



Community Hospital of Bremen| Elkhart General Hospital| Memorial Hospital South Bend
Beacon Community Impact
Community Health Needs Assessment
Implementation Plan
2018-2021

Executive Summary

From January to September 2018, Beacon Health System (BHS) contracted enFocus, a nonprofit based in the South Bend – Elkhart region, to conduct a comprehensive Community Health Needs Assessment (CHNA). The CHNA goal was to provide Beacon Health system with a clear picture of current priority health needs in Elkhart, Marshall, and St. Joseph County communities where BHS operates non-profit hospitals. The results will direct BHS’ efforts to address these identified needs from January 2019 through December 2021.

To identify the collective top health needs of this three-county region, the CHNA gathered data from several sources identified below. This information focused on a variety of topics related to health indicators and social determinants of health.

- Key informants (n=120 community leaders) who represented a broad knowledge of interests, including public health, and minority, cultural, and underserved populations.
- Community members at large (n=1,496); *Please Note:* In order to achieve a 99% confidence level with a 5% margin of error the goal was to obtain at least 670 survey responses from the three-county area.
- Secondary data (n=4,300 data points) representing information related to the current state of our community’s economic, social, and health status published by established, reputable sources that included federal and state levels of government, academia and well-known national research centers.

This report includes three sections:

1. A brief description of the St. Joseph County (SJC), Elkhart County (EC), and Marshall County (MC) communities served by the 2018 Community Health Needs Assessment (CHNA).
2. An overview of the 2018 CHNA process and prioritization methods utilized by Beacon Health System in Saint Joseph County.
3. Beacon Health System’s Implementation Strategies for the three hospitals for sustaining and developing the appropriate community benefit programs to address each of the four prioritized needs in EC, SJC, and MC counties.

The assessment process identified four health priorities that can be streamlined into the essential components of Beacon Health System’s mission. The *Healthy Mind, Healthy Body, Healthy Spirit and Healthy Families* pillars provide a framework for the alignment of intervention strategies with BHS mission and values that aim for 1) providing information and enhance skills to patients/practitioners/community; 2) improving equitable access to health and wellness; 3) leveraging

incentives for long-term behavioral change; and 4) improving and strengthening the social and healthcare systems in the three-county area.

1-Description of the Communities Served

Population and Age

Indicator	Unit	Elkhart	Marshall	St. Joseph
Total Population	#	203,781	46,556	269,141
Under 18 years of age	%	27.9	25.1	23.9
65 years of age and older	%	14.0	16.9	15.0

Source: US Census Bureau. Estimates 2016.

Race/Ethnicity composition

Indicator	Unit	Elkhart	Marshall	St. Joseph
African American	%	5.8	0.6	12.9
American Indian/Alaskan Native	%	0.6	0.4	0.5
Asian	%	1.2	0.7	2.4
Native Hawaiian	%	0.1	0.1	0.1
Hispanic	%	15.5	9.7	8.6
Non-Hispanic White	%	75.5	87.8	73.3

Source: US Census Bureau. Estimates 2016.

Female participation as percentage of the total county population

Indicator	Unit	Elkhart	Marshall	St. Joseph
Female	%	50.5	50.2	51.4

Source: US Census Bureau. Estimates 2016.

Unemployment

Indicator	Unit	Elkhart	Marshall	St. Joseph
Unemployment	%	3.5	3.8	4.5

Source: US Census Bureau. Estimates 2016.

Health and Access to Healthcare

Indicator	Unit	Elkhart	Marshall	St. Joseph
Population without health insurance (2015)	%	15.0	15.1	8.6
Uninsured adults (2015)	%	18.14	15.34	13.78
Uninsured children (2015)	%	12.18	9.66	5.88
Primary Health Physician Density (2015)	#	1,850	2,130	1,045
Mental Health Provider Density (2016)	#	896	1,171	506
Dentist Density (2016)	#	2,885	2,617	1,772
Poor or Fair Health (Self-reported, 2016)	%	16.3	17.5	16.9

Source: University of Wisconsin Population Health Institute (2018). County Health Rankings Key Findings.

2-Overview of CHNA Priority Process

Beacon Community Impact (BCI) and enFocus came together to plan the deployment of a data-driven, evidence-based assessment of the community health needs of the communities served by Beacon Health System in St. Joseph (SJC), Elkhart (EC) and Marshall (MC) Counties. This process also included an assessment of pediatric needs (Pediatric Health Needs Assessment, PHNA), as maternal and child healthcare are keys to ensure quality of life, promote healthy habits and prevent future medical conditions that could afflict residents of all three counties. Both the CHNA and PHNA processes gathered data from three sources: surveys of the general public, key informant interviews and a comprehensive review of secondary data. These data sources were chosen to comply with the requirements contained in the Patient Protection and Affordable Care Act, and the Internal Revenue Service (IRS) Instructions to Not-for-profit hospitals in the country that govern the CHNA process to be done every three years. In addition to meeting U.S. legal requirements, BHS has designed the CHNA to serve two fundamental purposes:

1. Identify community health needs
2. Prioritize needs and determine the strategic objectives for BCI programming.

Since community engagement and feedback are essential to the integrity and validity of the CHNA process, input was actively solicited and secured from three sources (elaborated below) to understand community health needs. To ensure a representative sample of the community completed the community survey, a special effort was made to get feedback from hard to reach and minority populations. In addition to the survey being pushed out through digital platforms and listservs in both English and Spanish, the BCI/enFocus team partnered with 35 different organizations to collect feedback and attended 8 community events (listed below) to directly target individuals who typically do not complete community surveys. BCI’s partner organizations provided recommendations and restrictions for creating a variety of strategies to engage these harder-to reach samples within the tri-county population.

Data Collection - The data collection and analysis process started on February and concluded on September 2018. The key findings were consolidated in two reports: the first provided a snapshot of the three-county overall health status, and the second focused on the health needs of children in Elkhart, St. Joseph and Marshall counties. The Key Informant Survey collected information from March 28th to August 20th, 2018. The Community Survey was launched on May 7th and was closed on August 20th, 2018. The methodology followed for the needs assessment was based on three steps: 1) Identify needs; 2) Analyze the links between the needs and the information required to make decisions; 3) Make recommendations that guide decision-making.

The data collection process comprised three data streams that were analyzed, in aggregate, to inform the identification of priority areas:

- Secondary Data Research –an analysis of information related to the current state of our community’s economic, social, and health status published by established sources. Available info was collected and compared across three-year time periods to establish trends. Over 4,300 data points were collected and analyzed.
- Key Informant Interviews - a survey of community leaders to understand what they view as the top health issues. The list of key informants was identified and initially contacted by BCI staff. A total of 120 completed responses were collected and analyzed by enFocus.
- Community Survey - a survey of the general public to understand what they view as the most relevant health issues. A significant focus was put on achieving a representative sample and reaching traditionally vulnerable and hard to reach populations while achieving a statically significant sample size. In order to achieve a 99% confidence level with a 5% margin of error, the goal was to obtain at least 670 survey responses for the three-county area. Beacon and enFocus partnered with over 35 organizations and held seven events to collect over 1,400 responses with a 77% completion rate.

Priority Analysis and Ranking Process – Once the data was analyzed, five top needs emerged in each county:

- Overweight/Obesity
- Substance and Alcohol abuse
- Mental Health/Suicide
- Healthcare Coverage/Insurance
- Diabetes

The following table reveals each county’s unique rank order of the identified needs:

Elkhart County	Marshall County	St. Joseph County
1. Healthcare Coverage/Insurance	1. Overweight/Obesity	1. Overweight/Obesity
2. Overweight/Obesity	2. Substance and Alcohol Abuse	2. Healthcare Coverage/Insurance
3. Substance and Alcohol Abuse	3. Diabetes	3. Substance and Alcohol Abuse
4. Mental Health/Suicide	4. Healthcare Coverage/Insurance	4. Mental Health/Suicide
5. Diabetes	5. Mental Health/Suicide	5. Diabetes

Data used to assign ranking was taken from answers to three questions: “*What are the top 3 health issues you see in your community?*” (Community Survey); “*What are the top 5 health issues you see in your community?*” and “*Of those health issues mentioned, which ONE is the most significant?*” (Key Informant Survey).

These questions were selected because they best represent the importance of each problem to community members, the opportunity to intervene at the prevention level on each health issue identified and help determine whether the issue is a root cause of other health problems. These questions also allowed for comparisons with relevant secondary data and indicators that represent the magnitude and severity of each selected health concern, as well as trend analyses of each issue in a minimum 3-year context.

This cumulative process revealed three priorities with the same highest score ranking of 2.00: Overweight and Obesity, Mental Health and Suicide Prevention, and Substance and Alcohol Abuse. According to the data collected, addressing these priorities might impact positively the health outcomes that BHS’ has stated as its missional pillars: Healthy Body, Healthy Mind, and Healthy Spirit.

	Community Survey		Key Informant Survey		Secondary Data Trend			
	Score	33%	Score	33%	Score	33%	TOTAL SCORE	Ranking
Overweight/Obesity	2.00	0.67	2.00	0.67	2.00	0.67	2.00	1
Mental health/Suicide	2.00	0.67	2.00	0.67	2.00	0.67	2.00	2
Substance and Alcohol abuse (including opioids)	2.00	0.67	2.00	0.67	2.00	0.67	2.00	3
Healthcare Coverage/Insurance	2.00	0.67	2.00	0.67	-	-	1.33	4
Diabetes	2.00	0.67	-	-	2.00	0.67	1.33	5
Violence/Safety/Trauma	1.00	0.33	1.00	0.33	2.00	0.67	1.33	6

Evidence also suggests that the social, economic, environmental and family conditions in which infants and children develop and grow converge as indicators for current and future health disparities, providing, at the same time, opportunities to push forward on health equity and improved health outcomes in the long run. Family living conditions (social, economic, environmental) play a critical role in the protection and development of children. Therefore, a comprehensive approach to family needs and health status is adopted, addressing needs among pregnant mothers, infants and children to ensure that members of the community have long, healthy and fulfilling lives since the moment they are born.

Community Health Needs Not Being Directly Addressed and Rationale – BHS is focusing on the most pressing community health needs identified in the CHNA Report. In order to avoid overlapping with other organizations and use the limited resources available strategically, it is worth acknowledging that gaps in community health are not isolated, and that oftentimes they reinforce each other, or coexist in the form of comorbidities, as medical research evidence suggest:

- There are proven correlations between diabetes and obesity.
- Diabetic patients are more likely to suffer depression and anxiety, and more likely to be smokers and drinkers.
- Predictive risk factors of violence and trauma are often associated to behavioral issues, physical and emotional abuse, and substance abuse.
- Other drivers of violence and trauma are associated to lack of stress management and skills, conflict management skills, and supportive family/social relationships.

Community capacity-building and sustained behavioral change are expected to be the building blocks to improve community health outcomes, by creating transferable skills and healthy behaviors, effecting community-wide positive change. By doing this, BHS will continue to support efforts to address other community needs that emerged from key community leaders and stakeholders, community members at large, and prevalent health indicators.

Coverage and Access to Insurance as a Cross-cutting Issue - Access to Healthcare is considered transversal to the four issues identified above as priorities – Healthy Body (Overweight/Obesity), Healthy Mind (Mental Health), Healthy Spirit (Substance Abuse), and Healthy Families (Maternal, Infant and Child Health).

Increasing healthcare access, quality and equity implies addressing all major social, economic, environmental and behavioral factors that prevent individuals and communities to make healthy choices and enjoy a long, healthy life. BHS will leverage its Community Benefit programs to close health gaps, through increased awareness, knowledge and referral of under-served/underinsured residents to insurance providers.

This is an important outcome for the health system: the burden of disease is often shared by patients, families, communities and health services. Health Insurance not only reduces costs across the system, it also enables patients to receive timely, life-saving treatment and assistance. As a result, financial resources and social networks benefit from improved management practices that reduce the risk of disease, while increasing capacities at individual, family, community and organizational levels.

3-2018 CHNA Implementation Strategies for Priority Needs

Theory of Change – Based on BHS’ mission of enhancing the physical, mental, emotional and spiritual well-being of the communities we serve, the following conditions must be met, in order to achieve more equitable health outcomes:

1. The existence of a knowledge gap among individuals living in the service area of BHS is acknowledged as a factor preventing them from having a long, healthy life;
2. Knowledge resources are embraced and used by individuals to self-reflect on their attitudes, behaviors and habits towards improving their own health status;
3. Individual decision-making processes are updated by residents of the three-county area, who then incorporate newly acquired knowledge to make intentional adjustments to their behavior;
4. Individuals update their practices to make them consistent with the knowledge acquired, in accordance to their new personal/social attitudes towards improving their own health status;
5. The aggregated improvement on the health status of community members results in improved health outcomes for the residents of BHS service area.

To achieve improved community health outcomes, community members should adopt healthy behavioral practices, rooted on positive attitudes towards such practices and improved knowledge on prioritized health issues. That in turn would be the result of self-reflection and an increased awareness on each individuals’ health status. Awareness and Knowledge would allow individuals to make better informed decisions about their health habits, such as:

- Increasing the amount of physical activity performed and the quality of their nutrition;

- Keeping healthy and strong interpersonal relationships and fostering a sense of belonging to the community; and
- Being able to set goals, find their own sense of purpose and become more resilient.

This Theory of Change explains the overall logic of intervention. Three levels or “tiers” of intervention have been identified as part of an organic whole that should enable smooth transitions from one tier to the next, in a cumulative process of learning and practicing:

Tier 1. Awareness:

- Seeks to increase recognition of prioritized health issues among residents of BHS service area.
- Aims to spark resident’s curiosity about their own health status, and available options (services, practices) that could help them improve it.

Tier 2. Knowledge:

- Seeks to deepen people’s understanding on their health status, as well as the socioeconomic drivers that affect it.
- Aims to change attitudes towards healthy practices by introducing new, healthier ones into people’s lives.

Tier 3. Behavioral Change:

- Seeks to capitalize on the Awareness/Knowledge gains made by members of the community.
- Aims to build capacity and networks that reinforce positive health practices and makes them time-sustained changes in people’s behavior.

Implementation strategies are aligned with BHS mission and values aiming for 1) providing information to and enhance skills of patients, practitioners and the community; 2) improving equitable access to health and wellness; 3) leveraging incentives for long-term behavioral change; and 4) improving and strengthening the social and healthcare systems in the three-county area.

Implementation Strategies - As a general rule, the implementation of any of the four strategies will take into consideration the following approaches: 1) the program should address discrete factors, such as knowledge, beliefs and skills, at individual and family levels; and 2) the program should address context factors such as social support, available resources and services, and access barriers to financial/physical/information resources, at family and community levels.

By addressing risk and protective factors in a comprehensive way, BHS acknowledges the fact that comorbidities are very likely to happen to chronic disease patients, because different health issues or disorders share the same risk factors, so the interventions addressing such factors are reasonably expected to reduce the prevalence of these multiple conditions.

Healthy Body

Current Gap:

- Obesity rates in 2017 for EC (14.5%), MC (15.2%) and SJC (14.3%) are higher than IN.
- 1 in 3 children ages 10-17 are overweight or obese (33.9%),
- According to WIC, by 2017, 13.5% of children between 2-5 years of age who were part of the program were obese.

Intended Health Outcome:

- By the end of the program cycle, obesity and overweight rates are reduced through the adoption of individual habits of healthier nutrition and increased physical activity.

Behavioral Objective:

- By the end of the program cycle, participants are consuming enough healthier food to cover their caloric needs and are engaged in regular physical activity, in accordance to attitudes and practices promoted by BHS.

Rationale:

- Obesity results from a combination of causes and contributing factors, including individual factors such as behavior and genetics. Behaviors can include dietary patterns, physical activity, inactivity, medication use, and other exposures.
- Obesity is often associated with poorer mental health outcomes, reduced quality of life, and the leading causes of death in the U.S. and worldwide, including diabetes, heart disease, stroke, and some types of cancer.

Healthy Mind

Current Gap:

- The prevalence estimates for the IN North Central Region show that 4.7% of resident adults have suffered from a serious mental illness (diagnoses resulting in serious functional impairment).
- EC and SJC averaged 4.2 days of poor mental in the past 30 days before being surveyed.

Intended Health Outcome:

- By the end of the program cycle, participants are better able to cope with mental and emotional distress through enhanced community capacities (ability to provide mental health services).

Behavioral Objective:

- By the end of the program cycle, participants' socioemotional competences to reduce mental and emotional distress are strengthened.

Rationale:

- Conditions like depression, anxiety, bipolar disorder, or schizophrenia, among many others, may occur occasionally or over a long period, affecting people's ability to have a normal social life and be functional on a daily basis.
- Mental illness, especially depression, increases the risk for many types of physical health problems, particularly long-lasting conditions like stroke, type 2 diabetes, and heart disease. Similarly, the presence of chronic conditions can increase the risk for mental illness.
- Several factors can contribute to risk for mental illness, such as Adverse Child Experiences

(ACEs), experiencing other chronic medical conditions (such as cancer or diabetes), biological factors, use of alcohol or drugs, and being/feeling lonely or isolated.

Healthy Spirit

Current Gap:

- Drug overdose mortality rates have increased from 2014 to 2016 in all three counties (SJC, from 13.5% to 22.3%; EC, from 11.9% to 12.3%; and MC, from 7.8% to 9.3%).
- Excessive Drinking rates have increased from 2014 to 2016 in all three counties (SJC, from 15.6% to 19.5%; EC, from 15.5% to 15.7%; and MC, from 16.2% to 17.2%).

Intended Health Outcome:

- By the end of the program cycle, participants are better able to cope with substance use disorder (SUD) by strengthening their socioemotional competencies.

Behavioral Objective:

- By the end of the program cycle, participants' socioemotional competences to reduce exposure to SUDs are strengthened.

Rationale:

- Excessive drinking is a risk factor for a number of adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.
- Drug use is also a risk factor for respiratory conditions and cancer.
- Substance use disorders can be fatal to the user or others, by causing drunk driving fatalities and drug overdoses.
- Mental illnesses and substance use disorders often occur together (sometimes as a contributing factor to the other, or by making it worse).

Healthy Families

Current Gap:

- The infant mortality rate for the Northern IN region (EC, MC, SJC) is 7.7 compared to 7.1 for the state.
- African-American infants in IN have a higher mortality rate overall (14.4%), and for the Northern IN region is higher than the state rate (17.4%).
- The teenage birth rate is higher in EC (41%) than in MC (28%), SJC (29%), or the state (30%).

Intended Health Outcome:

- By the end of the program cycle, participant mothers and children have improved access to prenatal care and child development programs.

Behavioral Objective:

- By the end of the program cycle, participant families are able to sustain habits that promote healthy child development (e.g. prenatal care, safe sleep, smoking prevention during pregnancy, teen pregnancy prevention).

Rationale:

- Malnutrition, smoking and alcohol/substance use in pregnant women increase the risk of children having cardiovascular disease, respiratory conditions and cognitive problems (like palsy, and sensory impairments) later in life.
- Child Brain Development depends on many factors, like good nutrition starting in pregnancy, exposure to toxins or infections, and Adverse Child Experiences (ACEs). Exposure to stress and trauma can have long-term negative consequences for children.

Measuring Performance - In order to guide program partners through the formulation of initiatives aligned with BHS mission and objectives, and to ensure all stakeholders know this Implementation Plan is going in the right direction, a set of Key Performance Indicators (KPIs) has been set for each of the four strategies, outlined above.

These KPIs aim to measure the level of achievement of the operational and strategic goals contained in this document. These indicators will allow program partners, BHS, community members and other stakeholders to compare data on actual vs. planned performance. These indicators will measure changes in health status, behaviors and patient/customer satisfaction with services provided by the programs part of this plan.

The charts below present KPIs for each strategy at different levels or tiers of implementation. The measures selected are considered the ones that best represent objectively verifiable indicators that, if achieved, will produce the positive health outcomes stated for each level of the strategy



Community Health Needs Assessment (CHNA) Implementation Plans St. Joseph, Elkhart and Marshall Counties 2019-2021



