The goal of the MacArthur Park Apartments Outreach Center & Community Garden is to enrich the lives of the children and families that live at MacArthur Park Apartments through increasing access to fresh fruits and vegetables as well as by providing a safe after-school program for the children that will provide tutoring, access to books, healthy snacks, gardening lessons, and cooking classes.

Strategy Selected/Commitments: GenH Kids is increasing access to fresh foods through community gardens in several neighborhoods. This initiative provides additional year-round outreach and education to children and families on healthy eating, cooking and exercise to help them adopt healthier lifestyles.

Commitment of Resources: Memorial Medical Center has committed $5,000 to this project for the coming year.

Collaborative Partners: Sangamon County Medical Society Alliance, HyVee grocery store, St. John's Hospital, MacArthur Boulevard Association, St. John's Lutheran Church, Central Illinois Food Bank and Sedesco.

Activity	Timeline	Anticipated Results
1. Grow and distribute fresh produce	April-Sept. 2016	Distribute fresh produce to 20 low-income families
2. Offer at least 40 after-school programs to 12 children/session	Oct. 2015-Sept. 2016	Complete 480 contacts with children, providing every child with healthy snacks, exercise, tutoring, and learning about good nutrition and growing healthy foods.

MEASURES: What will we measure to know the program is making a difference?	
Short term indicators & source	Engage 20 families in the 2016 garden project and increase amount of food distributed over the 2015 program. Results will be measured by genH.
Long term indicators & source	Children and families living in the apartment complex will demonstrate knowledge of healthy food choices and preparation of fresh produce for meals. This will be measured by pre- and –post evaluations conducted by genH.

Approved by the MMC Board of Directors 9-9-15
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