

# Community Health Enhancement

Community Health  
Report  
2012 - 2015

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Lighting the Way to Health and Well-Being

## VISION:

**Beacon Health System** aspires to achieve:

- Innovative health care and well-being services of the highest quality at the greatest value
- Easy access and convenience
- Outstanding patient experiences
- Ongoing education involving physicians, patients and the community

## MISSION:

The Mission of Beacon Health System exists to enhance the physical, mental and emotional well-being of the communities we serve.

## VALUES:

	<ol style="list-style-type: none"><li>1. We put patients at the center.</li><li>2. We respect one another.</li><li>3. We demonstrate compassion.</li><li>4. We operate with integrity.</li><li>5. We are trustworthy.</li></ol>
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## Community Health Enhancement

Memorial is committed to embracing the diversity of our community and strengthening the relationships within our community to help make St. Joseph County a healthy place to live!

Memorial Hospital is committed to helping our community become one of the healthiest in the nation. Creating a healthier community means helping people stay well by:

- educating on important topics,
- providing the means to adopt healthier lifestyle choices and to increase well-being, and
- removing barriers to ensure access to adequate health care.

Memorial established numerous community health programs and services and provides a significant amount of traditional financial assistance for uninsured patients who cannot afford health services. In addition, Memorial also has a unique community health program: Tithing. The hospital allocates (or tithes) a percentage of excess revenues (usually over a million dollars annually) to help local organizations develop innovative programs that address a wide range of community health issues.

Well-being is more than physical health, it's what matters most to your employees, members, patients and customers — and it's our answer to building a better business. We are the first to understand that to keep people healthy, help those at risk, and care for the chronically ill, we have to address all five elements of well-being:



-Gallup-Healthways Well-being

## **WHAT IS A COMMUNITY HEALTH NEEDS ASSESSEMENT (CHNA)?**

Both hospitals are held to rigorous standards of accountability under the Patient Protection and Affordable Care Act (PPACA). PPACA is commonly referred to as “health care reform.” These rules include the new requirements for non-profit hospitals, which had to be in place by December 2013.

One of the most significant requirements of PPACA is for hospitals to conduct a community health needs assessment (CHNA), which help us evaluate community health priorities. This gives residents a voice in identifying a population health strategy. Assuring our adherence to established guidelines is a serious responsibility, not only because hospitals failing to do so are in danger of losing their non-profit status. Fortunately, we are not strangers to investing in the health of our community, and we have been well prepared to meet this newly legislated requirement.

The Affordable Care Act specifically mandates that hospitals communicate their population health strategy, implementation plan, measurements and progress to the community, and ultimately to the Attorney General’s office. The Community Needs Assessment and Implementation Strategies can be found on our hospitals’ websites: <http://www.egh.org/CommunityHealthNeedsAssessment> / <https://qualityoflife.org/che/community-health-needs/>.

CHNA also required the organization of the Elkhart General and Memorial Hospital’s Community Health Enhancement (CHE) board-represented councils to oversee community partnerships and investment in the health issues in alignment with CHNA priorities.

## **Memorial Hospital of South Bend**

### **Community Health Needs Assessment Executive Summary**

The well-being of a community depends on the health of every individual.

Hospitals and Health Systems are moving from the ‘sick model’ to a health model; moving out of the hospital into the community with the goal of prevention, early intervention and keeping people healthier. It has been made clear by the federal government, the mandate set-forth in the Patient Protection and Affordable Care Act, will provide high scrutiny for community benefit investments provided by tax-exempt hospitals. The key actions for meeting the mandate rests upon a sound foundation for completing the Community Health Needs Assessment (including, developing a strategic plan with multiple partners to engage in activities that will clearly impact the health of the community. (See Appendix for methodology) The outcomes of these activities will be evaluated through credible measurement in demonstrating the quality of life of the community, based upon the crucial issues they collectively have identified.

### **Community Health Needs Assessment Priority Themes for St. Joseph County**

With the continued commitment of partner organizations to improve the health status of our community, the Community Health Needs Assessment will direct us to the most pressing needs within the community, and ultimately to improve the well-being of the residents of St. Joseph County, Indiana. Employing surveys, focus groups, key informant interviews, and a community advisory board, the CHNA process has identified the following health indicators to be addressed:

- Health Disparities: Income, Education, Race, Age, Gender
- Physical Health
  - Chronic Disease
  - Childhood Obesity
  - Diabetes
  - Exercise, smoking, binge drinking
- Mental Health
- Violence/Safety
  - Street/Neighborhood Violence
  - Domestic/Relationship Violence
  - Child Abuse
- Reproductive Health
  - Infant Mortality
  - Teen Birth Rate
  - Sexually Transmitted Infections
- Access to Health and Medical Care
- Economic Stability
  - Unemployment
  - Uninsured/underinsured
  - Generational Poverty

- Affordable, quality housing
- Aging Population
  - Health Care Availability
  - Safe Housing
  - Alzheimer's Disease
- Early Childhood Development

The identified priorities will guide the activities and measures of well-being in our community. Coalitions are being formed to address many of these issues with multiple approaches and measurable activities. Memorial Hospital will play a role in these coalitions; the function may be one of leadership, a partner at the table, a resource provider with human capital, or funding support.

### **Key issues which are currently being supported by Memorial's Community Tithing Investments**

- **Health Disparities:** Income, Education, Race, Age, Gender
  - 100 Black Men of Greater South Bend – Minority Diversity Leadership Initiative, Men's Barbershop Health
  - African American Literacy Councils: Charles Martin Youth Center, New Generations Christian Ministries
  - Sickle Cell Anemia
- **Physical Health:** Chronic Disease
  - Obesity – Coalition with the SJC Health Department, WIC, Memorial HealthWorks project
  - Diabetes Pilot
  - Community-based screens
  - BrainWorks
- **Reproductive Health**
  - Infant Mortality – Michiana Coalition: Elkhart General Hospital, IU Goshen Hospital, Memorial Hospital, St. Joseph Regional Medical Center, St. Joseph and Elkhart County Health Departments
  - Prenatal Care Coordination
  - BABE, added education and infant development materials and classes in 2011
  - Teen Birth Rate – Baby Think It Over; Draw the Line, Hold the Line
- **Aging Population**
  - Health Care Availability – Bendix Family Physicians, Volunteers Provider Network
  - Safe Housing – Aging in Place, avoiding premature or unnecessary nursing home placement
  - Alzheimer's Disease – BrainWorks: Memory skills, prevention acuties
- **Early Childhood Development**
  - HealthWorks! Kids Museum
  - Infant's and Toddler's Little Noggin' Niche
  - BrainWorks
    - Talk with Baby
    - FCC's Brain Train
    - Developmental Play Spaces – St. Margaret's House, St. Joseph County Public Library, YWCA, Youth Services Bureau
- **Access to Health and Medical Care**
  - Southeast Neighborhood Center, Central Clinic (located at the Center for the Homeless), and Centennial Clinic on the Hospital Campus (opened October 2012)
  - Bendix Family Physicians

The framework for indicator selection is based on the Health and Human Services' Healthy People Initiative. Healthy People 2020 established science-based objectives for improving the health of the nation. The initiative establishes benchmarks every ten years and tracks progress toward these achievable goals. This framework encourages collaboration across sectors and allows communities to track important health and quality of life indicators focusing on general health status, health-related quality of life and well-being, determinants of health and disparities.

### **Projected priorities to be addressed with Community Partnerships, 2013-2016**

- Health Disparities
- Chronic Diseases, beginning with Diabetes
- Childhood Obesity; community-wide as a disease prevention model
  - Exercise, nutrition
- Infant Mortality – Racial disparities; and Fetal Alcohol Syndrome
- Mental Health programming for non-chronic psychiatric disease; also mood disorders, anxiety, depression, etc.
- Family/Relationship and Neighborhood Violence

### **Conclusion and Recommendations**

This is not a one-time effort. More-over the Memorial Hospital Board of Directors/Trustees, or its appointed committee with board and community representation, must approve the process and commitment to move the dashboard measures of the health indicators.

In the stated context, recommendations are:

1. Community Health Enhancement's programming will align with the prioritized issues; programming will be evidence-based, and collaboration with community-wide teams will be the necessary components going forward in 2013.
2. Broad-based community education, screening, and outreach programming will align with and meet the requirement set-forth for definition of an approved community benefit investment, including HealthWorks!, Community-based Health Fairs, and the Health Discovery Center.

Community Health Enhancement will follow the lead of Memorial Hospital and support the Innovation Intent through investing resources toward population health. Building on Memorial's strengths of being community-oriented, having deep ties in the community, and being recognized as a core hub by the community, our future promise is to: Reduce by 40% the number of preventable chronic disease cases in our community by 2021 and reduce treatment expenditures by 50% at the same time.



## **Appendix**

### **Research Sampling and Methodology**

- A random sample of 599 individuals who reside within St. Joseph County's service area were interviewed by telephone to assess their health behaviors, preventative practices, and access to health care. Individuals were randomly selected for participation based on a statistically valid sampling frame developed by Holleran. The sampling frame represented 19 zip codes within St. Joseph County, Indiana.
- The zip codes were segmented as the Primary Service Area being identified as the South Bend/Mishawaka Metropolitan area, and Secondary Service Area as rural and small towns in St. Joseph County. The zip code representing Notre Dame was not sampled due to the density of out-of-county, non-permanent residents.
- Interviews were conducted by Holleran's Tele-research Center between the dates of March 19, 2012 and May 4, 2012. Interviewers contacted respondents via land-line telephone numbers generated from a random call list. Each interview lasted approximately 12 - 15 minutes (depending on the criteria met) and was completely confidential. Only respondents who were at least 18 years of age and lived in a private residence were included.
- Data collected from the 599 respondents was aggregated and analyzed by Holleran between the dates of May 7 and June 22, 2012. Analysis was conducted using IBM SPSS Statistics.
- The frequency of responses for each survey question is reported. In addition, 2010 BRFSS results for Indiana and the United States were included to indicate how the health status of St. Joseph County compares on a state and national level. Statistically significant differences between service area responses and state and/or national responses are noted.
- The number of completed interviews yielded a response rate of 40.7%\* with an error rate of +/- 4.1% at a 95% confidence level.

### **Additional Data Sources**

- St. Joseph Health Department Annual Report
- United Way Community Needs Assessment
- Saint Joseph Regional Medical Center Community Needs Assessment
- Indiana and Memorial Cancer Registry
- University of Notre Dame Latino Studies Health Survey of the Community
- County Health Rankings and Roadmaps, University of Wisconsin, Madison
- Center for Disease Control and Prevention
- Healthy Communities Institute
- Community Focus Groups
- Key Informant Interviews
- Purdue Technical Assistance Program
- Association for Community Health Improvement

# Physical Health

# Memorial

## Community Health Enhancement™

### COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:

#### Physical Health

#### Healthy Diabetics

#### PROJECT SUMMARY/ PURPOSE

- To provide culturally appropriate diabetes education and case management to the underserved in our community while reducing hospital costs associated with diabetes.

#### COMMUNITY PARTNERS

Centennial Clinic; Central Clinic; Southeast Clinic; Bendix Family Physicians; Indiana Health Center; Project Homecoming; Oaklawn; Center for the Homeless; Northern Indiana Food Bank; and Salvation Army.

#### POPULATION SERVED

- 330 Diabetic clients were served in 2014 with a total of more than 12,000 contacts
- 58% were self-pay, Medicaid or un-insured, which is down from our first year of 75%
- 35% each Latino/Hispanic and African American

#### OUTPUTS=immediate effect

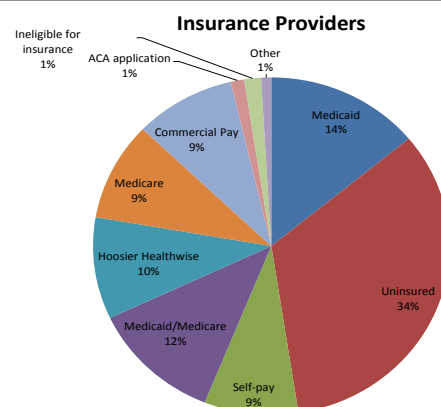
- 100% of clients without a PCP upon entering program now have a PCP

#### OUTCOMES/IMPACTS=medium term changes

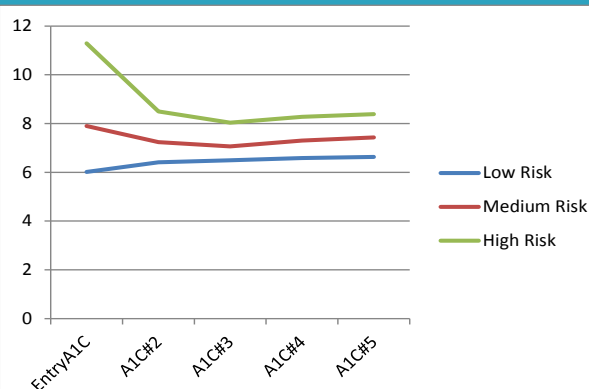
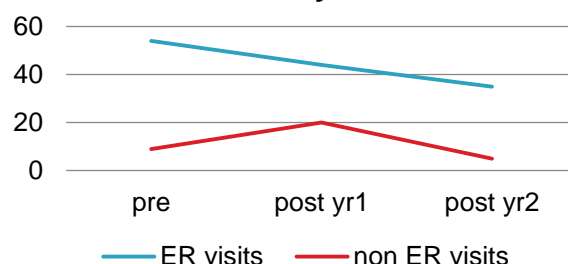
- Improved A1C Scores
- Over \$500,000 savings to Hospital



## Program Data



#### Comparison of average # of Visits for clients in program for 2 years



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## COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:

### Health Disparities and Physical Health **Beacon Heights Attraction Project**

## PROJECT SUMMARY/ PURPOSE

- Increasing access to fresh vegetables and increased physical activity
- Increased knowledge of healthy foods
- Increased Beacon Heights Neighborhood Relationships through contact with Garden guides, and participation in welcome picnics and free Garden Camp

## COMMUNITY PARTNERS

St Joseph County Health Department, SJC Public Library, Soil and Water Conservation District, April Pulley Sayre, Cardno J F New, Beacon Heights Management Office, Bendix Coffee

## POPULATION SERVED

- All garden visitors were welcome
- Targeted intervention was directed toward Beacon Heights Apartment residents (8-10% of picnic participants)
- African-American, Caucasian, Hispanic/Latino

## OUTPUTS

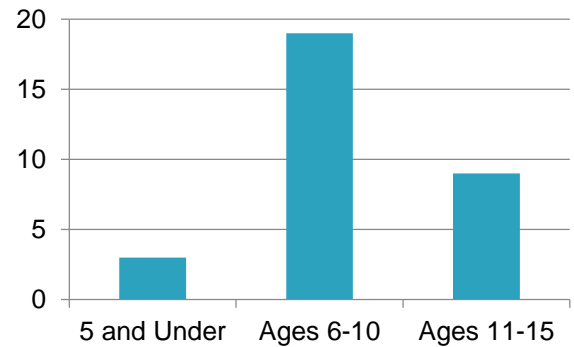
- Increased number of harvesters (June=5.5 @ day, July=8.7)
- More 1<sup>st</sup> time garden visitors (June=33, July=73)
- More Beacon Heights visitors at community picnics (12 in May, 19 in August)
- Lack of Beacon youth among Garden Camp youth
- In 2014, 95% of campers ate 3 veg servings per day, sampled 27 different vegetables
- In 2014, most campers engaged in 2 hours of physical activities per day

## OUTCOMES/IMPACTS

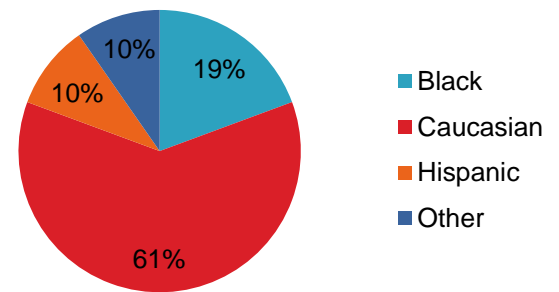
- Increased engagement from garden guides is building relationships with neighbors
- Beacon Heights residents continue to use new shaded shelter and picnic area

## Program Data

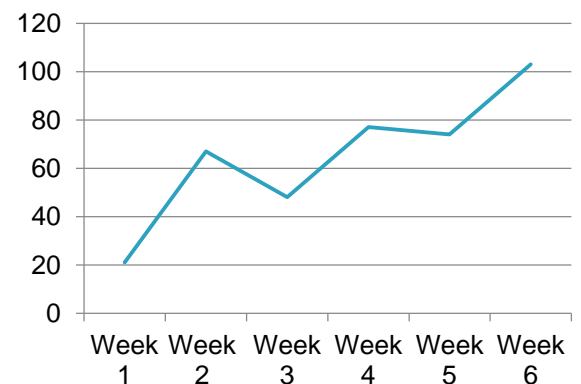
### Garden Campers Age



### Garden Campers' Ethnicity



### Visitors to the Garden



Sara Stewart, RN, MSN  
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Mother of five quit smoking three months ago and wants to have a healthy lifestyle now, but veggies are expensive and she doesn't know how to cook them. She comes to learn and to get food.



Carmen lives in a horrible housing situation and comes to the garden to find peace, water, and company. She is so gentle she doesn't even like picking plants but will take what I show her. Her son loves birds, so he comes for the chickens.



People learned how to find and pick greens, lemon cucumbers, yellow tomatoes, arugula, chard leaf and stems.

Being a garden guide was one of the most fulfilling and rewarding adventures. Coming to the garden is always a new experience! What really made it rewarding was talking to the people from the neighborhood. One individual stood out to me more than any. He was a 12 year old boy that lived across the street. He approached one day as I was weeding. He started asking me questions about the garden so I took him on a tour. He was so amazed and interested in everything around him. He had never been to the garden before that day because he did not realize what it was about. What stood out to me most about this young man is when he asked me how he could be a part of it. I simply told him he already was! He showed up quite often when I was there and would help me pull weeds or sometimes just talk. He is truly an amazing young man full of curiosity. He started bringing some friends and his little sister with him. I was glad I was able to be there to explain and teach this young man. He probably would have walked away from the garden and never came back. Now he knows how to start his own garden and knows where to come for help if he has questions or just wants a friend to talk to.

From Rick Linner, a Garden camp counselor, garden guide.





## COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:

### Physical Health

## YMCA's Diabetes Prevention Program

### PROJECT SUMMARY/ PURPOSE

- Help high risk individuals adopt and maintain healthy lifestyles
- Achieve 7% weight loss and increase physical activity to 150 minutes per week.
- Yearlong program; 16 weekly core sessions and 8 monthly maintenance sessions
- National YMCA program

### COMMUNITY PARTNERS

Memorial Hospital's Community Health Enhancement, Memorial Hospital South Bend Clinics, IN State Health Dept., Pokagon Fund, United Health Services, St. Joseph County Health Dept., IN Health Center, MHIN, Allied Physicians of Michiana, Paragon Clinic

### POPULATION SERVED (n=32)

- 20% male, 80% female; Ages 28-72
- 22% below poverty level, 78% eligible for reduced cost

### OUTPUTS

- Created referral system via mail/email to 923 physicians and 56 regional medical offices
- 300 individuals had risk assessments; 72 qualified
- 56 a1c tests administered at no cost
- 92% attendance rate

### OUTCOMES/IMPACTS (Changes as a result of the program)

- Average weight loss=6.02% of body weight/national average=4.57%; 82% exercising 150 min. a week
- Increased energy, stamina, and awareness of fat intake
- Regularly reading food labels
- Able to eliminate medications for cholesterol and blood pressure
- Better quality sleep

## Program Data

**Cohort 1: average weight loss=6.02%; 82% exercising 150 min. @ week**

**Increased energy, stamina, and awareness of fat intake**

**Regularly read food labels**

**Able to eliminate medications for cholesterol and blood pressure**

**Better quality sleep**

"I have started and failed so many weight loss programs that I lost count. And being physically active has never been something I thought I could sustain. But this program has shown me how to get healthy and stay there, and I am fully convinced that I can make it happen."

"Make better food choices. Be physically active. Simple to understand, and with the guidance of our Lifestyle Coach, very doable. For the first time in my life, I now fully believe that I can live out the rest of my days being healthy, and I am excited about what the future holds!"

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## COMMUNITY HEALTH NEED ASSESSMENT PRIORITY THEME:

### Healthy Points: Empowerment in Patient and Community Diabetic Management

## PROJECT SUMMARY/ PURPOSE

- Create a digital community of patients and adjunct health specialists working towards eliminating health disparities in underserved populations
- Diabetic patients were enrolled in a nine-month education and smartphone-based community digital behavioral management platform
- Patients earned points for attending classes, taking regular measurements, and posting photos of healthy behaviors; points were redeemable for rewards that increased access to health improvement modalities

## COMMUNITY PARTNERS

Memorial Hospital Community Health Enhancement, Outreach Services at St. Joseph Regional Medical Center, Bendix Family Physicians, Sprint, University of Notre Dame Department of Interdisciplinary Center for Network Science Applications, Michiana Health Information Network, Ray and Joan Kroc Center

## OUTPUTS

- 84% class attendance
- 1,232 social media posts
- 82% of rewards redeemed

## OUTCOMES/IMPACTS

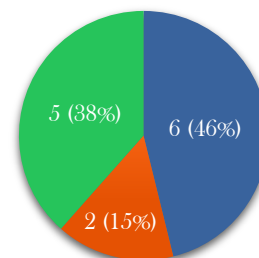
- Improved health status evidenced by significant reductions ( $p < 0.05$ ) in weight, waist circumference, blood pressure, and hospital encounters
- Patient charges with ICD-9 codes for diabetes in the 9 months prior to the program compared to those charges incurred during our program resulted in the total net charge avoidance of \$121,837.05
- Social media allowed for continued peer health coaching outside of classes and increased points of contact between patients and providers

## Program Data

### Patient Population

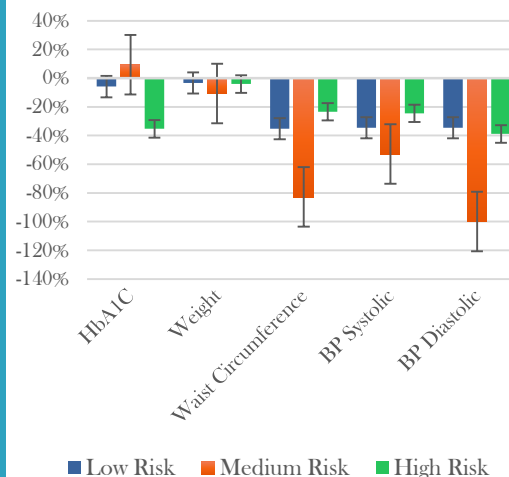
38% Male / 62% Female

Avg. age = 50.76 years

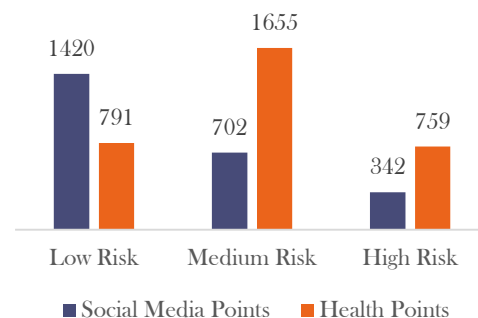


■ African-American ■ Hispanic/Latino ■ Caucasian

### Patient outcomes: change from baseline at 34 weeks



### Total Points by Risk Group



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## COMMUNITY HEALTH NEED ASSESSMENT PRIORITY THEME:

### Physical Health

### **HealthWorks! Kids' Museum**

#### PROJECT SUMMARY/ PURPOSE

- HealthWorks! Kids' Museum provides high quality health education experiences to children and families throughout Michiana and beyond. In addition to delivering cutting edge content, the HealthWorks! team specializes in techniques that result in a high level of connectivity with the audience.
- HealthWorks! provides evidence- and standards-based field trip programs on a wide range of health education topics for pre-school through middle school children, week long camp intensives around a variety of health education and clinical health topics, and opportunities for high quality interaction between parents/ care givers and children rooted in health education. In addition, we provide community outreach services, bringing health education flair to churches, schools, businesses, community-wide events, and youth service programs.

#### COMMUNITY PARTNERS

South Bend Parks and Recreation Department, St. Joseph County Parks Department, St. Joseph County Health Department, Martin's Supermarkets, Kohl's Department Stores, Reducing Obesity Coalition of St. Joseph County, Down Town South Bend, Inc.

#### POPULATION SERVED

In 2014, HealthWorks! served a total of 63,923 individuals through a combination of school field trips, general public visitors, and outreach events. Through July of 2015, year-to-date totals were 39,937 individuals served.

#### OUTPUTS-2014

- Over 3,000 pre-adolescents and adolescents took part in programs focusing on navigating the physical and emotional changes of adolescence and healthy decision-making
- More than 7,000 pre-school and school aged children experienced prevention-oriented programs emphasizing physical activity and nutrition
- Over 3,600 took part in free family programs that emphasized healthy, movement-oriented family play held in venues throughout St. Joseph County.
- An average of 37 families a month utilized Little Noggins Nook, a special place in the museum designed to foster infant and early childhood learning and brain development through play.

#### OUTCOMES/IMPACTS-2014

- 97% of school-aged children surveyed after HealthWorks! outreach programming pledged to practice a new behavior in the following ways:
- 26% pledged to exercise more frequently
- 40% pledged to increase their daily consumption of fruit and vegetables
- 34% pledged to drink more water

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## Madison Primary Center/ Leeper Park

### COMMUNITY HEALTH NEED ASSESSMENT THEME:

#### Physical Health

#### **Garden and Park Enhancements as STEAM and Service Learning Platform**

### PROJECT SUMMARY/ PURPOSE

- Purpose- help children at Madison Primary Center have better futures
- Project need in your region- failure at this age K-4 is an indicator for future prison population and higher incidence of major health issues-we need to help now or live with sad outcomes later
- Service provided: set stage for healthy food, flowers to cheer patients, park service to underscore ability of all to serve and STEAM education in the classroom and beyond
- Was program evidence based? An “F” School with 100% on subsidized nutrition was evidence of need-principal with turnaround track record was trust factor catalyst for change.

### COMMUNITY PARTNERS

Madison Primary Center, Memorial Community Health Enhancement, City of South Bend, City Park Board, and Park Foundation, Kuert Concrete and suppliers, Selge, Walsh and Kelly, Jones, Petrie Rafinski, Notre Dame School of Architecture, College of Engineering, Tau Beta Pi and Transfers Club.

### POPULATION SERVED

- 470 students in K-4 (5-9 years old), evenly distributed Gender, with 90% African American and Hispanic and from homeless shelters, Public Housing Authority with almost universal school supplemental nutrition program.
- 300 neighborhood households and hospital population served.

### OUTPUTS

- All 470 students signed huge Madison Cubs paw print thank you notes-learning gratitude
- 15 skilled labor professionals helped mentor the Garden Path project
- 500 feet of curved 8 foot wide garden sidewalk was donated- 60 cubic yard of concrete
- Over 50 college students engaged enthusiastically in the first phase forming, pouring and finishing that concrete walk and are eager to help with future phases

### OUTCOMES/IMPACTS

- Students, teachers and staff felt community support
- Community saw good things happening at a challenged school
- Talent met Purpose (engage the heart, intellect and physical effort)

## Program Photos



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**St. Joseph County Health Department  
United Way of St. Joseph County**

**COMMUNITY HEALTH NEED ASSESSMENT PRIORITY**

**THEME:**

Physical Health

**Prescription to PLAY!!**

**PROJECT SUMMARY/ PURPOSE**

- To reduce childhood obesity through physical activity programming and nutrition education.
- Nearly one in three children in the United States is overweight or obese. In St. Joseph County, over 17% of children are overweight and/or obese. Obese children face an increased risk for chronic illness, miss more school days and have poorer academic outcomes (CATCHinfo.org).
- This free program consists of organized physical games and nutrition education based off of the evidence-based Coordinated Approach to Children's Health program (CATCH) for families with a prescription referral from a local health provider.
- CATCH promotes physical activity and healthy food choices in preschool through middle school-aged children and their families. CATCH is based on the CDC Whole School, Whole Community, Whole Child model in which health education and the creation of a healthy school environment, and family/community involvement work together to support youth in a healthy lifestyle.

**COMMUNITY PARTNERS**

St. Joseph County Health Department, South Bend Parks and Recreation, United Way of St. Joseph County, Reducing Obesity Coalition of St. Joseph County, University of Notre Dame, Ray and Joan Kroc Center, The Michiana Family YMCA, Indiana Health Center, Centennial Clinic, E. Blaire Warner, WIC, Navarre Pediatrics South Bend and Granger, HealthLinc, Family Medicine of South Bend, South Bend Clinic, Community Pediatric Physicians, SJRMC Granger

**POPULATION SERVED**

- Children ages 7-12 who are in the 85 percentile or above on the growth chart. Their guardian is required to attend and their siblings are strongly encouraged to participate as well.
- Any child can receive a prescription if they qualify. We have, however, seen the majority of our participants are under-resourced, low-income families.

**OUTPUTS**

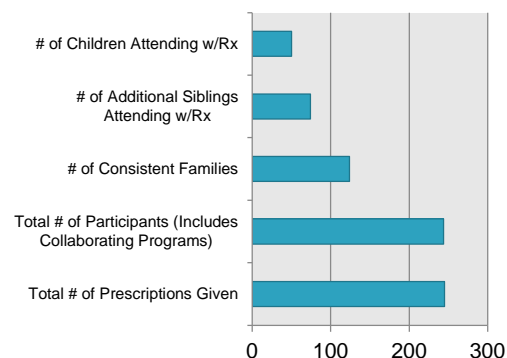
- Increased access to 60 minutes of free organized physical activity
- Increased participation by prescription holders
- Increased initiation contact through phone conversations
- Increased retention by prescription holders
- Increased attendance to all locations
- Increased number of clinical providers

**OUTCOMES/IMPACTS**

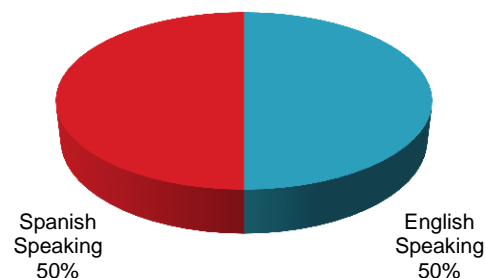
- Engaged participants have a reduction in weight acknowledged through parental self-reporting and observations
- Children gained nutritional education identified through family reporting and children's game/trivia answering
- Reduction in screen time shown through parental surveys
- Improved social skills, school work and literacy which exceeded projected outcomes confirmed through parental testimonials and observations
- Family resiliency due to an increase in social support

**Program Data**

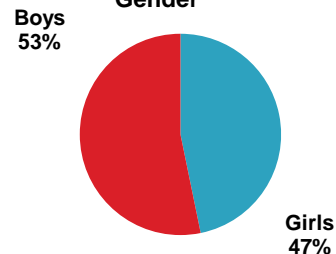
**Participation**



**Languages Spoken**



**Gender**



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Maggie Gibney  
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# Economic Stability



COMMUNITY HEALTH NEED ASSESSMENT THEME:  
ECONOMIC STABILITY

**Michiana Bridges: Employment Strategies to Break the Cycle of Poverty**

**PROJECT SUMMARY/ PURPOSE**

- Keeping a job is critical for building financial stability, but in an under-resourced world, many things can get in the way that adds up to a lost job. This new, unduplicated program in our area brings smart problem-solving and critical community resources right to the workplace.
- A Resource Navigator serves under-resourced employees with rapid problem resolution at or close to their job. This reduces the costly time needed by individuals to access agencies and find solutions to their problem.
- Provide workplace financial classes to move workers out of crisis mode into long-term healthier strategies.
- This demand-driven, market tested approach has received acclaim for its structure and results in nearby Michigan, as well as nationally.
- In St. Joseph County, 45,000 families live below 200% of the poverty line with 15% living in poverty, and the rest just a paycheck away from poverty.

**COMMUNITY PARTNERS**

A wide array of nonprofits, churches and social service agencies. Our lead business partner is Specialized Staffing Solutions and we are adding another 5-9 businesses. The City of South Bend and the St. Joseph County Chamber of Commerce are assisting us with this project. Lake City Bank provides key resources for our workplace financial class.

**POPULATION SERVED**

450+ employees

**OUTPUTS**

- Helped resolve almost 700 issues
- Developed Resource of the Week and shared with hundreds of employees
- Piloted workplace financial class

**OUTCOMES**

- Developed a dashboard to track key metrics
- Provided training to Human Resources and supervisor staff for better understanding of employees and better interface with program
- 100% of class members uses a budget

**Program Data**



New & Ongoing Services YTD	Avg Services/Mo YTD	Distinct Emps. Served YTD
177	14.8	169
64	5.3	65
33	2.8	31
29	2.4	28
146	12.2	127
37	3.1	32
<b>486</b>	<b>40.5</b>	<b>452</b>

Service Requests By Category	New Report Period	YTD
Housing	18	219
Transportation	5	123
Family/Relationships	4	86
Financial	7	103
Health	2	84
Necessities	4	44
Special Services (Taxes)		29
Ed / C/ T **		13
Legal **	3	21
	43	722

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### Michiana Bridges Provides:

- Financial Management Programs
- Transportation Issue Referrals
- Legal Assistance Referrals
- Rapid-Problem Resolutions
- Time Sensitive Referrals
- Long Term Problem Referrals

*We are here to connect (associates) to resources in the community. We want to be the bridge that will allow them to have stable employment. We want to provide innovative solutions.*

- Bonnie Bazata

*Executive Director, St. Joseph County Bridges  
Our of Poverty Initiative.*



Ashley bought her first house with the help of Michiana Bridges. She stated that “It’s endless what this organization can do for an individual. If they can do it for me, they can do it for you. I rented my home since I was 18 years old. I really wanted to buy a house but never thought it was possible. Bridges showed me a program where, if you lived in your home for two years, you could buy a house. I would recommends Bridges – not only to associates but to anyone.”





Memorial  
Community Health Enhancement<sup>SM</sup>

## COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:

## Economic Stability

## COMMUNITY HEALTH WORKERS (CHW) CAREER PATHWAY

## PROJECT SUMMARY/ PURPOSE

Community Health Workers are frontline public health workers, who are:

- Trusted members in the community
- Have a close understanding of the community served
- Liaisons between at risk individuals and health and social services
- Employed by Beacon Health System and trained to better assist the local underserved population.

## COMMUNITY PARTNERS

Ivy Tech Community College, Bethel College, BrainWorks

## POPULATION SERVED

- Past and current CHWs are multicultural as well as multidisciplinary (9 females, 6 males)
- African American=3, Caucasian=5, Hispanic=7

OUTPUTS=immediate effect

Certification training is intensive. The two-week foundation course includes training in basic case management, personality types, active listening, and basic content knowledge related to specific health problem (i.e., diabetes). In addition, CHW's are trained and certified in:

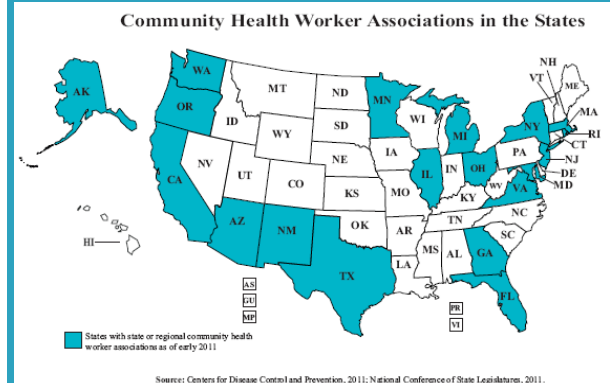
- ACA Navigation
- Mental Health First Aid.
- Acute Traumatic Incident Processing

OUTCOMES/IMPACTS=medium term changes

- Extensive training helps CHWs to adapt and overcome some of the hardships faced by community residents they assist.
- Local candidates receive continual learning, which promotes economic stability

## Program Data

## States with state or regional CHW associations as of early 2011



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# Reproductive Health

# Memorial

## Community Health Enhancement<sup>SM</sup>

COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:

### Reproductive Health

**Health and Wellness Education:  
Draw the Line/Respect the Line**

### PROJECT SUMMARY/ PURPOSE

- Provide education and training to at-risk youth populations in order to reduce teen pregnancy and teen birth rates
- Delivered an abstinence focused curriculum to students so they can develop positive attitudes, self-confidence, and less risky behaviors
- *Draw the Line/Respect the Line (DTL/RTL)* is an evidence-based program that develops skills necessary to prevent pregnancy, HIV, and STI's
- 2016 will include *Relationships Smart Plus 3.0*, also evidence-based and focuses on positive youth development and adult preparation subjects (grades 5<sup>th</sup>-12<sup>th</sup>)

### COMMUNITY PARTNERS

South Bend Community School Corporation, AIDS Ministries/ AIDS Assist of Northern Indiana, St. Joseph County Health Department

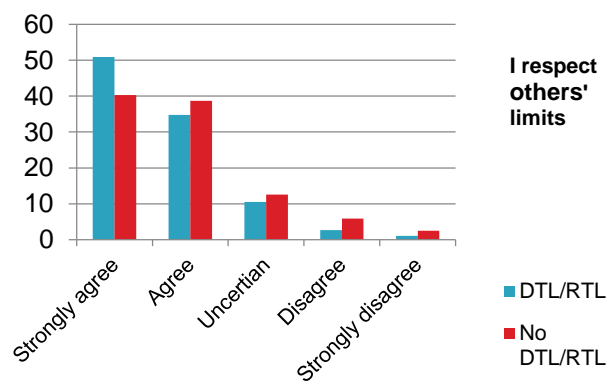
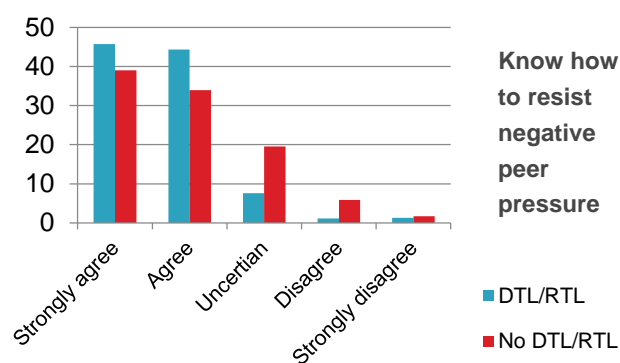
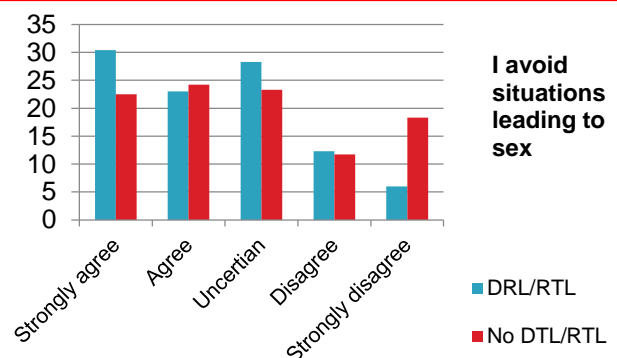
**OUTPUTS** (n=576 students surveyed, 78.6% (445) received some *DTL/RTL* instruction and 69% received three years of class training)

### OUTCOMES/IMPACTS

- Reduce pregnancy rates,
- Delay initiation of sex,
- Reduce risk of sexually transmitted infection
- Promote positive youth development,
- Promote healthy relationship skills
- 21 surveyed items targeted four categories: knowledge, attitude, intention and behaviors-the mean score for students with DTL/RTL training were higher than those without training, indicating positive benefits from the education
- 9 of the 21 survey items showed statistical significant differences

## Program Data

**55%- Female/ 45% Male:  
36% White, 31% African, 18% Hispanic,  
12.2% racial mix/other, 2.6% Asian**



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"Thank you for your service! You taught me that I'm not a bad person at the time I needed to hear it the most. You also opened my eyes to different topics like STD's (mostly). All in all thank you 😊

- 8<sup>th</sup> grader LaSalle School

"If Mrs. Cruz didn't come to the school I would not have known about most of this stuff. I think it will help a lot of other people if she keeps talking to kids."

8<sup>th</sup> grader Jackson School

Helped me learn how to deal with peer pressure.

- 6<sup>th</sup> grader Jefferson

It help me to tell my friends or anyone that I know of to wait to have sex. I loved having Mrs. Val as a teacher she was nice helpful, and help me understand better and to wait to have sex and you shouldn't rush to have sex at any time.

- 7<sup>th</sup> grader Brown

I really liked this program because it's telling me how to make healthy choices for my life.

- 6<sup>th</sup> grader Jefferson

Now I don't feel scared no more.

- 6<sup>th</sup> grader Brown

I thought that having sex just was getting pregnant but no, we get STD, this was really helpful. – 7<sup>th</sup> grader Navarre

"It helped my, by learning some of the disease and that I shouldn't have any sex until I'm older and if I do, use protection!

- 7<sup>th</sup> grader Clay

"I needed to know these things because I feel really awkward to ask my parents. Thanks a lot."

- 8<sup>th</sup> grader Jackson School

"The class was "creative" but thanks for showing me that I have the power to draw the Line."

- 8<sup>th</sup> Graders – Edison School



"Thanks for not shoving abstinence in everyone's face – condom demonstration really helped also and I learned a lot."

- 8<sup>th</sup> grader LaSalle School

# Access to Medical/Health Care

# Memorial

## Community Health Enhancement<sup>SM</sup>

### COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:

#### Access to Health/Medical Care

#### Language Services – Medical Interpreters

#### PROJECT SUMMARY/ PURPOSE

- Provide Language Services to all Limited English Proficient – Non English speaking and deaf or hard of hearing patients.
- Federal Law - Title VI Regulation require that organizations receiving federal funding provide interpretation services.
- The American with Disabilities Act - requires that deaf or hard of hearing patients are provided an interpreter.

#### POPULATION SERVED

- We serve all Limited English Proficient and Deaf or Hard of Hearing.
- We provide face to face interpreters in Spanish, Arabic and Vietnamese.
- For all other languages we provide an interpreter via telephone.
- For the Deaf or Hard of Hearing a Video Remote Interpreter (VRI) or a face to face interpreter will be provided.

#### OUTPUTS

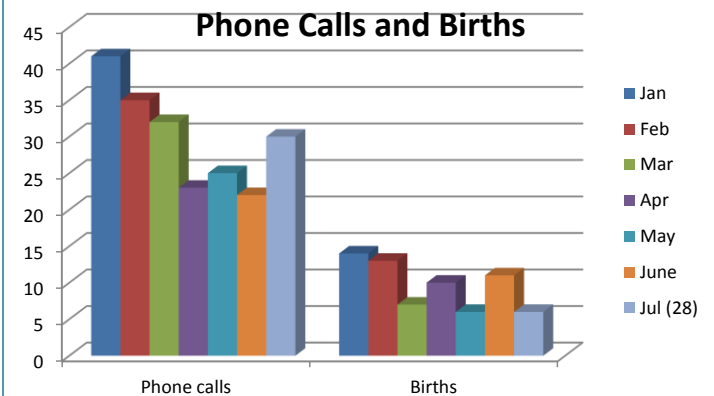
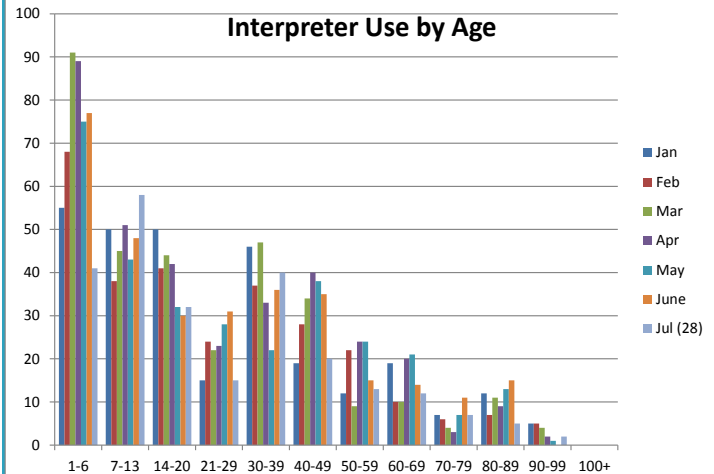
- To facilitate and improve the quality communication between providers, staff, patients and their families.
- Safety – Avoid medical errors and unnecessary procedures
- Using a medical interpreter reduces medical costs to providers and patients.

#### OUTCOMES/IMPACTS

- By facilitating communication patients and providers have a better understanding of medical treatment plan and care.
- Better understanding of patient's symptoms and medical history.
- Decrease in medical errors and complications.
- Adherence and understanding of medical treatment.
- Comprehension of discharge instructions.
- Avoid readmissions.

## Program Data

### 2015 to Date



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# Memorial

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## Community Health Enhancement<sup>SM</sup>

### COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:

#### ACCESS TO HEALTH/MEDICAL CARE

#### **BEACON HEALTH NAVIGATORS**

#### PROJECT SUMMARY/ PURPOSE

- Beacon Health Coverage Enrollment Effort assists Michiana residents in accessing health insurance coverage.
- 60,000 uninsured individuals in Elkhart, St. Joseph, and LaPorte counties
- IN Dept. of Insurance-certified Navigators assess eligibility for HIP, HHW, Medicaid, and Marketplace programs and assist with application.

#### COMMUNITY PARTNERS

HealthLinc, BrightPoint, Indiana Health Center, Heart City Health Center, Maple City Health Center, IVY Tech/ASPIN, Elkhart County Health Department, Covering Kids and Families Indiana

#### POPULATION SERVED

- Low income people eligible for ACA and HIP

#### OUTPUTS

- Single-point of entry across 3 county area with dedicated toll-free phone line
- 728 low income people have enrolled.
- Average call=1 hour, 4 minutes

#### OUTCOMES/IMPACTS

- For the Affordable Care Act to be successful, uninsured must be enrolled.
- The system-wide Beacon Health Coverage Enrollment effort is essential for providing families with unbiased, factual assistance to make informed decisions about health plan coverage and selections.
- Collaboration across the health system increases access points for uninsured individuals needing to enroll in health coverage.
- Increased coverage promotes health care utilization across the region.

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COMMUNITY HEALTH NEED ASSESSMENT THEME:

Access to Health/Medical Care

**COMMUNITY HEALTH CENTERS  
(EXAMPLE: BENDIX FAMILY PHYSICIANS)**

**PROJECT SUMMARY/ PURPOSE**

- To reduce economic challenges in LaSalle Square area, collaboration created a community health center
- Provides comprehensive, high quality, cost-effective, and patient-friendly primary care and preventative services
- Consumers served by the family practice include 51% of the 501c3 board members

**COMMUNITY PARTNERS**

St. Joseph Regional Medical Center and Memorial Hospital of South Bend equally contributed to remodeling the building (\$1.2 million); City of South Bend-donated property; SJRMC provided a FT physician and nurse practitioner; MHSB provided clinical support and office staff

**POPULATION SERVED** since 2013

- 2,428 patients; 5,779 visits

**VOLUNTEER PROVIDER NETWORK (VPN)**

**PROJECT SUMMARY/ PURPOSE**

- Addresses unmet medical needs of uninsured residents in St. Joseph County
- Fair and equitable referral mechanism

**COMMUNITY PARTNERS** since 2003

Memorial Hospital South Bend, St. Joseph Regional Medical Center, and South Bend Medical Foundation have provided 368 physician volunteers with donated services over \$48 million

**POPULATION SERVED**

- Active VPN patients in 2013 (prior to Patient Protection and Affordable Care Act) = 1,500+
- Active VPN patients in 2014 (after Patient Protection and Affordable Care Act ) = 600+
- Active VPN patients in 2015 = 286 (90% are undocumented)

**OUTPUTS**

Utilization of services

2013 - \$669,788; 2014 - \$359,186

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# Aging Population

# Memorial

## Community Health Enhancement<sup>SM</sup>

COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:

Aging Population

### eSeniorCare (eSC) Project

#### PROJECT SUMMARY/ PURPOSE

- Study the impact of technology and relationship building on quality of life for low-income seniors in the South Bend, (n=37) by helping to sustain and support independent living
- Help the care provider manage residents' activities and medication intake
- Minimize intergenerational gap by facilitating technology and medical workshops between seniors and high school students

#### COMMUNITY PARTNERS

Housing Authority of South Bend (HASB), The Rushton, Heritage Place at LaSalle Square (Sterling), University of Notre Dame, and South Bend Community School Cooperation

#### POPULATION SERVED (reported at the start of Year 2; n=37)

- Reported Education levels (n=34): high school (12%); high school diploma (32%); some college credit (26%); technical training (12%); Associate degree (9%); Bachelor's degree (6%); Master's degree (3%)
- Age: Minimum (54); Maximum (82); Mean (64)
- Marital Status: Married (6%); Divorced (32%); Widowed (16%); Separated (9%); Never Been Married (33%)
- Gender: Female (53%), Male (46%); Missing (1%)

#### OUTPUTS

eSC Year 1	eSC Year 2 Facility 1	eSC Year 2 Facility 2	eSC Year 2 Facility 3
16	6	15	16

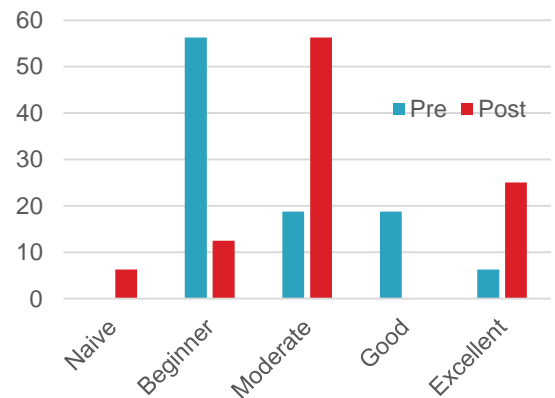
#### OUTCOMES/IMPACTS (eSeniorCare Year One)

- Participants reported an improvement in their technology skills
- Pre-study one participant was at risk for depression. Post-study no one was at risk for depression
- Improvement in care provider and participant communication with respect to medication intake. Real-time provider feedback had a positive impact on participants' emotional health

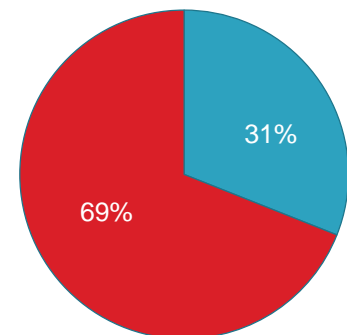
## Program Data

### eSeniorCare

#### Technology Skill Improvement



#### eSC Yr1 Medication Tracking



■ High Tracking ■ Low/ Medium Tracking

The data, as a result, prompts dialogue and action steps towards reaching medication adherence

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COMMUNITY HEALTH NEED ASSESSMENT PRIORITY  
THEME:

Aging Population, Early Childhood Education  
**Memorial BrainWorks**

PROJECT SUMMARY/ PURPOSE:

- Foster an understanding of a brain healthy lifestyle as a delaying or prevention strategy for Alzheimer's, other dementias, and variables that compromise short and long term brain health.
- Brain Health impacts all members of the community from school readiness and the impact of adverse childhood events, to navigating the teen years toward successful school completion, to juggling stress and efficiency for professionals, to resilience and living disease free with meaning and purpose into the older years.
- Services include CEU trainings, live and remote educational workshops, research projects and curriculum development.
- BrainWorks translates evidence based peer reviewed literature on neuroscience and psychology into easy to implement strategies for increased brain health and overall wellbeing across the lifespan.

COMMUNITY PARTNERS:

IUSB, Holy Cross College, Jewish Federation, Forever Learning Center, Northern Indiana Alzheimer's and Dementia Services, University of Notre Dame, St. Joseph County Public Library System and St. Joe Parks and Rec.

POPULATION SERVED (2014)

- Age range from under 20 to 90+ yrs.

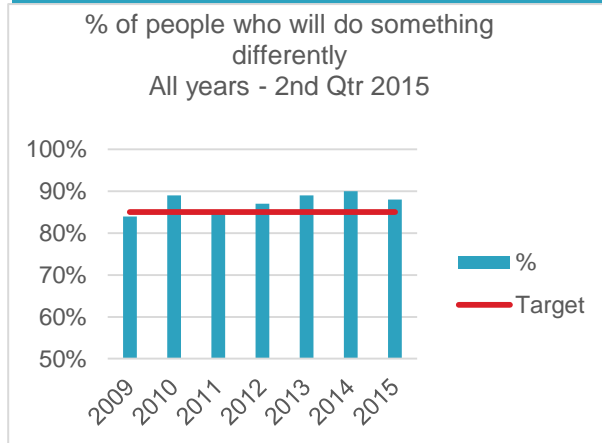
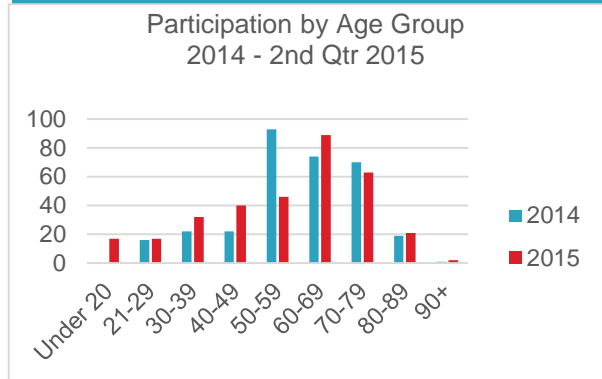
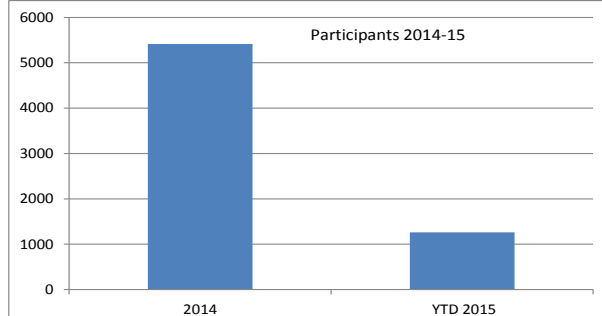
OUTPUTS

- Leighton Lecture had 800 attendees in 2014; 68 attended a special CME event from the Medical Education Department
- 510 Beacon employees attended special training sessions
- Local community programs attracted 1,887 people
- 1,626 participants attended events in other Indiana cities and across the nation

OUTCOMES/IMPACTS

- Over 86% state they are learning new information on their brain.
- Over 87% state they intend to make a change based on what they learned.
- Trained facilitators of *Heart of Aging with Wisdom and Vitality* curriculum in U.S., Canada, Israel

Program Data



Memorial BrainWorks

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# Memorial

## Community Health Enhancement<sup>SM</sup>

COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:  
Aging Population

### Aging in Place

#### PROJECT SUMMARY/ PURPOSE

- Maintain or improve the quality of life of low-income elderly in South Bend, at four sites, helping sustain and support independent living
- A Nurse and Resident-life Assistant (RA) provide health oversight and education, community resource navigation, and social activities

#### COMMUNITY PARTNERS

Robertson's Apartments, Housing Authority of South Bend (HASB), The Rushton, for-profit Heritage Place at LaSalle Square (Sterling)

#### POPULATION SERVED (n=171)

- 86% live alone
- 5.8% Married, 31.6% divorced, 15.8% widowed, 9.4% separated, 32.7% never married, 1.2% unmarried couple

#### OUTPUTS (average monthly basis at 4 sites-2014)

Health Activities	Social Activities	Resident Participation	Visits with Nurse/RA
20	13	230	132

#### OUTCOMES/IMPACTS

Average rating per quality of life dimensions (highest score=20)

- Health=13.57
- Independence=14.55
- Psychological and emotional well-being=16.24
- Financial=11.93
- Home/neighborhood=15.33

50.3% have no physical limits

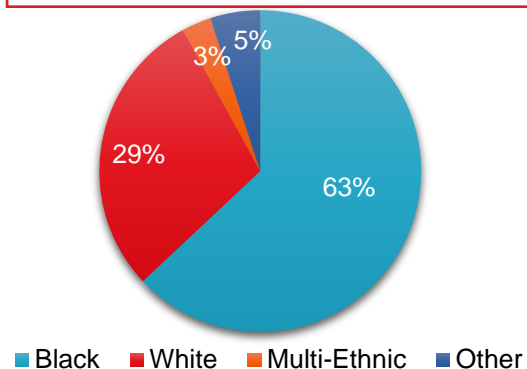
60.2% participate in community room activities

68.4% have a medical home

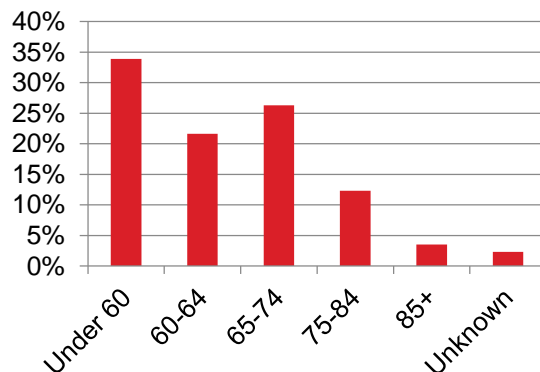
## Program Data

### Gender/ Ethnicity

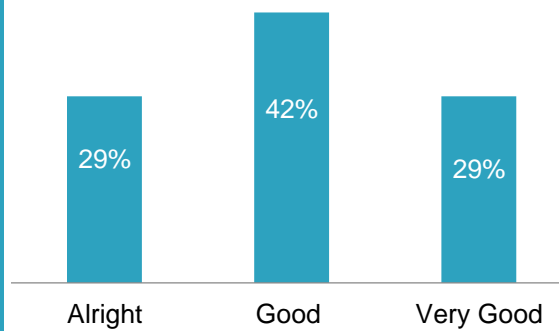
Males 45%/ Females 55%



### Age of Participants



### Quality of Life Overall



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# Health Disparities



COMMUNITY HEALTH NEED ASSESSMENT THEME:  
Health Disparities

**Men's Barbershop Health**

PROJECT SUMMARY/ PURPOSE

- African Americans traditionally have higher incidences of preventable diseases than their white counterparts.
- The Health and Wellness Committee develops and implements programs designed to change these norms in an effort to eradicate healthcare disparities.
- Barbers received high blood pressure monitoring devices and training on the importance of detecting of hypertension early. They encourage clients to take their blood pressure each time they visit. Clients with high blood pressure receive a listing of medical resources.

COMMUNITY PARTNERS

Al's House of Style, Wigfall's Barbershop, Main Event Barbershop, Inspiration Barber-Salon, Nothin' But Cuts, Memorial Hospital South Bend, South Bend area chapters of Delta Sigma Theta Sorority, Alpha Kappa Alpha Sorority, Zeta Phi Beta Sorority, Sigma Gamma Rho Sorority, The Links, The Drifters

POPULATION SERVED

- 184 people

OUTPUTS

- 2014 Blood pressure readings=815
- January-April 2015 Blood pressure readings=314

## Program



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# Memorial Community Health Enhancement™

## COMMUNITY HEALTH NEED ASSESSMENT THEME: Health Disparities

### North Central Indiana Sickle Cell Initiative

#### PROJECT SUMMARY/ PURPOSE

- Raise awareness of sickle cell disease & trait through education and screening to help reduce the incidence of this painful and sometimes deadly disease.
- Provide newborn screening follow ups, referrals, counseling sessions, home and clinic visits with families (e.g., importance of folic acid and having a primary care physician, dangers of second hand smoke; getting insurance through ACA)
- Provide educational presentations on preventative measures in high schools, various collegiate nursing programs, and area community health agencies.
- Provide care coordination with school nurses, families, coaches, students, pediatricians and Hematologists
- Evidence based program-see citation below.

#### COMMUNITY PARTNERS (31 counties in Indiana)

Pediatric Hematology/Oncology Clinic, Pediatric Doctor offices, South Bend Medical Foundation, South Bend (SBCSC), Elkhart, and LaPorte Community School Corporations, Community School Nurses, area universities and colleges, Women Infant and Children, St. Joe County Health Department, East Chicago Department of Public and Environmental Health, City of Gary, IN, IU Health: LaPorte Hospital & Physicians, Bendix Family Physicians, Division of Family and Children Services, Meridian Health Services (Counseling & Referrals)

#### POPULATION SERVED (January - December 2014)

2,899 individuals, birth to middle age, all ethnicities, all income levels; 375 infants included in the total born with newborn screening results, presumptive positive for sickle cell trait.

#### OUTPUTS

- Genetic counseling and education to 375 families
- Case management to 11 patients with frequent ER admissions
- 657 total presentations with 2,162 individuals in attendance, including Athletic Directors and coaches of community schools and current community partners
- 228 students screened for Sickle Cell Trait

#### OUTCOME/IMPACT

- Expanding network of awareness to 106 agencies and doctors' offices
- Ongoing support for all school nurses in SBCSC schools
- Follow-up school visits show engaged communication about effects of sickle cell and prevention among 2/3 of students

## Program Data

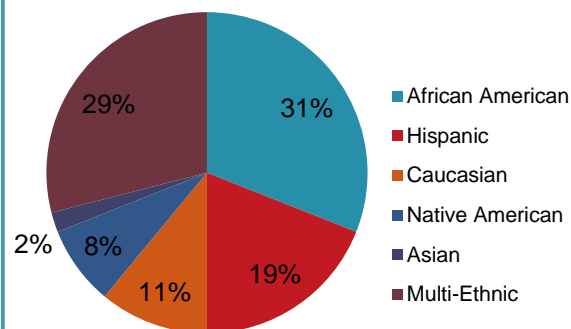


#### \*Evidence Based Results:

#### Incidence of Sickle Cell Trait in the United States

Incidences vary within the U.S.	Incidences among Ethnicities
Overall: 1.6%	Black: 7.3%
Montana: 0.08%	Hispanic: 0.7%
Mississippi: 3.4%	Caucasian: as high as 0.40%

#### 375 babies born with SC Trait (31 Indiana Counties) July 1, 2014-June 30, 2015



#### \*Evidence Based Results:

[Http://www.updte.com/contents/sickle-cell-trait](http://www.updte.com/contents/sickle-cell-trait)  
Literature review current through: July 2015  
Last Update: July 17, 2015

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# Mental Health



**COMMUNITY HEALTH NEED ASSESSMENT:**  
**Mental Health**  
**Trauma-Informed Care Program**

**PROJECT SUMMARY/ PURPOSE**

- Increase staff and parent understanding of the emotional needs of children impacted by trauma.
- Increase emotional wellness of traumatized and at-risk children through individual, group and family counseling.
- Reduce the barriers to mental health care for traumatized and at-risk children including wait list, transportation and cost.
- Provide alternative to punitive responses to children with behavioral challenges.

**COMMUNITY PARTNERS**

Family & Children's Center, South Bend Community School Corporation, Indiana University South Bend, Memorial Community Health Enhancement, Oaklawn

**POPULATION SERVED**

- 26 children, ages 5 to 12
- 9 girls, 17 boys
- 88% on free and reduced lunch

**OUTPUTS**

- 147 Sessions of Individual Counseling
- 15 Hours of Parenting Classes
- 92 Hours of Consultation/Behavioral Intervention
- 6 Hours of Staff Training in ACES and Trauma Informed Care for 38 Employees

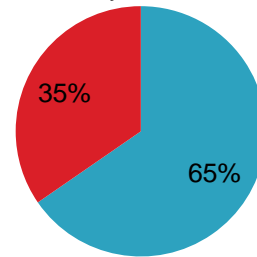
**OUTCOMES/IMPACTS**

- Improved emotional and behavioral health of children served
- All full-time staff trained in Adverse Childhood Events and trauma-informed behavioral interventions
- Fewer suspensions and elimination of expulsions from the Boys & Girls Club
- Increased parent communication and participation in parenting classes

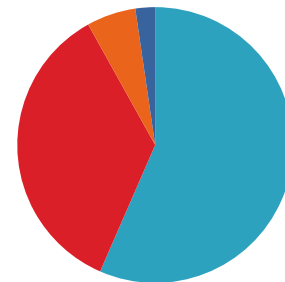
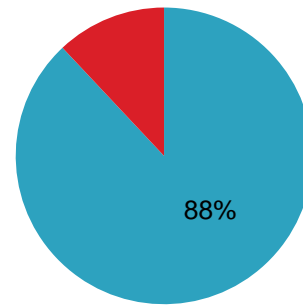
## Program Data

### Gender

■ Boys ■ Girls



### Free and Reduced Lunch



■ Individual Counseling Sessions

■ Hours of Staff Consultation/Behavioral Intervention

■ Hours of Parenting Classes

■ Hours of Staff Training in ACES and Trauma Informed Care

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# Memorial

## Community Health Enhancement<sup>SM</sup>

### COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:

#### MENTAL HEALTH

#### **Eye Movement Desensitization and Reprocessing (EMDR)/Acute Traumatic Incident Processing (A-Tip)**

#### PROJECT SUMMARY/ PURPOSE

- Exposure to multiple Adverse Childhood Events (ACE) is linked to Post Traumatic Stress Disorder and higher rates of health-risk behaviors and disease.
- 2012 Behavioral Risk Factor Surveillance System results showed 57% of residents responding had experienced at least 1 ACE; 21% experienced 3 or more
- Mental health interventions are necessary to reduce the effect of trauma in our community.
- SOLUTION: Train licensed mental health professionals and licensed clinical social workers from the region in EMDR and A-Tip, evidence-based trauma treatments using eye movements to process traumatic experiences.

#### COMMUNITY PARTNERS

Oaklawn Psychiatric Center, Center for the Homeless, IUSB School of Social Work,

#### POPULATION SERVED

EMDR: Mental health professionals and  
licensed clinical social workers

A-Tip: professionals and para-professionals

#### OUTPUTS

##### EMDR

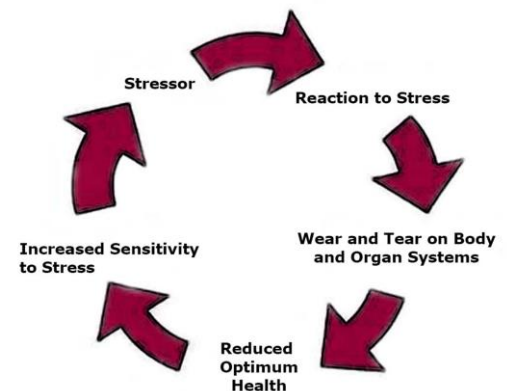
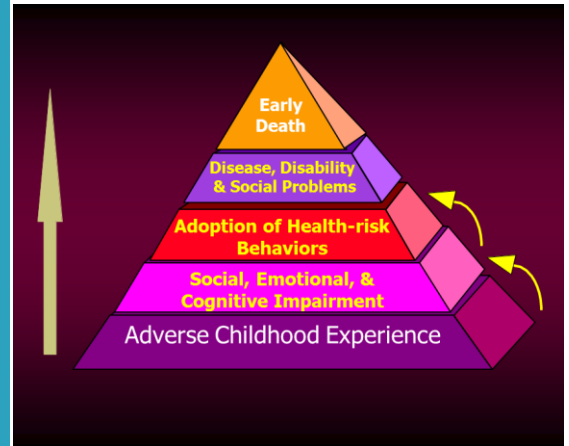
55 people completed both 3-day sessions in August and November, 2014 (4 males) and fulfilled requisite practicum hours

##### A-Tip

- 67 in May (5 males)
- 53 in Nov (8 males)

## Program Data

### ACE Influences



### CORRELATIONS

#### **Risky Behaviors**

**Smoking, Substance Abuse, Obesity,  
Sexual Promiscuity, Violence**

#### **Health Effects**

**Cardiovascular Illness, Hypertension,  
Diabetes, Depression**

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# Memorial

## Community Health Enhancement™

COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:

### Mental Health EMDR School Counselor

#### PROJECT SUMMARY/ PURPOSE

- Provide trauma-focused Eye Movement Desensitization and Reprocessing (EMDR) counseling services to immigrant students at two schools in our community
- Provide trauma-awareness training to immigrant families

#### COMMUNITY PARTNERS

St. Adalbert School, Our Lady of Hungary School

#### POPULATION SERVED

- 40 Hispanic/Latino families from both schools received training on ACEs
- 12 Hispanic students K through 8<sup>th</sup> grade, 9 females/3 males

#### OUTPUTS=immediate effect

- Students participated in 26 individual EMDR sessions
- At each session, pre-/post self- assessments of internal distress (SUD scores) were completed. Pre- scores ranged from 1-9 (0-10 point scale). 24 of 26 post-scores were 0; the remaining 2 were lower.
- Pre- assessments of self-beliefs (VOC) from all 26 sessions averaged 4.25, but ended with highest positive score of 7.

#### OUTCOMES/IMPACTS

Comparing each student's 1<sup>st</sup> quarter and 4<sup>th</sup> quarter performance on the following indicators showed:

- GPA- increased for 5 students and decreased for 3 students with no visible trends by age
- Absence-decreased for 5 students; increased for 2 students
- Tardy-decreased for 4 students; increased for 2 students

## Program Data

Student	Grade	Sex	Session #	Beginning/ Ending SUD		Beginning/ Ending VoC	
A	Kdg	F	S1	7	0	5	7
			S2	4	0	5	7
			S3	3	0	5	7
B	4 <sup>th</sup>	F	S1	4	0	4	7
			S2	1	0	3	7
C	6 <sup>th</sup>	F	S1	4	0	3	7
			S2	3	0	3	7
			S3	3	0	6	7
D	7 <sup>th</sup>	F	S1	4	0	5	7
			S2	4	0	4	7
			S3	3	0	5	7
E	7 <sup>th</sup>	F	S1	5	4	N/A	N/A
			S2	6	4		
			S3	7	0	3	7
			S4	5	0	4	7
F	7 <sup>th</sup>	M	S1	5	0	3	7
			S2	1	0	7	7
G	8 <sup>th</sup>	F	S1	3	0	4	7
			S2	2	0	5	7
H	Pre-K	F	S1	6	0	3	7
			S2	3	0	5	7
I	1 <sup>st</sup>	M	S1	6	0	3	7
			S2	3	0	6	7
J	1 <sup>st</sup>	M	S1	7	0	4	7
K	4 <sup>th</sup>	F	S1	6	0	5	7
L	8 <sup>th</sup>	F	S1	9	0	2	7

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COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:  
Mental Health

**Mental Health Counseling's Effect on Quality of Life**

PROJECT SUMMARY/ PURPOSE

- Purpose is to evaluate the effectiveness of mental health counseling on the quality of life and well-being of cancer survivors, care givers and loved ones who seek support services.
- Today, there are over 10,000 people living with a cancer diagnosis in St. Joseph County. As a result of improved screening and treatment, the odds of surviving have greatly increased and the number of survivors living 5 or more years after diagnosis is expected to rise by 37% in the next decade.
- As defined by RiverBend Cancer Services, Mental Health counseling is individual counseling with a Master's level social worker. A counseling session may include a family member or caregiver, depending upon an individual's needs.
- Studies have shown that specialized counseling for cancer patients can reduce depression and anxiety and improve relationships with friends and family.

COMMUNITY PARTNERS

St. Mary's College Social work intern; Laboratory for Psycho-oncology Research at the University of Notre Dame

OUTPUTS (7 of 12 months completed)

- 28 people have participated in 3 counseling sessions each, for a total of 84 sessions.
- We have seen 89 clients for mental health counseling; 54 of those clients were new, 26 of those new clients did not satisfy the parameters of this study

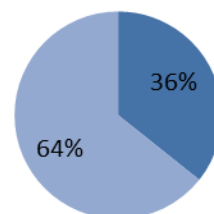
OUTCOMES/IMPACTS/TRENDS

- We anticipate that the project will establish the positive effect mental health counseling has on the quality of life of cancer survivors.
- Reflecting cancer's reach, 1 in 10 American households now includes a family member who has been diagnosed or treated for cancer within the past 5 years & 41% can expect to be diagnosed with cancer at some point in their life.
- While some cancer patients will likely die, numerous others are being effectively treated and will survive cancer-free for many years. Still others will have a type of cancer that meets the definition of chronic disease and will need to be controlled by intermittent or continuous treatment, including mental health counseling.

## Program Data

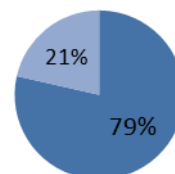
### Gender

■ Male ■ Female



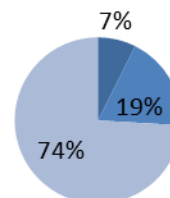
### Race

■ Caucasian  
■ African American



### Self Assessed Quality of Life at 1st Session

■ Very Good  
■ Good  
■ Not Good-Clinically Significant



Kate Voelker  
Executive Director

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# Early Childhood Development



El Campito Inc. • 1024 Thomas Street South Bend, Indiana 46601 • P: 574.232.0220 • F: 574.232.7662 • [www.elcampito.org](http://www.elcampito.org)

## COMMUNITY HEALTH NEED ASSESSMENT PRIORITY: Early Childhood Development

### Parents Are the First Teachers

#### PROJECT SUMMARY/ PURPOSE.

- Latino/Hispanic students can struggle in school
- 7-week program for Spanish-speaking parents
- Equips parents of preschoolers with skills and content knowledge (literacy, math, how the brain learns, child development) to prepare their children for entering kindergarten.

#### COMMUNITY PARTNERS

Read Baby Read, The Latino Task Force for Education, Inc., The Discovery Learning Program, Education Department-Holy Cross College

#### POPULATION SERVED-spring session

- 13 Hispanic/Latino parents of preschoolers and their children (n=20)

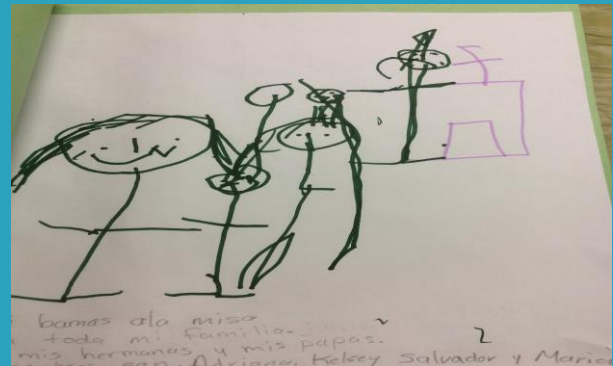
#### OUTPUTS

- 234 books read at home
- 95% attendance rate
- 100% completion of parent with children homework assignments

#### OUTCOMES/IMPACTS (Changes as a result of the program)

- Greater detail in children's artwork accompanied by expanded vocabulary use
- All parents rated program as beneficial.
- Significantly higher scores in number of days parents read to children
- Formation of parent learning network

## Program Outcomes



Pre-/Post Alphabet 26 letters		Pre-/Post 9 Colors		Pre-/Post 4 Shapes		Pre-/Post Numbers 1 to 30		Spell 1 <sup>st</sup> & Last Name	
2.1	3.3	4.3	6.0	2.1	3.3	3.9	11.2	0	3

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# Memorial

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## Community Health Enhancement<sup>SM</sup>

### COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:

#### Physical Health/Early Childhood Development

#### **Prenatal Care Coordination and WIC**

#### PROJECT SUMMARY/ PURPOSE

- Decrease infant health disparities through an extended intervention, education and referral program.
- Improve nutritional status

#### COMMUNITY PARTNERS

Memorial Hospital, Prenatal Care Coordination, Prevent Child Abuse of St. Joseph County, St. Joseph County Women Infants and Children nutrition program

#### POPULATION SERVED

- High Risk pregnant women, ages 11-45 years as well as infants and young children
- 43% white, 28% black, 19% Latino, 8% mixed race
- Low income
- 14,000 mothers, infants and children annually

#### OUTPUTS

- Provide vouchers for fruits, vegetables, whole grain and low-fat dairy products
- Grocery store tours
- 79% of local WIC mothers breastfeed
- 192 attended prenatal care support groups; 60 attended safe sleep class and 70 attended safety class

#### OUTCOMES/IMPACTS (Changes as a result of the program)

- Increased breastfeeding initiation and duration (79% in 2014, 77% in 2013)
- Increased number of women who receive adequate prenatal care
- Decreased risk of giving birth to premature or low birth weight infants
- Increased maternal/infant bonding and understanding of child development.
- Program ranks 7<sup>th</sup> of 41 in breastfeeding start and continuation; 2<sup>nd</sup> in nutrition contacts and retention

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# Violence and Safety



COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:  
Group/Gang Associated Gun Violence

**South Bend Group Violence Intervention**

PROJECT SUMMARY/ PURPOSE

- The South Bend Group Violence Intervention (SBGVI) strategy unites our community around the common goal to stop gun violence and keep South Bend's highest risk citizens alive and out of prison.
- Research finds that members of highly active street groups commit most homicides and shootings—these groups are gangs, drug crews, and the like.
- Based on a proven model developed by David M. Kennedy director of the National Network for Safe Communities at John Jay College of Criminal Justice, SBGVI strategy helps direct, sustained engagement with street groups that cause the majority of South Bend's gun violence
- The SBGVI strategy empowers community members to set clear moral standards against violence in their communities and reclaim a voice in the way they want to live.
- The SBGVI strategy coordinates the efforts of local, state and federal law enforcement to focus crime prevention efforts on the groups most associated with gun violence.
- The SBGVI strategy also draws on the expertise of social service providers to offer group members a path away from violence.

COMMUNITY PARTNERS

- SBGVI is a partnership among 30 community leaders from law enforcement, government, education, civil service, health care and faith-based agencies.

OUTPUTS

(Year 1+ of Implementation: May 15, 2014 – July 31, 2015)

- Four (4) SBGVI Call-Ins
- 82 men representing 31 unique group affiliations
- Increased law enforcement collaborations
- Increased social service coordination

OUTCOMES/IMPACTS

(Year 1+ of Implementation: May 15, 2014 – July 31, 2015)

- Group Member Involved (GMI) shooting incidents decreased (-12)
- Community engagement and intolerance has increased
- Social Services interactions and availability has increased

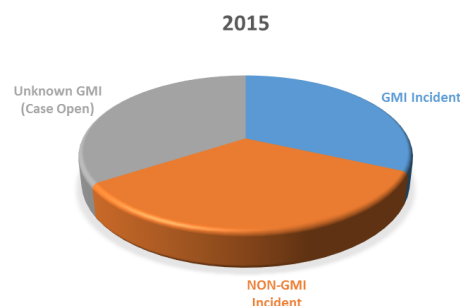
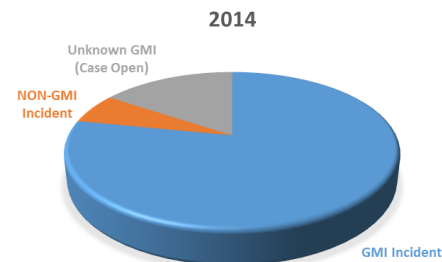
## Program Data

### Cumulative Shooting Victims

Cumulative: Criminally Assaulted Shooting Victims  
14.5 Month Cycle Comparison  
First Call-In Anniversary Date (May 15th)  
Complete year continued to July 31st



### Group Member Involved Incidents



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**Group Violence Intervention –**  
**Operations Manager**  
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**Office: (574) 235-7501**

# Memorial

## Community Health Enhancement<sup>SM</sup>

### COMMUNITY HEALTH NEED ASSESSMENT PRIORITY:

#### Violence/Safety

### **TRAUMA LIAISON**

#### PROJECT SUMMARY/ PURPOSE

- Decrease violent acts, the effects of violence, and injury recidivism
- Anti-violence specialist working in Memorial Hospital-South Bend ER and Trauma Unit
- Modeled after successful programs in Baltimore, San Francisco

#### COMMUNITY PARTNERS

South Bend Police Dept., Goodwill-job training, Oaklawn-mental health counseling, SBCSC, Juvenile Justice Center, SJC Prosecutor's Office

#### POPULATION SERVED=86

- Victims of gunshots/stabbings/assault/battery
- Ages 16-71
- 31.4% female, 68.6% male
- 2.7% separated, 5.5% divorced, 15.1% married, 27.4% member of unmarried couple, 49.3% single

#### OUTPUTS (after 4 months of operation)

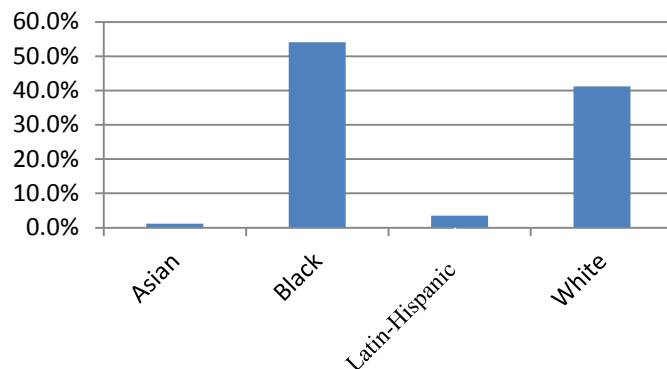
- Average number of face-to-face contacts in hospital: 1.37
- Face-to-face contacts after discharge: 11
- Phone contacts after discharge: 51
- Family contacts: 53-pre/26-post
- 48.8% trauma, 50% ER, 1.2% both
- Of the 24 clients with ACE scores, 42% have  $\geq 3$  ACES

#### PROJECTED OUTCOMES/IMPACTS (Changes as a result of the program)

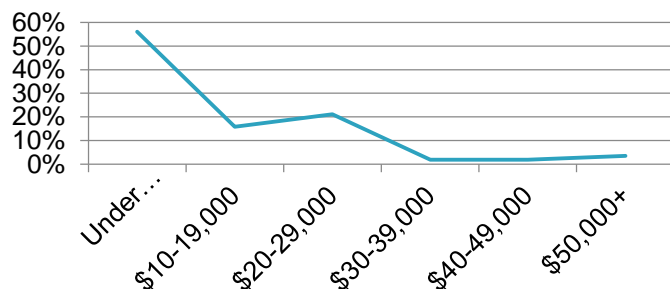
- Reduced retaliation
- Reduced recidivism
- Improved quality of life

## Program Data

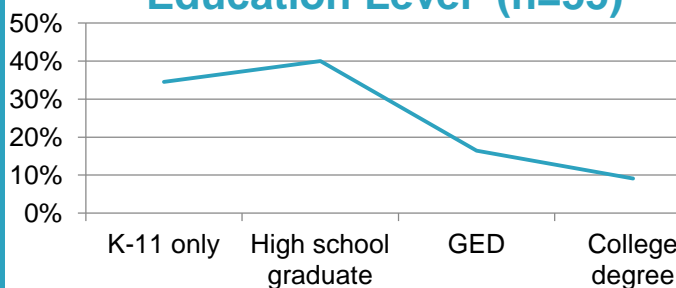
### Race/ Ethnicity (n=85)



### Income Level (n=57)



### Education Level (n=55)



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## Community Benefit

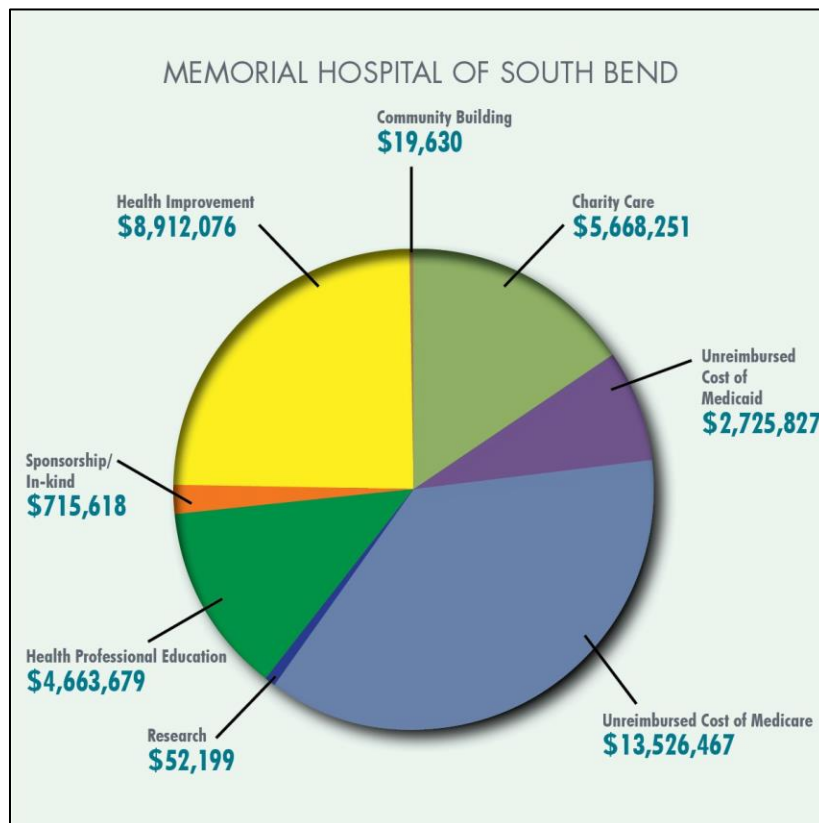
Creating community health has always been at the core of Memorial Hospital and Beacon Health System's mission. There is only so much impact a hospital can have by just helping the sick. Creating a healthy community goes beyond just treating an illness. It's about prevention, health education, community outreach, innovative partnerships and dynamic services and programs that change behaviors, empowers good decision making and ultimately improves the quality of life.

Memorial Hospital's investment in the community the past three years was vital in addressing needs identified as a result of the Community Health Needs Assessment. As a community not-for-profit organization, we take seriously our responsibility to invest our resources and energies into understanding and meeting the divergent health care needs of all, especially the underserved members of our communities.

We seek to achieve the following community benefit objective(s) as defined by the federal government:

1. Improve access to health care and services
2. Enhance the health of the community
3. Advance knowledge through education and research
4. Relieve or reduce a burden of government to improve health

The preceding highlights and statements are testaments of how we touch and improve the health and the quality of lives throughout Michiana. It is a testimony to the commitment and leadership of our medical staff, volunteer board of trustees, employees, auxiliary volunteers, and community partners, whose dedication to meaningfully serve, touch many lives, in order to make our community a better place to live, work, and play.



Community Benefit Investment in 2014



