Memorial Medical Center
Community Health Need Assessment Implementation Strategy
FY2018: October 1, 2017 – September 30, 2018

FY2018 IMPLEMENTATION STRATEGY 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 has been revised, updated and approved by the MHS Board for FY2017 and FY2018. The FY18 implementation strategy was approved by the MMC board on September 13, 2017.

FY18 IMPLEMENTATION STRATEGY

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

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

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

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

Collaborative Partners: HSHS St. John's Hospital, SIU School of Medicine's Center for Family Medicine federally qualified health center, Enos Park Neighborhood Improvement Association, 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	Final Outcomes Cumulative FY16-FY18
1. Steering Committee continues to monitor project objectives and outcomes.	FY2018	• Produce and distribute an annual impact statement by November 2017 for the second year of the program.	• First-year Impact statement was distributed November 2016 and second-year statement was and distributed in November 2017. A third-year impact statement for FY18 will be distributed in December 2018.

2. Continue the Community Health Worker Program	FY2018	• 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.	• Collaboration continued in FY18 with multiple social service agencies. From FY16-FY18, 1,238 referrals were made to social service agencies. • Hotspotting work continues on ED utilization.
3. Continue to support Enos Park Access Advisory Council	FY2018	• Continue to support the neighborhood in identifying key issues that would improve the health of the neighborhood. Enos Park Access Collaborative leaders participate in and report monthly to the Enos Park Neighborhood Improvement Association.	• At the end of FY18, the Enos Park community advisory group included 16 neighborhood residents who meet monthly as part of the Enos Park Neighborhood Improvement Association. Over the three years they have participated in 31 meetings and supported 153 neighborhood activities. • 10 clubs took place in 2018 for the third summer of children's enrichment programs for neighborhood children.
4. Continue to support Enos Park Providers Alliance	FY2018	• Continue to work with social service providers in the neighborhood to provide education and address issues to help them better serve their clients. • Continue work with Springfield Police Dept. neighborhood officers in the Enos neighborhood on identified issues. • Work to improve documentation and online platform for tracking client encounters and outcomes.	• The Health Care Providers Alliance had 39 meetings, training and education opportunities over the three years. • Work with Springfield Police Department continues, including a community-wide meeting in May attended by 200 people on HOT (Homeless Outreach Team), which addresses collaborative approaches to address homelessness. • Police calls from the Enos Park neighborhood have decreased by 35%. • Documentation and client tracking continues to be addressed and improved.
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		• Enos Park residents continue to use the CHW program; numbers of participants is high and steady. Access to health care, mental health and social services continue to increase

	by surveys of Advisory Council, Providers Alliance and number of new clients due to increased visibility. • Program identifies Enos Park residents who will participate in CHW program and increases their access to medical, mental health and other services; measures to be determined during the first quarter of the program. • Program collaborates with the MOSAIC mental health project's social worker at McClernand Elementary School in Enos Park; measured by referrals between the two programs.	for clients. 422 individual clients have been served since Oct. 2015; 75% have graduated from the program. • CHWs made 4,975 visits with clients. • 100% of clients have a medical home. There were 236 appointments with specialty providers; 158 dental appointments; 525 mental health services visits; CWHs accompanied clients to 960 appointments. Transportation was provided 6,354 times. • 14 families were referred from MOSAIC.
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.	• 422 clients served since Oct. 2015; 75% have graduated from the program, including 61 parolees, 52 homeless individuals and 21 veterans. • 100% of clients now have a medical home. • When clients called CHW, unnecessary use of emergency department decreased by 22%. • There was a 36% reduction in inpatient hospital charges. • Clients had a 28% increase in hospital outpatient utilization. • Clients report improved outcomes; 75% have graduated from the program. A research study documented client perceptions. • Enos Park Neighborhood Improvement Association has expressed appreciation for the collaboration and its impact on improving overall care for neighborhood residents and neighborhood safety. • MMC and HSHS SJH receive American Hospital Association 2018 NOVA award for collaboration and outcomes 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 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	Final Outcomes FY18
1. Provide screening of children at McClernand Elementary School.	FY2018	• All students enrolled at McClernand will be offered social/emotional screening.	• 241 students screened Oct. 2017 and again in March 2018.
2. Provide behavioral health intervention by the BHC to students attending McClernand Elementary School and to children/families living in the Enos Park neighborhood.	FY2018	• 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	• 29 students had highly elevated screens. • 61 children received MOSAIC services at McClernand in 2017-18 school year. • There were no children identified for services who were not students at McClernand.

		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.	
3. Provide education on healthy social/emotional development and parenting.	FY2018	• The BHC will offer two opportunities for the parents/caregivers in the community to receive education on healthy social/emotional development and parenting.	• Clinician continues to work with community health workers in Enos Park. Discussion is ongoing re: referral processes. • BHC has strengthened relationships with stakeholders in the Enos Park project. • BHC was present at school registration and open house.
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 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.	241 children screened. 61 received services.	
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	241 children screened. 61 received services.	

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	Final Outcomes FY18
1. Provide financial support for training of new physicians	FY2018	SIU School of Medicine has operating support for educating new physicians	Goal met.
2. Employ medical residents and fellows to facilitate completion of residencies and fellowships.	FY2018	Medical residents and fellows students complete post-medical school training	Goal met. 286 residents currently active.
3. Provide state-of-the art clinical simulation and surgical skills laboratories as well as classroom space.	FY2018	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.	During FY18, The Memorial Center for Learning and Innovation hosted 1,282 different education, training or simulation events for SIU Medicine. There were 18,789 attendees at these events.
4. Provide physical facilities for faculty offices, clinics and classrooms.	FY2018	SIU School of Medicine has necessary space for programs and staff.	Goal met.

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.	• Medical students in their second, third and fourth years are on the campus, with an average of 68 students per class = 204 students. • There are 286 residents on campus. • In FY18, the Memorial Center for Learning and Innovation hosted 1,282 different education, training or simulation events for SIU Medicine. There were 18,789 attendees at these events. • Memorial provided 44,128 square feet of academic space for in various locations on and off campus, as well as 3,931 square feet on the fourth floor of the MCLI.
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 students who receive education in the clinical simulation and surgical skills labs	• 490 students, both undergrad and residents/fellows, were on the MMC campus throughout the year. 72 physicians graduated in May 2018.

Goal 4: Support Southern Illinois University School of Medicine's Center for Family and Community Medicine Federally Qualified Health Center (FQHC).	
	Underserved and uninsured residents of Sangamon County.
	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	Final FY18 Outcomes
1. Provide financial support for operation of FQHC.	FY2018	FQHC providing access to underserved and uninsured residents of Sangamon County.	SIU CFM has increased its access to underserved and underinsured patients throughout Sangamon County as well as Central Illinois. As patients and visit counts increased, so did the change in our payer mix, For Sangamon County, SIU's original payer mix for serving the Medicaid population was 46% and it now stands at 59%. SIU's Medicare population which are considered underinsured has gone from 17% to 24%. SIU has also taken more than 10% of our original self-pay uninsured patients and worked with them to find insurance coverage for more than 7% of this group. In addition, SIU CFM has expanded in the Central Illinois region with 6 other sites in Lincoln, Jacksonville, Decatur, Quincy and at the Memorial Behavioral Health site in Springfield. Numbers of patients are shown in the Measures section below.

2. Complete construction of 30,315 sq. ft., $16 million clinic expansion.	FY2017	Goal met year 2 of FY2016-FY2018 CHNA Implementation Strategy.	Goal met. Construction complete.
3. Recruit additional FQHC health care providers.	FY2018	Execution of plan to expand FQHC provider capacity is under way.	Goal met.
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.		SIU has met this goal as we are in a much better position to recruit providers than most FQHC's are. First, we have a graduating family physician residency class of 10 each year to recruit from and many do choose to stay in the area and work with us or at an MPS site. Second, we have 5 physician assistant students each year that spend a full year of clinical rotations with us in Springfield. Also, we provide clinical rotations for nurse practitioner students from SIU-E and often recruit them to stay on as faculty. We have had excellent recruitment from these sources and are now up to 34 practitioners. See details below under "Measures".
Long term indicators & source	• Number of physician and mid-level providers at end of FY2018 = 31. • Number of individual patients served in FY2018 = 22,000. • Number of patient visits in FY2018 = 65,000. • Facility expansion project completed on-time and on-budget.		Current Stats as of September 30, 2018: • Number of Physician and Advance Practice Professionals: MET @ 36. • 24 Physicians (21 Family Medicine, 3 Psychiatrists) • 10 Advance Practice Professionals (PA's and NP's) • 2 Nurse Midwives • 36 Medical Staff Other Practitioners: • 4 Behavioral Health Staff • 2 Dietitians • 2 Doctors of Clinical Pharmacy Staff: 131 Number of individual patients on record: MET @ 22,101

		Number of patient visits: SIU CFM is at 60,355 annually but continue with our outreach efforts in Springfield neighborhoods to bring access to additional patients.

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**	**Final FY18 Outcomes**
1. Support the MOSAIC project coordinator position while sustainable or other funding is secured.	FY2018	• Develop a written plan outlining options to fully sustain position with more permanent funding.	• Goal met. The MOSAIC manager's position has been absorbed by the manager of Springfield Children's Center.
2. Add one new school to increase number of sites within Springfield Public Schools.	FY2018	• Increased number of school sites with MOSAIC services in Springfield Public Schools.	• Goal met. Enos School was added in school year 2017-18. Eleven Springfield Dis. 186 schools are served by MOSAIC. The program has also expanded to a school in Lincoln and one in Jacksonville.
3. Sustain current MOSAIC school based clinicians while sustainable or other funding is secured.	FY2018	• Develop a written plan outlining options to fully sustain positions with more permanent funding.	• In progress. Effective January 1, 2018, MOSAIC is no longer supported by the Illinois Children's Healthcare Foundation, the original and primary funder since 2010. To improve staff sustainability and retention, MBH created three clinician positions that divide their time between a MOSAIC school and the Springfield Children's Center. Re-defining the MOSAIC clinician position addresses a concern for professional isolation when a new clinician is assigned to a school without an opportunity to interact with their behavioral health peers on a regular basis. In addition, the blended positions afford the following benefits: - More clinical over sight during a new clinician's probation period. - New clinicians gain experience meeting clients and providing services in a community setting. - Clinicians maintain a steady client caseload during school breaks when school-based services are suspended. • MBH also continues to be 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.	FY2018	• Screenings will be offered to students at schools with an embedded clinician.	• Completed as of the end of 2017. It should be noted that because of MOSAIC screening, District 186 has begun screening all children enrolled in Springfield public schools.
5. Provide ongoing program evaluation of MOSAIC's impact.	FY2018	• Completion of annual report of MOSAIC results to the community.	• Completed. There is a final MOSAIC program evaluation report completed in April 2018.
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 2016-2018. • 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.		• N=33 SPS schools providing social-emotional screening • N=11 SPS schools considered MOSAIC schools • N= 4,055 children receiving a social-emotional screening in FY18 • N=218 children receiving MOSAIC services in the school setting in school year 2017-18 in Dist. 186 Schools
Long term indicators & source	• Number of children receiving on-site intervention 2016-2018. • Source: MOSAIC records		• N=535 students have received MOSAIC services October 1, 2015-June 30, 2018

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	Final Outcomes FY18
1. MHFA Coordinator will develop an ongoing list of community partners and agencies to receive training.	FY2018	Certified MHFA instructors have a list of potential audiences in each community to teach a MHFA course.	Completed. We have a resource list on our portal with potential agencies organized by county. This list has been distributed to each affiliate marketing/ communication person, as well as available to all MHFA Instructors via the Instructor Portal.
2. Memorial Behavioral Health continues to lead the program, including an online communication portal for certified MHFA instructors to provide communication about training opportunities, coordinate distribution of training materials, and data collection.	12/2016-FY2018	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.	• Dates and ability to register for the program is coordinated and managed through Memorial Behavioral Health's website. • Instructors work with Memorial Health System Organization Learning to schedule dates on the website. Organization Learning provides customer/instructor support for questions, reservation changes and managing information. • Data gathered through the MHFA national website.

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<td>3. Promote the program to communities in Sangamon, Logan, Morgan and Christian counties.</td>
<td>FY2018</td>
<td>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 in their communities.</td>
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MHS Communication continues to promote and educate the community about MHFA. This includes regular Facebook postings, general information distribution, and WAND TV featured a story about Mental Health First Aid with one of our instructors in November of 2017.

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<tr>
<td>4. Hold at minimum three MHFA community trainings by certified MHFA instructors in each county, for a total of 12 courses.</td>
<td>FY2018</td>
<td>Increased number of individuals in each community trained as mental health first aiders.</td>
<td>

Number of MHS-sponsored community training events completed through 10/31/18:

<table>
<tr><th>County</th><th>MHFA classes completed in FY18 as of 10/31/18</th></tr>
<tr><td>Sangamon</td><td>15*</td></tr>
<tr><td>Christian</td><td>7*</td></tr>
<tr><td>Morgan</td><td>4*</td></tr>
<tr><td>Logan</td><td>6*</td></tr>
<tr><td>Macoupin</td><td>1</td></tr>
<tr><td>Totals to date</td><td>34</td></tr>
<tr><td>YTD First Aiders</td><td>546</td></tr>
</table>
*Meeting FY18 goal of at least 3 events per county

Total number of community members participating in Mental Health First Aid since program inception in 2017 – 1,438

Of note:

Two learning consultants from Memorial’s Organization Development Division have been certified in the Youth Curriculum and will be getting certified in Adult Mental Health First Aid in early 2019.

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			• Classes will be offered at the Memorial Center for Learning and Innovation to provide expanded opportunities for Memorial employees as well as small community groups that may not have enough attendees to host a class. • One Christian County trainer has received their youth certification in September for Christian County. • Two instructors through Memorial Behavioral Health are obtaining a specialty certification to provide training to law enforcement and working with the Illinois State Police on their annual education needs. • Additional content will be required for all instructors beginning in 2019 to include education regarding opioid awareness and use.
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		• Total number of first aiders trained in FY18 - 546 • Number of MHS-sponsored trainings in FY18 – 17 (plus additional trainings held by other community trainers) • Total number of community members participating in Mental Health First Aid since program inception in 2017 – 1,438 • Number of active trainers – 20, plus 2 additional being certified for FY19.
Long term indicators & source	• Among instructors and first aiders, increases in: mental health literacy, awareness of available resources, and confidence in assisting individuals in distress • Source: Survey of community members trained as instructors and first aiders.		• Out of a sample of 44 FY18 participants (N=44), the median and mean scores (on a scale of 1-5) for each of the below activities indicates a high training impact for MHFA: – Recognize the signs that someone may be dealing with a mental health challenge or crisis – Median=5.0, Mean=4.71 – Reach out to someone who may be dealing with a mental health challenge – Median=5.0, Mean=4.75 – Ask a person whether s/he is considering killing her/himself – Median=5.0, Mean=4.68

		– Actively and compassionately listen to a person in distress – Median=5.0, Mean=4.66 – Offer a distressed person basic "first aid" level of information and reassurance about mental health problems – Median=5.0, Mean=4.65 – Assist a person who may be dealing with a mental health problem or crisis to seek professional help – Median=5.0, Mean=4.72 – Assist a person who may be dealing with a mental health problem or crisis to connect with appropriate community, peer, and personal supports – Median=5.0, Mean=4.68

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	Final Outcomes FY18
1. MWLWC at ALMH will average 20 active patients/mo.	FY2018	• Patients enrolled	• Average 36/mo.
2. MWLWC will collaborate with ALMH to execute a marketing and communication plan	FY2018	• Increase community and provider awareness of treatment options for patients in Logan county	• Complete
3. MWLWC will collaborate with ALMH to collect outcome variables on patients enrolled	FY2018	• Data collected	• Data collection occurring
4. MWLWC at Passavant will average 20 active patients/mo.	FY2018	• Patients enrolled	• 85/mo.
5. MWLWC will collaborate with Passavant to execute a communication and marketing plan	FY2018	• Increase community and provider awareness of treatment options for patients in Morgan county	• Complete

6. MWLWC will collaborate with Passavant to collect outcome variables on patients enrolled	FY2018	• Data collected	• Data collection occurring
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.		• Complete
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).		• Med Weight Loss patients lose on average 5% total body weight • Bari surg patients lose on average 70% excess body weight • ALMH has achieved 49 referrals FY18 • PAH has received 82 referrals FY18

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

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

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

Memorial's Weight Loss and Wellness Center is based on the nationally recognized, evidence-based model of Geisinger Health System. Memorial's program includes a medical (non-surgical) weight loss program; accredited bariatric surgery program; diabetes services; outpatient nutrition services; and fitness. It provides physicians a comprehensive resource to refer their patients to for individualized

counseling and education. Since its inception in 2013, the program has focused on adults. There is no pediatric program offering this comprehensive approach in central Illinois, and physicians and community members are requesting the addition of this service.

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

Collaborative Partners: Springfield Clinic, Memorial Physician Services, SIU School of Medicine, Springfield YMCA, Mental Health Centers of Central Illinois

Activity	Timeline	Anticipated Results	Final Outcomes FY18
1. Memorial Center for Healthy Families (within MWLWC) will complete at least ten outreach meetings	FY2018	• Increase community and provider awareness of treatment options for pediatric obesity.	• 12 outreach meetings have been completed FY18 for Healthy Families.
2. Memorial Center for Healthy Families will develop action plan for Healthy Mom & Healthy Baby programming	FY2018	• Determine program design and physician partners for Healthy Mom & Healthy Baby	• This program was incorporated into MMC's optimization program, where a subset of this program is targeted toward infertility related to weight. We have partnered with SIU fertility specialist (Dr. Loret De Mola) to work with patients who do not meet criteria for IVF due to weight. Currently there are 10 active patients at the end of FY18.
MEASURES: What will we measure to know the program is making a difference?			
Short term indicators & source	Program implemented and begins seeing pediatric patients.		Complete
Long term indicators & source	Program will serve 100 families by the end of FY18.		102 served in FY18.

Goal 3: Memorial Medical Center and YMCA of Springfield will collaborate to establish the Center for Disease Control's National Diabetes Prevention Program in Springfield.	
Target Population	Residents of Springfield and Sangamon County
Objective	Memorial Weight Loss and Wellness Center's Diabetes Services and the Springfield YMCA will partner to attain a CDC-recognized Diabetes Prevention Program through the process identified by the American Association of Diabetes Educators (AADE).

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

Commitment of Resources: MMC's AADE-certified Diabetes Services program will lead the initiative and have staff complete required training. A $23,500 grant from Memorial Medical Center Foundation is helping with expenses for creation of the program and the application process. That grant concluded in 2016 and the program is now funded through participant fees. There is a secondary scholarship grant from the Foundation that does help defray cost for qualifying participants.

Collaborative Partners: YMCA of Springfield, IL

Activity	Timeline	Anticipated Results	**Final Outcomes FY18**
Memorial/YMCA will continue to establish and conduct cohorts in FY18 and collect data from these groups.	FY2018	• Cohort 2 concludes; participants demonstrated lifestyle changes regarding diet, exercise and weight. • Cohort 3 begins; participants demonstrated lifestyle changes regarding diet, exercise and weight. • Begin preparation for Cohort 4.	• Cohort 2 concluded on December 6, 2017. The results were thus: 10 participants started, 4 dropped out over the course of the year. At the end of the year, the group as a whole lost 5.8% of their collective weight (3 individuals met >5% weight lost personally). All increased their physical activity minutes. • Cohort 3 began on 1/4/2018 with 8 participants; 5 completed the program. As a group they have lost 4.7%, 2 participants have achieved >5% weight loss personally. • Cohort 4 will begin in November 2018 (FY19). • Three additional lifestyle coaches have been trained as well, and the program is expanding into Lincoln, which expects expecting to start a cohort in January 2019.
2. Memorial/YMCA will start a third cohort early in FY18 and prepare for Cohort 4 to start.	FY2018	• Begin third cohort and collect data. • Identify participants and location for fourth cohort. Begin to collect data.	• As of 4/5/18, cohort 3 has lost 3% of their collective weight, 6 of 8 active participants have increased their physical activity minutes. • Cohort 4 is not definitively identified but will start fall 2018. Outreach will include employees of School Dist. 186.

3. Memorial/YMCA will collect data for submission as a CDC Recognized National Diabetes Prevention Program. Certification of the program is expected spring 2018.	FY2018	• Continue to collect/submit data. • Full certification from the CDC is expected in May 2018.	• The program received full recognition from the Centers for Disease Control at the end of the summer of 2018. This opens up to the possibility of being covered by Medicare. The application process for that has not yet begun.
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).	• Completed November 2015	
Long term indicators & source	• CDC-certified program is established and implemented. • Program participants demonstrate documented lifestyle changes.	• Goal met summer 2018. • Goal met.	

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 FY2018. **Collaborative Partners:** Memorial Sports Care, Memorial Weight Loss and Wellness, Enos Park Neighborhood Improvement Association			
Activity	**Timeline**	**Anticipated Results**	**Final Outcomes FY18**
1. Increase the number of community collaborations that the YMCA participates in during FY2018 and serve	FY2018	• YMCA Healthier Communities Director will increase the YMCA's community outreach and collaborations on specific identified common core issues: establishing and enacting healthier beverage/snack	• Community collaborations and partnerships have increased from five to 12 organizations between FY16 and FY18.

as a resource to help identify common core issues that could be impacted by policy or system changes.		options in vending machines and address an identified gap in programming/services for middle school aged youth. Collaborative partners include, but are not limited to: • 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	
2. Engage in programming that addresses issues of physical inactivity, childhood obesity and poor nutrition, particularly those impacting low-income or at-risk families.	FY2018	• YMCA Healthier Communities Director will increase the YMCA's community outreach and collaborations.	• Beginning stages of the development of an obesity prevention/improvement program with community partner(s) that will target at risk families/youth. • Expansion of Brandon Court initiative to include more of the Eastside of the community. • Provided physical activity opportunities quarterly at Pure Haven Resource Center events who serve at-risk families. • Participate in Juneteenth community celebration • Demonstrated physical activity at Highway to Health at Hazel Dell school. • Walking challenge during Move more month with American heart Association • Swim lessons for youth at St. Patrick's school.

			• Implemented monthly fitness activities aimed at youth
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 FY18 versus FY17. • Ten percent (10%) increase the number of low-income/at-risk children who benefit from YMCA community health initiatives in FY18 versus FY17.		• Consistent addition of community partners. Partnerships sustain ongoing initiatives, slower to initiate new ones. • Indicators were met and exceeded. New programming and collaborations increased exposure to target populations. The increased by over 50% in addition to the number of at-risk youth served over doubled.
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		• Establishing and enacting healthier beverage/snack options in vending. Vending machine options have improved in some locations. • Signage and vending changes that decreased availability of high sodium, high fat foods, will certainly impact youth patronizing vending. • Convenience sampling survey of youth, indicated they had seen the signage and noticed vending changes.

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 HeathLink

Activity	Timeline	Anticipated Results	Final Outcomes FY18
1. Offer program to at least 1,000 girls in central Illinois during the 2017-18 school year.	FY2018	1,000 girls will participate in the 2017-18 school year programs.	• 1,050 participants
2. Encourage community health and physical fitness through family member participation in the end-of-season 5k event.	FY2018	A total of 600 community members and families of the program girls will complete either the fall or spring the 5k events.	• 288 in fall run and 523 for spring run = 811 participants, an all-time record.
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.		• 95% of our families reported that the Girls on the Run program or 5k event positively affected their girl's and/or their family's 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		• During the 2017-18 school year, added 14 new partner sites for a total of 16 new teams (some sites have more than one team) • There were 1050 girls on 86 teams.

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	Final Outcomes FY18
1. Continue to promote the community garden started in summer 2016.	FY2018	• Reach families living in the Poplar Place development.	• GenH hosted a garden kickoff party for summer 2018, and invited families from across the area to join them us for garden workdays, education and produce giveaways on Thursday evening.
2. Enlist families to participate in the garden.	FY2018	• At least 10 families will plant and grow produce in the garden.	• On average, GenH worked with 7-10 families each week. There have been a total of 20 families that were part of the garden program since its inception in Poplar Place in 2017.
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.	• In addition to the garden and garden activities, GenH hosted several educational opportunities that have allowed us to teach why fresh produce is better than canned and some frozen foods. They held weekly workday and education sessions to teach planting techniques, harvesting tips and food preparation tips. They distributed cookbooks to all of the families who participated in the garden.

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

Short term indicators & source	Engage at least 10 families in the 2018 garden and increase access to healthy food. Results will be measured by genH.	In addition to the 20 families who were actively engaged in the garden, GenH distributed 450 pounds of fresh produce to 70 different families, discussed the benefits of produce, and

		the fact that produce was available for them to harvest from the garden. It also hosted a demo nights to show residents how to make salsa from the produce, and how to make a healthy ranch dip for raw vegetables.
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.	Children and families living in the Poplar Place area are more accustomed to seeing and eating fresh produce. At the beginning of our relationship, most children couldn't identify tomatoes, cucumbers, and zucchini, much less other types of vegetables. At the end of the program, children not only recognize these foods, but they also report that they eat them frequently.

Approved by the Memorial Medical Center board on Sept. 13, 2017.