
BEACON
HEALTH SYSTEM
Community
BENEFIT
2017 | REPORT

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2017
Community Benefit Report

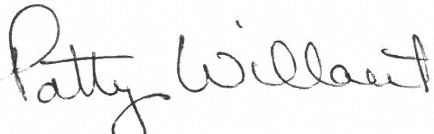
Dear Reader,

Improving the quality of life of community members continued to be the primary objective for Beacon Community Health in 2017. We were fortunate to work collaboratively with wonderful community partners who help us address the needs of many, especially those most vulnerable. In doing so, our joint efforts have demonstrated progression within population health. We created a framework for utilizing data necessary for making informed decisions and put strategies in place to address health issues. Alongside our community partners we continue to understand the value of prevention, health education, community outreach, innovative partnerships and dynamic services and programs that change behaviors, empower good decision making and in due course create opportunities for optimal health outcomes. Furthermore, Community Health took a multidisciplinary approach, acknowledging there were many ways to arrive at a solution or begin to address an issue. As a change agent we asked necessary questions to get to the source of barriers and executed a plan for successful outcomes. By creating working groups within our Community Health Needs Assessment Advisory Council, we demonstrated the importance of making sure we had community stakeholder input needed to make well-versed decisions.

While reading this report you will find each hospital's outcomes detailed respectively per county. Although highlighted individually, it was also important to illustrate combined results across priority outcomes and regionally when possible. In order to deliver that information efficiently and effectively, we outlined additional data needs by priority, requested program data necessary to show collective impact, and collected common data points. Additionally, we evaluated the interdisciplinary role of stakeholders and population-based public health strategies. We also adjusted approaches to influence public health interventions, and applied evidence-based research and practices to promote positive social change.

The primary goal of our evaluation is to ensure that community benefit efforts are addressing targeted health needs and making a difference in the community. **This Community Benefit (CHNA) Report is a collaboration between Elkhart General Hospital and Memorial Hospital South Bend; the two hospitals share prioritized needs and strategies for community health improvement.** Moving forward we will provide more program equity and better regional alignment and will scale out programs to increase participation. We remain committed to developing and supporting the work done by one organization as well as aligning efforts necessary to achieve collective impact. We want to thank all our partners for having a shared vision to create change and being an essential part of achieving health outcomes for the identified priorities in our communities.

Patty Gremaux
Director, Community Health (EGH)
Beacon Health System



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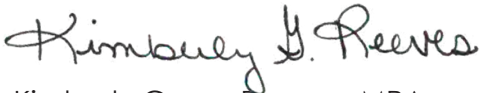

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Director, Community Health (MHSB)
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content

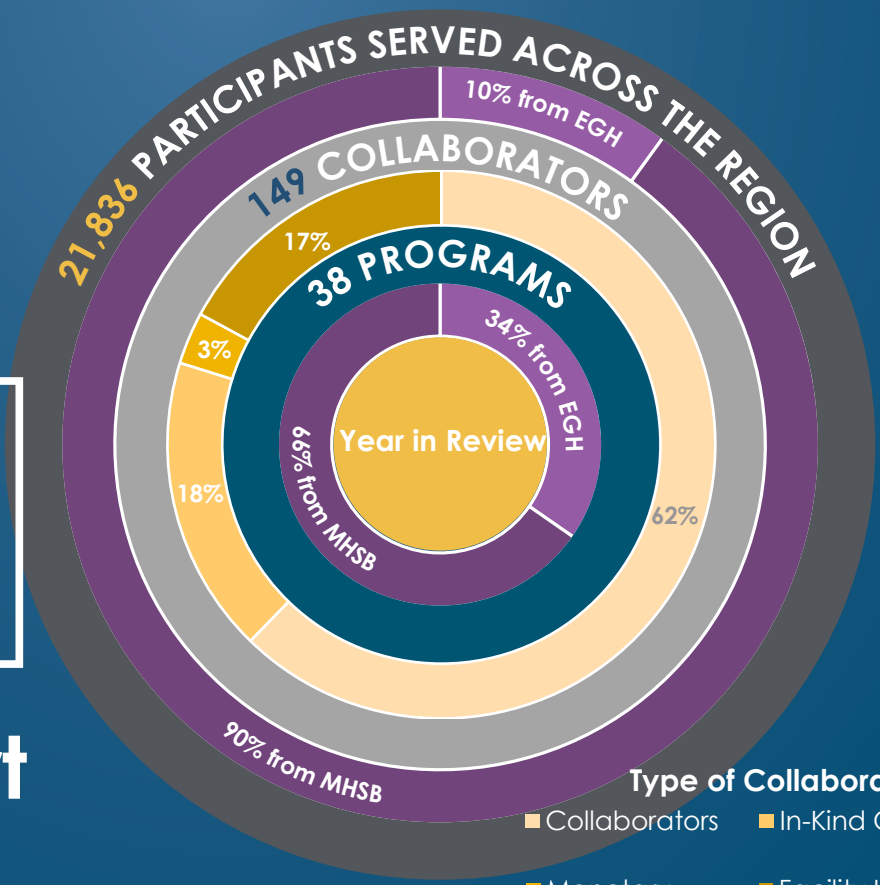
EXECUTIVE Summary

Beacon Community Health works with multiple organizations in a collaborative health network. We use data-driven, evidence-based and transparent practices to chart progress and measure health impact as a result of the Community Health Needs Assessment (CHNA).

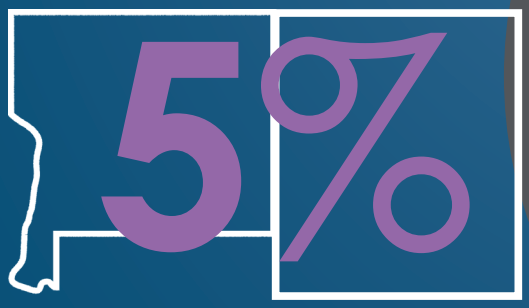
The primary goal of our evaluation is to ensure that community benefit efforts are addressing targeted health needs and making a difference in the community. By analyzing the effects and results of the actions implemented, we can assess whether programs have achieved their intended impact on prevention, add value to the work of clinical transformation teams in the hospital, and make informed decisions when addressing the divergent health care needs of those needing it the most.

During the second year of the CHNA's three year cycle, Community Health continued working at integrating outreach efforts and hospital data to create population health solutions. For community outreach, population health represents community benefit programs rightly focusing on the underlying causes of health problems, including the social determinants of health for vulnerable and at-risk community members. Hence, Beacon Health System's community outreach extends beyond the individual and focuses on health outcomes of an entire group, community, culture or institution.

Bottom Right: *Legend describing different types of collaboration by community partners (golden ring)*



In 2017 we reached



of the SJC & Elkhart population

What is a COMMUNITY HEALTH NEEDS ASSESSMENT CHNA?

A Community Health Needs Assessment -- or **CHNA** -- is the blueprint a hospital uses to build better community health.

The CHNA is also an ACA requirement for the hospital to retain its nonprofit status.

Every 3 years, the hospital completes a new assessment. In addition to **secondary data**, such as census and city-county data, the hospital utilizes three primary sources for this assessment:

Key Informants

Leaders active in the community are asked to give their opinions about what health needs they see affecting their organizations, neighbors, and friends.

Community Members

A strong push goes out to survey everyday members of the community about what health needs they see affecting their parents, children, and themselves.

Advisory Council

Assembled community professionals are asked to use their experience and the gathered data to recommend specific health needs.

Once the results are in, the hospital identifies available resources and existing programs that already meet these needs.

This information determines **priority health needs** for the next 3 years.

Each priority has **Goals**

Activities

and **Gauges of Success**.

Outcomes are reported **annually**.

2016-2018 Priorities

Access To Healthcare/Uninsured is a regional health need across both Elkhart and St. Joseph Counties. As many as one in five people in Elhkart County, and one in six in St. Joseph County remain without health insurance and a primary care physician.

Diabetes is a health need in St. Joseph County. One in five people who completed the 2015 CHNA survey reported having diabetes. In fact, there was a marked increase in those with diabetes, pre-diabetes, or gestational diabetes from the 2012 survey.

Maternal/Infant Health & Prenatal Care is a regional health need across both Elkhart and St. Joseph Counties. Teen birthrates and neonatal mortality rates remain too high. Minorities are disproportionately affected with low first trimester prenatal care rates.

Mental Health/Suicide is a health need in St. Joseph County. One in three respondents to the 2015 survey reported living with someone who was depressed, mentally ill, or suicidal. Knowing when to ask for help is paramount to maintaining good overall health.

Overweight/Obesity is a regional health need across both Elkhart and St. Joseph Counties. It was cited as the most significant health need in both county CHNA surveys. This comes as no surprise, as one in eight children across the region is reported to be obese or overweight.

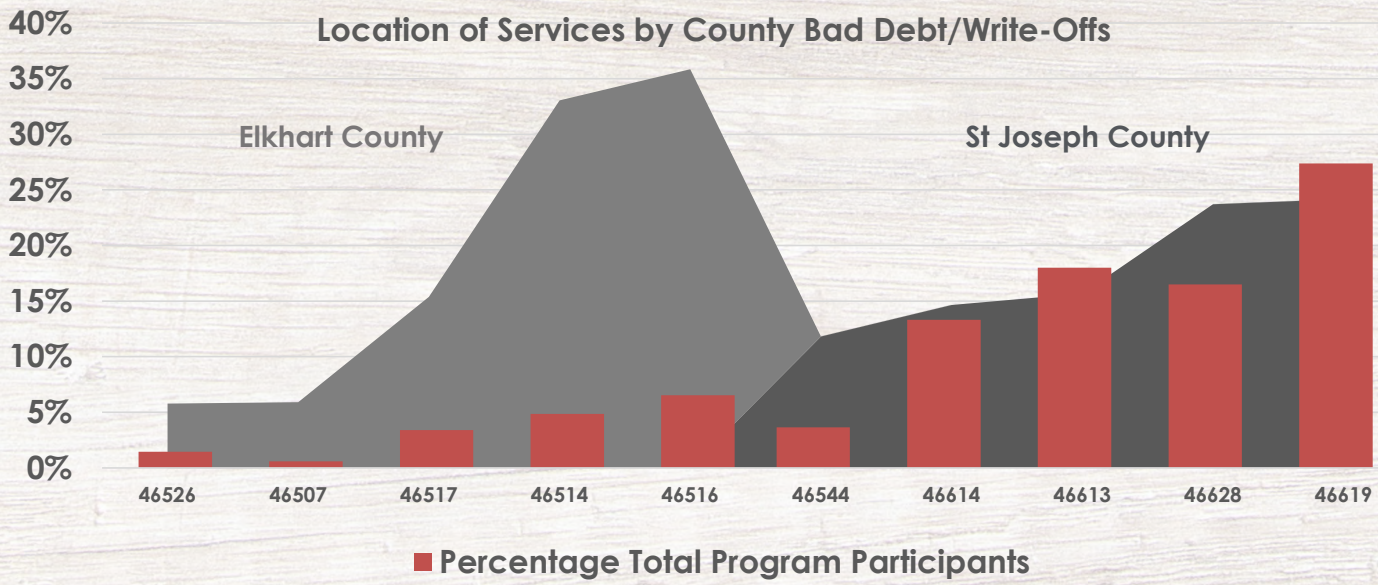
Violence/Safety/Trauma is a health need in St. Joseph County. The county has a higher violent crime rate than Elkhart, Indiana, and the nation. Nearly one in four respondents reported being assaulted by a parent in the home, a significant increase from 2012.

Asthma is a regional pediatric health need across both Elkhart and St. Joseph Counties. It is one of the most commonly diagnosed conditions, with one in five parents across the region reporting an asthmatic child.

- Regional priorities (EGH & MHSB)
- MHSB priorities
- Pediatric Health Needs Assessment (PHNA) priorities

Community Benefit by the numbers

According to the U.S. Census, poverty is prevalent in the 5 zip codes noted below in each county. Likewise, the graph below is depicting the same five zip codes where each hospital spends the highest amount in bad debt and write-offs. The **$20.5M** in bad debt found **in the Elkhart zip codes** makes up **85%** of the total bad debt for the county. **In St. Joseph County**, the five zip codes make up a total of **$15.3M**, or **58%** of the bad debt for the county. This is important because Community Benefit seeks to implement programs and activities to improve health outcomes by addressing the health-related needs of the broader community as well as the vulnerable and at-risk, as illustrated below.



2017 Priority OUTCOMES

Program Goals: Formulated: 102 Achieved: 59 In-Progress: 43

Access to Healthcare

1,677 people served. 86% were able to get health insurance. 87 participants provided further information regarding primary care providers - 59% reported having one.

Beacon Language Services provided access to healthcare for 8,086 individuals.

PREDICTIVE ANALYTICS
Using regression results from 2016 provided insight into the strength and direction of local data for a more targeted approach.

For example, predictive analytic trend data for Access to Care programs directed outreach efforts to be more intentional and strategic. This set up placement of promotional material to reach young Black men and older Hispanic men.

Diabetes

The YMCA served 45 pre-diabetics in 2017.

SECONDARY DATA COMPARISON
42% of participants in the YMCA program reported 150 minutes of exercise each week, as compared with HP2020's goal of 49% achieving 150 minutes of exercise each week.

Maternal/Infant Health

We saw 416 mothers across the region:

- 26% were severely obese.
- 35% were at a healthy weight.
- 17% had an ACE score greater than 4.

There were 324 babies born in 2017:

- only 5% were born preterm (<37 weeks)
- 6% weighed less than 2,500 grams.
- just 3% spent time in the NICU.

SECONDARY DATA COMPARISON
In Beacon Community Health programs, only 4% of mothers continued smoking or using substances during pregnancy, compared to 11% in St. Joseph County, and 14% in the state of Indiana.

Mental Health

178 South Bend Community School Corporation (SBCSC) students attended a QPR training.

There was a 17% increase in knowledge of the best option for helping peers with suicide ideation.

JJC youth saw emotional reactivity scores - representing resilience - climb 23% by the end of the program.

SECONDARY DATA COMPARISON
HP2020's goal is to reduce the proportion of adolescents aged 12 to 17 who experience a major depressive episode from 8.3% to 7.5%. At the JJC, 34 youth took the Drumbeat program. 38% started the program with depression or anxiety, compared to 21% at its completion.

Obesity

125 people joined Elkhart Community Health's two Walking Challenges.

91% completed the program.
Total Daily Steps increased by 13%.

749 children participated in Community Health obesity programming in SJC.
94% increased their physical activity.

Indicators of Success

Beacon Community Health's Scorecard displays progress over time as we move toward specific, measurable goals. We use both clinical and program data (EGH & MHSB) to correlate program outcomes with identified healthcare needs.

Violence/Safety/Trauma

The YWCA's Take Charge program saw 1,276 youth increase their knowledge of dating violence and abuse by 13%.

From January to April, Beacon's Trauma Intervention Specialist (TIS) worked with 83 victims of violence. 5% had repeated experiences, compared to 11% of the 90 people who did not receive TIS services.

Asthma

96% of the 23 SBCSC school nurses who attended an asthma presentation clearly identified conditions for calling 911 when students are in respiratory distress.

At a physician-family Asthma Night, 23 parents gained knowledge about allergies, triggers, and daily management of the disease.

What's our score?

MHSB & EGH Scorecard Legend

Indicator = outcome or objective

Trend & Duration = Direction measure is moving and number of times data has been reported

Target Value = Target or goal of measure

\+ = Measure is moving toward meeting the target value

\- = Measure is moving away from meeting the target value

• = Measure value has not changed

= Measure is at or beyond the target value

= Measure is within 20% of the target value

= Measure is more than 20% away from the target value

Hospital Value = Measure based on relevant demographic, clinical, and ICD-10 primary and secondary diagnostic data of patients served at MHSB and/or EGH

Indicator	Hospital Value	Trend & Duration	Target Value	Current Value
Access to Care				
% of individuals enrolled via Beacon and CKF Navigators	-	+ 1yr	83%	86%
% of patients without health insurance	16%	-	-	-
% of uninsured contacted (***87***) who reported having a Primary Care Provider	-	+ 1yr	50%	58%
% of patients served without a Primary Care Provider	32%	-	-	-
Diabetes				
% of patients with pre-diabetes	37%	-	-	-
% of pre-diabetics who completed 150 minutes of activity per week.	-	• 2yr	50%	42%
Maternal/Infant Health & Prenatal Care				
% of mothers smoking or using substances	12%	+ 2yr	< 20%	4%
% of mothers breastfeeding when leaving the hospital	-	+ 2yr	80%	86%
% of mothers who receive early and adequate prenatal care	-	+ 1yr	70%	68%
# of infants in the NICU	558	-	-	11
% of intants born prematurely	-	+ 2yr	< 9%	5%
% of infants born with low birth weight	13%	+ 2yr	< 9%	6%
Mental Health/Suicide				
% of youth with anxiety or depression	4%	+ 2yr	-	21%
% of adults with anxiety or depression	7%	-	-	-
% of aging individuals who engage in socio-emotional activities	-	+ 2yr	81%	76%
% decrease in youth emotional reactivity scores	-	+ 2yr	-	23%
% of youth with increased knowledge of assisting others with suicide ideation	-	+ 1yr	-	17%

Indicator	Hospital Value	Trend & Duration	Target Value	Current Value
Obesity/Overweight				
% of children who are obese	2%	-	-	-
% of children who increase their physical activity	-	+ 1yr	-	90%
% of adults who are obese	13%	-	-	-
% of adult participants who increased their physical activity	-	+ 1yr	-	91%
Violence/Safety/Trauma				
% of increased teen knowledge scores of dating violence and abuse	-	+ 1yr	-	12%
% of supportive care interactions with victims of violence who appear at Memorial Hospital's emergency department (Jan-Apr)	-	+ 2yr, 4mo	60%	48%
% of victims of violence with repeat episodes after contact with supportive care(Jan-Apr)	-	- 2yr, 4mo	3%	4.8%
#of shooting victims	122	-	-	-
# of individuals with repeated episodes of trauma	1,744	-	-	-
Asthma				
# of asthma-related ED admissions in children	-	-	-	-
% of students with asthma with improved responses to breathing emergencies	-	-	-	-

Next Steps

- Scale out programs to increase participation as appropriate.
- Provide more program equity and better regional alignment.
- Continue progress toward achieving Collective Impact, both internally and in the community.

Principles of Wellness

The best health results come from focusing efforts on changing the whole person: mind, body, and spirit. That's why we've asked our community partners to connect these three Principles of Wellness to their programming.

Mind

Connections: 37

Financial, emotional, and physical safety are essential to mental health. Strong personal relationships and ties to the community create a mental security that cannot be replaced.

Body

Connections: 33

Physical activity, good nutrition, and mental stimulation keep your body in good health and help you maintain wellness of mind and spirit too.

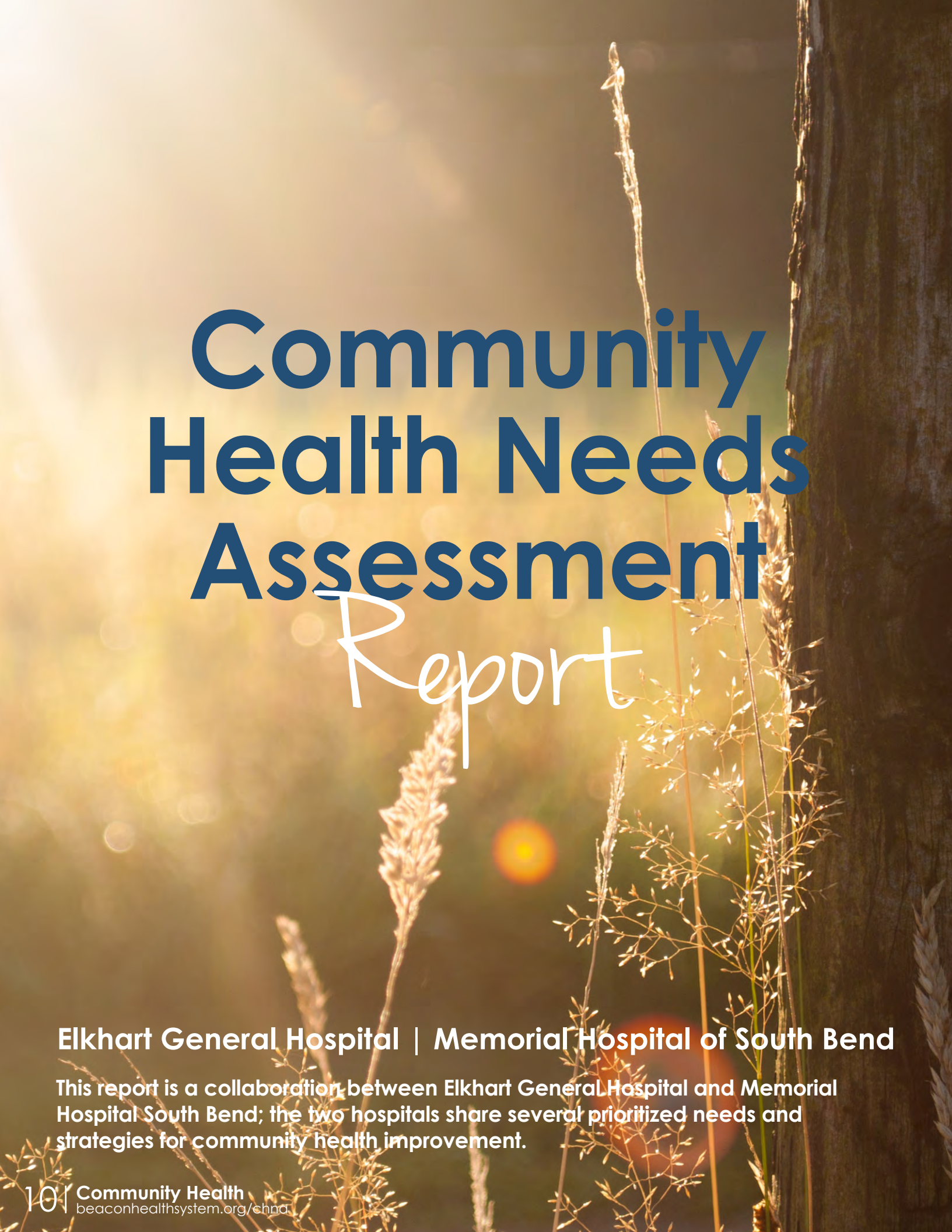
Spirit

Connections: 9

A healthy spirit is one content with daily activities and achievable goals. Having resilience and a driving purpose in life are key to personal wellness.

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

BEACON HEALTH SYSTEM



Community Health Needs Assessment Report

Elkhart General Hospital | Memorial Hospital of South Bend

This report is a collaboration between Elkhart General Hospital and Memorial Hospital South Bend; the two hospitals share several prioritized needs and strategies for community health improvement.

Regional Priority Demographics

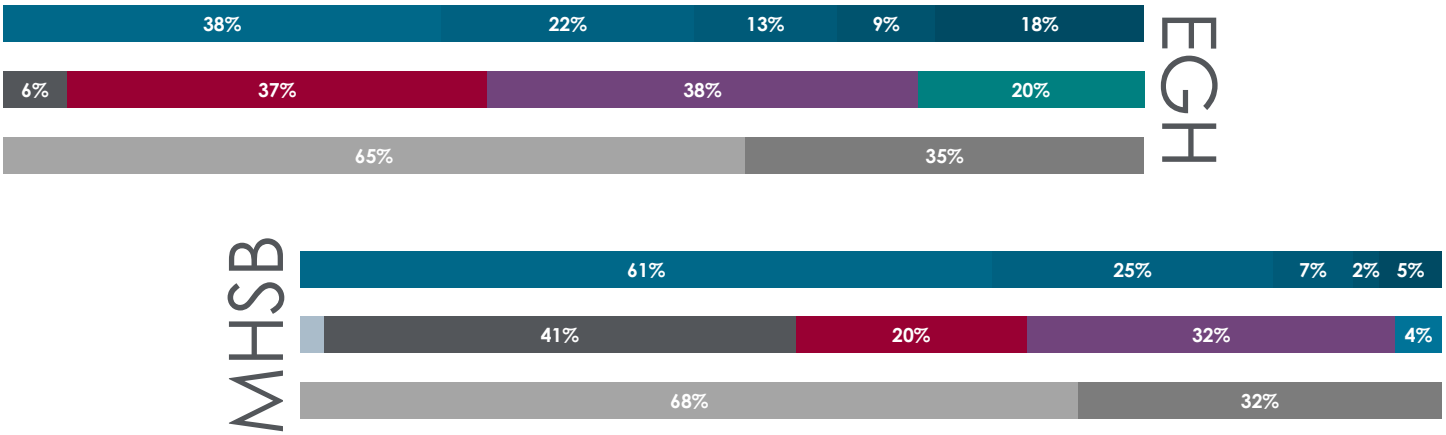
These demographics represent the community members who receive services across the region of Elkhart and St Joseph counties, allowing us to see what groups we are missing and may need to double efforts to reach.

Gender
Female Male

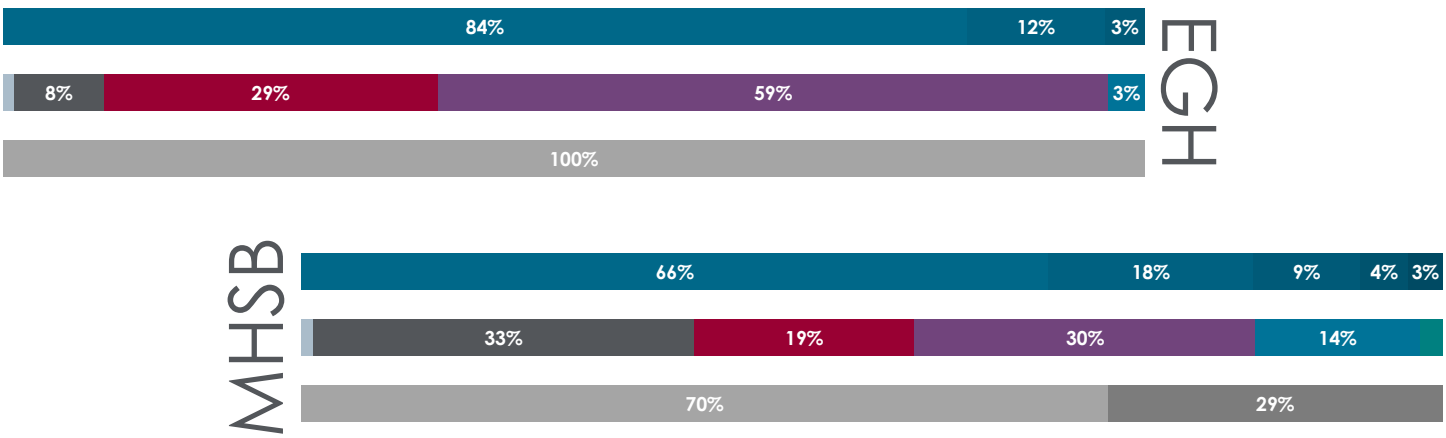
Race/Ethnicity
Asian Black Hispanic White Mixed Race Other

Age
<20 20-29 30-39 40-49 50+

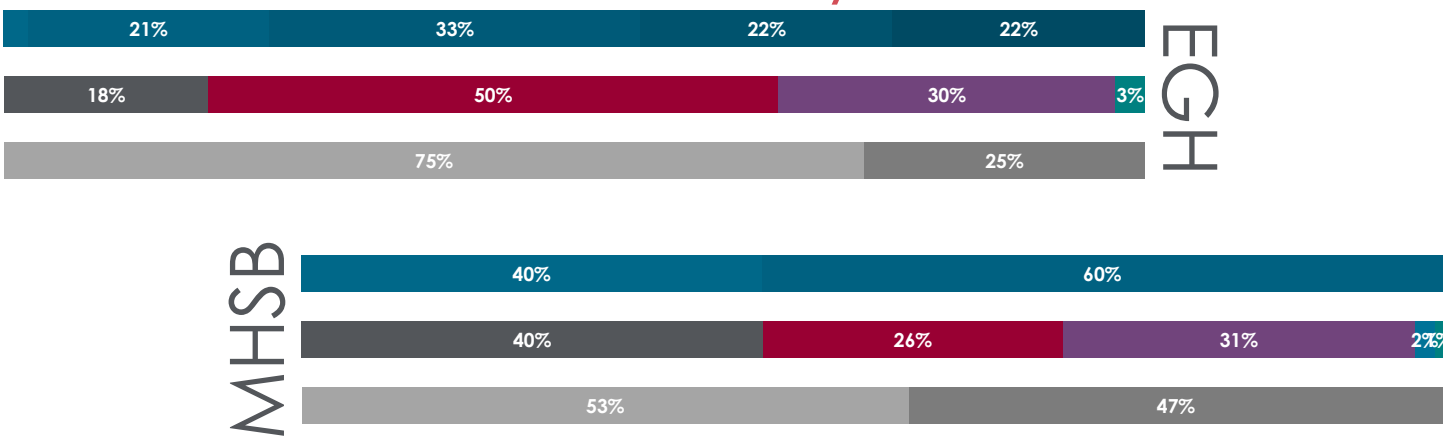
Access to Healthcare



Maternal/Infant Health



Obesity



ELKHART GENERAL HOSPITAL

Elkhart County, Indiana, was established in 1830, with the original county seat in Dunlap and was later moved to Goshen. Today Elkhart County has three growing cities, four towns, and 16 townships. Elkhart County is located in northern Indiana and borders the state of Michigan. The County is approximately 463.91 square miles in size. Elkhart County lies halfway between Chicago and Cleveland and is located near Interstate 80/90 and the Indiana Toll Road. Elkhart County's service providers have a history of actively forming partnerships in an effort to meet the health needs of its residents. Elkhart County takes pride in offering its residents a great place to live and continually strives to establish new businesses and provide an entrepreneurial atmosphere.

Elkhart County is Elkhart General Hospital's (EGH) primary service area. According to the 2016 US Census estimates, Elkhart County's population rose to 203, 781. In 2016, the percentage of persons 65 years and older was estimated at 14%. Census data show that 89.6% of Elkhart County residents are White, 6.2% are Black, and 1.2% Asian. Hispanics may be of any race, and the data show that 15.5% are Hispanic or Latino in origin. In 2016, 3.3% of the total labor force was unemployed. The median household income (2016) of Elkhart County residents was $54,582. The percentage of persons living in poverty was 13.2% in 2016.

EGH has historically defined its geographic primary market area as Elkhart County. For the purpose of the Community Health Needs Assessment (CHNA), the community served is defined as those persons residing in Elkhart County. As identified though U.S. Census data, Elkhart County encompasses a mix of cultural, ethnic, and economic populations.

Depicted above from right to left: Goshen City Courthouse; the Century Center in South Bend and St Joseph River.

MEMORIAL HOSPITAL SOUTH BEND

Established in 1830, St Joseph County (SJC), Indiana has become the fourth largest county in the state of Indiana. The county spans 467 square miles, which includes a comfortable mix of rural cultural heritage and urban amenities. SJC is also the regional center for higher education, with more than eight colleges and universities, including but not limited to the University of Notre Dame, Indiana University South Bend, Ivy Tech Community College, Purdue University, Holy Cross College, Bethel College and St. Mary's College

The heart of MHSB is located within a mile of the University of Notre Dame, ten miles south of the Michigan state line, and forty miles east of Lake Michigan. Through the years the environment of South Bend, the largest city in St. Joseph County, has changed from a focus on manufacturing (Studebaker, Bosch, and Uniroyal) to health, education and customer services.

According to the U.S. Census, the population for St Joseph County in 2016 was estimated at 269,141 individuals. According to the United States Census in 2016 the racial statistics in the county are 80.6% White, 13.4% Black, and 2.4% Asian. Hispanics may be of any race, and the data show that 8.6% of residents are Hispanic or Latino in origin. As expected, with an area well-saturated with post-secondary educational institutions, the county has higher than would be projected educational levels; 87.6% of the population are high school graduates, and 28.2% have a bachelor's degree or higher. The median household income was $48,960; persons below the poverty level accounted for 16% of the population; while the poverty rate among children under 18 was 22%. This need is even more pronounced in South Bend, the county seat where the median household income in 2016 was estimated at $35,758 with 26.7% of the residents living below the poverty level.

The population mix in surrounding counties is diverse and includes large numbers of first-generation European, African, Middle Eastern immigrants, African Americans, Asians, Hispanics, and Amish. MHSB makes a special effort to focus on those populations with the highest unmet needs, specifically those persons who are known as vulnerable, through chronic diseases, lower-income and poverty, members of a minority population and/or the uninsured.

ORGANIZATIONAL ALIGNMENT

Utilization of Hospital Data

In 2016, Community Health consulted with enFocus to analyze the data of both Elkhart General and Memorial-South Bend Hospitals. We believe the data can enable us to be more informed and focused in our decisions on meeting the designated priority needs. Ultimately, the data will help us achieve the following three important goals:

1. More thoroughly align and focus joint efforts between the hospitals and its community partners to improve our community's health and well-being.
2. Identify areas where Community Health and clinical teams could collaborate and use resources more effectively for community benefit.
3. Determine how Beacon Health System resources could be used more efficiently across its own organizations and health partners for regional benefit.

Predictive Analytics

Every year we look at hospital data using a multivariate regression analysis. All of the predictions from these predictive analytics have a significance level of 95% and higher using IBM's Watson Analytics and R.

We use the race, ethnicity, gender and age statistics from the previous year to predict what groups of people will be in need in the coming year. This helps us know where to focus our efforts to achieve the greatest impact in the coming year.

For example, in our 2016 report we predicted that those most likely to be without health insurance were young Black men and older Hispanic men. As a result, we promoted our insurance enrollment at locations more likely to reach these men, and with unique materials designed to reach them.

Organizational Alignment for Providing Community Benefit

As a community not-for-profit organization, our history confirms that we take seriously our responsibility to invest our resources and energies into understanding and meeting the health care needs of all members of our communities, especially the underserved. In order to ensure our organizational alignment with Beacon Health System's mission, vision, and values, we provide and support community programming that:

- Addresses one of the health priority themes identified in the most recent Community Health Needs Assessment.
- Promotes the principles of wellness - mind, body, and spirit.

NEEDS NOT BEING ADDRESSED

Elkhart General Hospital

While mental health was identified as a community health need through the key informant survey and community member survey, the Elkhart County suicide rate is lower when compared to St. Joseph County, Indiana as a whole, and the nation. Because of this, other community needs took precedent.

Elkhart General Hospital does not intend to include diabetes in its Implementation Strategies due to limited resources to implement and effectively measure impact.

Alzheimer's disease was found to be a potential community health need; however the data may be misleading due to a recent change in reporting. Further investigation is warranted to confirm the validity of this data point, so EGH does not intend to pursue Alzheimer's disease in its Implementation Strategies.

Finally, immunizations for school-aged children were identified as a health need due to the number of children being removed from school due to noncompliance with state-mandated immunization schedules. EGH does not intend to make immunization a priority because of the numerous community resources already addressing this need.

Memorial Hospital of South Bend

Of the remaining thirteen (13) issues identified in the CHNA, nine (9) were scored at zero and four (4) cancer, education, poverty, and substance/ alcohol abuse were scored from forty (40) to sixty (60) percent. MHSB does not intend to include them in its Implementation Strategy due to other community health needs taking precedent, limited resources, and the recognition that these needs are being addressed by other organizations within the community.

Access to HEALTHCARE AND UNINSURED

This health need crosses both Elkhart and St Joseph counties, and Beacon Community Health is very intentional about addressing it on a regional level. This collaborative alignment between counties helps us maintain our momentum toward collective impact in our communities.

Significant Health Need

While the arrival of the Affordable Care Act (ACA) provided many Elkhart and St. Joseph County (SJC) residents with needed health coverage, a large segment of our county continues to fall through the cracks for myriad reasons including ineligibility due to lack of legal residency status, the unaffordability of Indiana ACA Marketplace programs for eligible persons, and the increasing trend of high-deductible employer-sponsored plans that are creating delays or barriers for insured persons to utilize health care at an appropriate time.

Residents of Elkhart County are more likely to be uninsured (20.8%) when compared to St. Joseph County (14.5%), Indiana (14.2%), and the nation (14.8%). The ratio of primary care providers (PCP), dentists, and mental health providers to residents is worse in Elkhart County than in St. Joseph County, all of Indiana, and the national benchmark. Access to health care and access to health coverage continue to be identified as community health priorities in Elkhart County.

MHSB data from January through December 2016 indicate more than 5,500 patients are uninsured, but those unsure or without a Primary Care Provider (PCP) outnumber the uninsured by almost 2:1. This hinders the completion of routine wellness visits and could lead to higher demand for ED services when ill, and confirms the need for prioritizing Access to Care among their patients and in the community.

Priority Focus 1: Ensure access to health insurance, education and self-management skills
Priority Focus 2: Provide screenings and education

Predictive Analytics

Based on the demographics statistics coming out of the hospitals in 2017, we can predict that:

EGH Service Area

- Black young men between 17 and 29 years old have a 55% chance of being uninsured.
- Women aged 29-44 who are White, Hispanic, Asian, or listed as Unknown race have a 35% chance of being uninsured.

MHSB Service Area

- Black young men between 22 and 32 years old have a 66% chance of being uninsured.
- Women aged 32-48 who are Black, Hispanic, or listed as Unknown race have a 40% chance of being uninsured.

Priority Outcomes

In 2017, insurance enrollment providers were able to serve 1,677 people across the region, with 86% getting health insurance.

A six month follow-up process was piloted to discover and record how effective initial efforts were. Phone calls went out to 87 participants who were successfully enrolled, and 59% said they now had a PCP.

Programs

Aging in Place (AIP) programming helps St Joseph County seniors in low-income housing remain productively and successfully independent by providing them with caring and holistic services so they can continue to be a rich part of the community and society.

Beacon Health System Navigators provide outreach-based, free enrollment and advocacy services for low-income and/or eligible residents through health coverage enrollment efforts across the region. Elkhart General Hospital also funds a contracted Indiana Navigator enrollment position through a collaboration with Covering Kids & Families, an entity of United Health Services.

Dame Tu Mano Health Education and Outreach seeks to empower and motivate the Hispanic Latino residents in the Michiana area, with specific focus on Elkhart County, through broad-based education using radio, print, and social media as well as group presentations.

The North Central Indiana Sickle Cell Initiative (NCISCI) raises awareness of sickle cell disease and trait through education and screening that help reduce the incidence of this painful and sometimes deadly disease. Both the Health Coordinator and Educator provide newborn screening follow-ups, referrals, counseling sessions, home and clinic visits with families on additional topics such as, the dangers of secondhand smoke and getting insurance.

Additional Highlights

7,088 served

93 residents consistently participated in AIP programs. **77%** maintained a PCP.

1,677 uninsured across the region were served by Beacon Navigators and CKF.

1,680 community members engaged in **266** Dame Tu Mano health topics which were covered from a total of **532** live on-air radio segments, resulting in a total of **789** phone calls received and **43** vision referrals.

3,638 families and individuals received Sickle Cell case management, counseling, awareness education and/or free testing for Sickle Cell trait across Northern Indiana.

Diabetes

This health priority reflects the need found in the Memorial Hospital of South Bend (MHSB) service area and among St Joseph County (SJC) community members.

Significant Health Need

Diabetes was the fourth most pressing health need in the CHNA's key informant surveys. Data shows 20% of SJC respondents reported having been diagnosed with diabetes, compared to fewer than 8% in Elkhart County. In SJC the percentage of respondents with diabetes, pre-diabetes, or gestational diabetes has increased from 2012 community member survey responses. Approximately 49% of diabetic respondents in SJC maintain an A1C level of 7% or below, compared with 37% in Elkhart County. To face those challenges and meet this need, Beacon Community Health has created these focus areas and indicators to assess progress over time.

Priority Focus 1: Diabetes disease management
Priority Focus 2: Diabetes prevention

Predictive Analytics

Based on the demographics statistics coming out of the hospitals in 2017, we can predict that:

MHSB Service Area

- Men are 1.21 times as likely to have complications as women.
- Black diabetics are 1.31 times more likely to have complications than White diabetics.
- Having complications with diabetes results in a $20,872 increase in charges compared to diabetes without complications.

Priority Outcomes

The YMCA served 45 pre-diabetics who completed the 12 month program in 2017. Of this cohort, 42% reported engaging in 150 minutes of exercise each week, and 25% met their weight loss goal of 7%. Their success rate for exercising is lower than HP2020's goal of 49%.

Lessons learned from the 2016-2107 group helped the YMCA adapt motivational support for the next group scheduled to complete the program in 2018. These adaptations are making a difference as 54% are reported to have already achieved their weight loss goal.

Programs

The YMCA City of South Bend's Diabetes Prevention Program (DPP) helps those at high risk for developing type-2 diabetes (i.e., overweight with pre-diabetic conditions) to adopt and maintain more healthy lifestyle habits, and prevent the onset of the disease.


MATERNAL
INFANT
Health
Prenatal Care

Like Access to Healthcare, Maternal/Infant Health is a regional health priority. Community outreach efforts are coordinated and intentional across both counties to further direct our communities toward collective impact.

Significant Health Need

Multiple health measures from the 2015 CHNA support the issue of maternal/infant health/prenatal care as a regional health priority. The teenage birth rate is higher in SJC (28.4) than the nation overall (26.5). Both St. Joseph and Elkhart counties have low first trimester prenatal care rates among Black/African American residents (approximately 50%). Infant and neonatal mortality rates are likewise higher in SJC (8.7 and 6.7, respectively) when compared to Indiana and the nation. Several perinatal health indicators were also noted, including smoking rates during pregnancy; and low birth weight. Research has clearly shown a positive correlation between late entry into prenatal care and adverse birth outcomes. To face those challenges and meet this need, Community Health has created this focus area and indicators to assess progress over time.

Priority Focus 1: Provide active case management for low-income mothers and infants during and after pregnancy
Priority Focus 2: Diabetes management during pregnancy
Priority Focus 3: Sexual health education
Priority Focus 4: Identify variables that decrease infant mortality

Predictive Analytics

Based on the demographics statistics coming out of the hospitals in 2017, we can predict that:

EGH Service Area

- Gestational age decreases by 7.2 days for each previous miscarriage.
- There is a $2,954 per day increase in charges for those in the NICU.

MHSB Service Area

- Hispanic babies have 3.3 gestational days fewer than white babies.
- There is a 9.6 day decrease in gestational period for mothers with gestational diabetes compared to mothers without gestational diabetes.

Priority Outcomes

Together, their programs served 416 mothers and delivered 324 live births across the region in 2017. Of the mothers,

- 26% were severely obese.
- 35% were at a healthy weight.
- 17% had an ACE score greater than 4.

With their maternal support,

- only 5% of the babies were born preterm (<37 weeks)
- 6% weighed less than 2,500 grams.
- 3% spent time in the NICU.

In Beacon Community Health programs, only 4% of mothers continued smoking during pregnancy. County rates for smoking or substance abuse are 11% in St. Joseph County, and 14% in the state of Indiana.

Programs

Since 1992, the Beds and Britches, Etc. (B.A.B.E.) program has offered incentives to expectant mothers and parents to promote responsible parenting. Encouraging responsibility and improving self-esteem, the program provides goods and services that new parents need to nurture healthy babies and foster skills that will help the family through life.

The PEERS Project in Elkhart County is a middle school risk avoidance curriculum that emphasizes nurturing and maintaining the emotional health of youth. This peer-led program focuses on abstinence from sexual involvement, alcohol, drugs, and smoking. It empowers youth with assertive life skills, and helps them learn to regulate their emotional health to make positive life decisions.

There are two primary CH providers of programming in this health need area: Prenatal Care Coordination (PCC) in Elkhart, Perinatal and Infant Health (PIHP) in SJC. Both programs have previous experience in achieving positive

outcomes with their high-need participant groups. In 2017, for the first time these programs used the same data collection system and re-worded their individual goals to be similar across counties so that comparisons could be made, joint challenges could be identified and addressed, and meaningful approaches could be shared. Both programs also participated in a focus group targeting this priority need, which increased communication and strategic support for improving health in this area across the region.

The Safety class is aimed at parents and caregivers of children ages birth to teen and a variety of topics are covered to prevent accidents and injuries. The Safe Sleep Program is aimed at parents and caregivers to prevent SIDS (Sudden Infant Death Syndrome). During the class the caregivers are given education, Survival kit, and a pack and play.

The School Health and Wellness Educator Team provides education and training to intermediate and high school youth within South Bend Community School Corporation, many of whom are at-risk. They prepare children for a world of complex relationships, promoting healthy decision making through neuroscience education, digital training, and sexual health curriculum.

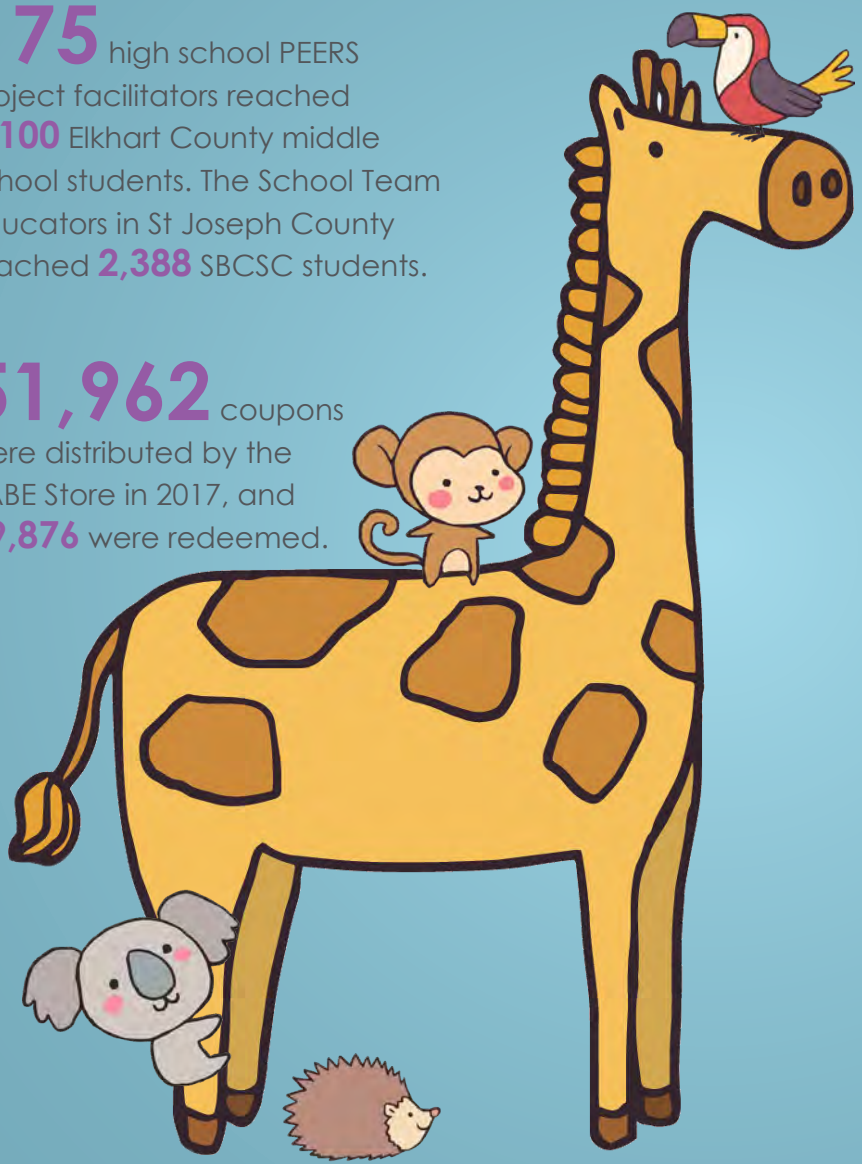
The St. Joseph County Health Department (SJCHD) Fetal Infant Mortality Review (FIMR) Program examines the social, economic, cultural, health, safety and systems issues related to infant death and determines local factors upon which interventions for improvement in the perinatal health system can be based.

Women, Infants, and Children (WIC) improves nutrition by providing vouchers for specific types of foods (e.g., fruits, vegetables, whole grains and low-fat dairy products) that tend to be lacking in the diets of low-income women and young children. Nationally, prenatal WIC participation is associated with healthier births and lower infant mortality rates. WIC is also linked with stronger connections to preventive health care and helps ensure that children are properly immunized.

Additional Highlights

175 high school PEERS Project facilitators reached **1,100** Elkhart County middle school students. The School Team Educators in St Joseph County reached **2,388** SBCSC students.

51,962 coupons were distributed by the BABE Store in 2017, and **29,876** were redeemed.



Only **14.4%** of children aged 2 to 5 seen by WIC were recorded as obese, exceeding their goal of 15% after their successful campaign to trade in soda pop for water.

231 parents or caregivers participated in the Safety/Safe Sleep program. Pre- and post-education surveys show an increase in knowledge for **98%** of caregivers.

FIMR saw **40** maternal cases in 2017. **18** women used either drugs, nicotine, alcohol, or a combination during pregnancy. **28** fathers were involved and **36** mothers initiated prenatal care.

MENTAL HEALTH & Suicide

This health priority need was identified only in St Joseph County for Memorial Hospital of South Bend.

Significant Health Need

The suicide rate per 100,000 is higher in SJC (13.4) than the nation (12.6), and Beacon Children's Hospital reported a dramatic increase in pediatric patients hospitalized from failed-suicide attempts. The years of potential life lost before age 75 per age-adjusted 100,000 is also higher in SJC (7,424) than the national benchmark of 5,200. SJC reported more average days of poor mental health when compared to the national benchmark (3.7 versus 2.3 out of 30 days). Of the 549 community survey respondents, 27% reported living with someone depressed, mentally ill, or suicidal – up from 14% in 2012. Mirroring this, 21.5% of SJC respondents reported having been diagnosed with an anxiety disorder (15% in 2012) and 29.2% were diagnosed with a depressive disorder (21% in 2012). To face those challenges and meet this need, Beacon Community Health has created these focus areas and indicators to assess progress over time.

Priority Focus 1: Youth and adolescent development
Priority Focus 2: Mental health in aging populations
Priority Focus 3: Increase youth resiliency
Priority Focus 4: Increase awareness of suicide prevention

Predictive Analytics

Based on the demographics statistics coming out of the hospitals in 2017, we can predict that:

MHSB Service Area

- Women are nearly twice as likely as men to be diagnosed with depression and anxiety
- Black residents are 15% less likely to be diagnosed with anxiety as White residents

Priority Outcomes

178 South Bend Community School Corporation (SBCSC) students attended a QPR training, meeting the state mandate for suicide awareness. There was a 17% increase in knowledge of the best option for helping peers with suicide ideation.

At the JJC, 34 youth took the Drumbeat program. Emotional reactivity scores - representing resilience - climbed 23% by the end of the program. 38% started the program with depression or anxiety, compared to 21% at its completion. HP2020's goal is to reduce the proportion of adolescents aged 12 to 17 who experience a major depressive episode from 8.3% to 7.5%.

Programs

AIP programming helps seniors in low-income housing remain productively and successfully independent by providing them with caring and holistic services so they can continue to be a rich part of the community and society.

DRUMBEAT is a program provided by the ARC Alliance for youth at the Juvenile Justice Center. It promotes and teaches hand drumming as a tool for promoting social networks, relationship building, physical exercise, and stress management.

The Mary Morris Leighton Lecture, an annual event organized by Beacon Community Health and sponsored by the Leighton-Oare Foundation, brings the opportunity of sharing health and wellness information with our community. Each year the topic connects back to one of our CHNA health priority areas. Aligning the lecture focus with our priority areas ensures that the most valuable health information is conveyed.

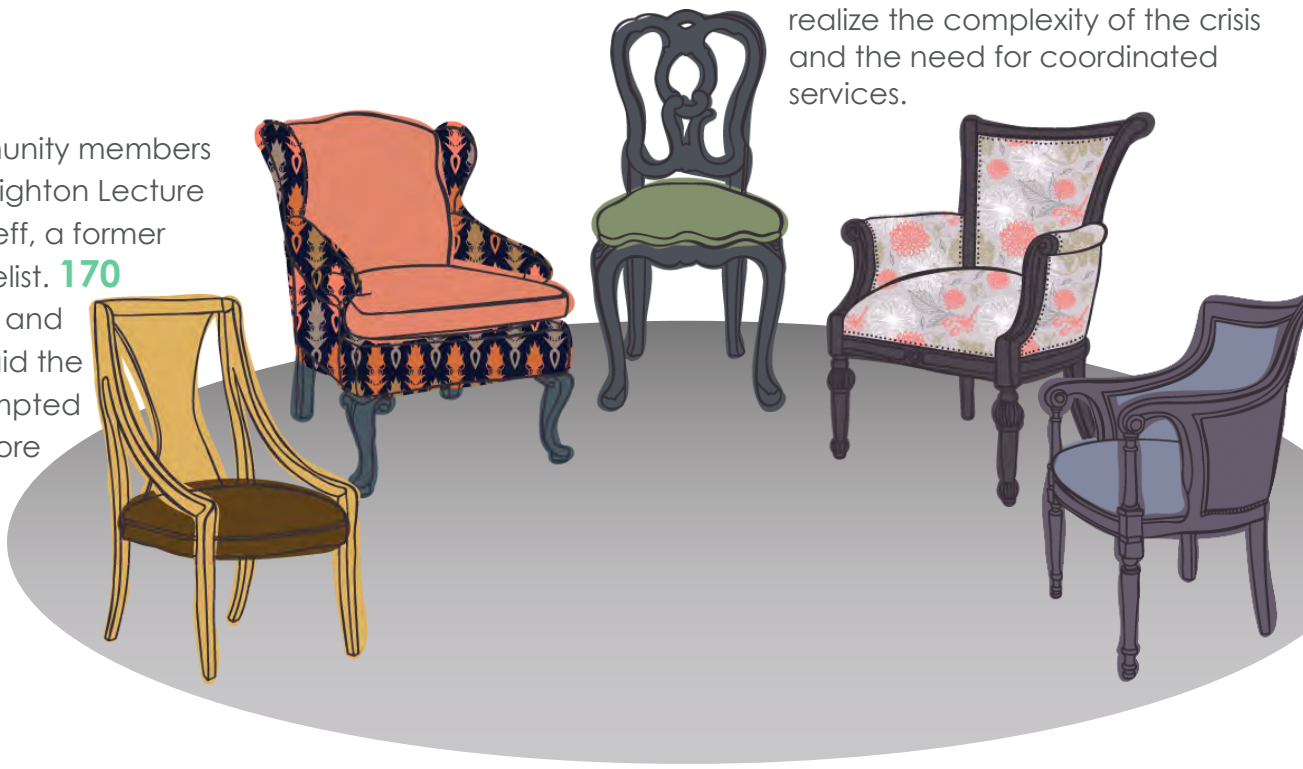
Beacon Community Health organized a Community Plunge around the opioid epidemic. A Community Plunge is a small event where executive, stakeholders, and community leaders come together to learn about an issue affecting the community and work together to come up with actionable solutions. For this Community Plunge, Beacon Community Health put together a local documentary titled *In Plain Sight: The Hidden Opioid Struggle in Indiana*.

Additional Highlights

93 aging adults participated in AIP's socio-emotional activities - **22%** more than last year.

350 community members attended the Leighton Lecture featuring Nic Sheff, a former addict and novelist. **170** returned surveys and **91%** of those said the information prompted them to learn more about this issue.

70 stakeholders engaged in the Opioid Community Plunge. **32** completed surveys showed that **87%** felt the plunge helped them realize the complexity of the crisis and the need for coordinated services.



OVERWEIGHT Obesity

This is a regional health priority. Community outreach efforts are coordinated and intentional across both counties to further direct our communities toward collective impact.

Significant Health Need

Being overweight or obese was cited as the most significant community health issue in the key informant survey and a high priority during group discussions in both Elkhart and St Joseph counties. In Elkhart 33% of the adult population is obese, and 30% of the adults in St Joseph County are obese. Additionaly, over 17% of the children in St Joseph County are overweight and/or obese. Overweight/obesity is challenging enough on its own, but it is also often correlated with heart disease, diabetes, sleep apnea, and stroke. To face those challenges and meet this need, Beacon Community Health has created these focus areas and indicators to assess progress over time.

Priority Focus 1: Community and youth engagement in physical activity
Priority Focus 2: Knowledge and consumption of healthy food

Predictive Analytics

Based on the demographics statistics coming out of the hospitals in 2017, we can predict that:

EGH Service Area

- Hispanic residents are over 3 times more likely to be very severely obese than White residents

MHSB Service Area

- White patients are twice as likely to be overweight compared to Hispanic and Black patients

Priority Outcomes

125 adults joined Elkhart Community Health's two Walking Challenges under Dame Tu Mano and Health Enhancement Lifestyle. 91% of them completed the program. Their total daily steps increased by 13%.

Four of SJC's programs focused on increasing physical activity for children: FitNoggins, FitKids, Madison STEAM Academy/ Leeper Park, and Unity Gardens. Collectively, they served 749 children and 94% increased their physical activity levels by the end of programming.

Programs

The Bariatric and Metabolic Institute provides free behavioral classes to program participants every three weeks with the classes focusing on various topics pertaining to behavioral modification to help with weight loss.

Dame Tu Mano ("Give Me Your Hand") is Elkhart General Hospital's Hispanic Latino health improvement outreach program. The program's focus is a broad-based community health empowerment effort to address the health needs of the nearly 31,000 Hispanic Latinos in Elkhart County. To address obesity Dame Tu Mano provides information, resources, and referrals on obesity, weight loss, and nutrition for the Hispanic and Latino communities. Health promotion and educational messages are offered via print, radio, and social media, and through educational summits and community screenings.

The Elkhart General Hospital Health Screening Program provides free education and health screenings measuring glucose, cholesterol, blood pressure, body fat, and BMI to Elkhart County residents in partnership with local organizations and businesses.

Fit Noggins provides youth, ages 6-12 a fun way to increase physical activity.

Health Enhancement Lifestyle Program (HELP) is a six-week program to promote increased exercise and improved personal nutrition awareness in Elkhart County residents and employees.

Operation FitKids encourages youth to be physically active and eat healthy in a fun and engaging way, providing healthier choices and increasing physical activity.

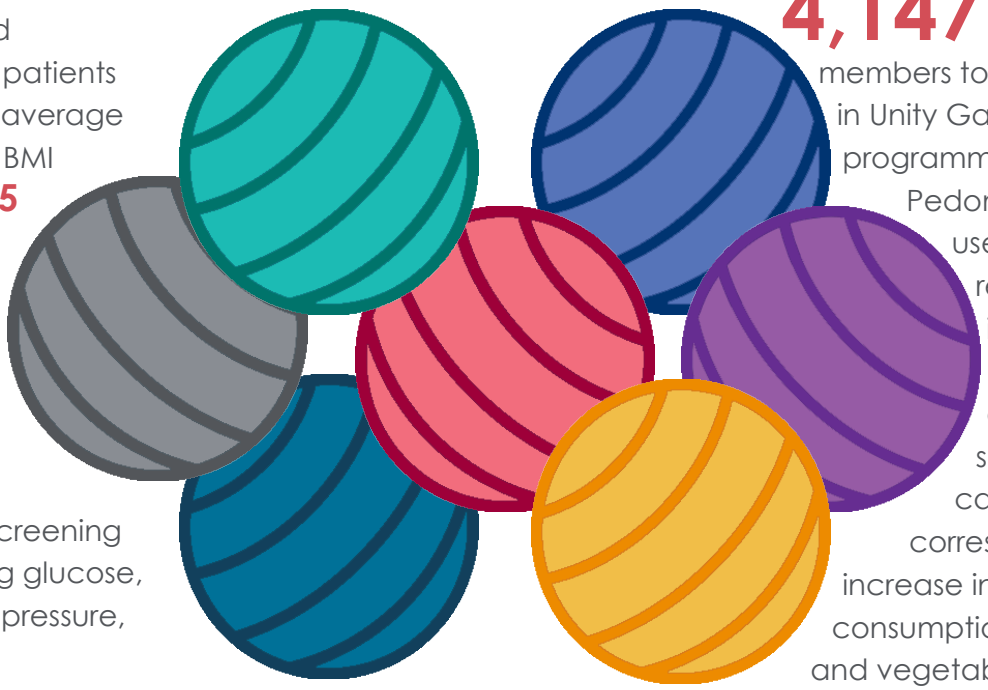
The purpose of our Park Foundation, Madison Primary Center, Leeper Park, and Memorial Hospital collaboration is to positively impact childhood obesity. This program is five years in duration. A college student and community business partner team-building and project management approach is utilized to execute the plan and leverage resources to achieve a big goal. The park is being revitalized and restored specifically to encourage physical engagement.

Unity Gardens Food and Fun Immersion included programs and activities designed to enhance coomunity garden experience and connection with fresh produce. This program targeted vulnerable aggregates within the area surrounding LaSalle Square Unity Garden, especially the Beacon Heights Apartments community. Increased garden involvement for youth and adults was designed to improve access to fresh produce, and subsequently decrease obesity rates and increase food security long term. In addition, opportunities for increased physical activity were actively planned, not only with events, but also in the structural plan of the Unity Garden.

Additional Highlights

25 Bariatric and Metabolic Institute patients saw a reduction in average BMI starting from a BMI of **48** down to **44.5** post-program.

279 health screenings were provided through Elkhart General Hospital's Health Screening Program measuring glucose, cholesterol, blood pressure, body fat, and BMI.



4,147 community members took part in Unity Gardens programming.

Pedometers used by youth revealed an increase in activity during summer camp, with a corresponding increase in consumption of fruits and vegetables.

VIOLENCE | SAFETY

Trauma

This health priority need was identified only in St Joseph County for Memorial Hospital of South Bend.

Significant Health Need

The violent crime rate per 100,000 is higher in SJC (370) than in Elkhart County (264), Indiana (334) and the national benchmark (59). Almost 40% of the Key Informants indicated Violence/Safety/Trauma was a key theme. The Community Survey data showed 23% had been hit, beat, kicked, or physically hurt by a parent or adult in the home, up from the 18.9% in 2012. To face those challenges and meet this need, Beacon Community Health has created these focus areas and indicators to assess progress over time.

Priority Focus 1: Traumatic situation assistance
Priority Focus 2: Shooting incident tracking and reduction
Priority Focus 3: Support for trauma patients at Memorial Hospital of South Bend

Predictive Analytics

Based on the demographics statistics coming out of the hospitals in 2017, we can predict that:

MHSB Service Area

- Men are nearly 8 times more likely to be assaulted with a gun.
- Black community members are 4 times more likely than White community members to experience a gun-related injury

Priority Outcomes

Beacon's Trauma Intervention Specialist (TIS) worked with 83 victims of violence between January and April. 5% had repeated experiences, compared to 11% of the 90 people who did not receive TIS services.

The YWCA's Take Charge program helped 1,276 youth increase their knowledge of dating violence and abuse by 13%.

Programs

ACE Interface was created in 2016 to create a trauma informed community that conveys care and compassion for all people, and builds resilience in people impacted by ACEs (Adverse Childhood Experiences). Building resilience not only increases the likelihood that ACEs will not occur but also helps people recover from ACEs, enabling them to thrive in spite of adversity.

The Addressing Childhood Trauma (ACT) Grant from the Federal Office of Minority Health and Health and Human Services funds the Community Resilience Center, a program developing interventions to build resilience in children who have experienced trauma.

Beacon Health System Trauma Team social workers seek to promote wellness and a positive quality of life for adult patients who are recovering from a trauma induced injury. As trauma can lead to posttraumatic stress disorder, team members and interns have been trained in ATIP/Eye Movement Desensitization and Reprocessing (EMDR), one emotional debriefing strategy found to be effective with trauma victims.

The South Bend Group Violence Intervention (SBGVI) unites community leaders around a common goal: to stop gun violence and keep South Bend's highest risk citizens alive and out of prison. SBGVI is a partnership among 30 community leaders from law enforcement, government, education, civil service, health-care and faith-based agencies. 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 advocates direct, sustained engagement with street groups that cause the majority of South Bend's gun violence. The 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 Trauma Intervention Specialist was established at Memorial Hospital to work with victims of violent crime and their families. The purpose of this position is to help victims of violence and prevent violent personal injury, retaliation, and recidivism among the population of South Bend through research, data monitoring/ evaluation, and community involvement.

YWCA Take Charge is primary violence prevention program for youth in schools or with community organizations with a focus on Increasing knowledge of components of a healthy relationship and knowledge of all forms of teen dating violence/ abuse.

Additional Highlights

556 residents were reached by ACE Interface facilitators and reported learning more about how to help those with ACEs.

200 community members were directed by SBGVI coordinators to needed resources.

12 people were screened for ATIP - and **6** reported a significant decrease in their emotional stress.

PEDIATRIC HEALTH NEEDS ASSESSMENT

As the only comprehensive children's hospital in our region, Beacon Children's Hospital has a responsibility to know and understand the health needs and concerns of its local patient population. For this reason, Beacon Community Health and Beacon Children's Hospital conduced a Pediatric Health Needs Assessment (PHNA) in 2016.

Beacon Community Health conducted the assessment with the following six area counties: Elkhart, Lake, LaPorte, Marshall, Porter, and St. Joseph.

Primary areas of focus taken from the PHNA and beginning in 2017 are Asthma, Mental Health/Suicide, and Obesity. Work will include gaining an understanding of initiatives and programs currently addressing these priorities, identifying gaps and opportunities, and creating and implementing strategies to improve health in the three focus areas. Initial efforts will be focused in Elkhart and St. Joseph Counties, with plans to share information and build relationships with the other four counties.

Many of the PHNA initiatives cross into our CHNA priorities, and these have been included there for more consistency. The PHNA will be rolled into the next Community Health Needs Assessment moving forward, allowing for more consistency and alignment of goals and objectives.

U-Turn for Youth: Preventing Suicide and Improving Mental Health in Our Community is a philanthropically funded initiative to bring mental health information programs to our community on a wide scale. Thanks to this initiative, Community Health is able to reach thousands of students, teachers, health care professionals, and community members with suicide prevention and mental health programs.

During the first year of programming, U-Turn for Youth implemented Question, Persuade, Refer (QPR) Gatekeeper Suicide Prevention, Adolescent Depression Awareness Program (ADAP) and This Is (Not) About Drugs. QPR is of particular note because the program meets a state-mandated need for SBCSC students and teachers to attend or participate in at least two hours of evidence-based in-service youth suicide and prevention training.

In 2017, Beacon Community Health trained **160** SBCSC teachers and school staff members using QPR, with data showing increased knowledge of suicide prevention referral from **20%** to **93%** after training.

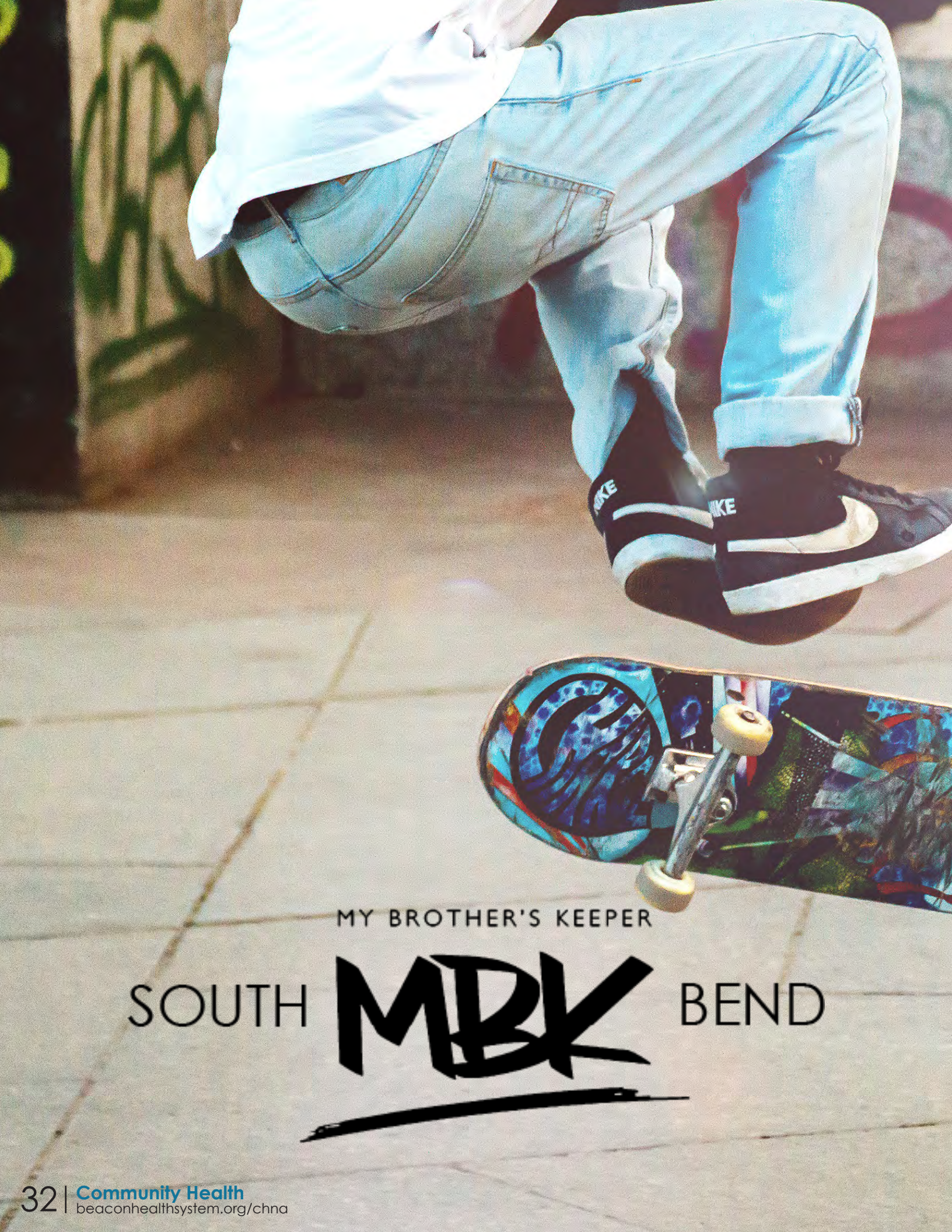
U-turn for Youth has also implemented Adolescent Depression Awareness Program (ADAP) created by Johns Hopkins University. ADAP seeks to educate high school students, teachers, and parents about adolescent depression. The curriculum increases awareness about depression and bipolar disorder, stressing the need for evaluation and treatment, while decreasing the stigma associated with mood disorders. The program's key message is that depression and bipolar disorder are treatable, and help is available.

We were able to reach **356** students with ADAP, and strategy is already being implemented based on what we learned in year one. Students rating their confidence level as high when asking about suicidal intention was increased from **17%** to **29%** post-training.

Along with QPR and ADAP, we implemented This is (Not) About Drugs - an educational program created by Overdose Lifeline, Inc to raise awareness of the risks of misusing prescription opioids and the connection between misuse and addiction, heroin use, and overdose. Students are encouraged to make good choices and provided with the skills to combat peer pressure, gain support, and resources for making decisions about their own body and health.

We administered pre and post-program surveys to the **180** students who took This is (Not) About Drugs. More than half (**52.7%**) of the students who attended said the information presented in the training was good/helpful. Of the total, **16** students said that they knew someone misusing prescription pain medicine, and **136** of the students (about **79%**) said they are now less likely to abuse prescription pain medicine or do heroin. Overall, the education changed the perception of the students; there was a noticeable increase in positive responses to each statement on the post-survey.

Asthma is not a focus of U-Turn, but it remains an important PHNA health need. In the last year, work was started to prevent and decrease acute asthma emergencies among the pediatric population of the region. Two informational events were piloted, the Asthma Nurses Night and the Asthma Family Night. The nurses were taken through the steps to correctly identify a respiratory emergency requiring 911, many of whom were already very familiar with it. The families were treated to a night at HealthWorks! Kids Museum with informational break-out sessions run by Memorial pediatrician Dr. Charisse Johnson. Both the families and nurses agreed that the nights were fun and informational. We can't wait to do even better next year.


MY BROTHER'S KEEPER
SOUTH MBK BEND

The My Brother's Keeper (MBK) Community Challenge was announced by the White House in February 2014 as an initiative aimed at improving the outcomes of boys and young men of color. The MBK Community Challenge encourages communities to implement a cradle-to-college-and-career strategy intended to improve the outcomes for young people regardless of who they are, where they come from, or the circumstances into which they are born. Nearly 200 mayors, tribal leaders, and county executives across 43 states and the District of Columbia have accepted the MBK Community Challenge.

South Bend accepted the challenge in October 2015, joining hundreds of cities in recognizing the opportunity gaps facing boys and young men of color and in committing to rectify the disparities.

A community action summit was held that same month. Community partners came together and talked about the efforts needed to eliminate the opportunity gaps, pointed out barriers, brought to light challenges the youth face in our community, and strategized ways that we as a community can ensure that young people are better positioned to succeed.

Several specific challenges that boys and young men of color face were identified at the summit. These included violence, access to quality early childhood education to get boys of color off to a good start when they enter kindergarten, police-community relations, and access to employment opportunities that would allow young men of color to support themselves and their families. Based on this feedback, the South Bend MBK initiative will focus on the following:

Getting a healthy start and entering school ready to learn
Keeping kids on track and giving them second chances
Successfully entering the workforce

As the anchor organization, Beacon Health System networks and collaborates with MBK community partners to complete the mission of closing opportunity gaps for boys and young men of color. Beacon Health System has committed to spearheading the development and implementation of data-driven outcomes; ensuring efficiency; and facilitating analysis, management, and presentation of data.

In the two years since South Bend joined the MBK Challenge, much of the focus has been on implementing data collection among the partner programs. The outcome data gathered in 2017 identified the need for a systematic process of data collection.

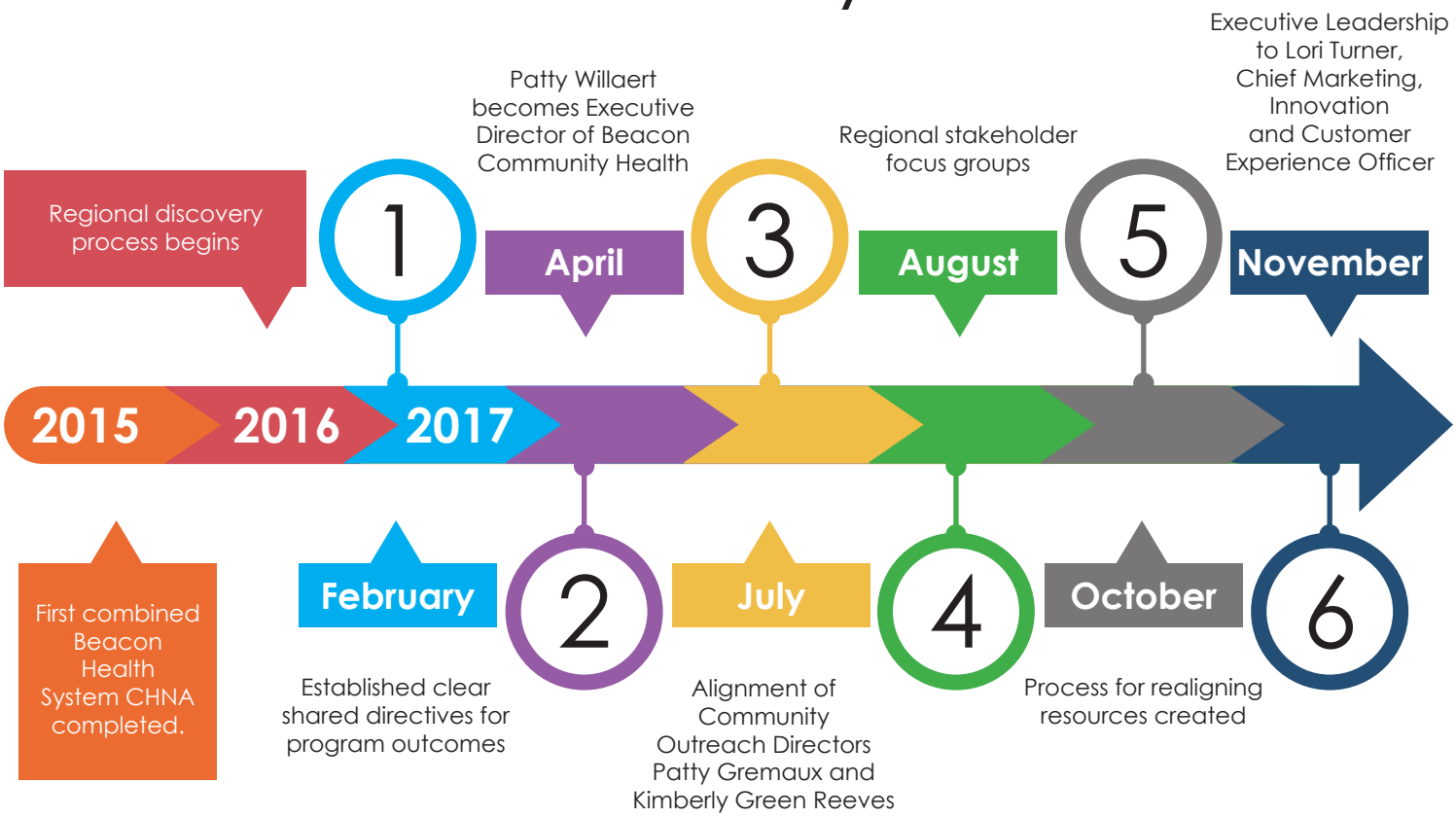
We reviewed current MBK programming practices and found three areas of opportunity for improvement. Throughout this process we will utilize the talent and skills provided by the MBK Advisory Council to help us support the community partners, as noted below.

First, we want to make sure that each program has individual, measurable goals and indicators. This will mean meeting with periodically throughout the year to provide support. Over the next year we want to see specific, measured outcomes from each program. This will help us determine what successes the program sees, and where they can improve programming.

Next, we want to align the data being collected by our community partners. We will ensure that each of them are collecting data relevant to the indicators chosen to represent our success at addressing the disparities for boys and young men of color in our community. Each of the indicators represents success for one of the milestones above, so all of the programs addressing one each milestone will collect the same indicator data.

Finally, we recognize that our community partners want to ensure their program is accessible. We will foster collaboration between community partners and other organizations in the city to help increase participation. We will also assist community partners with finding resources to support their programs, and will encourage community partner collaboration for resource support as well.

The Evolution of Beacon Community Health



To the Future, and Beyond!

Scale Out Programs to Increase Participation

Partners who have achieved positive outcomes will receive specific guidance on increasing participation to extend their program's impact to a larger audience.

Some of our community partners will be asked to replicate their services at additional locations, while others with similar or complementary programming will be requested to collaborate.

These arrangements will optimize provider resources, improve access to a wider variety of services for community members, and forge more cooperative partnerships – all of which lead to a more sustained impact.

Provide More Program Equity and Better Regional Alignment

Align with Beacon Health System's 2018 Strategic Focus Areas.

More balance will be provided across the region in terms of what services we offer and to whom we offer them. Community organizations and internal programs will be asked to work toward cross-county partnerships and collaborate on programming.

Internal resources will be better balanced across counties, and we will seek grant opportunities for regional programming to build further program equity and better alignment.

Our reporting process continues to be improved and streamlined, and we will also make a concerted effort to support capacity building for individual program documentation and reporting.

Continue Progress Toward Achieving Collective Impact

Early in the year we will establish firm goals for regional health needs, creating metrics necessary for illustrating widespread outcomes when reporting in December.

Priority indicators will be adjusted to better demonstrate the regional effect of programming in our communities.

We will also provide the networking cabability necessary to address CHNA health needs regionally.

Finally, integrating and visualizing the clinical and program data necessary for improving population health remains the ultimate goal of Beacon Community Health.

What is Wellness?

Principles of Wellness

The best health results come from focusing efforts on changing the whole person: mind, body, and spirit. That's why we've asked our community partners to connect these three Principles of Wellness to their programming. Not only were they able to describe what wellness meant to them, they were also able to provide examples of what wellness means in the community.

Mind

Connections: 37

Financial, emotional, and physical safety are essential to mental health. Strong personal relationships and ties to the community create a mental security that cannot be replaced.

The **Beacon Navigators** and **CKF** coordinators have seen that providing affordable options for health coverage brings peace of mind and self-efficacy to those they help.

Dame Tu Mano's Walking Challenge provided a platform for residents to encourage each other and gain a sense of community.

Body

Connections: 33

Physical activity, good nutrition, and mental stimulation keep your body in good health and help you maintain wellness of mind and spirit too.

The Bariatric and Metabolic Institute told us that patients who increase activity and reduce their BMI, have increased energy to get things done throughout the day, and better health to boot!

The aging adults participating in the **Aging in Place** program gained physical confidence through Nintendo Wii video game contests.

Spirit

Connections: 9

A healthy spirit is one content with daily activities and achievable goals. Having resilience and a driving purpose in life are key to personal wellness.

The PEERS Project wrote that supportive teen networks promote making healthy choices, which results in positive consequences.

The **ACT Grant** team saw that when they used enrichment activities, participants developed sustainable life and resilience skills.

APPENDIX: Beacon Community Health Comparison Goals

1= Elkhart County (EC), 2= St. Joseph County (SJC)

Priority		Program Name	2017 Goal	IN State Department of Health Goals	Healthy People 2020 Goals
ACCESS to CARE	2	Aging In Place	GOAL 1-Increase percentage of AIP participants who have a primary care provider		Increase the proportion of persons with a usual primary care provider from 76.3% to 83.9%
	2		GOAL 2-Maintain participation rate of community members in health education services provided through AIP		Increase the proportion of persons with medical insurance from 83.2% to 100% total coverage
ACCESS to CARE	1, 2	CKF Navigator Partnership	GOAL 1-83% of uninsured applications will be coverted to insured status	Increase the percentage of health insurance coverage from 83.4% to 100% of adults 18 to 64 years' old	Increase the proportion of persons with medical insurance from 83.2% to 100% total coverage
	1, 2		GOAL 2-50% of uninsured/no PCP applications secure PCP	Expand and strengthen statewide and local grassroots network	Increase the proportion of persons with a usual primary care provider from 76.3% to 83.9%
ACCESS to CARE	2	enFocus Asthma	GOAL 1-Identify target population for pilot study		Reduce emergency department (ED) visits for asthma among children and adults aged 5 to 64 years -57.0 ED visits per 10,000 children and adults aged 5 to 64 years occurred in 2005–07 - Target 49.6 ED visits per 10,000
	2		GOAL 2-Train and certify SBFD paramedics as community paramedics		
	2		GOAL 3-Begin intervention 1/1/2017		
ACCESS to CARE	1,2	Sickle Cell	GOAL 1-Increase access for community members to sickle cell educational sessions sickle cell trait testing opportunities		(Developmental) Increase the proportion of community-based organizations (CBOs) that provide outreach and awareness campaigns for hemoglobinopathies
			GOAL 2-Plan and execute Sickle Cell Conferences in three counties - Elkhart, Allen, and Lake counties		
DIABETES	2	YMCA	GOAL 1-Help 50% of participants achieve their physical fitness goal of 150 minutes of total physical activity/per week during the program		Increase the proportion of person at risk for diabetes with prediabetes who report increasing their levels of physical activity from 44.6% to 49.1%
			GOAL 2-Help 50% of participants achieve their weight loss goal of losing 7% of their starting body weight within 12 months		Increase the proportion of persons at risk for diabetes with prediabetes who report trying to lose weight 50% to 55%
MATERNAL/ INFANT HEALTH/ PRENATAL CARE	2	BABE Store	GOAL 1-Increase redemption of BABE coupons		
MATERNAL/ INFANT HEALTH/ PRENATAL CARE	2	Child Safety	GOAL 1-Increase knowledge of proper safety techniques for taking care of infants		Reduce the rate of infant deaths (within 1 year) from 6.7 to 6 per 1,000 births
MATERNAL/ INFANT HEALTH/ PRENATAL CARE	1, 2	Elkhart Prenatal, PIHP	GOAL 1-Increase the percent of mothers who receive prenatal care in the first trimester to 70%	Reduce the infant death mortality rate from 7.1 to 6 per 1,000 live births [CHECK FACTS: is "6" supposed to be in this goal?	Reduce the infant death mortality rate from 7.1 per 1,000 live births
	1, 2	Elkhart Prenatal, PIHP	GOAL 2-Less than 8.7% of infants are born preterm (<37 weeks gestational age)	Reduce births considered premature (<37 weeks) to 9.7% or below	Reduce total preterm births from 12.7% to 11.4%

Priority		Program Name	2017 Goal	IN State Department of Health Goals	Healthy People 2020 Goals
	1, 2	Elkhart Prenatal, PIHP	GOAL 3-Decrease the percent of infants born with weight less than 2500 grams to 9%	Reduce the rate of infants born with low birth weight to 8% or less	Reduce the rate of infants born with low birth weight to 8.2% to 7.8%
	1, 2	Elkhart Prenatal, PIHP	GOAL 4-Increase percent of breastfeeding mothers at hospital discharge to 80%	Increase the proportion of women who breastfeed at discharge from 68.5% in 2008 to 81.9% by 2016. (2012: 75.6%)	Increase the proportion of infants who are breastfed from 74% to 81.9%
MATERNAL/ INFANT HEALTH/ PRENATAL CARE	1	Elkhart Prenatal	GOAL 5 ELKHART-Increase the percent of mothers who practice safe sleep at time of postpartum encounter to 80%	Reduce the rate of infant deaths from suffocation from 33.80 per 100,000 live births in 2008 to 20.43 per 100,000 live births by 2016. (2012: 13.20 per 100,000 live births)* *Although this rate is below the goal and some true decrease is occurring, the rate is likely to fluctuate due to the instability of low numbers and the vulnerability of miscoding	68.9 percent of infants were put to sleep on their backs in 2007 - Target 75.8%
	1	Elkhart Prenatal	GOAL 6 ELKHART-Increase the percent of mothers who stop smoking prior to delivery to 55%	Decrease the births (%) where mother smoked during pregnancy from 15.1% in 2014	Increase abstinence from cigarette smoking among pregnant women from 89.6% to 98.6%
MATERNAL/ INFANT HEALTH/ PRENATAL CARE	2	PIHP	GOAL 5 PIHP-More than 80% of smoking mothers have reduced or quit smoking by delivery of child	Decrease births (%) where mother smoked during pregnancy from 15.1% in 2014	Increase abstinence from cigarette smoking among pregnant women from 89.6% to 98.6%
	2	PIHP	GOAL 6 PIHP-All infants born healthy at birth to mothers in PIHP will live through their first year	Reduce the infant death mortality rate from 7.1 to 6 per 1,000 live births	Reduce the rate of infant deaths (within 1 year) from 6.7 to 6 per 1,000 births
MATERNAL/ INFANT HEALTH/ PRENATAL CARE	2	Safe Sleep	GOAL 1-Increase knowledge of safe sleep practices with infants		Reduce the rate of all infant deaths (within 1 year) from 6.7 to 6 per 1,000 births
MATERNAL/ INFANT HEALTH/ PRENATAL CARE	2	FIMR	GOAL 1-FIMR program will identify variables that decrease infant mortality, and more specifically, the racial disparity that exists in our county		0.98 infant deaths per 1,000 live births were attributed to sudden unexpected/ unexplained causes in 2007 - 0.84 infant deaths per 1,000 live births
MATERNAL/ INFANT HEALTH/ PRENATAL CARE	2	School Health & Wellness Educators	GOAL 1-Less than 30% of those completing 3 years of DTL/RTL will engage in sex		
	2		GOAL 2-90% know who to resist peer pressure for those completing 3 years of DTL/RTL		
	2		GOAL 3-85% will respect limits others set for themselves for those completing 3 years of DTL/RTL		
MENTAL HEALTH/ SUICIDE	1, 2	Mary Morris Leighton Lecture	Provide education and additional insight to community members and professionals surrounding the opioid epidemic. Goal will be refined once objectives are received from the speaker		
MENTAL HEALTH/ SUICIDE	2	ACT - CRC	GOAL 1-Build resilience in minority and disadvantaged youth ages 5-12		
	2		GOAL 2-Reduce depressive symptoms in minority and disadvantaged youth ages 5-12		
	2		GOAL 3-Decrease posttraumatic stress symptoms in minority and disadvantaged youth ages 5-12		

Priority		Program Name	2017 Goal	IN State Department of Health Goals	Healthy People 2020 Goals
MENTAL HEALTH/ SUICIDE	2	Aging In Place	GOAL 1-Engage 81% of participants in socio-emotional activities	Reduce the number of adults 18 and older without social or emotional support to below 19.1%	Reduce the proportion of adults aged 18 years and older who experience major depressive episodes (MDEs) from 6.5% to 5.8%
	2		GOAL 2-Increase socio-emotional quality of life	Reduce the number of adults 18 and older without social or emotional support to below 19.1%	Reduce the proportion of adults aged 18 years and older who experience major depressive episodes (MDEs) from 6.5% to 5.8%
MENTAL HEALTH/ SUICIDE	2	Friends of the JJC	GOAL 1-Improve JJC program participants' indicators that determine if they are showing signs of depression or anxiety	Decrease the suicide death rate from 14.4 to 10 per 100,00 in the population	Reduce the proportion of adolescents aged 12-17 who experience a major depressive episode from 8.3 to 7.5
			GOAL 2-Improve resiliency of JJC program participants		Reduce suicide attempts by adolescents from 1.9 to 1.7 per 100 population
					Reduce the suicide rate from 11..3 to 10.2 per 100,000 population
OBESITY	1	Elkhart Bariatric	GOAL 1-Weight loss and reduction in BMI by 3% every 12 weeks on program.		
OBESITY	2	Rx to Play	GOAL 1-Increase number of children who were able to reduce their BMI	Reduce a high school obese percentage from 14.7% to 10%	Reduce the proportion of children and adolescents aged 2 to 19 year who are considered obese from 16.1% to 14.5%
	2		GOAL 2-Increase number of children who met or exceeded their physical fitness ability goal	Increase opportunities for and engagement in regular physical activity.	Increase the proportion of adolescents who meet current federal physical activity from 28.7% to 31.6%
	2		GOAL 3-Increase the total number of children who are able to utilize the activities and resources provided by Prescription to Play	Increase opportunities for engagement in regular physical activity	Increase the proportion of physician office visits that include counseling or education related to physical activity from 12.2% to 15.2%
OBESITY	2	SB Leeper Park, Madison Primary Ctr	GOAL 1-Increase in number of Madison student trips taken to Leeper Park to use its resources		Increase the proportion of adolescents who meet current federal physical activity from 28.7% to 31.6%
	2		GOAL 2-Increase physical activity of school children		
OBESITY	2	Unity Gardens	GOAL 1-Increase physical activity in youth over the weeklong Unity Gardens Camp Session		
	2		GOAL 2-Increase consumption of fruits and vegetables in youth campers	Increase access to and consumption of healthy foods and beverages	Increase the contribution of total vegetables to the diets of the population aged 2 years and older from .76 to 1.16 cup equivalent per 1,000 calories
	2		GOAL 3-Increase accessibility to fresh fruits and vegetables in food desert areas of SJC		
	2		GOAL 4-Longitudinal research report of collaborative efforts between Unity and MHSB to amend food deserts in SJC		
VIOLENCE/ SAFETY/ TRAUMA	2	ACE Interface	GOAL 1-Increase community knowledge of trauma and its effects		
	2		GOAL 2-Increase trauma-informed training of professionals who work with families/youth		

Priority		Program Name	2017 Goal	IN State Department of Health Goals	Healthy People 2020 Goals
	2		GOAL 3-Increase organizational and community-wide responsiveness to trauma		
VIOLENCE/ SAFETY/ TRAUMA	2	EMDR	GOAL 1-Reduce emotional distress in clients with qualifying levels of post-trauma symptoms (PCL or DSM criteria)		
VIOLENCE/ SAFETY/ TRAUMA	2	SBGVI	GOAL 1-Decrease group member shooting incidents	Reduce the number of violent crimes to below 345 per 100,000 population	Reduce the percentage of children exposure to violence from 58.9% to 53.0%
	2		GOAL 2-Decrease the number of criminally assaulted shooting victims		
VIOLENCE/ SAFETY/ TRAUMA	2	TIS	GOAL 1-Contact 60% of victims of violence who utilize the ED		
	2		GOAL 2-Assess Adverse Childhood Experience (ACE) scores for 30% of TIS contacts		
	2		GOAL 3-Reduce recidivism of victims of violence		
	2		GOAL 4-Increase follow-up community referrals to clients		
VIOLENCE/ SAFETY/ TRAUMA	2	YWCA-Take Charge	GOAL 1-Increase knowledge, prevention, and action against all forms of teen dating violence and abuse.		
PEDIATRIC HEALTH NEEDS ASSESSMENT					
ASTHMA	2	Asthma	GOAL 1-Among school nurses, increase knowledge of appropriate response priorities for students experiencing breathing emergencies		Increase the proportion of elementary, middle, and senior high schools that have a full-time registered school nurse-to-student ratio of at least 1:750
	2		GOAL 2-Identify parents' concerns re: school preparedness for students experiencing breathing emergencies		64.8 percent of persons with current asthma received education about appropriate response to an asthma episode, including recognizing early signs and symptoms or monitoring peak flow results in 2008 (age adjusted to the year 2000 standard population) Target: 68.5 percent
	2		GOAL 3-Students with asthma will experience improved responses to breathing emergencies		
PARTNERS-Beacon Home Care, South Bend Community School Corporation					
	1, 2	Digital Learning on Asthma	GOAL 4-Increase teachers' knowledge of asthma emergency response		
PARTNERS-Beacon Home Care, South Bend Community School Corporation					
MENTAL HEALTH	1, 2	QPR Gatekeeper Suicide Prevention	GOAL 1-Increase community awareness of suicide risk factors	Decrease the suicide death rate from 14.4 to 10 per 100,00 in the population	Reduce the proportion of adolescents aged 12-17 who experience a major depressive episode from 8.3 to 7.5
	1, 2	QPR Gatekeeper Suicide Prevention	GOAL 2-Students, teachers, and health professionals will improve identification of suicide risk factors		Reduce suicide attempts by adolescents from 1.9 to 1.7 per 100 population

Priority		Program Name	2017 Goal	IN State Department of Health Goals	Healthy People 2020 Goals
	1, 2	QPR Gatekeeper Suicide Prevention	GOAL 3-Students, teachers, and health professionals will increase knowledge on how to respond effectively in a suicide ideation emergency		Reduce the suicide rate from 11..3 to 10.2 per 100,000 population
PARTNERS-Estate of Norma Frank, Beacon Health Foundation, South Bend Community School Corporation					
	1, 2	Digital Learning on Mental Health	GOAL 1-Increase knowledge of mental health conditions, self-management strategies, local treatment and referral options		
PARTNERS-Beacon Medical Group physicians and advanced practitioners					
OBESITY	2	Adapted Operation Fit Kids	GOAL 1-Increase physical activity and fitness in youth, ages 6-12	Increase opportunities for and engagement in regular physical activity	Increase the proportion of school districts that require regularly scheduled elementary school recess from 57.1 to 62.8
PARTNERS-Boys and Girls Club, Charles Black Center, Kroc Center, Martin Luther King Center					
OBESITY	2	FitNoggins	GOAL 1-Increase physical activity in youth, ages 6-12	Increase the opportunity for and engagement in regular physical activity	Increase the proportion of adolescents who meet current federal physical activity from 28.7% to 31.6%
	2	Zumbini	GOAL 1-Increase physical activity in youth, ages 1-6		
PARTNERS-HealthWorks! Kids Museum					
	2	Digital Learning on physical activity and brain health	GOAL 1-Increase knowledge of about the connection between physical activity and brain health		

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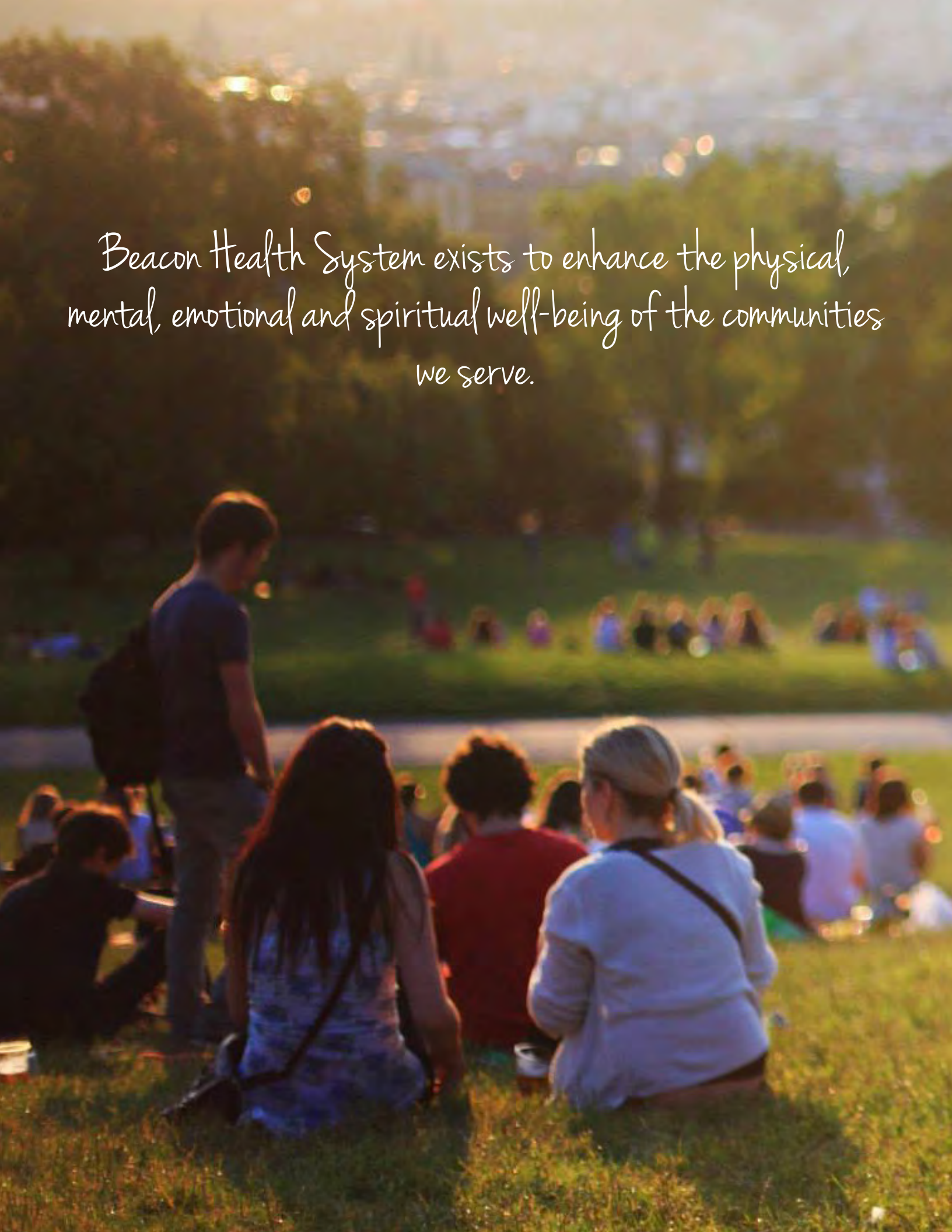
Community Partner Organizations

ACE Interface
Adressing Childhood Trauma (ACT) Grant
BABE Store
The Bariatric & Metabolic Institute of Elkhart County
Beacon Navigators
Covering Kids & Families
Dame Tu Mano
Elkhart County Health Department
enFocus
HealthWorks! Kids Museum
Leeper Park/Madison Primary Center
South Bend Group Violence Intervention
St Joseph County Health Department
Unity Gardens
WIC of St Joseph County
Michiana YMCA
YWCA North Central Indiana


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