



 **BEACON**TM
HEALTH SYSTEM

Community **BENEFIT**

2018 | REPORT

2018
**Community Benefit
Report**

Statement:

Beacon Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Beacon Health System cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Greetings,

Welcome to this 2018 Year-End Report of Beacon Health System's programming efforts in the community!

As a community not-for-profit organization, Beacon Health System takes 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. Arguably the most important part of this process is monitoring and reporting. 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

In 2018, we were very fortunate to work collaboratively with many wonderful community partners, whose programs and outcomes are featured throughout this report. Together we focused on improving the health of individuals as well as the population of our communities. We want 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. In July of 2018, a third service area was added: Marshall County through the Community Hospital of Bremen. Community Hospital of Bremen will report their 2018 outcomes in a separate report. We look forward to including their information in future reports. 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. We are also very grateful for the input of our Community Health Needs Assessment Advisory Council.

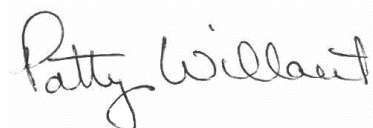
As agents of change, Beacon's Community Impact Department is asking more focused questions to pinpoint how we can effectively help our community partners and our internal programming achieve their stated goals. In 2018, we also began designing and implementing more digital learning platforms to educate a larger audience on targeted health topics.

We understand the importance of prevention, health education, community outreach, innovative partnerships, and dynamic program services in changing behaviors and achieving optimal health outcomes. However, we recognize that today's complex health issues require a multi-dimensional approach that accurately identifies areas where we are achieving positive results and encountering unanticipated challenges. To more effectively chart our progress, this year we implemented a new framework that includes four tiers of potential outcomes: awareness, knowledge, action, and impact. These elements are explained further on page 8. This framework helps us utilize data to make informed decisions and strategically address health issues.

While reading this report you will find each county's program outcomes detailed individually. Those results are also combined to depict priority and regional outcomes when possible. In this report, we compare those priority results with county, state, and federal Healthy People 2020 benchmarks to determine our alignment with those standards.

It is beneficial for us to evaluate the effectiveness of evidence-based research and practices within and across counties and different demographic groups. We also continually look for opportunities to participate in alliances and consortiums to enlarge the scope and scale of our public health interventions so they can collaboratively promote improved health impact across the cities and counties we are privileged to serve.

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content

Executive Summary



Access to Healthcare



Diabetes



Maternal/Infant Health



Mental Health



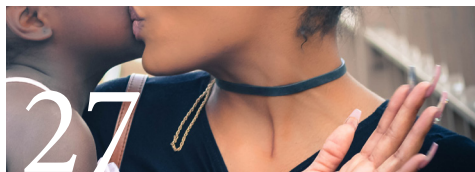
Obesity



Violence/Safety/Trauma



Pediatric Health Needs Assessment



My Brother's Keeper



EXECUTIVE SUMMARY

Communities Served

Until recently, Beacon Health System's primary service areas were Elkhart County and St Joseph County through their corresponding hospitals - Elkhart General Hospital and Memorial Hospital of South Bend. In July of 2018, a third service area was added: Marshall County through the Community Hospital of Bremen. This report includes community health needs assessment priority outcomes for Elkhart General Hospital and Memorial Hospital South Bend only. Community Hospital of Bremen will report their 2018 outcomes in a separate report. We look forward to including their information in future reports.

Elkhart County

Elkhart County, Indiana, 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. As identified through U.S. Census data, Elkhart County encompasses a mix of cultural, ethnic, and economic populations totaling 205,032 individuals. Elkhart County is considered the Recreational Vehicle (RV) Capital of the World. Today, the RV industry is a multi-billion-dollar industry. Nearly 1,000 of the RV manufacturers are located in Elkhart County. The median household income (2017) of Elkhart County residents was \$52,449. The percentage of persons living in poverty was 11%. In the city of Elkhart specifically the population estimate is 52,558 with a median household income of \$37,121, and 25% persons in poverty.

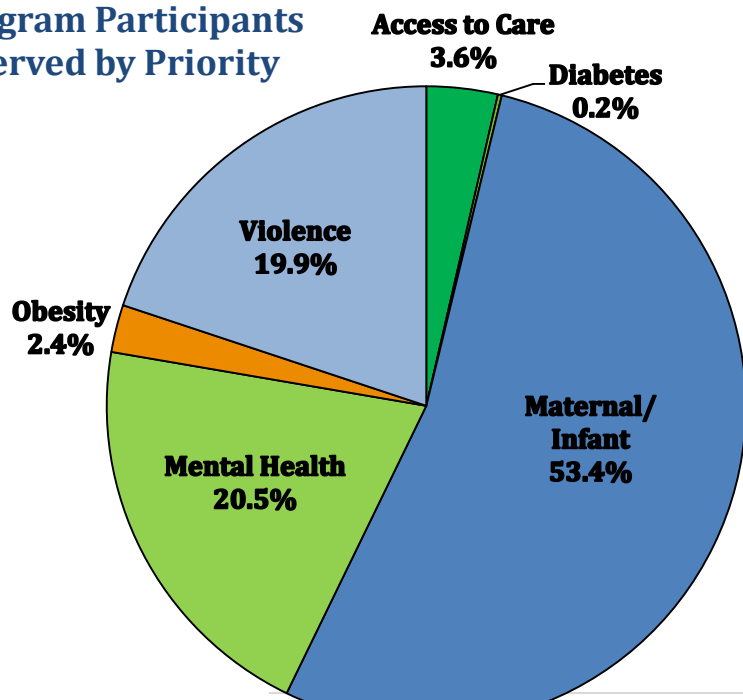
St. Joseph County

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 with a population of 270,434 according to the U.S. Census Bureau. 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. South Bend's estimated population in 2017 was 102,245. For SJC the median household income was \$48,121; persons below the poverty level accounted for 16% of the population; while the poverty rate among children under 18 was 25%. This need is even more pronounced in South Bend, the county seat where the median household income in 2017 was estimated at \$37,441 with 25% of the residents living below the poverty level.

Community Impact Framework

In 2018, Community Health programming served **36,293 participants** across both counties.

Program Participants Served by Priority



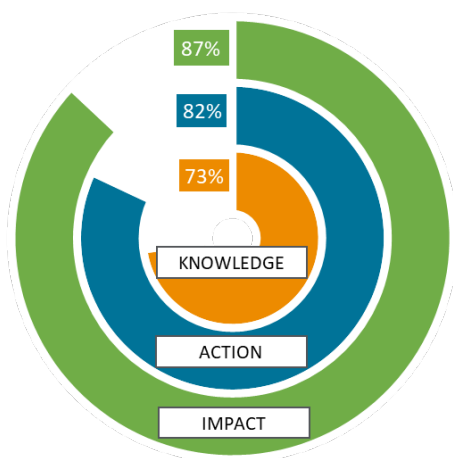
To serve residents regionally, Community Impact programming targeted multiple priorities, which emerged from the 2015 CHNA selection process described on pages 12-13. We had a total of six priorities: three regional priorities implemented in both counties:
1-Access to Healthcare/Uninsured
2-Maternal/Infant Health
3-Obesity/Overweight

There are three additional priorities in St. Joseph County:
4-Diabetes,
5-Mental Health
6-Violence/Safety/Trauma)

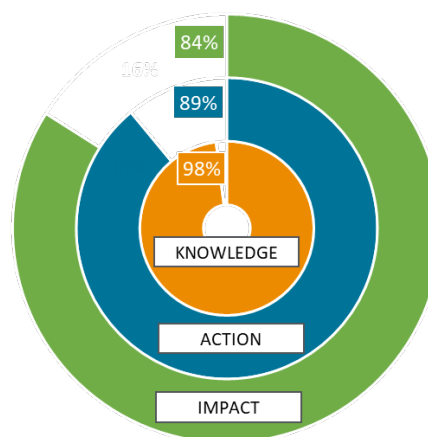
This pie chart shows the number of program participants served by each priority.

Beacon Community Impact Department Indicators

ALL PROGRAMS TOTAL
2017



ALL PROGRAMS TOTAL
2018



This diagram shows the rates of program effectiveness in each area:

Knowledge-Did programming increase participants' awareness and knowledge of the problem and solutions?

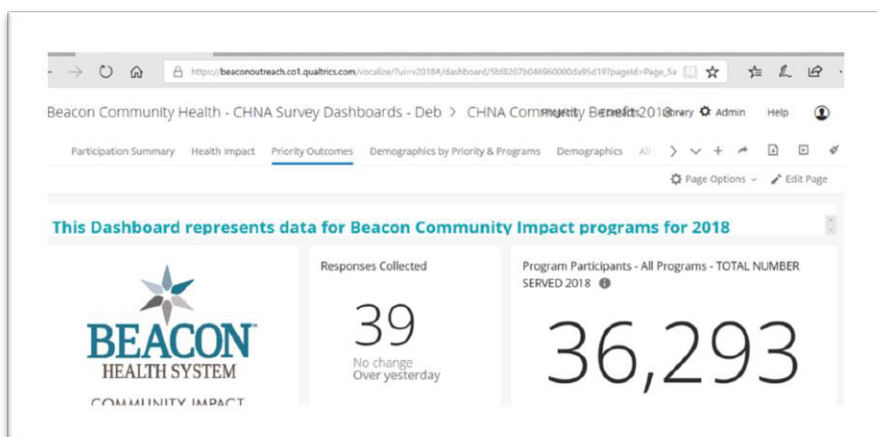
Action-Did programming enable participants to build new skills and implement what they learned?

Impact-Did programming improve health?

Beacon Health System financially supported 39 programs. Of those programs, community partners provided 12, and Beacon Community Impact staff provided 27. The following bar graph shows the breakdown of programming by county beginning in 2017.

We use three measures to assess program effectiveness: Knowledge, Action, and Impact.

Community Health Needs Assessment Dashboard



The dashboard is a comprehensive survey tool with methodologies to help take control of our impact strategy. This can be achieved by taking a longitudinal look at CHNA program data and identifying what's gone well and where there may be gaps and opportunity. Additionally, custom dashboards will display program and priority outcomes, providing a snapshot of the impact as it pertains to our 3 indicators – knowledge, action (implementation) and impact (improved health).

PRIORITY IMPACT SUMMARIES

ACCESS TO CARE

In 2018, Access to Care served a total of 1,468 participants. 58% of the health coverage applicants were enrolled in St. Joseph County, 42% in Elkhart (N=544). 16.7% of those applicants were successfully converted to insured status. Of the total participants under Access to Care, 44.8% received socio-economic supports and 55.2% received education and preventive services (screenings).

ACCESS TO HEALTHCARE/ UNINSURED	Beacon Community Impact 2017	Beacon Community Impact 2018	BCI*-SJC 2018	BCI-EC 2018	St. Joseph County	Elkhart County	State	US
	Target							
Percentage with PCP (HP2020: 83.9%)	↑ 82.1%	71.3%	75.0%	68.0%	-	-	81.7%	88.1%
Without Insurance (HP2020: 0%)	↓ 18.9%	10.6%	13.6%	9.8%	10.4%	14.7%	11.1%	9.0%
Source:					US Census Bureau	ISDH	CDC	

RED Highlight: NOT meeting State benchmark.

DIABETES

YMCA's Diabetes Prevention Program is the only program operating currently under the Diabetes Priority. Aside from preventing the onset of type 2-diabetes, the program has impacted participants from getting off some of their medications tied to high blood pressure and high cholesterol.

DIABETES	Beacon Community Impact 2017	Beacon Community Impact 2018	St. Joseph County	Elkhart County	State	US
	Target					
150 minutes Physical Activity (HP2020: 31.3%)	↑ 42.0%	30.8%	-	-	46.0%	51.6%
BMI > 30* (HP2020: 30.5%)	↓ 70.6%	71.1%	30.0%	32.8%	32.7%	39.8%
Source:			CDC	CDC	CDC	CDC

* Total Population with BMI greater than 30. Target = as low as possible.

RED Highlight: NOT meeting State benchmark.

MATERNAL/INFANT HEALTH

21,644 people served by the maternal and infant health priority program.

Of the programming provided to parents and infants:

- 70% initiated prenatal care in the 1st trimester (N=770)
- 83.7% of mothers initiated breastfeeding at discharge (N= 424)
- 93.9% practiced safe sleep (N=326)
- 8.0 % low birth weight (N= 424)
- 9.4% had premature births (N= 424)
- 5.9% of babies were in NICU (N= 424)

Other maternal characteristics that have an impact on a healthy baby are:

- 4.9% of mothers drink alcohol (N= 798) & 24 mothers quit later
- 10.6% of mother use drugs (N=817)
- 29.7% of mothers were obese (N=817)

- 75.6% had "involved father" (N= 817)
- 6.2% mothers had experienced domestic abuse, and 4% were homeless (N=817)
- 48% of mothers smoke before entering in the program, and 72.7% of mothers quit smoking during pregnancy (N=381).
- 44.5% of mothers had unplanned pregnancy (N= 668)
- 85% had ACE scores >4 (N=206)
- Of the programming offered to K-12 students:
- Both DTL/RTL and PEERS projects helped 1,345 students understand the difference between a healthy and an unhealthy relationship (Pre= 62.5% & Post = 74%).

MATERNAL/INFANT/ PRENATAL HEALTH	Target	BCI 2017	BCI 2018	BCI-SJC	BCI-EC	St. Joseph County	Elkhart County	State	US
Low Birth Weight (LBW) (HP2020: 7.8%)	↓	5.5%	8%	9.1%	7.5%	8.6%	7.4%	8.2%	8.2%
Premature Births (HP2020: 9.4%)	↓	5.2%	9.4%	15.2%	6.8%	10.7%	9.9%	10.0%	9.9%
Prenatal Care (PNC) in 1st trimester (HP2020: 77.9%)	↑	68.2%	70%	72.6%	67.5%	67.0%	62.6%	69.3%	77.1%
Breastfeeding (discharge)	↑	85.8%	83.7%	81.8%	84.6%	88.8%	89.6%	81.9%	83.1%
Quit smoking (HP2020: 98.6%)	↑	68.7%	72.7%	72.0%	74.7%	11.4%*	10.6%*	14.3%*	20.9%
Source:						ISDH	ISDH	ISDH	CDC

*Smoke during pregnancy

RED Highlight: NOT meeting State benchmark.

MENTAL HEALTH

MENTAL HEALTH/SUICIDE	Target	Beacon Community Impact 2018	Indiana State	US
Sad/hopeless almost every day for 2 weeks	↓	34.7%	29.3%	32%
Seriously considered attempting suicide	↓	15.9%	19.8%	17%
High School Students Attempted Suicide (HP2020: 1.7%)	↓	13.1%	9.9%	13.6%
Source:			ISDH	CDC

A total of 8,326 people were served by the mental health priority programs.

- 87% of the people attended awareness program related to mental health
- 13% of the people received socio-emotional support

RED Highlight: NOT meeting State benchmark.

OBESITY

Obesity Priority Programs impacted 975 youth and adults in the community. Both physical activity and changes in knowledge and consumption of healthy food increased in post-program. 83.5% of the participants have shown improvement in physical activity (this includes increase in either of the activity listed here: number of complete laps, push-up, curls-up & chair squats; regular activity in 7 days; 150 minutes of physical activity per week). In post-program following results were obtained:

- 84% (53 of 63) of children and youth improved their abilities to choose foods according to Federal Dietary Recommendations or gained knowledge
- 66% (73 of 115) of adults served by obesity priority programs ate 2 servings of fruits
- 32% (37 of 115) of adults served by obesity priority programs ate 3 servings of vegetables
- 24.8% (42 of 169) of people who reported BMI were obese
- 42.7% (117 of 274) of people were physically active for 150 minutes/week

OBESITY/ OVERWEIGHT	Target	Beacon Community Impact 2018			St. Joseph County	Elkhart County	State	US
		BCI-SJC	BCI-EC					
BMI > 30* (HP2020: 30.5%)	↓	24.8%	11.7%	39.1%	30.0%	32.8%	32.7%	39.8%
150 min. Physical Activity (HP2020: 31.3%)	↑	42.7%	25.2%	67.0%			46.0%	51.6%
Adult Fruit Intake** (HP2020: 1.16 cup; BCI: 50%)	↑	66.0%	—	66.0%			11.5%	12.2%
Adult Vegetable Intake*** (HP2020: 0.93 cup; BCI 50%)	↑	32.2%	—	32.2%			8.6%	9.3%
Source:					CDC	CDC	CDC	CDC

* Total Population with BMI greater than 30.
Target = as low as possible.

**Fruit intake is 2 servings per day
***Vegetable intake is 3 servings per day

RED Highlight: NOT meeting State benchmark.

VIOLENCE/ SAFETY/TRAUMA

Violence/Safety/Trauma Priority Programs impacted 8,058 people.

- The combined effort of DTL/RTL and PEERS influenced 4,130 students, who attended classes on the dangers and consequences of risky behaviors. Our results show that 83.5% of the total students were happy with their friendships and only 30% of the total 556 high school students who took follow-up survey were engaged in sex. These statistics indicate students are being helped to maintain happy and healthy relationships with their friends.
- 3 of the 7 violence prevention programs provide supportive social services to people.

99.3% of the total served by violence/safety/trauma priority programs received education on violence prevention and online safety.

VIOLENCE/SAFETY/TRAUMA	Target	Beacon Community Impact 2018	Indiana State	US
Were electronically bullied	↓	13.2%	15.7%	14.9%
Experienced sexual dating violence	↓	13.5%	12.6%	6.9%
Source:			YRBS 2015	YRBS 2007-2017

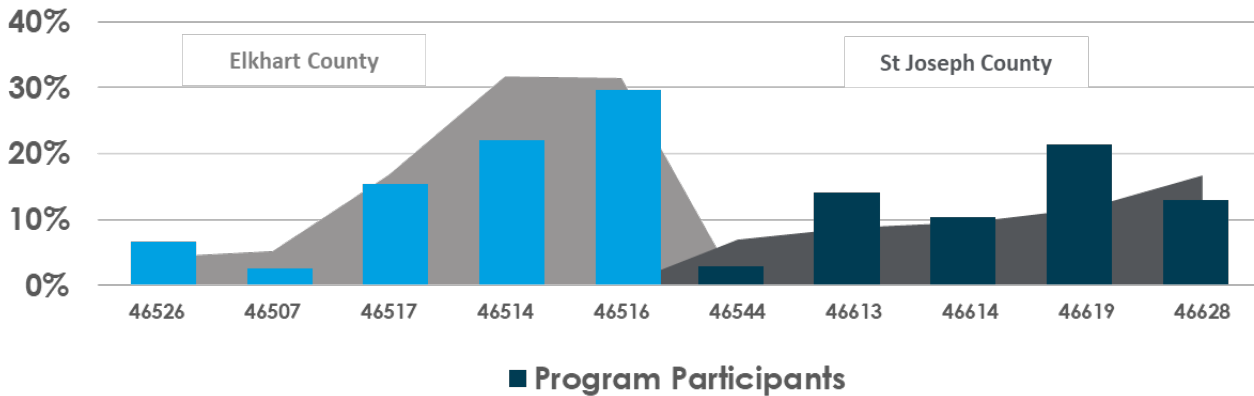
RED Highlight: NOT meeting State benchmark.

Community Benefit by the numbers

According to the U.S. Census, poverty is prevalent in the 5 zip codes noted by county in these two annual graphs. The graphs also depict where each hospital allocates bad debt and write-offs in those same zip code areas. The bad debt generated in Elkhart's top 5 zip codes totaled **\$20.2M** in 2017, which was **89%** of the total county's bad debt for that year. In 2018, the total bad debt figure of Elkhart's top 5 zip codes was **\$24.1M**, representing **86%** of the county's total bad debt figure. St. Joseph County comparable figures in 2017 were **\$13.7M** or **54%** of the bad debt for the county, and **\$15.2M** or **40%** of the county's total bad debt in 2018. This is important because Community Benefit seeks to implement health improvement programs and activities by addressing the health-related needs of the broader community as well as those who are vulnerable and at-risk.

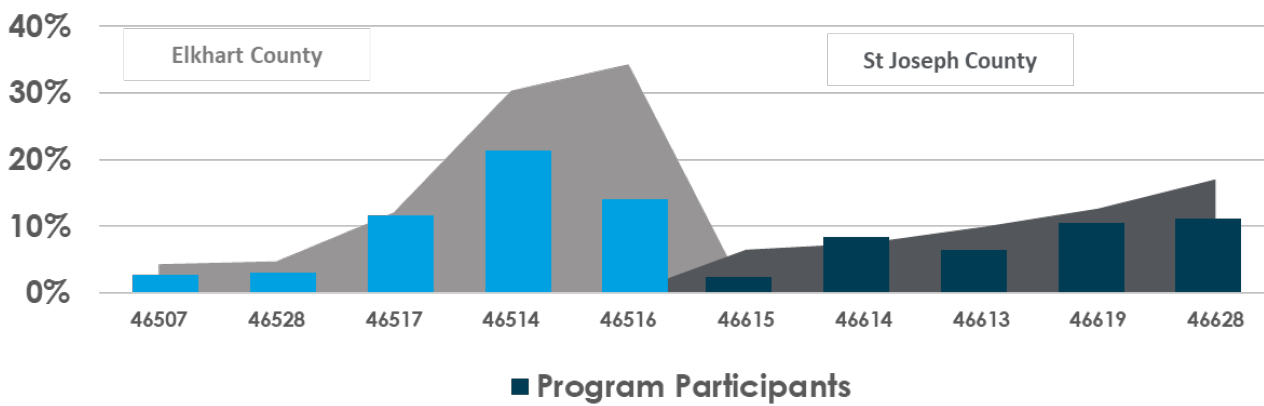
2017

Location of Services by County Bad Debt/Write-Offs



2018

Location of Services by County Bad Debt/Write-Offs



DESCRIPTION OF POPULATION SERVED

For the purpose of the Community Health Needs Assessment (CHNA), the community served is defined as those persons residing in Elkhart and St. Joseph Counties, who were program participants. Beacon Community Impact makes a special effort to focus on 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.

	Population		
	Elkhart County	St Joseph County	Indiana
Population (2017)	205,032	270,434	6,666,818
Age			
<5 years old	7.6%	6.4%	6.3%
<18 years old	27.7%	23.7%	32.6%
65+ years old	14.4%	15.4%	15.4%
Sex			
Female	50.6%	51.3%	50.7%
Male	49.4%	48.7%	49.3%
Race			
White	89.5%	80.3%	85.4%
Black	6.2%	13.6%	9.7%
American Indian	0.6%	0.5%	0.4%
Asian	1.2%	2.5%	2.4%
Pacific Islander	0.1%	0.1%	0.1%
Mixed Race	2.4%	3.0%	2.1%
Hispanic or Latino	16.0%	8.8%	7.0%
White alone	74.9%	72.7%	79.2%
Median Household Income (2016)	\$49,692	\$46,174	\$50,433
Residents in Poverty (2016)	13.2%	16.2%	14.1%
Education Level – HS or Higher (2016)	80.5%	87.7%	88.1%
Land Area in Square Miles (2010)	463.17	457.85	35,826.11

OVERVIEW OF CHNA PRIORITY PROCESS

In 2015 Beacon Health System conducted a joint Community Health Needs Assessment (CHNA) representing approximately 267,000 residents of St. Joseph County (SJC) and approximately 200,000 residents of Elkhart County, which reflect the primary market service areas for Memorial Hospital of South Bend (MHSB), and Elkhart General Hospital (EGH) respectively. In late 2014 through February 2015, dialogue on CHNA planning and coordination occurred among Beacon Health System executives and the Community Benefit staff from both hospitals. It was agreed that a third party consultant – Holleran Consulting of Lancaster, Pennsylvania – would serve as the data gathering entity for the multi-county system.

An online CHNA survey conducted through August 2015, provided insight to barriers to accessing care, the impact of social determinants of health, resource utilization and underserved populations. Community engagement and feedback are essential to the integrity and validity of the CHNA process. Therefore, input was actively solicited and secured from three sources:

- Key informants (n=104) who hold a broad knowledge of community health priorities and barriers to health in each county, including public health, and minority, cultural, and underserved populations
- Community members at large (n=1,053) representing residents from both counties
- Community Health Advisory Council representing medical and health service fields and other community leaders

Description of Input from persons who represent the broad community

The CHNA was comprised of both quantitative and qualitative research components. A brief synopsis of the research components are included below with further details provided throughout the document:

- A Statistical Secondary Data Profile depicting population and household statistics, education and economic measures, morbidity and mortality rates, incidence rates, and other health statistics for Elkhart and St. Joseph counties were compiled.
- Key Informant Interviews were conducted with 104 community leaders and partners between January and March, 2015. Key informants represented a variety of sectors, including public health and medical services, non-profit and social organizations, children and youth agencies, and the business community. Respondents were asked to provide their gender, race, and community affiliation. The key informants were primarily female (69% in Elkhart County and 82% in St. Joseph County) and White/Caucasian (82% in Elkhart County and 77% in St. Joseph County). The largest percentage of informants were affiliated with Health Care/Public Health Organizations, followed by Non-Profit/Social Services/Aging Services. The following table further depicts participants' community affiliations. "Other" affiliations included the community foundation (Elkhart County) and a firefighter (St. Joseph County).

Organizations invited to provide input from each county are listed in Appendix A, where there is additional information about the types of organizations they represented.

- An Online Community Member Survey was conducted with community residents between March and June, 2015. The survey was designed to assess their health status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. A total of 1,053 resident surveys were completed throughout the counties to promote geographical diversity among respondents. To attract responses from medically underserved, low-income, or minority populations, Community Impact staff visited low-income housing centers, day care centers, and inner-city churches with high numbers of minority attendees to distribute and collect paper copies of the survey. Gift cards to a local grocery store were provided for completion.

Prioritization and description of the significant community health needs

Based upon primary and secondary data, a Priority Setting Worksheet was created. The secondary data profile depicts population and household statistics, education, and economic measures, morbidity and mortality rates, disease incidence rates, and other health statistics. Input from each source was inserted into a separate column and assigned a unique weighted percentage based on several factors (e.g., sample size): Key Informants (20%); Community Members at Large (40%); Advisory Council (20%); Secondary Data (20%). The 19 rows in the worksheet represented each of the potential health and social issues listed in the CHNA. After tabulating the total scores for each issue (ranging from 0 -100%), the following issues emerged with a score greater than eighty percent (80%) – and were selected as 2016-2018 priorities for each county.

Elkhart General Hospital

- Access to Health Care/Uninsured
- Maternal/Infant Health/Prenatal Care
- Obesity/Overweight

Memorial Hospital South Bend

- Access to Health Care/Uninsured
- Mental Health/Suicide
- Violence/Safety/Trauma
- Diabetes
- Maternal/Infant Health/Prenatal Care
- Obesity/Overweight

Of the remaining thirteen (13) issues, 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. Therefore, Beacon Health System chose not to include them in its Implementation Strategy for the following reasons: other community health needs taking precedent, limited resources, and the need being addressed by other organizations within the community.

PROGRAM SUMMARIES BY PRIORITY

Access to Health Care and Uninsured

Access to Health Care is a regional health need across both Elkhart and St. Joseph Counties. Residents of Elkhart County are more likely to be uninsured (14.7%) when compared to St. Joseph County (10.4%), Indiana (11.1%), and the nation (9.0%).

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 indicates more than 5500 patients are uninsured, but those unsure or without a Primary Care Provider (PCP) outnumber the uninsured by almost 2:1, which hinders the completion of routine wellness visits and could lead to higher demand for ED services when ill.

Indicators

- % of individuals enrolled via Beacon and CKF Navigators
- % of patients without health insurance
- % of patients served without a Primary Care Provide

ACCESS TO CARE				
	PRIORITY TOTAL	% Total of Demographic Group	Elkhart County %	St Joseph County %
Gender				
Female	784	58.1%	36.8%	21.3%
Male	566	41.9%	30.7%	11.2%
Other	0	0.0%	0.0%	0.0%

Total Served with Data Provided	1,350	100.0%	67.6%	32.4%
% of Total Served	92.0%		62.1%	29.8%
Age Range Demographics				
<5	555	34.2%	35.9%	30.8%
6-19	259	33.2%	12.3%	0.9%
20-69	565	27.3%	19.5%	9.0%
70+	44	0.8%	0.5%	12.4%
Total Served with Data Provided	1,423	100.0%	68.2%	2.8%
% of Total Served	96.9%		66.1%	2.7%
Race & Ethnicity				
Asian	33	2.5%	1.3%	1.2%
Black	534	40.5%	27.3%	13.2%
Hispanic	302	22.9%	17.7%	5.2%
White	332	25.2%	14.3%	10.8%
Mixed Race	87	6.6%	5.9%	0.7%
Other	32	2.4%	1.7%	0.7%
Total Served with Data Provided	1,320	100.0%	68.2%	31.8%
% of Total Served	89.9%		61.3%	28.6%
TOTAL SERVED	1,468			

AGING IN PLACE

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. The Resident Life Administrator provides and / or coordinates health education and oversight, resource navigation and social activities.

Total number of participants: 113

Location: HeritagePlace at LaSalle Square (38); Monroe Circle Community Center (75)

Year-End Outcome AIP worked with nine community partners to provide activities within the Access to Care priority and an additional partner when the activities expanded to include all areas of cognitive and physical health with a total of 27 and 42 activities conducted respectively.

- 52% of all active participant engaged in health education services provided through AIP
- Out of 48 people who completed need assessment survey, 69.3% have a PCP

ASTHMA PILOT

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.

The Asthma program is a digital curriculum for elementary children created to increase students' knowledge about asthma, triggers, and best practices for those with asthma. The pilot was necessary to determine best practices for incorporating digital curricula for school-aged children and meeting health outcomes.

Total number of participants: 22 5th grade students

Location: Marshall Intermediate Center

Year-End Outcome We were not able to achieve our goal to increase student's knowledge of asthma in the post-test. Half of the students were missing post-tests, and this likely affected our results. We recommend implementing this program in another school to determine areas for improvement.

BEACON HEALTH SYSTEM NAVIGATORS

Beacon Health System Navigators provide in- reach and outreach-based, free enrollment and advocacy services for low-income and/or eligible residents through health coverage enrollment efforts. Specifically health coverage enrollment efforts for 2018 focused on connecting with past uninsured patients of Elkhart General Hospital to assess current insurance status, and to offer, schedule, and complete enrollment appointments post-discharge.

Total phone calls placed to past EGH uninsured patients: 1,624

Total texts sent to past uninsured EGH patients: 211

Total number of people assisted: 544

Location: Elkhart General Hospital (228); Memorial Hospital South Bend (316)

Year-End Outcome A total of 544 persons were converted from uninsured to insured (Elkhart = 228 & St. Joseph = 316) and 34 people converted from without a PCP to with PCP (Elkhart = 15 & St. Joseph = 19). The target population is past uninsured patients of MHSB & EGH. A total of 91 persons were successfully enrolled in Elkhart County (EGH). One of the main challenges of this program is low participation in six weeks follow up due to myriad reasons difficulty in reaching, connecting with, scheduling appointments, and patients completing appointment and any follow up requirement. At the time of follow up:

- 88.9% of the patients had insurance (N=54)
- 63% of the patients had a PCP (N= 54)

DAME TU MANO (DTM) (“GIVE ME YOUR HAND”)

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 via radio, print, and social media as well as group presentations.

Total number of participants who completed the survey: 29

Location: Elkhart County

Year-End Outcome

- 31% (9 of 29) of the participants engaged with other community partners as a result of DTM radio program.
- 41.4% (12 of 29) use the information provided by DTM radio program.
- 55.2 % said the DTM radio program was helpful.
- Many of the participants who completed the survey said the program has helped to choose and eat healthy food. An anonymous participant said “A lot, when taking the classes and putting into practice the information received, my health and the quality of life have improved a lot!!”

EGH COMMUNITY CANCER EDUCATION AND SCREENING

Identify abnormal or suspicious skin cancer screenings in 10% of the population.

Total number of community members assisted at Sunburst 2018: 82

Year-End Outcome

Of the total participants, abnormal or suspicious skin screens occurred in 18.3% of the screened population.

- 60% of the participants with abnormal or suspicious skin screenings that have a PCP and attend follow-up visits.
- At the follow-up, 90% had insurance (N=50) and 83.7% had a PCP (N=43)

NORTH CENTRAL INDIANA SICKLE CELL INITIATIVE (NCISCI)

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. NCISCI provides services to ensure individuals return for follow-up visits and refer them to appropriate psychosocial services if needed. Families and individuals referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy receive case management, counseling, awareness education, and/or free Sickle Cell trait testing in St. Joseph and Elkhart Counties and 31 surrounding counties. Sickle Cell conferences were also provided.

Total number of infants with positive sickle cell screenings: 483

Total number of conferences: 3 (Elkhart, Allen, and Lake Counties)

Total number of educational sessions: 51 (including conferences)

Location: Newborn screenings (31 Counties); Sickle cell trait screenings (St. Joe County, Fort Wayne)

Year-End Outcome

All newborns served had a primary medical provider, and had completed or were scheduled for their physicals.

- 100% of the families received regular support to use PCP for children with positive sickle cell screenings (N=483)
- 100% of infants (birth to 6 months) with positive sickle cell screenings have PCP and attend initial well-baby visits (N=483)
- 195 high school students attended education sessions on sickle cell disease and traits, and 102 students screened for sickle cell and other hemoglobinopathies.

Diabetes

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.

Results from the key informant survey show that in both Elkhart and St. Joseph counties, the fourth most pressing health concern is diabetes. 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 Impact has created these focus areas and indicators to assess progress over time.

Indicators

- % of patients with pre-diabetes
- % of pre-diabetics who completed 150 minutes of activity per week

DIABETES	
Gender	
Female	52
Male	13
Other	0
Total Served with Data Provided	65
% of Total	0.3%
Age Range Demographics	
<5	0
6-18	0
19-69	55
70+	10
Total Served with Data Provided	65
% of Total	0.2%
Race & Ethnicity	
Asian	0
Black	11
Hispanic	9
White	42
Mixed Race	0
Other	0
Total Served with Data Provided	62
% of Total	0.3%

MICHIANA YMCA

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.

Total number of program participants: 65
Total sessions: 16 weeks; 25 classes per year
Location: St. Joseph County

Year-End Outcome

- 41.5% of the total served had improved their BMI
- 30.8% of the participants completed 150 minutes of activity/week for more than nine weeks
- 2 participants had such faith in the program they attended training to become coaches.

Maternal/Infant Health & Prenatal Care

Maternal/Infant Health & Prenatal Care is a regional health need across both Elkhart and St. Joseph Counties. Multiple health measures from the 2015 CHNA support the issue of maternal/infant health/prenatal care as a community 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. The termination of the County's prenatal care coordination program magnified the urgency of prioritizing perinatal health care as an EGH health need. To face those challenges and meet this need, Community Health created this focus area and indicators to assess progress over time. 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, The Perinatal and Infant Health Project (PIHP) and Prenatal Care Coordinator provides several direct services to assist low-income, vulnerable, and at-risk women.

Indicators

- % of mothers smoking or using substances
- % of mothers' breastfeeding when leaving the hospital
- % of mothers who receive early and adequate prenatal care
- # of infants in the NICU
- % of infants born with low birth weight
- % of infants born prematurely

MATERNAL / INFANT HEALTH / PRENATAL				
	PRIORITY TOTAL	% Total Served for PRIORITY	Elkhart County %	St Joseph County %
Gender				
Female	9,502	59.9%	3.6%	56.4%
Male	6,325	39.9%	1.0%	38.9%
Other	32	0.2%	0.0%	0.2%
Total Served with Data Provided	15,859	100.0%	4.5%	95.5%
% of Total	73.3%		3.3%	70.0%
Age Range Demographics				
<5	9,942	47.7%	1.4%	46.3%
6-18	3,766	18.1%	1.6%	16.5%
20-69	7,133	34.2%	1.7%	32.5%
70+	0	0.0%	0.0%	0.0%
Total Served with Data Provided	20,841	100.0%	4.7%	95.3%
% of Total	96.3%		4.5%	91.8%
Race & Ethnicity				
Asian	139	0.9%	0.1%	0.8%
Black	4,734	29.8%	0.5%	29.3%
Hispanic	2,608	16.4%	0.9%	15.6%
White	6,757	42.6%	2.6%	40.0%
Mixed Race	1,517	9.6%	0.3%	9.2%
Other	113	0.7%	0.0%	0.7%
Total Served with Data Provided	15,868	100.0%	4.4%	95.6%
% of Total	73.3%		3.2%	70.1%
TOTAL SERVED	21,644			

BABY & ME TOBACCO FREE

Baby and Me Tobacco Free is a program aimed to reduce prenatal smoking and hence decrease low birth weight and premature deliveries. This program includes prenatal patients and postpartum patients up to 1 year. Data included is based on the cycle year 1 through quarter 3.

Total number served: 238

Total number of live births: 46

Location: St. Joseph County

Year-End Outcome

- Of the total 238 people served, 74.8% of active participants quit smoking, and 74% (168 of 227) of mothers continued to maintain smoking cessation during postpartum.
- Only 2.1% of infants had LBW; 26.1% pre-mature births; 82.6% practiced safe sleep; 80.4% breastfeed at discharge; and 84.6% initiated prenatal care in 1st trimester.

BEDS AND BRITCHES, ETC. (B.A.B.E.)

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. BABE store provides basic items for infants and children through a coupon-based program, and distributes coupons to partner vendors. Additionally, BABE

store also provides an awareness program to increase parents' knowledge on how to raise healthy preschoolers.

Total number served: 1,227

Total number of classes (sessions): 286

Location: St. Joseph County

Year-End Outcome

- 79% redemption rate of BABE coupons (a total of 81,398 coupons distributed)
- 51% of the parents attended the class on how to raise healthy preschoolers.

CHILDHOOD SAFETY

The Safety class is aimed at parents and caregivers of children ages birth to teen and provides a variety of topics to prevent accidents and injuries.

Total number served: 84

Location: St. Joseph County

Year-End Outcome

Participant knowledge on proper safety techniques for taking care of infants increased from 87% in pre-test to 99% in post-test. This program has been effective to have zero preventable injuries for the infant served through PIHP and BMTF programs.

DEDICATED ACTIVE DADS (DADs) PROGRAM

The DAD's Program is directed toward fathers or other male role models who want to be more involved with their children. The program hopes to reach fathers who may be absent or not as involved with their children, educate fathers on the importance of their presence in their children's lives, inform about child development, and provide additional parenting skills to fathers.

Total number served: 5

Location: St. Joseph County

Year-End Outcome

- 100% of the participants have an understanding of the father's importance in a child's life in post-test.
- 100% of the participants have an understanding of child development in post-test.

DRAW THE LINE RESPECT THE LINE (DTL/RTL)

The School Health and Wellness Educator Team provides education and training to at-risk intermediate and high school youth within South Bend Community School Corporation. They prepare children for a world of complex relationships, promoting healthy decision-making through sexual health curriculum. To help determine the lasting effects of the team's curricula, and also function as a measure for further outcomes of whether there are any additional areas of influence where students can be reached for intervention, a high school follow-up survey is administered to students predominantly in the 9th and 11th grades.

Total number of 6-8th grade students: 2,839

Total number of high school students: 556

Total number of sessions: 155

Total number of schools: High schools (5); Middle Schools (10)

Location: St. Joseph County, South Bend Community School Corporation

Year-End Outcome

Through the DTL/RTL program, we were able to achieve our goals in increasing student knowledge. Students with 3 years of DTL/RTL curriculum were able to increase awareness on methods of STD and pregnancy prevention, as well as set and respect limits for themselves and others as compared to 0-2 years of DTL/RTL curriculum. This reflects that high school students were able to retain knowledge taught in grade 6, 7 and 8. This may be students are already exposed to other resources which help them to understand the risks associated with sex. 77.8% said the program was helpful.

- 3 years of DTL/RTL have lower rates of engagement in sex than those with 0-2 years (0-2 years = 36%, 3 years = 30%)
- 3 years of DTL/RTL have higher levels of knowledge about STD & pregnancy prevention than those with 0-2 years. (0-2 years = 77%, 3 years = 78%)
- 3 years of DTL/RTL are more likely to respect others' limits than those with 0-2 years. (0-2 years = 86%, 3 years = 89%)
- 3 years of DTL/RTL are more likely to set and respect limits for themselves than those with 0-2 years. (0-2 years = 76%, 3 years = 78%)

LEAD SCREENINGS

Conduct lead testing on 18-month old children as well as providing lead education to households during WIC follow up visit. Also test and provide education in community partnering with Near Northwest Neighborhood Association where a history of lead problems has been documented.

Total number served: 608

Location: St. Joseph County

Year-End Outcome

Of the 608 tests performed in this time period, 583 had results within accepted range, 17 were identified as high and 8 were insufficient samples for testing. The 17 high results were all referred to the appropriate County Health Department for follow up, and all results were shared both with the patient family and primary physician (if known).

PEERS PROJECT

The PEERS Project in Elkhart County is a middle school risk avoidance curriculum that emphasizes nurturing and maintaining the emotional health of youth and increasing about the dangers and consequences of risky behaviors. This 5-sessions program utilizing the leadership of high school peer leaders 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.

Total number of 7th and 8th grade students: 735

Total number of high school mentors who provide instruction: 125

Total number of schools: High schools (3); Middle Schools (4)

Location: Elkhart County, Elkhart Community Schools, Baugo Community Schools

Year-End Outcome

Students were able to identify the difference between a healthy and an unhealthy relationship, understand the risks associated with sex and sexting, and set limits/boundaries and respect those limits. The average percentage increase in knowledge was 13.5%. 75% of the participants said that the program/presentation was helpful.

- Participants increased understanding of the risks associated with sex. (Pre-test = 55% & Post-test = 78%)
- Set limits/boundaries and respect those limits (Pre-test = 75% & Post-test = 83%)
- Identified difference between a healthy and an unhealthy relationship (Pre-test = 79% & Post-test = 90%)

PRENATAL CARE COORDINATION – HEALTHY BABIES

Healthy Babies addresses infant mortality by working with many of the most at-risk women in Elkhart County. The program provides support, resources, referrals, and appointments with OB Offices. We address psycho-social issues that are affecting the pregnant woman. Thus reducing the likelihood of a low or very low birth weight baby, reducing tobacco use, ensure prenatal visits and ensure a safe place for baby to sleep. This program uses social workers.

Total number of mothers: 394

Total babies: 292 (infant deaths = 0)

Location: Elkhart County

Year-End Outcome

Only 7.5% of infants had LBW; 6.8% pre-mature births; 98% practiced safe sleep; 84.6% breastfeed at discharge; 74.7% mothers who smoke quit smoking before delivery; and 67.5% initiated prenatal care in 1st trimester.

PRENATAL INFANT HEALTH PROGRAM

The objective of the Perinatal and Infant Health Project (PIHP) program is to assist low-income, vulnerable and at-risk women in gaining access to services during pregnancy and after delivery until the child's first birthday. This program is necessary to improve women's health and birth outcomes, which in turn influence infant mortality. By the end of year one, we expect to provide maternal and child services to 50 families with children up to six months of age. During pregnancy, PIHP social workers will provide several direct services to promote maternal physical and emotional health through an integration of home and clinic visits.

Total number of mothers: 149

Total babies: 86 (infant deaths = 0)

Location: St. Joseph County

Year-End Outcome

Only 12.8 % of infants had Low Birth Weight; 9.3% pre-mature births; 90.7% practiced safe sleep; 82.6% breastfeed at discharge; 64.4% mothers who smoke quit smoking before delivery; 54.4% initiated prenatal care in 1st trimester; and 100% of infants who continued to participate in PIHP were alive at one year.

Year-End Outcomes for both programs: A total of 543 mothers and 378 babies were served.

- Low birth weight (LBW) = 8.7% (N=378)
- Pre-term births = 7.4% (N=378)
- Prenatal visit in 1st trimester = 63.9% (N= 543)
- Mothers who practiced safe sleep = 95.7% (N=280)
- Initiated breastfeeding at discharge = 84.1% (N= 378)
- Mothers who quit smoking before delivery = 70.8% (N= 154)

SAFE SLEEP

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.

Total number served: 156

Location: St. Joseph County

Year-End Outcome

Participants gained knowledge on safe sleep practices as the knowledge rate 86% in pre-test improved to 99% in post-test.

ST. JOSEPH COUNTY HEALTH DEPARTMENT FETAL INFANT MORTALITY REVIEW (FIMR)

SJCHD FIMR program studies all cases of infant and fetal mortality in St. Joseph that occurred between 12/1/17 and 06/30/2018. The FIMR Coordinator interviewed 20 of mothers who experienced an infant loss. Based on these case studies, the team provided recommendations to the community to reduce infant deaths including "Stay Close. Sleep Apart," the need for pregnancy intention screening (One Key Question), and changes to the Medicaid system.

Total Cases Reviewed: 28 infant deaths (in 2018), 19 fetal deaths (in 2018)

In 2018 FIMR program interviewed 28 mothers who experienced an infant loss, and from 2015-Nov 2018, a total 77 cases of infant loss were reviewed. Based on these (77) case studies, the team come to the conclusion that prematurity remains the top factor contributing to infant mortality at 65% in St. Joseph County. Sudden Unexpected Infant Death is the cause in 21%, the remaining 13% of causes are other including congenital anomalies, infection.

The top factors present in infant mortality cases that have led to our focus on preconception health, social determinants of health and connection to home visiting include: Medicaid, Racial/Ethnic Minority, Unintended pregnancy, Age at first pregnancy less than 19 years old, mental illness, tobacco use and sexually transmitted infections.

Factors present in infant mortality cases.

- 79% Medicaid
- 65% Prematurity
- 57% Racial/Ethnic Minority
- 54% known to be unintended pregnancy
- 51% Age at first pregnancy, less than or equal to 19 years old (not the age of mother at loss)
- 39% Chorioamnionitis (Associated with preterm labor and preterm rupture of membranes.)
- 38% Pre-existing Mental Health Diagnosis
- 34% Tobacco Use
- 33% Sexually Transmitted Infection during pregnancy
- 30% THC Use (While a factor affecting child development, THC use has not been linked to infant death.)

With the roll out of the Stay Close. Sleep Apart initiative last August, total sleep-related deaths are at 1 for 2018 compared to 10 for 2017. The team provided recommendations to the community to reduce infant deaths including "Stay Close. Sleep apart," the need for pregnancy intention screening (One Key Question), increasing the tax on cigarettes as a study published in the journal of Pediatrics found that increasing the cigarette tax is associated with reductions in infant mortality, addressing other socio-economic policies to support families in Indiana, and changes to the Medicaid system.

WOMEN, INFANTS & CHILDREN (WIC)

WIC is a Food nutrition education, breastfeeding or referral program for women, infants, and children that aims to reduce childhood obesity and increase breastfeeding initiation rate by providing education on food & nutrition and breastfeeding. WIC also provides vouchers for specific types of food that tend to lack in the diet of low-income women and children.

Total number served: 14,712

Total number of mother served: 5,764

Number of coupons distributed: 45,631

Location: St. Joseph County

Year-End Outcome

The program was able to achieve 75% breastfeeding initiation rate, 14% obesity rate in 2-5 years, and 90% redemption of their fruit and vegetable allotment for children, breastfeeding women and postpartum women. ISDH figures show that in 2017, both Elkhart (72.8%) and SJC (71.5%) counties had more WIC/Medicaid births than the state WIC enrollment average rate of 68.5%. SJC (n=1,298) and Elkhart (n=1,149) were the 4th and 5th highest counties in the state for number of WIC births.

Mental Health/Suicide

The suicide rate per 100,000 is higher in SJC (13.4) than the nation (12.6), and Memorial's 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.

MENTAL HEALTH / SUICIDE	
Gender	
Female	2,173
Male	2,044
Other	14
Total Served with Data Provided	4,231
% of Total	16.4%
Age Range Demographics	
<5	45
6-18	2,419
19-69	662
70+	240
Total Served with Data Provided	3,366
% of Total	10.8%
Race & Ethnicity	
Asian	41
Black	866
Hispanic	473
White	1,193
Mixed Race	466
Other	94
Total Served with Data Provided	3,133
% of Total	12.7%

Indicators

- % of youth with anxiety or depression
- % of adults with anxiety or depression
- % of aging individuals who engage in socio-emotional activities
- % decrease in youth emotional reactivity scores
- % of youth with increased knowledge of assisting others with suicide ideation

AGING IN PLACE

To improve mental health in the aging population, AIP conducts socio-emotional activities on a weekly basis. The activities/events include social activities; such as bingo, holiday activities, counseling (group or private), and mental health seminars.

Total number of participants: 113

Location: Heritage Place at LaSalle Square (38); Monroe Circle Community Center (75)

Year-End Outcome

AIP worked with nine community partners to provide activities within the Access to Care priority and an additional partner when the activities expanded to include all areas of cognitive and physical health with a total of 27 and 42 activities conducted respectively.

- 75% of the active participants received socio-emotional support
- 75% of the active participants maintained or increased socio-emotional quality of life

HORIZON EDUCATION ALLIANCE

Horizon Education Alliance (HEA) is working collaboratively with school districts, social service agencies, businesses, churches and government agencies in Elkhart County to improve the health and well-being of children across the county. HEA and our partner organizations identified a commitment to helping children gain the self-regulation, social-emotional skills and executive function skills that contribute to positive physical and mental health over the long-term. This priority led to the identification of two evidence-based programs: Triple P Positive Parenting Program (Triple P) and the PAX Good Behavior Game (PAX GBG). These two interventions each meet the highest standards of effectiveness and have proven outcomes for child behavior, mental health and long-term well-being. Both programs are based on prevention science research and utilize a public health approach.

Total number of parents served: 85

Total number of students: 2,600 (approximately)

Total number of teachers trained: 38

Location: Elkhart County

Year-End Outcome:

PAX Good Behavior Game

- Implement PAX throughout 4 elementary schools
- On an average there is 49% reduction in behavioral issues across all classrooms.

Triple P Positive Parenting Program

- 85 parents received parent intervention, including 41 parents have been reached by standard intervention
- # of parents who improved awareness and use of parenting practice (in process of tracking information)

MARY MORRIS LEIGHTON LECTURE

Ben Nemtin presentation in 3 different events

Total number served: 1,036 (600 high school students, 275 leaders, & 161 community members)

Location: Riley High School, Century Center, & Lerner Theater

Year-End Outcome: The participants showed high agreement on all the statements indicating positive attitudes toward mental illness. 81.38% of them disagreed with the idea of not telling anyone about their mental illness, and 82.36% of them disagreed that they were likely to feel embarrassed about having a mental illness. 60% community members and high school students know where to go/recommend if someone else has mental health issues and 57% named the mental health resources available or trusted adults to whom they can go when they had mental health issues.

- 86.4% (70 of 81) felt the need to implement mental health awareness programs to the associates
- 38.3% (31 of 81) leaders indicated associates have a positive attitude towards mental illness.
- Of all three events 81% of the participants enjoyed the program and would recommend it to others.

RIBBON OF HOPE

Ribbon of Hope was created to provide emotional and spiritual support for patients diagnosed with cancer. The purpose of this project is to track if and how we are able to reduce the stress experience by those in our program who have been given a cancer diagnosis.

Total number of participants: 786

Location: Elkhart County

Year-End Outcome

93% of those who received emotional and spiritual support confirmed that ROH help to reduce their stress experience while facing a cancer diagnosis. Regular contact with a person, mailing encouragement notes, spending countless hours on the phone helping patients work through the day to day reality of cancer diagnosis, and praying for them has helped to reduce their stress.

STRESS HAPPENS

The program addresses what stress is, the difference between good and bad stress, the influence of stress on the lives of kids, and ways to cope. In year one, programming was primarily delivered in one class session (40-50 minutes) to an assembly of all 4th graders at each school site. Only one school visited HealthWorks! for programming.

Total number of 4th grade students: 1,039

Total number of schools: Elementary Schools (16)

Location: St. Joseph County, South Bend Community School Corporation

Year-End Outcome

90.7% of the children identified a personal stressor; 9.3% responded they were not experiencing stress. Gained some knowledge on how to handle stress, but not at the rate expected. School is the most stressful experience for students, which was true for 56% of the participants. The next highest (45%) stressor is family compared with friends (31%). For 91% of the students, stress causes tangible cognitive, physical and emotional outcomes that indicate help is needed to restore health and wellness

Obesity/Overweight

Obesity/overweight 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. Currently Elkhart General Hospital (EGH) engages in multiple efforts aimed at addressing obesity. In March 2015, Elkhart's Youth and Community Center, formerly known as the Elkhart YMCA, a magnet health and fitness facility with which EGH has historically partnered with in obesity prevention and reduction initiatives, abruptly announced its imminent closing due to lack of funding for critical infrastructure needs, and other concerns. A regional redevelopment plan unveiled in September 2015 proposed massive changes to the downtown area of Elkhart known as the Market District.

Over 17% of children in SJC are overweight and/or obese. With the correlation between numerous adverse chronic and emergent health conditions, 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. To face those challenges and meet this need, Beacon Community Health has created these focus areas and indicators to assess progress over time.

Indicators

- % of children who are obese
- % of children who increase their physical activity
- % of adults who are obese
- % of adult participants who increased their physical activity

OBESITY				
	PRIORITY TOTAL	% Total Served for PRIORITY	Elkhart County %	St Joseph County %
Gender				
Female	431	46.3%	10.1%	36.2%
Male	500	53.7%	14.6%	39.1%
Other	0	0.0%	0.0%	0.0%
Total Served with Data Provided	931	100.0%	24.7%	75.3%
% of Total	95.5%		23.6%	71.9%
Age Range Demographics				
<5	126	13.5%	0.6%	12.8%
6-19	691	74.0%	11.9%	62.1%
20-69	116	12.4%	12.4%	0.0%
70+	1	0.1%	0.1%	0.0%
Total Served with Data Provided	934	100.0%	25.1%	74.9%
% of Total	95.8%		24.0%	71.8%
Race & Ethnicity				
Asian	7	0.8%	0.2%	0.6%
Black	385	42.4%	5.0%	37.4%
Hispanic	224	24.7%	3.2%	21.5%
White	192	21.1%	10.8%	10.4%
Mixed Race	94	10.4%	3.2%	7.2%
Other	6	0.7%	0.6%	0.1%
Total Served with Data Provided	908	100.0%	22.9%	77.1%
% of Total	93.1%		21.3%	71.8%
TOTAL SERVED	975			

FIT NOGGINS

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

Total number served: 28

Location: St. Joseph County

Year-End Outcome

Almost all the kids do exercise or play sports regularly. Before the start of program, 29% of kids were physically active during the last 7 days. By the end of the program, 46% of the kids had been physically active during that same time segment. The

program has helped to increase students' knowledge of connection between physical activity and brain health. 98% of the kids responded that there is a connection between physical activity and brain health.

HEALTH ENHANCEMENT LIFESTYLE PROGRAM (HELP)

This is a six-week program to promote increased exercise and improved personal nutrition awareness in Elkhart County residents and employees through these objectives: increase physical activity level in employees by 10%; 50% of program participants will achieve 150 minutes of total physical activity/week; 50% of the program participants will eat 2 cups of fruits daily; 50% of the program participants will eat 3 cups of vegetables daily during the program.

Total number served: 115

Location: Elkhart County

Year-End Outcome

75.3% of participants found the program to be helpful in encouraging them to eat healthy food and do physical activity. The post-survey showed that there was an improvement in the participant's eating habits and physical activity.

- At the end of the program 67% of the participants were physically active 150 minutes per week
- 58% of participants increases their physical activity by 10%
- 66% ate at least 2 servings of fruits daily
- 69% ate at least 3 servings of fruits daily
- 35.9% were obese

OPERATION FIT KIDS

Operation Fit Kids encourages youth (ages 6-12) to be physically active and eat healthy in a fun and engaging way, providing healthier choices and increasing physical activity during the summer.

Total number served: 159

Total number of classes (sessions): 9

Location: St. Joseph County

Year-End Outcomes

- 25.2% (40 of the total 159) of the participants did 150 minutes of total
- 80% (127 of 159) of children and youth improved in at least 1 or more physical activity measurement which includes no. of complete laps, no. of push-up, curls- up and chair squats.
- 84% (53 of 63) of children and youth improved their abilities to choose foods according to Federal Dietary Recommendations or gained knowledge.
- 35% (22 of 63) of children and youth use safe food handling practices more often or gained knowledge.
- 76% of the participants said the program was helpful

PARK FOUNDATION/LEEPER PARK

The purpose of our Park Foundation, Madison STEAM Academy, 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.

Total number served: 673 Madison STEAM Academy students

Location: St. Joseph County

Year-end Outcome

Over 188 days 22 teachers led an average of 30 students each for trips into the healing power of nature in Leeper Park. Students ran around and used existing park equipment. The students ate at least a couple more servings of fruits and vegetables and learned about healthy alternatives to junk food. There is a concentration of minority and poverty populations who attend this school. Focusing here is a great act of inclusion and empowerment. The collaborators that have engaged have shown Madison Primary, an F School, has become Madison STEAM Academy, now a C school where teachers, students, parents and the community have embraced better outcomes for these children.

- 4,136 times youth were taken to the Leeper Park by teachers
- Over 126,000 student visits to the park in a year
- All the students (100%) increased in physical activity

Violence/Safety/Trauma

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. 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 Impact has created these focus areas and indicators to assess progress over time.

Indicators

- % of increased teen knowledge scores of dating violence and abuse
- % of supportive care interactions with victims of violence who appear at Memorial Hospital's emergency department
- % of victims of violence with repeat episodes after contact with supportive care
- # of shooting victims
- # of individuals with repeated episodes of trauma

VIOLENCE / SAFETY / TRAUMA

Gender	
Female	1,574
Male	1,303
Other	0
Total Served with Data Provided	2,877
% of Total	11.2%
Age Range Demographics	
<5	0
6-18	6,740
19-69	58
70+	2
Total Served with Data Provided	6,800
% of Total	21.8%
Race & Ethnicity	
Asian	112
Black	1,784
Hispanic	1,274
White	2,395
Mixed Race	1,308
Other	209
Total Served with Data Provided	7,082
% of Total	28.8%

ACE INTERFACE

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. Locally, ACE Interface aims to increase community knowledge of trauma and its effects, increase the number of trained professionals, engage more professionals in providing community sessions, and increase Beacon Community Impact's knowledge of ACEs. Community sessions are 2 hours; facilitator training sessions last 7 hours.

- Total community members served:** 238
- Total community members trained as facilitators:** 6 (Educators from SBCSC and La Porte County)
- Total number of classes (sessions):** 23 community sessions; 2 facilitator training sessions
- Location:** St. Joseph County, Elkhart County, La Porte County

Year-End Outcome

Attendees showed significant gains in knowledge for each of the 11 survey items (e.g., ACE's impact on brains, health, and role of resilience). Collectively, the mean of total pre-score knowledge items was M=33.70, SD=2.59, compared with a mean of total post-score of M=48.47, SD=5.73. The training will be mandatory for all department employees in 2018-19, so far 4 associates attended training.

Because of the training, participants intend to:

- Seek more info and guidance regarding trauma-informed practice (80%)
- Participate in prevention (72%) & intervention (73%) efforts
- Use the training to improve their family interactions (80%)
- 39% also listed specific behaviors or actions they intended to implement, such as educate others, develop resilience provide students with more support, emphasize positive responses

ATIP/EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

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 post-traumatic 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.

Total number served: 25
Location: St. Joseph County

Year-End Outcome

Patients have reported overall positive results with A-TIP treatment. Patients calm and are able to rest easier post treatment. Patients are also educated on methods they can use without social worker present when they begin to feel anxious and/or

distressed. 44% of the patients reported they have PCP.

DIGITAL CITIZENSHIP

The Common Sense Education's K-12 Digital Citizenship Curriculum, is designed to educate and guide students on how to harness the power of the internet and digital tools so they can become safe, responsible, and respectful digital citizens. Digital Citizenship empowers youth to think critically, behave safely, and participate responsibly in our digital world.

Total number of 5th and 6th grade students served: 1,511

Total number of classes (sessions): 77

Location: St. Joseph County, South Bend Community School Corporation

Year-End Outcome: Students were able to increase their knowledge of how to protect their own digital media, how to respond to cyberbullying, and how to engage in a safe online talk in post-test. The average increase in knowledge was 9.85%. 22.3% (332 of 1487) students were electronically bullied during the past 12 months.

- Increased knowledge on ways to protect their digital media. (Pre = 61.7% & Post= 72.3%)
- Increased knowledge on how to respond to cyberbullying. (Pre= 53.3% & Post=64%)
- Increased knowledge on how to engage in safe online talk. (Pre= 65.6% & Post= 72%)

OLIVER APARTMENTS - SUPPORTIVE SERVICES

South Bend Heritage recently developed 32 one-bedroom apartments of Permanent Supportive Housing (PSH) at the corner of Indiana and Kemble called Oliver Apartments. The apartments are reserved for homeless individuals who frequently use emergency services and are often victims of trauma. This program provides critical support services for residents at Oliver Apartments. SBH provides access to quality foods through an on-site Food Pantry and the supportive services of our Resident Life Coordinator (RLC) in the amount of 5 hours per week. Funding also supplements work being completed by Oaklawn Mental Health & Addictions Center and the Upper Room Recovery Community to include a peer support specialist/health worker/Resident Assistant for Oliver Apartments. The specialist works with residents and property management staff on de-escalation and conflict resolution tactics among other self-determination improvement activities (setting & meeting goals).

Total numbers served: 32 occupants (housed)

Location: St. Joseph County

Year-End Outcome: South Bend Heritage has successfully housed 32 individual at Oliver Apartments. At this time only one resident does not have insurance. 13 residents have some form of income. 29 of 32 residents are participating in regular Oaklawn Case Management. 29 residents are also engaging with our Certified Recovery Specialist for mental health and addictions counseling.

- 2 residents have obtained employment through Sunshine Clubhouse.
- 15+/- tenants attend the monthly Resident Council Meetings.
- Residents' engagements with Oaklawn increased (pre-housing engagements = 433 & post-housing engagement = 1100)
- ER utilization decreased from 302 visits in pre-housing to 74 visits in post-housing.
- Reduction of 70 percent of criminal proceedings. (Arrests resulting in court cases have gone from 23 instances in 2017 to 7 in 2018 for all residents currently residing at Oliver.)

YWCA TEEN DATING VIOLENCE PREVENTION

YWCA Take Charge is a primary violence prevention program for youth in schools or community organizations that focus on increasing knowledge related to components of a healthy relationship and all forms of teen dating violence/ abuse. YWCA Teen Dating Violence Prevention "Safe Dates" aims to reduce the rate of teen dating violence in our community by educating young people on the warning signs and consequences of abusive relationships. It helps schools establish preventative and supportive measures that support young people experiencing any abuse.

Total number teens served: 2,360

Total number of classes (sessions): 177

Location: Elkhart County, St. Joseph County

Year-End Outcome: Pre and post- survey were used to assess students' knowledge. Students understand the different forms of abuse. 69% of students were electronically bullied during the past 12 months.

- Increased knowledge on all forms of teen dating violence and abuse. (Pre =67.4% & Post = 71.4%)
- 78% of students recognized that emotional abuse can be just as dangerous as physical abuse.
- 76% of students recognized that both males and females are victims of dating abuse.

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: 21

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: 21

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: 12

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

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 Impact and Beacon Children's Hospital conducted a Pediatric Health Needs Assessment (PHNA) in 2016 in the following six area counties: Elkhart, Lake, LaPorte, Marshall, Porter, and St. Joseph. Initial efforts were focused in Elkhart and St. Joseph Counties, with plans to share information and build relationships with the other four counties.

Primary areas of focus taken from the PHNA and begun in 2017 were Asthma, Mental Health/Suicide, and Obesity. Work this year included gaining an understanding of initiatives and programs currently addressing these priorities, identifying gaps and opportunities, and creating and implementing strategies to improve health in these focus areas.

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 wider scale. Thanks to this initiative, Community Impact was able to reach hundreds of students with the following three suicide prevention and mental health programs.

ADOLESCENT DEPRESSION AWARENESS PROGRAMS

The Adolescent Depression Awareness Program (ADAP), created by John Hopkins Medical School, seeks to educate high school students, teachers, and parents about adolescent depression. Through education, ADAP increases awareness of depression and bipolar disorder, stressing the need for evaluation and treatment, while decreasing the stigma associated with mood disorders. The key program's message is that depression and bipolar disorder are treatable, and help is available.

Total number of students: 884 high school **Total number of classes (sessions):** 22

Location: St. Joseph County, South Bend Community School Corporation

Year-End Outcome

On the pre-test, 26.4% of the students achieved depression literacy (a score of 80% or higher), compared with 36.1% in the post-test. The number of students planning on "telling someone" went up by more than 12.3% in the post-test. Over 50% of the students would go to Parent/Guardian and 41.8% to adult for help. Students in the post test reported that Depression/treatment issues (66.8%) and "emotional/embarrassment/stigma" (52.4%) would stop them from seeking help, which was a higher rate than the pre-test. These statistics suggest the need for implementing mental health awareness programs.

GATEKEEPER SUICIDE PREVENTION (QPR)

QPR stands for Question, Persuade, and Refer; it is an evidence-based 1-2 hour training program designed to educate high school students and teachers about the warning signs of a suicide crisis and how to respond effectively in suicide ideation emergencies. The three steps include: (1) Question the individual's desire or intent regarding suicide, (2) Persuade the person to seek and accept help, and (3) Refer the person to appropriate resources.

Total number of students: 682 high school **Total number of classes (sessions):** 39

Location: St. Joseph County, South Bend Community School Corporation

Year-End Outcome: 76.8% of the students found the program/presentation helpful. The average percentage increase in

their knowledge was 12.5%. Statistics show the importance to implement this program as 15.9% of students had seriously considered suicidal attempts and 13.0 % responded they planned to attempt suicide.

- Increased knowledge on suicide risk factors (Pre = 84.2%, Post= 89.5%)
- Increased knowledge on how to respond effectively in a suicide ideation emergency (Pre= 51.1%, Post= 74.8%)

THIS IS NOT ABOUT DRUGS

This is (Not) About Drugs is 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. The lesson encourages students to make good choices and provides the student with skills to combat peer pressure, gain support, and resources for making decisions about their own body and health.

Total number of students: 597 high school **Total number of classes (sessions):** 22
Location: St. Joseph County, South Bend Community School Corporation

Year-End Outcome

The median knowledge score on misuse of opioids and risk behaviors to drug addiction was increased by 11.11% after the presentation. 73.1% of the students found the program was helpful.

- Increased knowledge on misuse of opioids. (Pre= 49%, Post= 67.2%)
- Increased knowledge on risk behaviors for drug addiction. (Pre= 57.28%, Post=79%)
- 54.4% of the students are more likely now to talk to someone if they are concerned about themselves or someone else.

Although asthma is not a focus of U-Turn, it remains an important PHNA health need. Last year, Community Impact piloted a digital curriculum designed for elementary children. Results are reported under Access to Care Priority Programs.

APPENDIX A

Key Informant Organizations invited to provide input

From Saint Joseph County

Samaritan Counseling Center; MDWise, a Medicaid Managed Care entity; Harper Cancer Research Institute University of Notre Dame; Junior League of South Bend; Bridges Out of Poverty; City of Mishawaka Fire Department; Memorial Family Residency Program; YMCA of Michiana; Hope Ministries, which serves homeless families; Goodwill Industries; Imani Unidad, a not-for-profit organization providing counseling to minorities and persons with HIV; Saint Mary's College; Bike Michiana Coalition; and Healthy Families of St. Joseph County.

From Elkhart County

Elkhart General Hospital, Child Abuse Prevention Services, Center for Healing and Hope, Elkhart County Council on Aging, Elkhart County Health Department, SPA Ministries, Beacon Medical Group, Elkhart County United Way, Emergency Physicians Inc., Elkhart County Minority Health Coalition, Association for the Disabled of Elkhart County, Elkhart Community Schools, Goshen Community Schools, Northern Indiana Hispanic Health Coalition, St. Vincent de Paul Catholic Church, Middlebury Community Schools, Baugo Community Schools, WaNee Community Schools, La Casa, Inc., Greater Elkhart Chamber of Commerce, Belmont Mennonite Church. Ribbon of Hope Ecumenical Cancer Ministry, Guidance Ministries, Heart City Health Center, YWCA of North Central Indiana, City of Goshen Planning Department, River Oaks Community Church, Fairfield Community Schools, Golden Living Center, Church Community Services, Golden Living Center, and selected health leaders representing the Amish community of Elkhart County.

Community Affiliation	Elkhart County	St. Joseph County
Health Care/Public Health Organization	33.3%	31.8%
Mental/Behavioral Health Organization	1.7%	4.5%
Non-Profit/Social Services/Aging Services	28.3%	29.5%
Faith-Based/Cultural Organization	13.3%	2.3%
Education/Youth Services	10.0%	11.4%
Government/Housing/Transportation Sector	8.3%	4.5%
Business Sector	1.7%	6.8%
Community Member	1.7%	6.8%
Other	1.7%	2.3%
Total Respondents	60	44



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. Beacon Health System is responsible for convening partners and assisting with collecting programmatic data to demonstrate outcomes for the My Brother's Keeper initiative in South Bend. We have a strong presence in the community, an established working relationship with the mayor, and a history of collaboration with local organizations. When the challenge was accepted in 2015, BCH worked closely with the MBK community partners to identify local indicators and metrics necessary for demonstrating collective impact. Our mission is to work with our partners to close opportunity gaps for boys and young men of color by spearheading the development and implementation of data-driven outcomes, ensuring efficiency and facility analysis, management, and presentation of data. Based on community feedback, the South Bend MBK initiative chose to focus on the following areas:

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

We still see a need for a more detailed systematic process of data collection, and we aim to accomplish this through aligning the data being collected by all MBK community partners. This will provide opportunities for tailored interventions specifically addressing identified needs. Alongside our community partners we continue to understand the value of prevention, 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 boys and young men of color (BYMOC) outcomes. The following Community Impact programs are part of the MBK initiative.

COMMUNITIES ADDRESSING CHILDHOOD TRAUMA (ACT) GRANT

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. This Center fulfills two primary purposes: 1) help children and families overcome high risk-behaviors associated with trauma by developing and strengthening resilience; and 2) build a trauma-informed collaborative community network that will increase trauma prevention and nurture trauma recovery.

Total number of students: 139 intervention; 71 comparison (51% BYMOC)

Total number of parents: 80 have completed their 2nd year assessments

Location: Madison STEAM Academy; Monroe Primary Center, Muessel Primary Centers in St. Joseph County, South Bend Community School Corporation

Year-End Outcome

Baseline results indicate that 81.1% of children assessed have endorsed at least one traumatic life event, 54 children in both the comparison and intervention cohorts have elevated symptoms of depression and 28 children are at risk for adaptive functioning. Data is not yet available regarding changes in outcomes between the two groups.

SOUTH BEND GROUP VIOLENCE INTERVENTION (SBGVI)

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 of 30 community leaders from law enforcement, government, education, civil service, health-care and faith-based agencies. 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. SBGVI had proactive communication with known members of violent groups to make them aware of the strategy, law enforcement consequences of their actions, and to refer them to services provided by partner organizations.

Total number served: 35 – Law Enforcement; 307 Social Services (92% BOYMC)

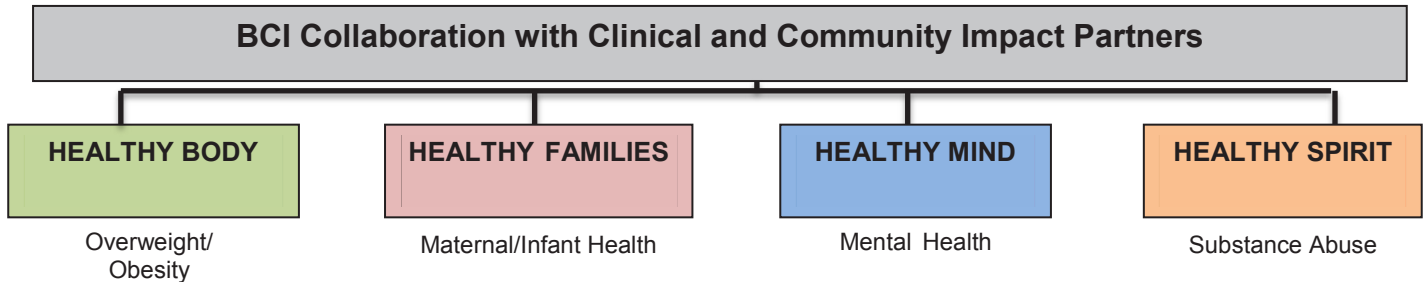
Location: St. Joseph County

Year-end Outcome

- Job Placement (2017 = 89 & 2018 = 63)
- Reduced shootings/group-involved shootings (2017 = 58 & 2018 = 48)
- Reduced criminally assaulted shootings (2017 = 102 & 2018 = 69)
- Reduced homicides shootings (2017 = 16 & 2018 = 8)
- Recidivism (2017 = 8% & 2018 = 8%)

TO THE FUTURE AND BEYOND!

In January, 2018 Beacon Health System began the CHNA process for identifying its health priorities during the next cycle of programming 2019-2021. In August we received the data from enFocus, using information from the same three sources: secondary data, key informants, and the community-at-large. They provided their final recommendations in August. Based on their report, BHS identified the following 4 priorities to address for the next three years.



Primary strategies to achieve impact in these priority areas

1-Scale Up 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.

2-Provide More Program Equity, Regional Alignment, Integration of Clinical and Community Services

More balance will be provided across the region in terms of services we offer and to whom we offer them. Community organizations and internal programs will be asked to work together to achieve cross-county partnerships, alliances, and networks that address priority areas. This collaboration will also include the inclusion and integration of clinical services to better utilize internal resources across counties. We will seek grant opportunities for regional programming to build further program equity and alignment. Our data and reporting process will continue to be improved and streamlined to support the capacity building of regional collaborations with outstandingly relevant local data.

3-Ensure Strengthening of Programs

Beacon Community Impact now has Priority Project Specialists (PPS), who support program providers with mentoring and technical assistance to achieve increased coordination of service efforts within priority areas. PPS communicate regularly with our internal program leads and our priority partners to strengthen programs, build network connections and achieve maximum impact as well as regional alignment for regional scaling of outcomes. Our partners welcome this additional help to meet our community's needs and improve wellness.

4-Continue Making Progress toward Achieving Collective Impact

Early in the year we will establish firm goals for meeting regional health needs and create metrics necessary to effectively document outcomes in June and December. We will also provide training to help partners and providers begin assessing Therapeutic Dose, which estimates the effect of a project on the average residents' behavior by calculating the product of reach and strength. Priority indicators will be adjusted to better demonstrate the regional effect of programming in our communities. By integrating clinical and community program data, we will be able to statistically identify problem areas and construct targeted interventions to improve population health.

Acknowledgements

This report and all of our work in the community would not be possible without the support and effort of our community partners. We truly value the opportunity to continue to build relationships with them, and would like to thank them for all that they do - for the community, and for their collaborative experience.

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Community Partner Organizations

ACE Interface
Addressing Childhood Trauma (ACT) Grant
BABE Store
Center for Healing and Hope
Elkhart County Health Department
enFocus
Horizon Education Alliance
Leeper Park/Madison Primary Center
Ribbon of Hope, Inc.
South Bend Group Violence Initiative
South Bend Heritage Foundation
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.

