Memorial Medical Center
Community Health Need Assessment Implementation Strategy
FY2017 October 1, 2016 – September 30, 2017

FY2017 Final Outcomes

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 would be the best 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 the best 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 a 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.]

MMC developed an implementation strategy in FY2016 that will be revised, updated and approved by the MHS Board for FY2017 and FY2018.

Implementation Strategy Changes from FY2016 toFY2017

- Access to Care Priority: Due to an increase in access to pharmaceutical assistance through the Affordable Care Act, community members using Kumler Neighborhood Ministries' program has declined significantly. After discussing the best approach with Kumler, both parties agreed that MMC will taper off its support of this program and Kumler will work with low-income residents to get them aligned with a medical home at a federally qualified health center, where they can access their prescription medications. Therefore, this goal from FY16 was eliminated for FY17.
- Mental Health Priority: Due to available funding, several capital projects at MMC have been put on hold. The planned expansion of inpatient psychiatric beds at MMC is included in this list of projects placed on hold and has therefore been removed from the FY17 implementation strategy.
- Obesity Priority: At the request of the genH director, support for genH Kids' community garden project has switched locations to a new project a Poplar Place, a low-income housing development.

MEMORIAL MEDICAL CENTER
FY2017 IMPLEMENTATION STRATEGY FINAL 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, 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	FY17 Final Outcomes
1. Steering Committee continues to monitor project objectives and outcomes.	FY2017	• Produce and distribute an annual impact statement by November 2016 for the first year of the program.	• Impact statement was completed/distributed. A presentation was given to the Springfield Citizens Club in November, and a press conference was held in January 2017.

2. Continue the Community Health Worker Program	FY2017	• Continue collaboration with social service agencies, EPNIA, McClernand Elementary School, Hildebrandt public housing high rise, MOSAIC and health care providers to provide assistance and case management for identified residents. • Continue work on hotspotting using hospital data on ED utilization and admissions; establish baseline measures.	• Collaborations continues to grow. New partnerships have been formed with the Springfield Police Department. Hildebrandt public housing has added a case worker who is collaborating with the community health workers. • 136 clients enrolled with the CHW in year 2; 300 total for years 1 & 2. • In year 2, there were 599 primary care appointments; 172 mental health appointments (103 accompanied by CHW) and 46 dental appointments. There was 22% reduction in unnecessary visits to the emergency department. • CHWs provided 2,891 transportation trips. • 640 individuals in the neighborhood were impacted in year 2, include 43 youth in summer enrichment activities, 8 families in MOSAIC, and others through outreach events. • 39 parolees were assisted: 0% recidivism rate. • Hotspotting has proved challenging due to transient nature of residents, but work continues in this area. Baseline measures are being established.
3. Continue to support Enos Park Access Advisory Council	FY2017	• Continue to support the neighborhood in identifying key issues that would improve the health of the neighborhood and hold monthly meetings.	• Neighborhood support continues. The Advisory Council is active and has been enfolded into a standing committee of the Enos Park Neighborhood Improvement Association and meets monthly, with regular updates to EPNIA. The summer youth program that the Advisory Council initiated in 2016 increased to five different clubs for neighborhood youth in grades 3-8 for the summer of 2017, including a bike program, art, gardening, construction/building, reading and Boy Scouts. Some community members are looking at innovative approaches to connecting with troubled youth, and a mentoring program is also being

			developed for children who have graduated from the COMPASS program. A senior club and sewing club are being started by Kumler Ministries. • Crime reduction is another concern of the Advisory Council. Collaboration with neighborhood police officers continues. Police report 22% reduction in calls from the Enos neighborhood in the first two years of the program.
4. Continue to support Enos Park Providers Alliance	FY2017	• Continue to work with social service providers in the neighborhood to provide education and address issues to help them better serve their clients. • Work to provide shared online platform for tracking client encounters and outcomes.	• Connections with social service providers continue, both with formal meetings and collaboration to serve client needs. • Enos residents received 479 referrals for social services; CHWs accompanied people to 238 of those visits. • Work on the shared online platform has continued, and other community platforms are being reviewed. • Work has started on a new documentation system within the patient electronic health record that will allow all SIU home visiting programs and care coordination programs to document data that includes a searchability feature. Also other community platforms still continue to be reviewed. • During Q3 the police re-implemented use of crisis intervention team (CIT) forms. Dr. Smith meets with the police to review any CIT reports in the Enos neighborhood to help address potential interventions.
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		• 300 total patients have enrolled with the community health workers in years 1 & 2. Patients leave the active caseload as their issues are resolved and they are connected to a medical home; 164 clients have graduated from the program. • Multiple measures show the impact of the project on improving access to health care services, mental

	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.	health, dental care, healthy foods, improved housing, job opportunities and many other socioeconomic determinants of health. • Collaboration with the MOSAIC project continues. The MOSAIC clinician has made contact with children and their families in the neighborhood, in addition to children served at McClernand School. The behavioral health clinician has been active in the neighborhood's children's summer program, building additional connections between MOSAIC, the Enos Park neighborhood and other organizations.
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**.** They will increase the use of a medical home in an appropriate manner. • Improve health outcomes and quality of life for enrolled program participants; measure to be determined in the first year including the research study on Client Perceptions of Coordination Questionnaire.	• Numbers of pts continues to increase, and requests frequently are more than the CHWs can handle in their caseloads. A total of 300 patients have been impacted by the community health workers since Oct. 2015. • Decreased use of the EDs for non-emergent is being tracked whenever possible, and the program was able to document a 22% decrease among enrolled clients who called prior to going to the ED. Use of medical homes at the two FQHCs has increased. . • A research study showed that client perceptions of the program are very positive, with significant improvements reported in health and quality of life. Neighbors provide numerous incidental reports of improved quality of life in the neighborhood.

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	FY17 Final Outcomes
1. Provide screening of children at McClernand Elementary School.	FY2017	• All students enrolled at McClernand will be offered social/emotional screening.	• Completed November 2016. A total of 255 students were screened using a social/emotional measure completed during Q2.
2. Provide behavioral health intervention by the BHC to students attending McClernand Elementary School and to children/families living in the Enos Park neighborhood.	FY2017	• Children displaying signs of needing behavioral health support, through screening results or parent/teacher referrals, will be able to engage in mental health intervention delivered by the Behavioral Health Clinician the school setting. • Children with social-emotional health needs who are not enrolled in McClernand Elementary School will have the opportunity to be identified by the Enos Park Collaborative Community Health Workers from SIU Center for Family Medicine and the Behavioral Health Clinician and referred to services in the community setting.	• Ongoing. 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 additional support. FY17 started with a new clinician at McClernand. Since then, we have met with the Enos Park Access to Care Initiative team to develop a streamlined referral process for families identified in the neighborhood by the CHWs as needing behavioral health supports. The principal of McClernand is also in support of and champion for children not enrolled at the elementary school to still receive behavioral health services on-site at McClernand. • The BHC has had more success engaging the whole family in family therapy during summer 2017. She has been able to work directly with parents to find age-appropriate activities for their kids to

			participate. The BHC is also volunteering in groups aimed for youth in Enos Park over the summer, including Bike Club and a Habitat for Humanity Construction Club, which has not only allowed time for the BHC to establish even stronger rapport with her clients, but has allowed for the BHC to also establish meaningful relationships with other non-MOSAIC kids that either go to McClernand or live in Enos Park. • During the summer, the BHC has been strengthening her professional relationship with other individuals, especially community gatekeepers, and organizations that have been a part of the Enos Park Access to Care Initiative.
3. Provide education on healthy social/emotional development and parenting.	FY2017	• The BHC will offer two opportunities for the parents/caregivers in the community to receive education on healthy social/emotional development and parenting.	• The BHC took part in the National Night Out Against Crime event in the neighborhood on August 1. She leveraged this opportunity to speak to parents in attendance on the importance of social-emotional wellness, as well as what services are available for children in the neighborhood and how to access MOSAIC services at McClernand. • The BHC was present at this school year's open house, so she could meet parents, introduce the program and the types of integrated behavioral health services available. She provided education around healthy social-emotional development and what warning signs to look for if a child could be at-risk of developing a behavioral health issue.
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.		• N=255 in FY17. • 4% of students received highly elevated screens; 16% of students received elevated screens. • Three children in the community have been identified for interventions. of children identified

	• Number of children identified in the community receiving intervention. • Number of community events offering education on social/emotional development and parenting. • Source: MOSAIC records, Electronic Health Record, school records.	in the community=3; it is hoped the visibility the BHC has established over the summer being involved in multiple groups aimed for Enos Park youth will drive more families to work with other organizations serving the neighborhood, including children's behavioral health services • 5 events total in which the BHC was present to offer education around healthy social-emotional development vs. the signs in which social-emotional interventions could be of benefit a child and family.
Long term indicators & source	• Number of children and/or families receiving intervention. (Source: MOSAIC records and measures from University of Illinois Springfield's Survey Research Office)	• N=38 • Direct client care hours=798.5

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	FY17 Final Outcomes
1. Provide financial support for training of new physicians	FY2017	SIU School of Medicine has operating support for educating new physicians	• Ongoing cash and in-kind operating support is being provided.

2. Employ medical residents and fellows to facilitate completion of residencies and fellowships.	FY2017	Medical residents and fellows students complete post- medical school training	• 72 medical residencies have been completed to date in FY17 (total will be 78 by end of Q4).
3. Provide state-of-the art clinical simulation and surgical skills laboratories as well as classroom space.	FY2017	Students, residents and fellows receive hands-on experiential education in simulation laboratories that offer top quality education in medical procedures they may encounter as physicians.	• Memorial is providing clinical simulation, surgical skills and classroom space in the Memorial Center for Learning and Innovation for SIUSM. Through Q3, 1,022 education events were held at the MCLI for SIU School of Medicine. There were 11,222 participants in these events, and MCLI staff spent 1,042 hours coordinating the trainings.
4. Provide physical facilities for faculty offices, clinics and classrooms.	FY2017	SIU School of Medicine has necessary space for programs and staff.	• Memorial continues to work with SIU Medicine to meet space for programs and staff in multiple locations, both on and off the main campus.
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.		• Number of medical students on MMC campus, measured by MMC/SIU records: 219 (2^{nd}-4^{th} year students) • Number of medical residencies supported by MMC, measured by MMC/SIU records: 278 (includes fellows) • Number of residents and fellows who complete their residencies or fellowships, measured by MMC/SIU records: 78. • Square footage for FY17 provided to SIU = 56,829
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		• 219 2^{nd}-4^{th} year students in FY17. • 278 medical residencies (some residents also work at HSHS SJH in addition to time at MMC) • 78 residencies completed through Q4.

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	FY17 Final Outcomes
1. Provide financial support for operation of FQHC.	FY2017	FQHC providing access to underserved and uninsured residents of Sangamon County.	Financial support continues. The integration of Memorial Behavioral Health into the primary care clinics has occurred. Behavioral health consultants serve as a part of the healthcare team, which allows for engagement of the patient at the time of the medical visit. The CEO of Center for Family Medicine reports this is working exceptionally well.
2. Complete construction of 30,315 sq. ft., $16 million clinic expansion.	FY2017	Facility expansion project completed on time and within budget. New building is occupied.	Construction was successfully completed and the space is occupied. The renovation of the old clinic was completed in March of 2017 and that space is occupied and fully operational.

3. Recruit additional FQHC health care providers.	FY2017	Execution of plan to expand FQHC provider capacity is under way.	Recruitment of staff continues but was challenging in 2017. Due to budget difficulties in the state of Illinois, recruitment of providers and staff was slowed down. Also, there is increased competition from hospitals, physician offices and the state for hiring nurses, and it can take a number of months to fill a position. Plans to expand staff continue.
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.		• FY 17 Number of Providers (Physicians + Mid-Levels) = 30 • FY 17 Number of individual Patients served = 19,620 • FY 17 Patient Visits = 52,700 • Facility is now fully operational – both the East and West Wings. Due to construction earlier in the year and moving programs into new space, there were several weeks the Center was not fully operational. FY18 will be the first year of complete operation with expanded staff. • Source: SIU Center for Family Medicine
Long term indicators & source	• Number of physician and mid-level providers at end of FY2018 = 32. • Number of individual patients served in FY2018 = 21,000. • Number of patient visits in FY2018 = 65,000, with 70,000 in FY19. • Facility expansion project completed on-time and on-budget in FY17.		• Facility expansion project goal is completed. • Long term outcomes will be reported in FY18.

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	FY17 Final Outcomes
1. Support the MOSAIC project coordinator position while sustainable or other funding is secured.	FY2017	• Develop a written plan outlining options to fully sustain position with more permanent funding.	• In progress/not yet complete. Internal discussions have started regarding options to fully sustain this position. The coming fiscal year will also be intentional planning with Springfield Public Schools

			to see how we can better align program processes to make the types of tasks a full-time MOSAIC Project Manager has historically taken on a more collaboratively supported system. ILCHF released an RFP to existing Children's Mental Health Initiative sites (MOSAIC Springfield is one site) for another year of CMHI funding to their four funded sites; however, these dollars would specifically be earmarked for CMHI site leadership and to serve as a mentor to other newly funded ILCHF SOC's around the state. MBH was recently notified that we have been awarded the CMHI Mentoring Year grant. This would provide funds for the MOSAIC Project Manager position in CY2018.
2. Add one new school clinician to increase number of sites within Springfield Public Schools.	FY2017	• Increased number of school sites with MOSAIC services in Springfield Public Schools.	• Completed January 2017. A new clinician was hired to provide MOSAIC services at two new SPS sites: Black Hawk Elementary School and Springfield Learning Academy.
3. Sustain current MOSAIC school based clinicians while sustainable or other funding is secured.	FY2017	• Develop a written plan outlining options to fully sustain positions with more permanent funding.	• In progress. MBH is looking at the MOSAIC total cost vs. revenue (both billing and grant), by clinician by month to see where our gaps are in generating billable services. This breakdown will help us identify which months are slower in billable revenue, which clinicians generate more billing, as well as what types of services we're delivering more frequently. Some ideas we have to help ensure sustainability include a draft proposal to SPS on a financial partnership to help pay for the non-billable activities crucial to integrated school behavioral health, as well as exploring the use of a 9 month contract for clinicians.

			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.
4. Provide screening of children at all identified MOSAIC schools.	FY2017	• Screenings will be offered to students at schools with an embedded clinician.	• Completed in 2016-2017 school year.
5. Provide ongoing program evaluation of MOSAIC's impact.	FY2017	• Completion of annual report of MOSAIC results to the community.	• Completed May 2017. The local evaluation report was released on May 31, 2017. A community partners evaluation meeting was held in late August 2017 to share the results of the evaluation report
MEASURES: What will we measure to know the program is making a difference?			
Short term indicators & source	• Number of Springfield Public School sites providing social/emotional screens and on-site intervention. • Number of children receiving social/emotional screening in the school setting. • MOSAIC annual report • Written sustainability plan • Source: MOSAIC records, Electronic Health Record, school records.		• 11 Springfield Public School sites • Children screened in school setting=2,045 • MOSAIC annual report was released in Q3, with additional distribution ongoing. • Written sustainability plan is in progress
Long term indicators & source	• Number of children receiving on-site intervention. • Source: MOSAIC records		• N=262 (school setting) • Direct client care hours=2,195.98

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 Health System committed funding in FY16 to bring trainers from the national program to Springfield to train up to 30 local community members in Mental Health First Aid, and additional training for certification in Youth Mental Health First Aid. Memorial paid for the tuition fee for attendees from Sangamon, Logan, Morgan and Christian counties and provided the conference center and promotion of the event. In FY17-FY18, Memorial commits to funding Memorial Behavioral Health to provide ongoing coordination of the program. Every MHS hospitals commits to promoting the program within their local communities.

Collaborative Partners: Memorial Behavioral Health, Memorial Medical Center, 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. Agencies sending a staff member(s) to receive MHFA/YMFA training include: The Phoenix Center, Community Connection Point, Sangamon County Dept. of Public Health, HSHS St. John's Hospital, Springfield Urban League, Springfield Public Schools, Lincoln Prairie Behavioral Health, SIU Center for Family Medicine, Jacksonville Public Schools District 117, Christian County Mental Health, and Taylorville First Presbyterian Church.

Activity	Timeline	Anticipated Results	FY17 Final Outcomes
1. MHFA Coordinator will develop an ongoing list of community partners and agencies to receive training.	FY2017	Certified MHFA instructors have a list of potential audiences in each community to teach a MHFA course.	• Completed. MBH has a resource list on our portal with potential agencies organized my county. This list has been handed out to each affiliate marketing/ communication person, as well as available to all MHFA Instructors via the Instructor Portal.
2. Explore development of a private communication portal for certified MHFA instructors to provide communication about training opportunities, coordinate distribution of training materials,	12/2016	A methodology is in place for certified MHFA instructors to report upcoming courses, request a course training partner, report tracking data and share their experiences.	• In progress. A private portal has been developed and is an area for trainers to download resources and marketing materials and communicate with other local MHFA instructors. We are still exploring whether we can develop and integrate a way to report tracking data within the private portal.

and provide a way to collect data and measures from the instructors.			
3. Promote the program to communities in Sangamon, Logan, Morgan and Christian counties.	FY2017	ALMH, TMH, PAH and MMC in collaboration with Memorial Behavioral Health have a localized communication plan for each hospital to create awareness of and promote available MHFA courses.	• Ongoing. We are currently working with each affiliate to promote the open trainings in their respective communities. MBH is posting on Facebook once a week about upcoming trainings and benefits of the program. Other affiliates have been working with us to promote the program through press releases and internal communications with employees. • Other local agencies have also promoted MHFA trainings, including Springfield School District 186, Community Connection Point and others.
4. Hold at minimum two MHFA community trainings by certified MHFA instructors in each county, for a total of eight courses.	FY2017	Increased number of individuals in each community trained as mental health first aiders.	Completed. A total of 52 community trainings have been held across all four counties. In FY17: • Christian County: 5 trainings • Logan County: 4 trainings • Morgan County: 13 trainings • Sangamon County: 30 trainings
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		• # of instructors=27 • # of MHFA trainings sponsored by MHS=352 • # of MHFAiders=785
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		Out of a sample of 37 participants (N=37), scores for each of the below activities indicates a high training impact for MHFA in the following areas:

	• Source: Survey of community members trained as instructors and first aiders.	• Recognize the signs that someone may be dealing with a mental health challenge or crisis • Reach out to someone who may be dealing with a mental health challenge • Ask a person whether s/he is considering killing her/himself • Actively and compassionately listen to a person in distress • Offer a distressed person basic "first aid" level of information and reassurance about mental health problems • Assist a person who may be dealing with a mental health problem or crisis to seek professional help • Assist a person who may be dealing with a mental health problem or crisis to connect with appropriate community, peer, and personal supports • Be aware of my own views and feelings about mental health problems and disorders • Recognize and correct misconceptions about mental health and illness

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 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) and 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	FY17 Final Outcomes
1. MWLWC at ALMH will average 30 active patients/mo.	FY2017	• Patients enrolled	• During Q1-Q4 of FY17, ALMH has averaged 35 patients per month.
2. MWLWC will collaborate with ALMH to execute a marketing and communication plan	10/2016-3/2017	• Increase community and provider awareness of treatment options for patients in Logan county	• Completed. MWLWC coordinated marketing and communication plan for ALMH with MMC marketing/PR and ALMH marketing/PR, including website, press release, and community outreach efforts.
3. MWLWC will collaborate with ALMH to collect outcome variables on patients enrolled	FY2017	• Data collected	• MWLWC collaborated with ALMH to implement the outcome data collection plan similarly to the methods used at MMC, tracking changes in weight, % body fat, BMI, blood pressure, HgA1c, cholesterol levels, iron, testosterone (males only), B12 and

			Vitamin D. Bariatric surgical patients from ALMH are monitored for outcomes by the Bariatric Surgery Clinical Review (BSCR). Medical Weight Loss Patients lose on average 8% of total body weight in 12 months. Surgical patient volumes at ALMH too low at this time for outcome data.
4. MWLWC at Passavant will average 20 active patients/mo.	FY2017	• Patients enrolled	• During Q1-Q4 of FY17, PAH has averaged 54 patients per month.
5. MWLWC will collaborate with Passavant to execute a communication and marketing plan	10/2016-3/2017	• Increase community and provider awareness of treatment options for patients in Morgan county	• Completed. MWLWC coordinated marketing and communication plan for Passavant with MMC marketing/PR and Passavant marketing/PR, including website, press release, direct mailings, physician outreach, and community outreach efforts.
6. MWLWC will collaborate with Passavant to collect outcome variables on patients enrolled	FY2017	• Data collected	• MWLWC collaborated with Passavant to implement the outcome data collection plan similarly to the methods used at MMC, tracking changes in weight, % body fat, BMI, blood pressure, HgA1c, cholesterol levels, iron, testosterone (males only), B12 and Vitamin D for medical weight loss patients. Bariatric surgical patients from Passavant are monitored for outcomes by the Bariatric Surgery Clinical Review (BSCR). Medical Weight Loss patients at Passavant Area Hospital have lost an average of over 10% of total body weight loss within 12 months. Bariatric Surgical patient volumes are too low and early for outcome data reporting.
7. MWLWC will work with Taylorville Memorial Hospital to determine the feasibility of expanding the program to Christian County.	FY2017	• Decision regarding program implementation will be made.	• MWLWC collaborated with TMH to determine the feasibility of expanding components of MWLWC at TMH for Christian County. After review of resources available at TMH, it was decided it was not feasible to expand the MWLWC program.

			However, the decision was made to implement Memorial Diabetes Services (one of the service lines within MWLWC) at TMH. That program is successfully running in Taylorville.
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 regarding MWLWC at TMH made.		• All complete. ALMH and Passavant programs have been implemented. ALMH went live in November 2015. Passavant went live July 2016. Decision was made to implement Memorial Diabetes Services (one service line within WLWC) at TMH.
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).		• All measures are on target or have been exceeded. • Weight loss outcomes for medical and surgical patients are being monitored for long-term indicators. Medical Weight Loss patients on average achieve 8% of total body weight. • YTD, ALMH has received 54 physician referrals. • Passavant has received 87 physician referrals.

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	FY17 Final Outcomes
1. Memorial Center for Healthy Families (within MWLWC) will complete at least ten outreach meetings	FY2017	• Increase community and provider awareness of treatment options for pediatric obesity.	• Completed more than 10 community outreach events to raise awareness of Memorial Center for Healthy Families. • The program had 107 referrals and averages 22 active patients per month.
2. Memorial Center for Healthy Families will develop action plan for Healthy Mom & Healthy Baby programming	FY2017	• Determine program design and physician partners for Healthy Mom & Healthy Baby	• Program development for Healthy Mom/Healthy Baby was explored, but has been put on hold to focus opportunity on Healthy Family programming.
MEASURES: What will we measure to know the program is making a difference?			
Short term indicators & source	Program implemented and begins seeing pediatric patients.		At the end of FY17, the program was averaging 22 active patients per month (ages 3-17).
Long term indicators & source	Program will serve 100 families by the end of FY18.		On target.

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	FY17 Final Outcomes
1. Memorial/YMCA will continue to conduct the two cohorts started in FY16 (at Chatham and Springfield Housing Authority's Hildebrandt high rise in Enos Park). Collect data from these groups.	6/2017 9/2017	• Chatham group will conclude; participants will demonstrate documented lifestyle changes regarding diet, exercise and weight. • Hildebrandt group will conclude; participants will demonstrate documented lifestyle changes regarding diet, exercise and weight • Participants will reduce risk of developing diabetes.	• Cohort 1 (Chatham) has concluded, with two participants completing the program. • Cohort 2 has concluded core sessions and will complete their program on Dec. 6, 2017. • Participants are documenting lifestyle changes. • Despite offering free screenings and free program participation, repeated attempts to recruit a cohort at the Hildebrandt public housing high rise were not successful. A different cohort was created to meet the program requirements. •
2. Memorial/YMCA will start a third cohort in FY17.	FY2017	• Identify participants and location for third cohort. • Form cohort and begin to collect data.	• Development for a third cohort is underway. Potential participants are being identified. The anticipated start date for fall 2017 was pushed back to January 2018 due to low engagement with the fall session. Tentative location is the Springfield YMCA.
3. Memorial/YMCA will collect data for submission as a CDC Recognized National Diabetes Prevention Program.	FY2017	• Data collected and submitted.	• First data submission cycle is completed.
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).	• We now have 5 trained facilitators, 3 at Springfield YMCA, 2 at MWLWC.

Long term indicators & source	• CDC-certified program is established and implemented. • Program participants demonstrate documented lifestyle changes.	• Our program is pending recognition with CDC; participants of both cohorts have reported increased physical activity with a majority of patients reporting weight loss as well. We are on track for certification.

Goal 4: Support YMCA Healthier Communities Initiative	
Target Population	Residents of Springfield and Sangamon County
Objective	Support the YMCA of Springfield's healthy community initiatives

Strategy Selected: Support the YMCA of Springfield's initiatives for involvement with community outreach and collaborations that raise awareness and strengthen the framework for local movements to reverse the trends of physical inactivity, childhood obesity and poor nutrition, particularly those impacting low-income or at-risk families.

Commitment of Resources: MMC will commit up to $50,000 in FY2017.

Collaborative Partners: Memorial Sports Care, Memorial Weight Loss and Wellness, Enos Park Neighborhood Improvement Association

Activity	Timeline	Anticipated Results	FY17 Final Outcomes
1. Increase the number of community collaborations that the YMCA participates in during FY2017 and serve as a resource to help identify common core issues that could be impacted by policy or system changes.	FY2017	• Anticipated Results: YMCA Healthier Communities Director will increase the YMCA's community outreach and collaborations.	Active partnerships ongoing with: • Boys & Girls Club • Big Brothers, Big Sisters • GenH • School District 186 • St. Patrick's School • Matthew Project (homeless students) • Sangamon County Health Dept • Memorial Health System • Joslin Diabetes Center (HSHS) • Central Counties Health Center FQHC • SIU Center for Family Medicine FQHC • Pure Haven Counseling & Resource Center • Springfield Urban League

2. Engage in programming that addresses issues of physical inactivity, childhood obesity and poor nutrition, particularly those impacting low-income or at-risk families.	FY2017	• Anticipated Results: YMCA Healthier Communities Director will increase the YMCA's community outreach and collaborations.	• Collaborating with other providers to offer a sport/personal development programming for at-risk middle school youth • Members of Brandon Court housing complex through Central Counties Health Center FQHC participate in monthly physical activities at Y. • Provide health education to the at-risk clients of Pure Haven monthly.
MEASURES: What will we measure to know the program is making a difference?			
Short term indicators & source		• Ten percent (10%) increase in the number of collaborative community partnerships/initiatives in FY17 versus FY16. • Ten percent (10%) increase the number of low-income/at-risk children who benefit from YMCA community health initiatives in FY17 versus FY16.	• The number of community partners has increased by 50% in FY17. • The number of low-income/at-risk youth benefiting from the community health initiative has increased by 55%.
Long term indicators & source		• The YMCA, in collaboration with other community organizations, identifies at least two (2) policy or system changes that would positively impact the health of the individuals and the community	Two changes have been identified and are being addressed. 1. Establishing and enacting healthier beverage/snack options in vending machines. 2. Identified gap in programming/services for middle school aged youth.

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. It teaches 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 Health Link

Activity	Timeline	Anticipated Results	FY17 Final Outcomes
1. Offer program to at least 1,000 girls in central Illinois during the 2016-17 school year.	FY2017	1,000 girls will participate in the 2016-17 school year programs.	• Fall 2016 = 347 • Spring 2017 = 674 • Total 1,021 participants
2. Encourage community health and physical fitness through family member participation in the end-of-season 5k event.	FY2017	A total of 600 community members and families of the program girls will complete either the fall or spring the 5k events.	• Fall = 249 • Due to a significant storm on the day of the 5k event, the large event, which had 1,400 registrations, had to be cancelled. Multiple local GOTR sites rescheduled the event in their communities, which were smaller scale but still celebrated the accomplishments of the girls. However, attendance was not taken at all of the smaller events. The total 600 attendance goal was likely reached in FY17, but it cannot be fully documented.
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.		• Fall = 88% • Spring = 82%
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		• New sites in fall = 3 • New sites in spring 2017 = 6

Goal 6: Support genH Kids establishment of a new community garden program at Poplar Place housing development.	
Target Population	Low-income children and families in Poplar Place, a Section 8 housing development.
Objective	The goal of the Poplar Place community garden is to enrich the lives of the children and families by increasing access to fresh fruits and vegetables as well as teaching gardening skills and providing information on healthy eating and preparation of fresh produce.

Strategy Selected/Commitments: GenH Kids is increasing access to fresh foods through community gardens in several neighborhoods. MMC will support the garden at Poplar Place, located on the east side of Springfield in a low-income, at-risk neighborhood. Families here have never had access to a community garden.

Commitment of Resources: Memorial Medical Center has committed $2,500 to this project for the coming year.

Collaborative Partners: genH Kids

Activity	Timeline	Anticipated Results	FY17 Final Outcomes
1. Continue to promote the community garden started in summer 2016.	FY2017	• Reach families living in the Poplar Place development.	• The garden at Poplar Place started with two raised beds. A high school student installed 4 more garden beds in 2017 as part of his Eagle Scout Project. • The garden was promoted with flyers and a cookout in May. A weekly workday for the garden started in May. A great deal of informal education occurs doing those workdays. • A kickoff cookout for the public took place in May. A weekly workday for the garden began in May. A great deal of informal education that occurs doing those workdays. • Held monthly Grow Your Grub lessons at the garden, engaging 10-15 kids each month with lessons about gardening and how to prepare/eat the food out of the garden.
2. Enlist families to participate in the garden.	FY2017	• At least 15 families will plant and grow produce in the garden.	• Numerous families have been engaged in the project but not all have remained engaged. Management changes at Poplar Place caused a number of families that started with the gardening program to be removed

			from tenancy at Poplar Place during the summer. GenH is working to set up an evening program over the winter/early spring to engage a full set of families for next summer.
3. Offer at least four education opportunities for growing, harvesting and cooking fresh produce from the garden.	FY2017	• Participants will learn about growing, preparing and eating fresh vegetables and fruits.	• GenH works closely with Ayesha Lawson, who runs the after school program at Poplar Place. She does a wonderful job of gathering kids in the neighborhood to participate in formal garden education activities. Some of these children and their families participate in the garden program. • GenHkids offered Monthly Grow Your Grub education lessons for children at the garden. These lessons taught children how to garden, how to harvest, and simple preparation methods. We collected children, going door to door in some cases, for this program. Plans are to continue the program, perhaps with support from management as weather gets colder, and to increase the number of engagements to more frequently than once a month, as this populations tends to be more mobile. • GenH has offered two education opportunities, with additional events taking place as more produce is harvested from the garden. In addition, GenH offers a monthly pop-up produce pantry, along with healthy cooking classes on the second Saturday from June through October for residents of Poplar Place and Brandon Court. The pop-up produce pantry was quite popular, and included demos and instructions on how to prepare the produce that was on hand. We reached 60 families through this program over the course of the summer.

MEASURES: What will we measure to know the program is making a difference?		
Short term indicators & source	Engage at least 15 families in the 2017 garden and increase access to healthy food. Results will be measured by genH.	• Access to healthy food was increased, but the transient nature of the residents made it difficult to reach and maintain relationships with 15 families in the summer. We will try again next summer, working closely with the management.
Long term indicators & source	Children and families living in Poplar Place 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.	• Post evaluations have not yet been conducted, since the programming had to stop and essentially start over. Plans are to conduct post-evaluations in the spring of 2018.

Strategy approved by the Memorial Medical Center board on Sept. 14, 2016.