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

FINAL OUTCOMES FOR FY2016

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.]

FY16 Outcomes

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, Central Counties Health Centers FQHC, Memorial Behavioral Health, MOSAIC, McClernand Elementary School, and a range of community social service agencies, community police officers and local residents.

Activity	Timeline	Anticipated Results	Outcomes for FY16
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.	• The steering committee, its mission statement and a signed MOU were all completed by 10/28/2015. • Measurable program objectives were identified by 11/2015. • Annual impact statement was started in Q4, with release to community scheduled for Nov. 2016.
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	• SIU Center for Family Medicine, a federally qualified health center, was identified as the hiring agency for the community health worker. Tracey Smith, DNP, PHCNS-BC, MS with SIU Center for Family Medicine, is serving as program coordinator for Enos Park initiative, and is overseeing the community health workers (CHW), program development and outcome measures. • SIU School of Medicine Job description, interviewing and hiring were completed by 10/2015. Two office locations were established, one at Third Presbyterian Church in Enos Park and the other at SIU Center for Family Medicine. Staff training requirements were identified and CHWs have received a number of training classes throughout the year. • Hospitalization emergency department utilization was analyzed by January. The transitory nature of patients leaving the local neighborhood has made consistency in

			addressing super utilizers a challenge. Additional analysis will continue to assess utilization changes in enrolled patients. • The community health worker began seeing clients in October 2015. By the end of FY16, 111 client had been served by the community health workers. Referrals came from the neighborhood, McClernand School, the parish nurse at Third Presbyterian Church, and local social service agencies, including MERCY, Inner City Mission and Rainbow House. Memorial Behavioral Health's MOSAIC project is also referring families. CHWs are also working with residents at Hildebrandt High Rise in collaboration with the Springfield Housing Authority. • At the request of McClernand School, a family health fair took place on Jan. 14 that focused on access to care. On Jan. 11-12, students participated in hands-on assemblies addressing hygiene issues.
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	• Potential Enos Park Advisory Council members were identified in November. A charter for the group was created. The first meeting took place 12/16/15. Monthly meetings take place on the second Tuesday of each month at 6:30 p.m. at Third Presbyterian Church, preceding the Enos Park Neighborhood Improvement Association meeting. • The Advisory Council identified the need to engage neighborhood youth in meaningful activities and created a summer enrichment program engaging 27 children and a bike club enrolling 19 children. Near the end of FY16 the Advisory Council selected addressing crime and safety in the neighborhood as its next priority.
4. Create Enos Park Providers Alliance	Nov. 2015 Dec. 2015	• Identify alliance membership of social service providers in the neighborhood • Draft charter for the council	• Potential Provider Alliance members were identified in November 2015. A charter was created for the group in December. The first meeting took place 2/17/2016. Five meetings took place in FY16 with providers selecting the

	Jan. 2016	• Create organizational structure. • Identify meeting schedule and location and hold meetings	topics for these 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 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 at least by referrals between the two programs.		• During its first year the Enos Park Collaborative has developed a number of meaningful connections with individuals, the neighborhood, mental health services, neighborhood policing officers and local service providers, as evidenced by serving 455 distinct neighborhood residents in the first year through various programs. • The program is increasing access to services, as evidenced by arranging 339 primary care appointments, 44 mental health appointments and 40 dental appointments for the 111 enrolled with the CHWs. The CHWs accompanied clients to 290 appointments. Transportation was provided for 983 trips to health care providers, local service agencies and other needed assistance. • The community health workers are collaborating with the MOSAIC project's mental health provider at McClernand School. Consent forms were developed and referrals are taking place between the two programs, serving 28 individuals.
Long term indicators & source	• Increase the number of enrolled Enos Park residents who have a medical home, measured by patient medical records. • Enrolled 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. • Improve health outcomes and quality of life for enrolled program participants; measure to be determined.		• Long-term measures will be reported and tracked over the three years of the program.

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 Memorial Behavioral Health, 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	Outcomes for FY16
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.	• Completed August 2015. One new school clinician was added to a new Springfield Public School, McClernand Elementary School.
2. Provide screening of children at McClernand Elementary School.	9/30/16	Increased number of children receiving a social/emotional screen.	• Fall screening completed September 2015. A total of 253 additional children were screened. • Spring screening completed March 2016. A total of 270 children were screened.
3. Provide behavioral health consultant to serve	9/30/16	Increased number of children receiving mental health intervention in school and community settings.	• The clinician located at McClernand Elementary School works with the Community Health Workers to help identify children and families in Enos Park that may need

McClernand Elementary School and Enos Park neighborhood.			additional support. Approximately 10 additional families in the neighborhood whose children did not attend McClernand were identified by the CHW as potentially benefiting from MOSAIC services.
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.	• The clinician is working with the Community Health Workers on various ideas to reaching families in Enos Park. A health resource fair was held at McClernand Elementary School in January 2016 to engage families with children that attend the school (approximately 100 families reached). The clinician also attended the 2016-2017 academic year Open House in August to meet families of enrolled students and provide brief education around social/emotional development (approximately 40 families reached). • Approximately 150 parents/caregivers receiving education on 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.		• N=253 (fall 2015). N=270 (spring 2016) • Fall screening: 8% of students received highly elevated screens; 17% received elevated screens • Spring 2016: 7% of students received highly elevated screens; 23% received elevated screens. • Approximately 150 parents/caregivers receiving education on social-emotional development and parenting.
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		• In FY16, 31 interventions have taken place at McClernand/Enos Park.

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	Outcomes for FY16
1. Provide financial support for training of new physicians	Oct. 2015-Sept. 2016	SIU School of Medicine has operating support for educating new physicians	MMC provided academic grant support totaling $33,187,000 during a time that funding from the state of Illinois continued to decline for higher education.
2. Employ medical residents and fellows to facilitate completion of residencies and fellowships.	Oct. 2015-Sept. 2016	Medical students complete and graduate medical school	Memorial employed 157 SIUSM medical residents and supported 17 residency programs and 8 fellowships. 43 residents/fellows completed their education at MMC in FY16.
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.	Memorial is providing clinical simulation, surgical skills and classroom space in the Memorial Center for Learning and Innovation for SIUSM. In FY16, 1,096 education events were hosted in the Memorial Center for Learning and Innovation for SIU School of Medicine, with 9,304 participants.
4. Provide physical facilities for faculty	Oct. 2015-Sept. 2016	SIU School of Medicine has necessary space for programs and staff.	Memorial is providing physical facilities for SIU faculty offices, clinics and classrooms on the MMC campus,

offices, clinics and classrooms.			totaling 124,742 square feet.
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.		Students starting July 2016 will be counted in FY17. • 288 medical students at MMC through June 30. • MMC paid 157 residents and supported 17 residency programs and 8 fellowships. • 43 residents/fellows completed their education at MMC. • In FY16, 1,096 education events were hosted in the Memorial Center for Learning and Innovation for SIU School of Medicine, with 9,304 participants. • Memorial is providing 124,742 square feet of office, classroom and clinic space for SIU School of Medicine programs. Main Campus 52,040 sq. ft. Baylis 35,932 sq. ft. 4th and Carpenter 28,385 sq. ft. MCLI 4,456 sq. ft. Baby Baylis - 1st floor 4,029 sq. ft.
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		Long-term outcomes to be determined.

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 Memorial Behavioral Health 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	Outcomes for FY16
1. Provide financial support for operation of FQHC.	Oct. 2015	FQHC providing access to underserved and uninsured residents of Sangamon County.	MMC is providing financial support for the operation of the SIUSM Family and Community Medicine FQHC.
2. Initiate construction of 30,315 sq. ft., $16,259,000 clinic expansion.	April 2016	Facility expansion project initiated.	Construction of the 30,315 sq. ft. expansion of the FQHC facility at the corner of 4th and Carpenter Streets was completed on time and within budget. The new expansion opened for patient care in September 2017.
3. Recruit additional FQHC health care providers.	Sept. 2016	Execution of plan to expand FQHC provider capacity under way.	Recruiting is under way to expand the provider capacity of the FQHC.
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.		• In FY16 there were 25 physicians and 5 mid-level providers: 17 physicians, 5 nurse practitioners and physician assistants and 3 midwives. • 16,491 individual patients were served. • Through June 2016, there were 52,159 outpatient visits. • Construction project was completed on time and on budget.
Long term indicators	• Number of physician and mid-level providers at		• To be determined.

& source	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.	• To be determined. • To be determined. • To be determined.

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.	Kumler assisted 363 clients in accessing prescription medications through June 30, 2016. The number of people assisted has declined due to access to pharmaceuticals and medical care through the Affordable Care Act. Memorial facilitated a meeting between Kumler and SIU Center for Family Medicine FQHC. Kumler is asking all who apply for assistance whether they have insurance and is referring those who are uninsured to Center for Family Medicine, as well as those whose other insurance does not cover prescriptions. Program support at the $2000 level decreased in FY17 to $500 per month.
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	Kumler reports that due to the ACA, fewer people need assistance; the total of 750 was not met.
Long term indicators & source	Program assists those in need to receive necessary prescription medications, as measured by Kumler	Memorial agreed to continue support for first half of FY17 at the rate of $500 per month to assist people requesting assistance from Kumler who, due to individual circumstances, are not covered by other programs. Measures for support of Kumler will not be included in MMC's FY17 CHNA implementation strategy.

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 Memorial Behavioral Health, 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	Outcomes for FY16
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.	Ongoing, with a goal for FY17 to develop a written plan outlining sustainability ideas for this position.
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.	SPS identified two new schools for the 2016-17 MOSAIC expansion. Black Hawk Elementary and Springfield Learning Academy started the MOSAIC program in fall 2016 and a new clinician is serving those schools in the 2016-17 school year.
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.	Ongoing. MBH continues to have internal conversations on the integrated school mental health model and how to fully sustain these positions, particularly in partnership with Springfield Public Schools. MBH has also been involved in discussions, through a grant-funded opportunity by Illinois Children's Healthcare Foundation, with the Sargent Shriver National Center on Poverty Law on the policy needs to sustain a school mental health model. There is commitment from SPS for a 1.0 FTE position at Matheny-Withrow Elementary School to provide 50% of the total cost of a MOSAIC clinician with School Improvement Grant funds. This funding will be earmarked specifically for integrated behavioral health activities, including behavior-specific groups, professional development for staff and teachers around

			classroom/behavioral management, as well as a prevention-focused approach through the team delivery of social-emotional curricula. This contracted position will also be used in a proposal to SPS for future partnership funding, with the proposal taking place FY17-18.
4. Add one new clinician to primary care sites.	9/30/16	Increased number of behavioral health consultants within primary care sites.	Goal met. Jonathan Ponser, LCPC was embedded at MPS Koke Mill as an additional behavioral health consultant for this site.
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.	Goal met. Three behavioral health consultants completed training in May.
6. Provide screening of children at the additional schools and physician offices.	9/30/16	Increased number of children receiving a social/ emotional screen.	In FY16, more than 11,250 screens were completed, with additional screenings at primary care offices to be tabulated and added to this number.
7. Provide ongoing program evaluation of MOSAIC's impact.	9/30/16	Completion of annual report of MOSAIC results to the community.	The 2015 local evaluation report was released in May 2016 and distributed co MOSAIC community partners.
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.		• 12 sites • Nine behavioral health consultants have been trained in the integrated health model • 3,433 children were screened October 1, 2015-March 31, 2016. Q3 screening numbers are currently being compiled.
Long term indicators & source	• Number of children receiving on-site intervention.		• 9,016 screens occurred October 1, 2015-June 30, 2016. Q4 screening numbers to date are 2,236, with screenings from

	• Source: MOSAIC records	two additional primary care sites to be added. Final number will be available in FY17. • 1,394 children received on-site interventions in FY16.

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 Memorial Behavioral Health, 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	Outcomes for FY16
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.	• Goal met. Training dates were set in Nov. 2015. A contract was finalized with the national program in Feb. 2016. MHFA took place Aug. 1-5, 2016 at Memorial Center for Learning and Innovation in Springfield. Youth Mental Health First Aid training took place Sept. 19-21 at the same location

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.	• Goal met. A presentation and accompanying handouts were developed and shared with community partners.
3. Hold MHFA instructor training	By 9/2016	Complete training of up to 30 individuals in central Illinois to become certified MHFA instructors.	• Goal met. A total of 27 people completed MHFA training, with an additional 20 completing certification for Youth Mental Health First Aid.
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.	• A communication plan was completed. MHFA has been promoted on Facebook, with an article in the newspaper, a radio interview, and meetings with the marketing directors at each MHS hospital. Fliers have been created as well and additional promotions will take place in FY17.
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.	• Due to the instructor training taking place late in FY16, only one YMFA session was completed on Sept. 23. Additional community trainings are being scheduled in FY17.
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		• Adult MHFA instructors: 28 • YMHFA instructors: 20 • 1 YMHFA training held for SPS Douglas School staff in September 2016 (Sangamon), with 18 community members trained as YMHF Aiders • Measures will continue to be tracked in FY17 and FY18.
Long term indicators & source	• Among instructors and first aiders, increases in: mental health literacy, awareness of available resources, and confidence in assisting individuals		• Measures will be tracked in Q4 and during FY17 and FY18.

	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**	**Outcomes for FY16**
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.	Preliminary space planning has been completed, but this project has been placed on hold due to capital budget constraints.
2. Initiate construction of inpatient psychiatric beds.	Sept. 2016	Construction milestones achieved.	This project has been placed on hold due to capital budget constraints.
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		This project has been placed on hold due to capital budget constraints
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		This project has been placed on hold due to capital budget constraints and will not be included in the FY17 implementation strategy.

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, Memorial Behavioral Health

Activity	Timeline	Anticipated Results	Outcomes for FY16
1. MWLWC will collaborate with	Sept 2016	• Staffing and space will be secured	• Goals met. Program space and staffing are complete.

ALMH to establish staffing and space requirements for program expansion to ALMH and complete staff training and implementation of protocols and processes.		for implementation of MWLWC at ALMH. • ALMH staff will be trained to implement MWLWC programming at affiliate location.	• ALMH staff have received training.
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.	• Goal met. Program opened 11/12/15. MWLWC at ALMH information was provided to local physicians in the Lincoln area. General awareness of services is growing and physicians are referring patients. In FY16, we averaged 34 active patients/month at the ALMH site.
3. MWLWC will collaborate with Passavant to determine staffing, space and physician involvement for program expansion to Passavant and complete staff training and implementation of protocols and processes.	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.	• Goal met. Staffing identified and training took place in July 2016 (Medical Director: Dr. Benjamin Montgomery; Nurse: Chris White RN; Dietitian: Karen Sibert; Program Manager: Lisa Pennell). Space for the new program is within the Specialty Clinic.

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.	• Goal met. A communications and marketing plan has been developed for both physicians and the community. • Program services set to begin in FY17.
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.	• Feasibility study is underway. Market study and staffing analysis has been completed. Initial indications are that diabetes education programming would be the first phase of MWLWC services to expand to Taylorville, and will begin in FY17.
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.		• Goal met. • Goal met • TMH will begin diabetes education programming in FY17.
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 met. Average weight loss for medical weight loss patients at 6 months is 5% of total body weight. • Goal met. Bariatric surgery patients have lost >45% of excess body weight at one year. Gastric bypass patients lose an average of 14.6 BMI points in 1 year. Sleeve Gastrectomy patients lose an average of 11.3 BMI points at 1 year. • ALMH and Passavant referrals TBD in FY17 and 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, Memorial Behavioral Health

Activity	Timeline	Anticipated Results	Outcomes for FY16
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	• Goal met. • Appropriate protocols and process have been implemented. The program provides two types of family-based classes, each 8 weeks long. • Healthy Kids provides classes for 3- to 7-year-olds and for 8- to 12-year-olds and their parents to address healthy lifestyles for the entire family. • Healthy Teens is designed for 13- to 18-year-olds and covers good eating, exercise and understanding body image. Parents attend an accompanying support group.
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.	• Goal met. Marketing campaign has begun and physicians have been informed of the new services available for their patients. • The program, called Center for Healthy Families, opened in January 2016 and began seeing patients. The program received more than 100 referrals in FY16.
MEASURES: What will we measure to know the program is making a difference?			
Short term indicators & source	Program implemented and begins seeing pediatric patients.		Goal met.

Long term indicators & source	Program will serve 100 families by the end of FY18.	To be determined.

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	Outcomes for FY16
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.	• Goals met. Partnership roles were identified and 2 YMCA staff and 3 Memorial staff completed Lifestyle Coach training November 2015.
2. Memorial/YMCA will submit application for CDC Pending Status. Initial cohort groups	Jan.-Sept. 2016	• Application submitted • Cohorts formed, program starts to be offered.	• Application to CDC submitted December 2015, program has CDC Pending Status. • Diabetes Prevention Program orientations completed

will start the program.			February-March 2016 • Initial cohort started April 2016. Participants are losing weight and program engagement has increased. • Screening of participants for a second cohort has begun. This group will meet in Enos Park at the Springfield Housing Authority's Hildebrandt High Rise starting in the fall of 2016.
3. Memorial/YMCA will collect data for submission as a CDC Recognized National Diabetes Prevention Program.	Jan. 2016-Dec. 2017	• Data collected.	• Data collection began April 2016 and continues on first cohort.
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).		• Staff training completed November 2015. • CDC status pending
Long term indicators & source	• CDC-certified program is established and implemented. • Program participants demonstrate documented lifestyle changes.		• To be determined.

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	Outcomes for FY16
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	• Community contacts have been made to discuss creation of a Healthier Communities Initiative. However, due to changes in staffing and outcomes of existing YMCA collaborations, overall goals and the timeline for the Springfield Healthier Communities Initiative are being modified. MMC support for the program continues, with $50,000 in funding provided in FY16.
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.		• Goals and indicators for this program have been modified for the FY17 implementation strategy.
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.		• To be determined.

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	Outcomes for FY16
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.	• Goal met. 385 girls participated in the fall 2015 session; with 712 girls completing registration for the spring 2016 session. A total of 1,097 girls participated. • This spring, the 6,000th participant signed up since the program began.
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.	• Goal met. There were 312 community participants in the fall 5k; 450 community members participated in spring for a total of 762 people. • Fall 2015 was the tenth community 5k event, with a total of 10,500 participants since the first 5k run.
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.		• Goal met: 92% of participants and families said the program positively impacted their attitude toward exercise.
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		• GOTR has expanded its geographic area to include Mason County. • Is began serving its first private school in Lincoln this spring: Carroll Catholic. • Re-engaged Riverton schools that had not hosted the program since 2012; they are now doing Girls on the Run (grades 3-5) and Heart & Sole (grades 6-8). • Other new spring sites include: Dubois (Springfield), Baum (Decatur), Triopia (Morgan Co.) and Edinburg (Christian Co.).

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	Outcomes for FY16
1. Grow and distribute fresh produce	April-Sept. 2016	Distribute fresh produce to 20 low-income families	• 177 weighed pounds of produce were distributed in fall 2015. Many families took advantage of the produce; much did not get weighed. • Due to a change in ownership, the MacArthur project was discontinued in spring 2016. Memorial provided funding to genH to begin a new community garden in September 2017 in Poplar Place, a low-income housing project that did not have a garden. Thirty children participated in planting the new garden with fall vegetables.
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.	• At MacArthur 529 contacts were made with children (average of 10 per day). • At Poplar Place, genH is incorporating its Grow Your Grub curriculum into an after-school program at the apartments.

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.	• Due to a change in ownership at MacArthur Park apartments, the garden project will be discontinued. MMC will support genH to create a new community garden project at Poplar Place, a low-income Section 8 housing subdivision on the east side of Springfield. The area has high rates of crime and a high mobility rate. Poplar Place has never had a community garden. New measures will be developed for this project. The new garden project will begin in August 2016. • GenH provided a bag of vegetables to the families of the 30 Poplar Place children participating in the garden project, along with a recipe to use the food. Future lessons on gardening and cooking are planned for the children and their families.
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.	• New FY17 measures have been developed for the new garden project at Poplar Place.

The Community Health Need Assessment Implementation Strategy for FY16 was:
Approved by the MMC Board of Directors 9-9-15
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