

Lakeland Health

# IMPLEMENTATION STRATEGY

for the Community Health Needs Assessment  
2016 - 2019



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## Acronyms

AAA . . . . .	Area Agency on Aging
ADHD. . . . .	Attention Deficit Hyperactivity Disorder
ALGEE. . . . .	Assess. Listen. Give. Encourage (professional help). Encourage (self-help).
AMHFA . . . . .	Adult Mental Health First Aid
BHAS . . . . .	Benton Harbor Area Schools
BHFM . . . . .	Benton Harbor Farmers' Market
BCHD . . . . .	Berrien County Health Department
CARES. . . . .	Community AIDS Resource and Education Services
CFN . . . . .	Community Food Network
CHNA . . . . .	2016-2019 Community Health Needs Assessment
CHW. . . . .	Department of Community Health and Wellness
CPR . . . . .	Cardiopulmonary Resuscitation
CPR-AED . . . . .	Cardiopulmonary Resuscitation-Automated External Defibrillator
CSHP . . . . .	Coordinated School Health Program
CSH Team . . . . .	Coordinated School Health Team
EMMI . . . . .	Expectation Management and Medical Information
HIPAA . . . . .	Health Insurance Portability and Accountability Act
HIV/AIDS . . . . .	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IS. . . . .	2017-2019 Implementation Strategy
KABs. . . . .	Knowledge, Attitudes and Behaviors
Lakeland . . . . .	Lakeland Health
LEAN . . . . .	Linking Education Activity and Nutrition
MHFA . . . . .	Mental Health First Aid
NAMI . . . . .	National Alliance on Mental Illness
NCS . . . . .	Niles Community Schools
ODD. . . . .	Oppositional Defiant Disorder
PFH . . . . .	Prescription for Health
PHN . . . . .	Priority Health Needs
RN-BSN . . . . .	Registered Nurse-Bachelor of Science in Nursing
RVSD . . . . .	River Valley School District
SNAP . . . . .	Supplemental Nutrition Assistance Program
ToC . . . . .	Theory of Change
Van Buren ISD. . . . .	Van Buren Intermediate School District
WIC . . . . .	Women, Infants and Children
WPS . . . . .	Watervliet Public Schools
YMHFA . . . . .	Youth Mental Health First Aid

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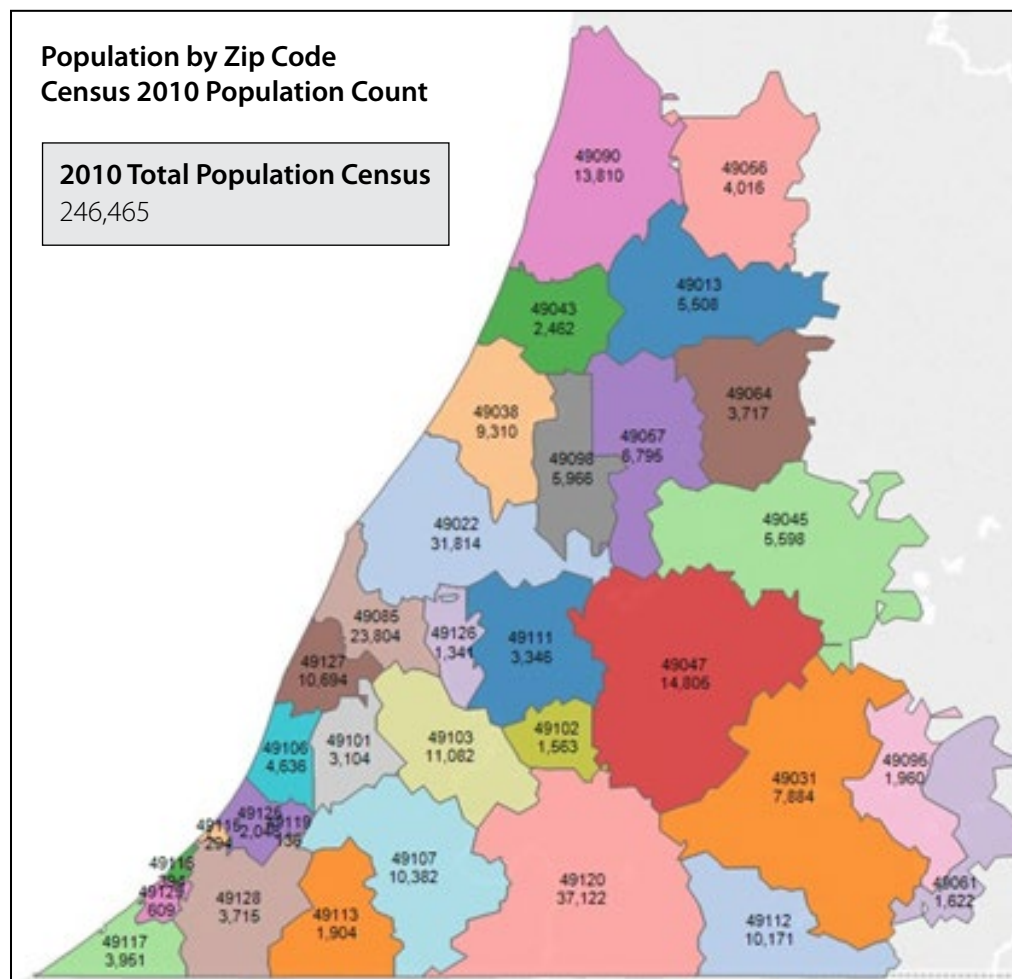
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## About Lakeland Health and Community Health and Wellness

### About Lakeland Health

Lakeland is a not-for-profit, community-owned health system that serves all of Berrien County and parts of Cass and Van Buren counties in the southwest corner of Michigan. The Lakeland service area includes the following zip codes:

**Berrien County** – 49022, 49023, 49038, 49039, 49084, 49085, 49098, 49101, 49102, 49103, 49104, 49106, 49107, 49111, 49113, 49115, 49116, 49117, 49119, 49120, 49125, 49126, 49127, 49128, 49129; **Cass County** – 49031, 49047, 49061, 49095, 49112; and **Van Buren County** – 49013, 49043, 49045, 49056, 49057, 49064, 49090.



**Map 1: Lakeland Service Area**

Note. U.S. Census Bureau (2011a).



Lakeland includes three hospitals, an outpatient surgery center, a regional cancer center, rehabilitation centers, two long-term care residences, home care and hospice services, and 34 affiliate-physician practice locations. With more than 3,800 professionals, including 500+ primary, specialty and other licensed providers, Lakeland serves all of southwest Michigan and is Berrien County's largest employer. For more information, visit [www.lakelandhealth.org](http://www.lakelandhealth.org).

Lakeland's mission is "To enhance health and serve our community." Its vision is "To positively transform healthcare and the health choices of those we serve and employ." To achieve this mission and vision, Lakeland set forth four 2014-2020 Strategic Goals, which are briefly summarized below.

- Goal 1: Achieve Exemplary Teams. The inherent complexity of the healthcare delivery system requires a team-based approach to providing safe, high-quality, patient-centered and compassionate care.
- Goal 2: Achieve Exemplary Service. Every patient expects to be treated with skill, respect and compassion.
- Goal 3: Achieve Exemplary Outcomes. Every patient expects personalized, safe and evidence-based care.
- Goal 4: Achieve Exemplary Stewardship. As a not-for-profit, community-owned organization, Lakeland must be a good steward of resources.

### **About the Department of Community Health and Wellness**

Lakeland is committed to reaching beyond our healthcare facilities to meet the health and wellness needs of our community. It does this through the Department of Community Health and Wellness which serves people of all ages through a wide array of health and wellness education and community benefit programs. These programs are designed to help enhance the quality of life for the residents of southwest Michigan.

## **Executive Summary**

In 2016, Lakeland Health, in collaboration with the Berrien County Health Department, conducted a Community Health Needs Assessment. More than 1,300 people across Lakeland's service area participated in surveys, interviews, focus groups and a Photovoice project to determine the region's Priority Health Needs. Those Priority Health Needs fall into three broad categories: (1) needs that are related to specific health conditions; they include mental health, obesity, diabetes and cardiovascular conditions; (2) needs that are a function of the ways in which the health system operates; they include provider availability, cost of care, and health education and information; (3) needs that are social determinants of good health; they include health behaviors and the food environment. This document includes the 2017-2019 Implementation Strategy designed to address these needs.

The Implementation Strategy adheres to four strategic principles: (1) health equity – the strategy seeks to address health disparities in Lakeland's service area; (2) health-in-all policies – its implementation relies heavily on collaborative partnerships among diverse stakeholder groups; (3) evidence-based – the strategy is based on the best evidence of what works to improve health; and (4) strategic use of resources – the strategy is based on thoughtful acquisition and utilization of key resources.

The overall goal of the Implementation Strategy is to improve population health by addressing the Priority Health Needs that emerged out of the Community Health Needs Assessment. The strategy is based on a Theory of Change in which four categories of activities, Mental Wellbeing, Nutrition Education and Access, K-12 Health Education and Community Health Education, are used to change key environmental conditions that impact health. Those conditions include trust, capacity, and knowledge, attitudes and behaviors, and they comprise the objectives of the strategy. A fifth category – Organizational Infrastructure – includes activities designed to help ensure the efficacy and sustainability of the overall strategy. Throughout the implementation of the strategy, independent evaluators will conduct a process and outcome evaluation to assess the fidelity by which the activities are implemented and their effectiveness in making the environmental changes required to optimize health.

## Program Contacts

The Department of Community Health and Wellness at Lakeland Health is open to anyone interested in supporting the Implementation Strategy efforts to improve population health in the Lakeland service area. To get involved, please contact the appropriate person below.

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## Introduction

In September 2016, the Board of Directors of Lakeland Hospitals in Niles and St. Joseph, and the Board of Directors of the Lakeland Regional Health System - Watervliet approved the health system's 2016-2019 Community Health Needs Assessment (CHNA).

The community served by this CHNA includes the entire population residing within the Lakeland service area. This includes all residents of Berrien County, the five western-most zip codes in Cass County, and the eight southern-most zip codes in Van Buren County (see Map 1 on Page 5). Table 1 below, provides basic demographic information about the Lakeland service area.

Location	Michigan	Berrien	Cass	Van Buren
Population	9,889,024	155,992	52,001	75,569
Education (High School Graduate & Beyond); 25 Years & Older	89.3%	88.3%	87.9%	86.5%
Poverty	16.9%	16.6%	14.3%	19.2%
Unemployment	11.4%	10.6%	10.5%	9.5%
Median Age	39.3 years	39.6 years	43.7 years	40.9 years
Median Income	\$49,087	\$44,701	\$45,166	\$46,536
Caucasian	79.2%	78.1%	88.9%	88.1%
African American	14.0	15.0%	5.0%	3.8%
Asian	2.6	1.8%	0.9%	0.06%
American Indian	0.6	0.4%	0.8%	0.7%
Hispanic	4.6%	4.9%	3.2%	10.7%
Uninsured	10.9%	12.1%	13.2%	13.7%
<b>Overall Health Ranking</b>	-	<b>66/83 (4th or worst performing quartile)</b>	<b>36/83 (2nd quartile)</b>	<b>60/83 (3rd quartile)</b>

**Table 1.** Service Area Demographics

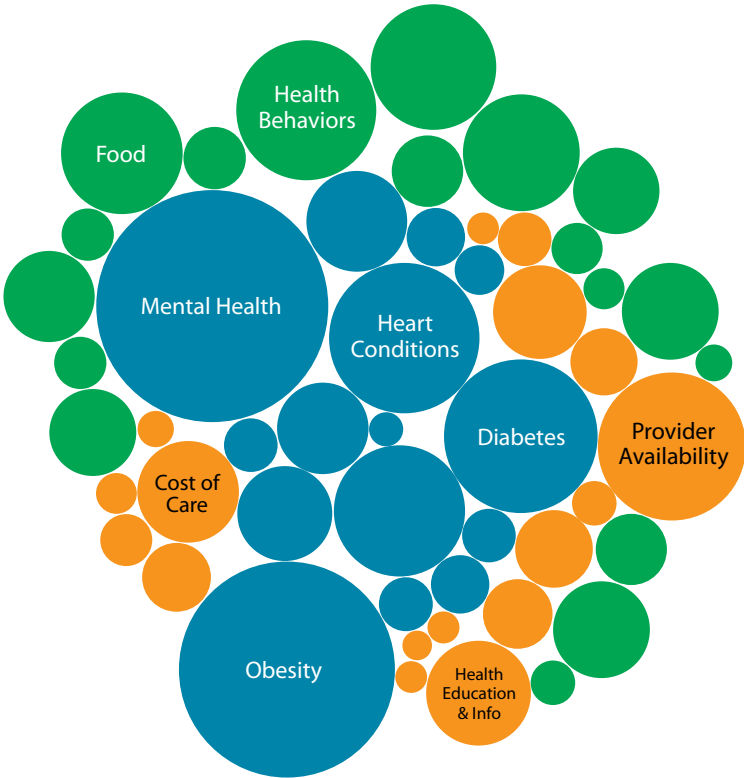
This document contains the 2017-2019 Implementation Strategy (IS) developed to address the Priority Health Needs (PHN) identified in the CHNA. The IS includes the following.

- I. An overview of the PHN identified in the CHNA
- II. A description of the Theory of Change (ToC) underlying the IS
- III. Key operating principles that underlie the IS
- IV. Key elements of the IS, including *actions* that will be taken to address the PHN; anticipated impacts of the actions; *programs and resources* that Lakeland plans to commit to the addressing the PHN; *planned collaborations* between Lakeland and other facilities or organizations in addressing the PHN; and the *evaluation* plan.

# The Context: 2016-2019 Community Health Needs Assessment

From December 2015 through March 2016, more than 1,300 residents of Berrien, Van Buren and Cass Counties provided input into the CHNA. Their input helped to identify the PHN of the community served by Lakeland Health (Lakeland). Based on focus groups, interviews, surveys and a Photovoice project, residents identified a wide range of health needs that fell into three broad categories: (i) needs related to specific health conditions including, Mental Health, Obesity, Diabetes and Cardiovascular Conditions; (ii) needs that are a function of the ways in which the health system operates including, Provider Availability, Cost of Care and Health Education and Information; and (iii) needs that are social requisites for good health including, Health Behaviors and the Food Environment. Image 1 provides a visual depiction of the PHN. Details on these and other health needs identified in the CHNA can be found on the website of Lakeland Health: [www.lakelandhealth.org/chna](http://www.lakelandhealth.org/chna).

As part of the CHNA, input was also generated on characteristics of the community that help residents be healthy, what a healthy community would look and feel like, and ideas about how to improve community health. The responses to these questions also informed this Implementation Strategy. Responses to these questions provided information on community assets, including organizations, programs and other resources, which can be leveraged to help address the PHN identified. The responses also provided insights into what community residents think would help make their community a healthier place to live.



**Image 1.** *Priority Health Needs*

Health Conditions	Health System	Social Determinants
1. Mental Health	1. Health Education and Information	1. Recreational Opportunities 2. Food Environment 3. Community Resources Availability

**Table 2.** *What are some good things in your community that help you be healthy?*

Table 2 provides a summary of the top responses to the question “What are some good things in your community that help you be healthy?”

Health Conditions

*Mental Health.* Many residents described ways in which their community helps them to optimize their mental health, such as peer support and being surrounded by positive people.

Health System

*Health Education and Information.* Community members identified several sources of Health Education and Information that helped them to be healthy, including a wide range of programs, seminars and classes offered by Lakeland, Berrien County Health Department, Michigan State University Extension and other local organizations.

Social Determinants of Health

*Recreational Opportunities.* Residents stated that outdoor recreational opportunities, especially in the summer, like biking and walking in parks and along beaches and lakes, make it easy to be healthy in our community. Opportunities available for indoor exercise were also mentioned, particularly in regards to free or low cost facilities, such as senior centers and schools. Residents also indicated that commercial recreational facilities helped them be healthy, but many recognized that cost is a barrier to their usage. Group activities, such as walking and running groups, exercise groups and clubs, Zumba classes, school and community-based sports programs and 5Ks, were also mentioned as valued recreational opportunities.

*Food Environment.* Many residents emphasized the benefits of having seasonal access to fresh fruits and vegetables from farmers, farmers’ markets and stands and community gardens. Community members also identified nutrition assistance programs such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Supplemental Nutrition Assistance Program (SNAP) and “Meals on Wheels.” They also mentioned other free or low cost meals and foods provided by the Salvation Army, church groups, Senior Centers, the Area Agency on Aging (AAA), food pantries and banks and soup kitchens.

*Community Resources Availability.* Senior Centers, the Salvation Army, the AAA, the YMCA, community gardens, resource centers, the Boys and Girls Club and local churches were all identified as resources that help the community be healthy. These resources were recognized as gathering places where community members can access free or low cost food, or exercise or socialize with peers.

Health Conditions	Health System	Social Determinants
1. Better Health 2. Mental Health 3. Obesity	1. Health Education and Information 2. Access to Care <ul style="list-style-type: none"><li>• Cost of Care</li><li>• Provider Availability</li><li>• Preventive Care</li></ul>	1. Social Cohesion 2. Physical Environment 3. Food Environment 4. Recreational Opportunities 5. Health Behavior 6. Education

**Table 3.** *In an ideal world, what would a healthy community look like? What would it have? How would it feel? What are your ideas on how to improve health in your community?*

Table 3 provides a summary of the top responses to the questions “In an ideal world, what would a healthy community look like? What would it have? How would it feel?” and “What are your ideas on how to improve health in your community?”

## Health Conditions

*Better Health.* Community members indicated that, ideally, everyone in the community would have better overall health.

*Mental Health.* Community members also indicated that, in a healthy community, everyone would have good mental health, and no one would be depressed, excessively stressed, anxious, drink too much or abuse drugs and other substances. They indicated that there would be enough resources to meet mental health challenges. They also suggested that addressing social and cultural factors by, for instance, eliminating stigma and increasing opportunities for social engagement, would be useful ways to improve mental health in the community.

*Obesity.* Residents also frequently responded that in a healthy community, fewer people would be obese. It was suggested that an approach to dealing with the obesity problem would be to reduce associated risk factors (e.g., unhealthy diet and physical inactivity).

## Health System

*Health Education and Information.* Residents' ideas for improving community health included increased availability of health education and information, specifically more nutrition education, such as cooking classes and classes on healthy eating and healthy food options. They also suggested that there should be more classes on healthy lifestyles, such as guidance on exercise and physical activity, education for youth on healthy eating, physical activity and substance abuse.

Respondents also suggested that health education occur in more diverse locations, such as in rural settings, in community centers and churches, in public housing and libraries, mobile home parks and in small business settings (e.g., barbershops, grocery stores or laundromats). This suggestion sheds light on a quandary that presented itself in the CHNA. When asked, "What makes it hard to be healthy in your community?" many residents noted a lack of health education and information. This was perplexing given the plethora of community health education programming offered by a wide range of entities throughout the region. By suggesting diverse, non-clinical, locations for the delivery of health education, residents are indicating that health education is currently being conducted in locations that are inaccessible to many community members.

*Access.* Community members identified access (to care) as something that, ideally, would exist in a healthy community. Regarding how to improve access to care, they shared many ideas related to reducing the cost of care, increasing provider availability and offering preventive care. With respect to the cost of care, they spoke about the need for more affordable and free healthcare, including mental healthcare and medication, and more affordable hospital stays, emergency department visits and walk-in clinics. With respect to provider availability, respondents offered ideas to increase the number and accessibility of physicians. They suggested that ideally, there would be more physicians, including primary care providers and specialists, and that more of them would accept Medicaid, Medicare and a wider range of private insurances. Comments focused on delivering healthcare services in more rural and underserved locations, such as Benton Harbor, by having more visiting doctors and mobile care units. Residents also suggested that more preventive care programs should be located in the community, as opposed to clinical settings.

## **Social Determinants**

*Social Cohesion.* Residents felt that in a healthy community, there would be feelings of togetherness and inclusiveness. Individuals would have encouragement from family, friends and support groups to help them reach their health goals, and there would be more opportunities for social interaction at community events and activities.

*Food Environment.* Discussion about the food environment focused on opportunities to procure healthy food close to where people live, increase the availability of affordable healthy foods, and decrease the availability and accessibility of unhealthy foods. Community members suggested that increasing opportunities to access healthier food could be accomplished through the establishment of more farmers' markets, community gardens and grocery stores within walking distance; an increase in neighborhood and corner stores offering fruits and vegetables; healthy food options at local restaurants; and year-round availability of fresh fruits and vegetables. It was also suggested that fresh fruits and vegetables be more affordable, especially in urban areas, with suggestions that prices at farmers' markets and stands be lower. Decreasing access to unhealthy foods included calls for fewer fast food restaurants in the area, and a reduction in the availability of high sugar, high calorie foods and beverages.

*Physical Environment.* Residents also suggested that, in an ideal world, a healthy community would be one without pollution, specifically street litter, but also dirty air and water. They also identified natural elements that a healthy community would have, such as lots of trees, flowers, and open and green spaces. They indicated one way to create a healthy community would be to improve neighborhood aesthetics by, for instance, removing houses and other structures that are in disrepair and unsafe.

*Built Environment.* Residents suggested that a healthy community would be safe, well lit, and connected with walking and bicycling trails and lanes throughout Berrien County. It would also have community playgrounds and recreation centers for indoor winter activity.

*Recreational Opportunities.* Residents spoke of affordable access to equipment and opportunities for physical activity (both indoor, outdoor and at work) in community settings and at community events as valuable to community health.

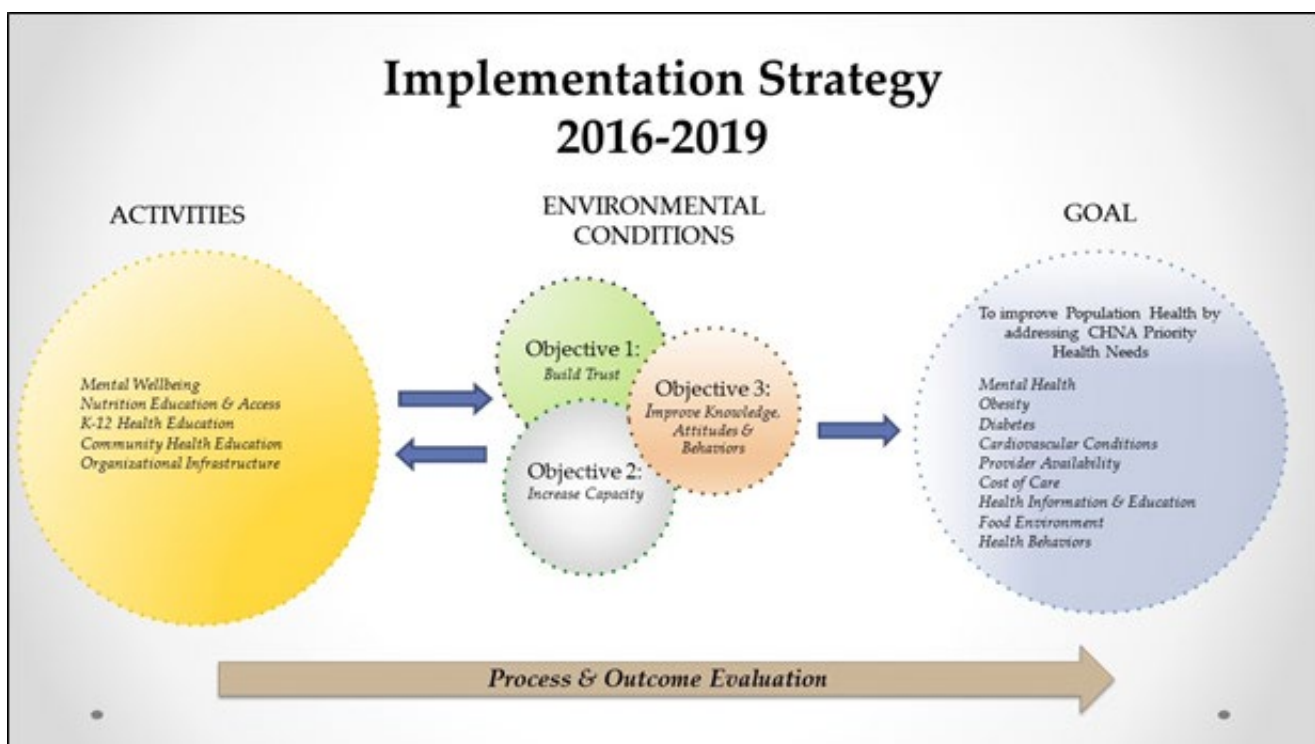
*Health Behaviors.* Improved eating habits, increased physical activity and decreased substance abuse were identified as aspects of a healthy community. As previously discussed, there were many ideas on how to improve the food environment and recreational opportunities, but few examples were given on how to address substance abuse. Increased substance abuse education in school systems was one strategy that was mentioned. Also mentioned was more education on healthy eating and physical activity.

*Education.* As a strategy to improve community health, residents suggested more classes on healthy eating, physical activity and substance abuse in the K-12 education system.

## Moving Forward: The 2017-2019 Implementation Strategy

The overarching goal of the IS is to improve population health by addressing the PHN that emerged from the CHNA. With the PHN in mind, guidance from community partners and reference to the evidence base of what works to promote health, five categories of IS activities are planned. They are (1) Mental Wellbeing, (2) Nutrition Education and Access, (3) K-12 Health Education and (4) Community Health Education. A fifth category – Organizational Infrastructure – includes activities designed to help ensure the efficacy and sustainability of the overall strategy.

Over the course of conducting the CHNA, it became clear that several environmental factors must be addressed to maximize the efficacy and sustainability of the IS. These factors inform a set of objectives that must be met in order to achieve the overarching goal of improving population health. Objective 1 is to increase the mutual trust between Lakeland Health and the community it serves. Objective 2 is to increase the capacity of Lakeland Health and the community it serves to implement the actions required to implement this strategy and improve population health. Objective 3 is to cultivate the Knowledge, Attitudes and Behaviors (KABs) necessary to achieve good population health.



**Image 2.** *Theory of Change*

Image 2 provides a visual depiction of the Theory of Change (ToC) underlying the IS. It highlights the relationships between the five IS activities, the three IS objectives, and the overall goal of the IS. The activities (on the far left hand side of the diagram) were developed based on the PHN (which are listed on the far right and include mental health, obesity, cardiovascular conditions, cost of care, provider availability, health education and information, food environment and health behaviors), community voice, and empirical evidence regarding what works. The activities are intended to achieve the objectives (i.e., the environmental conditions of trust, capacity and KABs), which are essential for achieving the goal to improve population health. The activities and objectives are bi-directionally related: activities help to build trust, increase capacity, enhance knowledge, shift attitudes and change behaviors; and, achieving the objectives will increase the efficacy of the activities. Together they create a solid foundation for the work required to make and sustain improvements in population health.



Throughout the course of the IS, process and outcome evaluations will be conducted to help ensure fidelity to the strategy, and that any variation from the strategy is informed, thoughtful and purposeful; and to assess the intermediate and final outcomes of the strategy.

Each activity that comprises the IS adheres to a set of basic principles.

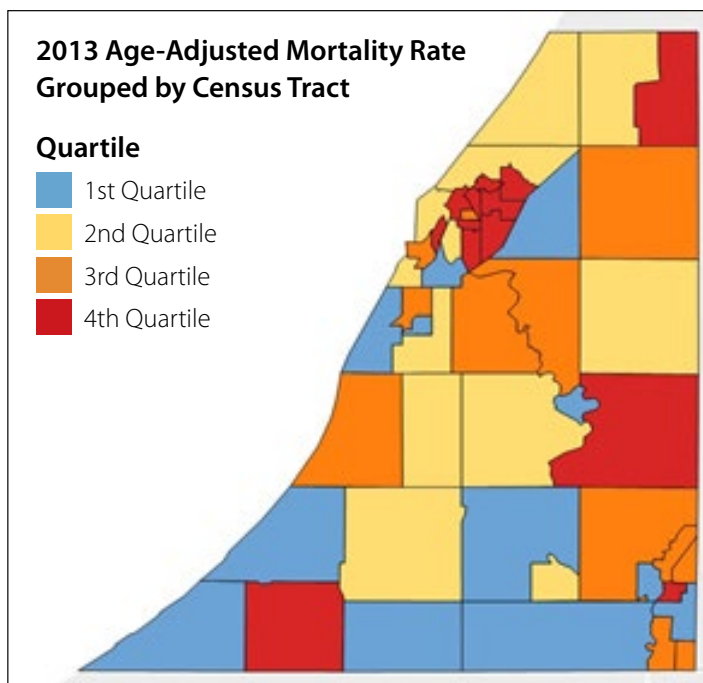
**Principle 1: Health Equity** – Overall improvements in population health require that activities target sub-populations of the community that have the worst health outcomes. Age-adjusted mortality rates for 2013, estimated at the census tract level, were used to identify those sub-populations. The IS will seek to target those census tracts in which the age-adjusted mortality rates are the highest – those in the 3rd and 4th quartiles (see Map 1 on Page 5) – which include, Benton Charter Township, Three Oaks Charter Township, Berrien Township, Niles City and Watervliet Township.

In addition to activities being “place-based” in geographies of greatest health need, achieving health equity requires that the activities are implemented and evaluated in a way that embodies community perspective and voice (i.e., they must be community-informed); reflect an appreciation of the salience and impact of psychological trauma on community health (i.e., they must be trauma-informed); address social factors (i.e., social determinants) that impact health; and augment community capacity to make and sustain improvements in its health status.

**Principle 2: Health-in-all policies** – No single industrial or economic sector, organization or profession has the breadth of knowledge, skills and tools needed to manage the many variables that determine the health of a population. Improvements in population health require multi-dimensional, multi-sectoral, multi-organizational, and multi-professional interventions capable of managing the complex and myriad factors that impact health. Thus, shared ownership with “non-traditional” partners that operate outside clinical settings is essential in population health improvement efforts, especially given the now widely-acknowledged fact that health is largely determined by social factors, not medical or clinical factors. Such partners may include, housing, transportation, workforce development and planning authorities; educational bodies, including both K-12 and higher education; law enforcement and the court system; local small businesses, large corporations and community non-profits; and many other entities whose decisions and actions have profound effects on population health and are essential for the co-learning and co-creation of innovative approaches to improving population health.

**Principle 3: Evidence-Based** – To optimize its effectiveness, the IS is based on the best available evidence on what can positively impact the PHN. That evidence may be the evaluation findings of an established program, theoretical or early empirical findings of a promising practice or the process evaluation of this IS. Whatever the source of evidence, to optimize its potential efficacy, the IS must be metrics and outcomes-driven.

**Principle 4: Strategic Use of Resources** – Improvements in population health require substantial investments of many types of resources. This IS includes efforts to mine and strategically mobilize key technical, human and financial resources.



**Map 2.** 2013 Age-Adjusted Mortality Rates (per 100,000)

## The 2017 - 2019 Implementation Strategy and Activities

### Activity Category 1: Mental Wellbeing

#### Activity 1: Mental Health First Aid

**Priority Health Needs Addressed:** Mental Health, Health Behaviors, and Health Education and Information.

Mental Health First Aid (MHFA) is an evidence-based program designed to teach people with no clinical training or experience how to identify, understand and respond to signs of mental illnesses and substance abuse disorders. The MHFA program builds mental health literacy among participants and increases their ability to support individuals undergoing a mental health crisis until appropriate professional help is available.

There are two types of MHFA courses — Youth Mental Health First Aid (YMHFA) and Adult Mental Health First Aid (AMHFA). Participants in both courses are trained to use a five-step action plan, or ALGEE, when working with adults or youth and adolescents: (1) **A**ssess risk for self-harm; (2) **L**isten non-judgmentally; (3) **G**ive reassurance and information; (4) **E**ncourage professional help and other supports; and (5) **E**ncourage self-help and other strategies.

Training consists of role-playing and simulation exercises in which participants learn how to assess mental health status; select appropriate interventions; provide first aid until help is available or the crisis has been resolved; connect people to professional, peer and social resources; and teach strategies and tactics for self-help care.

**Youth Mental Health First Aid** equips participants with the knowledge and skills needed to provide early help to youth and adolescents who are experiencing a mental health challenge, disorder or crisis. This course is for adults who regularly interact with youth and adolescents, including family members and legal guardians; health, social and public service providers; teachers, coaches, and other school staff and educators; and staff at faith and community based organizations.

Participants in the YMHFA program learn about youth and adolescent development and common mental illnesses, such as anxiety, depression, bipolar, substance abuse disorders, disorders in which psychosis may occur, suicidal thoughts and self-harm, panic attacks, disruptive behavior disorders, including Attention Deficit Hyperactivity Disorder (ADHD) or Oppositional Defiant Disorder (ODD) and eating disorders.



## Goals

- 1 Increase participant knowledge of the signs, symptoms and risk factors for mental illness and addiction.
- 2 Improve participants' attitudes and perceptions regarding mental illness and addiction, thereby reducing stigma surrounding mental illness.
- 3 Increase participant knowledge of local, professional, peer and social resources available to those experiencing mental illness and addiction.
- 4 Create a post-training support system for Youth Mental Health First Aiders.

## Objectives

- 1 Conduct 15 YMHFA trainings (serving between 6 and 15 people per training) by December 31, 2017, and a minimum of 24 trainings annually in subsequent years (2018 and 2019).
- 2 Demonstrate at least a 50% increase in participant knowledge of the signs, symptoms and risk factors for mental illness and addiction.
- 3 Demonstrate at least a 50% improvement in participants' attitudes and perceptions regarding mental illness and addiction.
- 4 Demonstrate at least a 50% increase in participant knowledge of local resources, including professional, peer and social supports available to those experiencing mental illness and addiction.
- 5 Conduct at least 50% of YMHFA trainings in locations with high age-adjusted mortality rates (census tracts within the 3rd or 4th quartiles).
- 6 A minimum of one school or youth-serving organization will make a change in policy or practice to improve youth mental health and emotional wellbeing annually (2017 to 2019).
- 7 Develop a database of trained Youth Mental Health First Aiders (including name, email address, mailing address, phone number, etc.) to aid post-training communication, program evaluation, continued education and trainings by December 31, 2017.

**Table 4.** *Youth Mental Health First Aid – Goals and Objectives*

### YMHFA Anticipated Impacts:

#### Trust

- More youth and adolescents in the community will trust that adults will be knowledgeable and able to assist them in the event they need mental health support.

#### Capacity

- There will be increased capacity within Lakeland and the broader community, to support youth and adolescents who are suffering from, or are at risk of developing, a mental health challenge, disorder or crisis.

#### Knowledge, Attitudes and Behaviors

- Youth Mental Health First Aiders will know how to assess the signs of mental illness and self-harm, and how to access local resources needed to support youth and adolescents who are suffering from, or are at risk of developing, a mental health challenge, disorder or crisis.
- Youth Mental Health First Aiders will adopt new attitudes and perceptions regarding mental illness and addiction, thereby, reducing stigma surrounding mental illness.
- Youth Mental Health First Aiders will engage in new behaviors, such as listening non-judgmentally, providing reassurance and information and encouraging professional help and self-care, to assist and support youth who are suffering from, or are at risk of developing, a mental health challenge, disorder or crisis.

**Programs and resources that Lakeland will commit to YMHFA.** Lakeland will provide the staff time to implement the program and support evaluation procedures. Lakeland has underwritten the cost of staff certification in YMHFA. Lakeland will pay for the curricular and marketing materials required to implement the course. Lakeland will also provide, as needed, facilities and space to host trainings. Lakeland will commit Community Benefits resources, as needed.

**Planned collaborations between Lakeland and other facilities or organizations for YMHFA.** Collaborators include: pre-schools, K-12 school districts (e.g., Niles, Benton Harbor and River Valley); post-secondary schools (e.g., Western Michigan University and Lake Michigan College); public and social services (e.g., housing, law enforcement, workforce development and transportation); healthcare organizations (e.g., Riverwood Center, BCHD, InterCare Community Health Network, Cass Family Clinic and the Van Buren/Cass District Health Department); faith and other community based organizations (e.g., churches, synagogues, the OutCenter, the YMCA, the Boys and Girls Club of Benton Harbor, YouthBuild and First Tee); local support and advocacy groups (e.g., National Alliance on Mental Illness or the Area Agency on Aging); and neighborhood and block clubs. Collaborators also include residents and managers of mobile home parks and public housing complexes, as well as libraries.

Mental Health First Aid USA will also be a key collaborator by providing ongoing technical assistance in program planning and implementation, marketing, funding and other core components critical to the sustainability of MHFA. Mental Health First Aid USA will also provide new research and updated materials, modules targeted to specific audiences and best practices from other MHFA instructors. Other collaborators will emerge as the program evolves.

**Adult Mental Health First Aid** is identical to YMHFA in that it equips participants with the knowledge and skills needed to assist those who are experiencing a mental health challenge, disorder or crisis. However, AMHFA addresses the mental health challenges faced by adults.

AMHFA is intended for all people who comprise the fabric of a community from organizations such as, professional associations and social clubs; staff at faith and community based organizations; health, public and social service providers; faculty and staff of colleges and universities; and friends and family members of individuals with mental illness or addiction.

Goals	
1	Increase participant knowledge of the signs, symptoms and risk factors for mental illness and addiction.
2	Improve participants’ attitudes and perceptions regarding mental illness and addiction, thereby reducing stigma surrounding mental illness.
3	Increase participant knowledge of local, professional, peer and social resources available to those experiencing mental illness and addiction.
4	Create a post-training support system for Adult Mental Health First Aiders.
Objectives	
1	Conduct between 18 and 20 AMHFA trainings (serving between 5 and 15 people per training) by December 31, 2017, and a minimum of 24 trainings annually in subsequent years (2018 and 2019).
2	Demonstrate at least a 50% increase in participant knowledge of the signs, symptoms and risk factors for mental illness and addiction.
3	Demonstrate at least a 50% improvement in participants’ attitudes and perceptions regarding mental illness and addiction.
4	Demonstrate at least a 50% increase in participant knowledge of local resources, including professional, peer and social supports available to those experiencing mental illness and addiction.
5	Conduct at least 50% of AMHFA trainings in locations with high age-adjusted mortality rates (census tracts within the 3 <sup>rd</sup> or 4 <sup>th</sup> quartiles).
6	A minimum of one organization will make change in policy or practice to improve adult mental health and emotional wellbeing annually (2017 to 2019).
7	Develop a database of trained Adult Mental Health First Aiders (including name, email address, mailing address, phone number, etc.) to aid post-training communication, program evaluation, continued education and trainings by December 31, 2017.

**Table 5.** *Adult Mental Health First Aid – Goals and Objectives*

## **AMHFA Anticipated Impacts:**

### Trust

- More adults in the community will trust that others will be knowledgeable and able to assist them in the event they need mental health support.

### Capacity

- There will be increased capacity within Lakeland and the broader community, to support adults who are suffering from, or are at risk of developing, a mental health challenge, disorder or crisis.

### Knowledge, Attitudes and Behaviors

- Adult Mental Health First Aiders will know how to assess the signs of mental illness and self-harm, and how to access local resources needed to support adults who are suffering from, or are at risk of developing, a mental health challenge, disorder or crisis.
- Adult Mental Health First Aiders will adopt new attitudes and perceptions regarding mental illness and addiction, thereby reducing stigma surrounding mental illness.
- Adult Mental Health First Aiders will engage in new behaviors, such as listening non-judgmentally, providing reassurance and information and encouraging professional help and self-care, to assist and support adults who are suffering from, or are at risk of developing, a mental health challenge, disorder or crisis.

**Programs and resources that Lakeland will commit to AMHFA.** Lakeland will provide the staff time to implement the program and support evaluation procedures. Lakeland has underwritten the cost of staff certification in AMHFA, and training in Adverse Childhood Experiences. Through Community Benefit allocations, Lakeland will pay for curricular and marketing materials, facilities to host trainings and other resources, as needed.

**Planned collaborations between Lakeland and other facilities or organizations for AMHFA.** Collaborators include: healthcare organizations (e.g., Riverwood Center, BCHD, InterCare Community Health Network, Cass Family Clinic, Sacred Heart Rehabilitation Center, ambulatory and paramedic service providers); post-secondary schools (e.g., Western Michigan University and Lake Michigan College); public and social services (e.g., housing, postal service, law enforcement, transportation and veteran assistance programs); faith and other community based organizations; neighborhood and block clubs; professional associations and social clubs (e.g., sororities and fraternities, Rotary, Chambers of Commerce); and local advocacy and support groups (e.g., cancer, diabetes, National Alliance on Mental Illness and Alcoholics Anonymous).

Mental Health First Aid USA will also be a key collaborator by providing ongoing technical assistance in program planning and implementation, marketing, funding and other core components critical to the sustainability of MHFA; This organization will also provide new research and updated materials; modules targeted to a variety of audiences and venues; and best practices from other MHFA instructors. Other collaborators will emerge as the program evolves.



Activity Category 1: Mental Wellbeing

Activity 2: Youth Mental Health Education – Incite Insight

**Priority Health Needs Addressed:** Mental Health, Health Education and Information, and Health Behaviors.

This middle-school and high-school curricular program includes a three-week theater performance arts piece that is designed to explore themes such, the definitions of mental health and mental illness, de-stigmatization of mental illness, and finding and providing support for people with mental illness. Other topics include trauma, eating disorders, suicide and substance abuse. The curriculum, which employs a trauma-informed approach to deliver information with sensitivity and respect, provides learning activities that integrate five educational themes that teachers can select from to add to their curricula. The curricular activities and resources can be adapted for the specific needs of individual classrooms or school buildings. The performance piece, which will also be developed and executed in a trauma-informed manner, may be done as an in-school program or as a main stage production, and includes a peer-to-peer talk-back. Both the curriculum and performance may be delivered by trained classroom teachers and/or a performance artist.

While the program will be implemented in a wide range of youth-serving institutions, it will focus on those populations with highest need as defined by census tracts with high age-adjusted mortality rates (3rd or 4th quartiles) and other metrics of disadvantage, such as the percentage of students who qualify for free and reduced lunch.

Goals	
1	Create networks of social support and inclusion.
2	Foster authentic conversation about mental health and illness.
3	Breakdown stereotypes and de-stigmatize mental illness.
4	Build capacity within schools and community-based youth programs to sustain Incite Insight.
Objectives	
1	Implement the program (curriculum and theater performance) in four schools or community-based youth programs (i.e., sites) annually (2017 to 2019).
2	Pre/post evaluations will show a 50% decrease in stereotypes and stigma related to mental illness.
3	Develop a curriculum for elementary school children by June 2018 and pilot the program in the 2019-20 academic year.
4	Develop a set of supportive policy and practice recommendations for schools and community-based organizations where the program was held.
5	Execute a staged implementation and capacity building process that produces 12 independently operating sites in 2020.
6	Between 80 and 100 youth will complete the curriculum, and between 40 and 60 youth will participate in a performance in each year of the project period (2017 to 2019).
7	Identify two champions (one adult and one student) at each school to become implementers of the program.

**Table 6.** Youth Mental Health Education – Incite Insight – Goals and Objectives



## Anticipated Impacts:

### Trust

- Youth will exhibit more willingness and comfort in engaging in conversations with adults and with each other about mental health and mental illness.

### Capacity

- Schools and community-based organizations where the program is implemented will have increased capacity (e.g., policies, practices, knowledge, skills and attitudes) to support youth experiencing mental health challenges.
- Through peer-to-peer networks, youth will have increased capacity to support one another.
- Youth who complete the program will be better able to take initiative and willing to seek help in managing their mental health.

### Knowledge, Attitudes and Behaviors:

- Youth will have better knowledge about mental health and mental illness.
- Youth will know how to distinguish between mental health and mental illness.
- Youth will know how to support those with mental health challenges.
- Youth will demonstrate more appropriate and empathic vernacular when discussing mental health and mental illness.
- Youth will develop empathy, and shed stigma and stereotypes related to mental illness.
- Youth will have the knowledge and skills needed to take the initiative to optimize their own mental health.
- Youth will engage in conversations with peers and adults about mental health and mental illness.
- Youth will show more empathy with their peers experiencing a mental illness.

**Programs and resources that Lakeland will commit to Incite Insight.** Lakeland has underwritten the cost of CHW staff training in Adverse Childhood Experiences and the impact of trauma on mental health, which will be critical to using a trauma-informed approach to deliver the curriculum and execute the theater performance. Through its Community Benefits allocations, Lakeland will pay for curricular and marketing materials, staff time required to implement and evaluate the program and other resources, as needed.

**Planned collaborations between Lakeland and other facilities or organizations for Incite Insight.** Collaborators include middle and high schools, community-based organizations, Lake Michigan College, local media outlets, local mental health organizations and support groups. New collaborators will emerge as the program evolves.

## Activity Category 2: Nutrition Education and Access

### Activity 3: Prescription for Health at the Benton Harbor Farmers' Market

**Priority Health Needs Addressed:** Obesity, Diabetes, Heart Disease, Health Education and Information, Food Environment, and Health Behaviors.

Prescription for Health (PFH) connects the medical system and the food sector by creating a relationship between clinic staff, their patients and the local farmers' market. Individuals with, or at-risk for, a chronic disease who also have low food access are eligible for the PFH program. In this program, healthcare providers write "prescriptions" for their patients to purchase fruits and vegetables.

Each cohort of PFH participants will receive health and nutrition counseling and education, blood pressure monitoring, assistance in connecting to community resources and \$10 in PFH benefits (up to \$100 per year) to spend on fruits and vegetables each week at the Benton Harbor Farmers' Market (BHFM). Additionally, all visitors to the Benton Harbor Farmers' Market, including those not signed up for the PFH program, will have access to all of these services (i.e., health and nutrition counseling and education, blood pressure monitoring, assistance in connecting to community resources) except the \$100 PFH benefits (which will only be offered to the PFH participants).



## Goals

- 1 Improve food access for PFH participants by increasing food affordability and acceptability, and culinary knowledge of healthy foods and preparation methods.
- 2 Engage Farmers' Market visitors beyond the PFH participants (at the BHFM Nutrition Education Booth).

## Objectives

- 1 Increase by 10% the number of PFH participants who report that they were able to afford to eat fruits and vegetables everyday by the end of the BHFM season. (Affordability)
- 2 Increase by 10% the number of participants who report increasing fruit and vegetable consumption by one fruit or vegetable daily by the end of the BHFM season. (Behavior)
- 3 Increase by 10% the number of participants who report an increase in the variety of fruits and vegetables they eat by one fruit or vegetable by the end of the BHFM season. (Acceptability)
- 4 Increase participant culinary knowledge by 10% by the end of the BHFM season. (Knowledge)
- 5 Seventy-five percent (75%) of Farmers' Market visitors will visit the BHFM Nutrition Education Booth.
- 6 Seventy-five percent (75%) of Farmers' Market visitors who taste the fruit and/or vegetable samples will report that they feel positive about the fruit and/or vegetable.

**Table 7.** *Prescription for Health – Goals and Objectives*

### Anticipated Impacts:

#### Trust

- PFH participants' trust in Lakeland will increase through CHW's provision of nutrition education, health counseling and goal setting support in a manner that is community-driven, acknowledges the community's food preferences and demonstrates respect for such preferences through the development of culturally-relevant programming.
- PFH participants' trust in Lakeland will increase as CHW staff are able to accurately and confidently address residents' questions regarding nutrition and PFH.
- PFH participants' trust in Lakeland will increase as CHW staff takes care to ensure that PFH benefit dollars and other resources are distributed equitably and transparently.

#### Capacity

- PFH participants will have increased capacity to prepare and consume foods that promote health.
- Lakeland's capacity to work in community settings, and to develop and implement programming that is helpful and meaningful to residents, will be enhanced through the findings of the formative evaluation of the program activities.

#### Knowledge, Attitudes and Behaviors

- PFH participants will acquire new knowledge on selecting, storing and utilizing seasonal fruits and vegetables to make healthy and inexpensive meals.
- PFH participants' attitudes and acceptance of seasonal fruits and vegetables will widen resulting in increased intent to purchase and prepare new ingredients and a willingness to try new fruits and vegetables with the belief that they can afford to prepare healthy meals.
- PFH participants' nutrition-related health behaviors will improve (e.g., increased variety and amount of fruits and vegetables consumed) due to the program's focus on the three components of food access (i.e., affordability, acceptability and culinary knowledge).

**Programs and resources that Lakeland will commit to PFH.** The Lakeland-employed nurse, who is onsite at Harbor Towers, will oversee PFH participant recruitment, track their health outcomes (e.g., blood pressure and body mass index), remind them of market days and organize them into walking groups to visit the Farmer's Market. A Lakeland-employed PFH and Nutrition Education Coordinator will oversee PFH enrollment sessions, provide student training, coordinate or liaise with the farmers' market manager, and collect and analyze data. Lakeland Graphics Department will provide printing of marketing and educational materials. Lakeland Marketing will provide marketing support. Lakeland Health Foundations will assist in finding resources to grow and sustain the program. Through Community Benefit allocations, Lakeland will also provide the staff time to support program implementation and evaluation, and other resources as needed.

**Planned collaborations between Lakeland and other facilities or organizations for PFH.** The Berrien County Health Department (BCHD) will contract with Lakeland for expenses related to nutrition education (e.g., staff time, food cost, supply cost and mileage). The BCHD will also arrange for a summer intern (an undergraduate student who studies health education, nutrition or public health) to assist with nutrition education activities, procurement of ingredients, and the setup and storage of nutrition booth displays and cooking equipment. Senior Nutrition Services of Southwest Michigan will allow use of their newsletter to advertise nutrition-related activities. The Van Buren Intermediate School District will provide educational materials such as recipe books and Nutrition Education Reinforcement Items, such as whisks, rubber spatulas, fridge thermometers and shopping totes.

Additional collaborations are being negotiated: Western Michigan University provides Registered Nurse-Bachelor of Science in Nursing (RN-BSN) students to assist with blood pressure screenings, referrals to community services, counseling and support services, the setup and storage of booth equipment and entering de-identified biometrics into the database for analysis.





## Activity Category 2: Nutrition Education and Access

### Activity 4: Taller Comunitario de cocina y nutrición (Community Kitchen Club)

**Priority Health Needs Addressed:** Mental Health, Obesity, Diabetes, Heart Disease, Health Education and Information, Food Environment and Health Behaviors.

The Community Kitchen Club program provides nutrition education to individuals with low food access who live in Berrien County by conducting hands-on cooking classes paired with education on nutrition, menu planning, basic cooking techniques, community food resources and eating healthy on a budget. All recipes used in classes will be decided upon by class participants, and used to reinforce education on nutrition topics. After cooking classes, participants will have the opportunity to sit together and enjoy the meal they prepared which provides an opportunity for socialization and the creation of social cohesion.

Once a week, classes will be offered at the Spring Lake Mobile Home Park in Stevensville and at the Elite Barbershop in Benton Harbor. Classes will be held in 12-week long sessions, however, participants are encouraged to attend as many sessions as they feel are needed. Recipes will vary among sessions, but educational materials will remain consistent.

As needed, English and Spanish speaking instructors will be available in both locations to teach in tandem.

Class structure will vary slightly between locations based upon the population's specific preferences and needs.



#### Goals

- 1 Improve diet-related health behaviors among program participants in Benton Harbor and Stevensville.
- 2 Increase participant awareness of food resources to increase access to food.
- 3 Increase participant confidence in their ability to prepare nutritionally balanced meals.
- 4 Increase social cohesion among English and Spanish-speaking participants by building a sense of community.

#### Objectives

- 1 Increase by 25% participant knowledge of basic nutrition concepts.
- 2 Increase by 25% participant knowledge of making healthy recipes at home.
- 3 Fifty percent (50%) of participants will have accessed one new local food resource by the end of one session.
- 4 Increase by 25% participants' consumption of fruits, vegetables and whole grains.
- 5 Increase participants' ability to cook with locally available foods.
- 6 Increase by 10% the number of participants who report an improved sense of social and emotional support by the end of one session.
- 7 A minimum of one participant will become an instructor by the end of each year in the project period (2017 to 2019).
- 8 Develop a formal curriculum.

**Table 8.** *Community Kitchen Club – Goals and Objectives*

## Anticipated Impacts:

### Trust

- Community Kitchen Club members will have increased confidence and trust that Lakeland can meet their needs as CHW staff create a learning environment informed by close collaboration with the community, and the development and implementation of a class curriculum that reflects members' cultural preferences.

### Capacity

- The capacity of Community Kitchen Club members to meet their nutritional needs with inexpensive foods will increase.
- The capacity of CHW staff to create and deliver educational programming that meets members' needs will increase.

### Knowledge, Attitudes and Behaviors

- Community Kitchen Club members will gain new knowledge regarding the procurement and preparation of local foods, and the creation of budget-friendly, healthy and culturally-appropriate meals.
- Community Kitchen Club members will be better able to prepare healthy meals and adhere to a balanced diet.
- Community Kitchen Club members will experience a positive shift in their attitudes toward the preparation of healthy foods.
- Community Kitchen Club members' diet-related behaviors, such as eating more fruits and vegetables, will improve.
- CHW associates will acquire new knowledge, shift pre-existing attitudes and engage in new behaviors that will enable them to provide nutrition education programming that is culturally-relevant to the region's Spanish speaking populations.

**Programs and resources that Lakeland will to commit to the Community Kitchen Club.** Lakeland will provide all kitchen supplies (e.g., portable cook tops, butane and cleaning supplies) and ingredients. Through its Community Benefit allocations, Lakeland will provide CHW staff time to develop, implement and evaluate the program, and other resources as needed.

**Planned collaborations between Lakeland and other facilities or organizations for the Community Kitchen Club.** Master's level dietetic students from Andrews University will assist in providing nutrition education to Community Kitchen Club members and their children. Spring Lake Mobile Home Park, located in the town of Stevensville, will provide a full kitchen with all required appliances and supplies. The Elite Barbershop, located in Benton Harbor, will provide space for cooking classes. New collaborators will emerge as the program evolves.



Activity Category 3: K-12 Health Education

Activity 5. Coordinated School Health

**Priority Health Needs Addressed:** Mental Health, Health Education and Information, Health Behaviors, Food Environment and Obesity.

Lakeland staff will support the implementation of an expanded model of the Coordinated School Health Program (CSHP). The CSHP is an integrated set of planned, sequential, school-affiliated strategies, activities and services that promote optimal physical, emotional, cognitive, social and educational development of students. This expanded CSHP utilizes a “whole child” framework in which educators, families, community members, policymakers, in both the health and education sectors, collaborate to improve children’s development. These partnerships reflect the symbiotic relationship between learning and health, and support the development of an aligned and integrated curriculum.

The CSHP has ten elements: Health Education; Nutrition Environment and Services; Social and Emotional Climate; Physical Environment; Health Services; Counseling, Psychological and Social Services; Community Involvement; Family Engagement; Employee Wellness; and Physical Education and Physical Activity. This IS will focus on the Health Education, Social and Emotional Climate, Community Involvement and Family Engagement elements. The Health Education component of the CSHP will be fulfilled through the Michigan Model for Health.

This work will be executed in three schools districts that serve children who reside in locations with high age-adjusted mortality rates (census tracts within 3rd or 4th quartiles): Niles Community Schools (NCS), River Valley School District (RVSD) and Benton Harbor Area Schools (BHAS). During the program period, 2017 to 2019, CHW will also work to cultivate relationships with a fourth school district, Watervliet Public Schools (WPS).

Goals

- 1 Develop and implement elements of the CSHP, customized to each targeted school district.
- 2 Support the implementation of the Michigan Model for Health curriculum in the targeted school districts.
- 3 Cultivate relationships with other school districts located in areas with high age-adjusted mortality rates.

Objectives

- 1 Cultivate relationships with key stakeholders in each targeted school district.
- 2 Cultivate relationships with key community stakeholders who will be involved in CSH efforts.
- 3 Support the establishment of, and actively participate in, the Coordinated School Health Team in each of the targeted school districts.
- 4 Implement the Michigan Model for Health in, at least, one grade within an elementary, middle and high school in each of the targeted school districts by the end of the 2018-19 school year.
- 5 Implement all modules (five elementary school units and five secondary level units) of the Michigan Model for Health in each targeted school district by the end of the school year 2018-19.
- 6 Cultivate a relationship with WPS.

**Table 9.** *Coordinated School Health – Goals and Objectives*

## Anticipated Impacts:

### Trust

- Through the formation and work of collaborative relationships, the trust between Lakeland, and all four schools districts (NCS, RVSD, BHAS and WPS) and the communities they serve, will increase.

### Capacity

- A Coordinated School Health Team (CSH Team) will be established in three of the targeted school districts – BHAS, NCS and RVSD.
- The capacity of BHAS, NCS and RVSD to implement four of the key elements of CSHP will increase.
- Staff, parents and students in BHAS, NCS and RVSD will be better equipped to identify trauma and mitigate its effects on children's health and educational achievement.
- Lakeland staff will be better equipped to address the health and educational needs identified by the staff, parents and students in BHAS, NCS, RVSD and WPS.

### Knowledge, Attitudes and Behaviors

- School staff, parents and students in BHAS, NCS and RVSD will better understand that health has mental and social components as well as physical elements.
- School staff, parents and students in BHAS, NCS and RVSD will better understand that health and academic achievement are linked.
- School staff, parents and students in BHAS, NCS and RVSD will understand what trauma is and how it impacts child health, development and educational outcomes.
- The health behaviors (e.g., diet and exercise) of parents and students in BHAS, NCS and RVSD will improve.
- Lakeland staff will develop a better understanding of how to build school-based and community teams or partnerships.
- Lakeland staff will better know how to identify and tap into community resources needed to meet school-identified needs.
- Lakeland staff will exhibit an increased understanding of curriculum development and implementation, policy-making and other internal procedures and processes.

**Programs and resources that Lakeland will to commit to the CSHP.** Lakeland will provide CHW staff time and funding for trainings (e.g., YMHFA, Michigan Model for Health Curriculum and Adverse Childhood Experiences). Lakeland will also provide CHW staff time for classroom observations, family engagement activities, CSH Team meetings and program evaluation. Lakeland Care Network (a partnership between Physician Hospital Organization and Lakeland Health) will provide contract school nurses to schools as requested. Lakeland will allocate Community Benefit resources to support staff time for program implementation and evaluation, materials and space, as needed

**Planned collaborations between Lakeland and other facilities or organizations for CSH.** Collaborators will include the four school districts – Niles Community Schools, River Valley School District, Benton Harbor Area Schools, and Watervliet Public Schools. The Van Buren Intermediate School District will provide support as our Regional School Health Coordinator while supplying additional programming, both in the school and community through Supplemental Nutrition Assistance Program Education. The Niles-Buchanan YMCA and InterCare's Pediatric Care Manager will support family engagement activities. The Riverwood Center will provide YMHFA Training and trauma training through the National Child Traumatic Stress Network. The Boys and Girls Club of Benton Harbor will support the implementation of the social emotional unit of the Michigan Model for Health in its after school programs. The Summer My Way Camp in Niles will serve as a site for provision of health information, physical activity and enrichment activities during the summer months for Niles youth. The BCHD will host a Positive Parenting Program; and the Education Impact Alliance will provide literacy programming. New collaborators will emerge as the program evolves.

#### Activity Category 4: Community Health Education

##### Activity 6: Neighborhood-Based Health Home - Elite Barbershop

**Priority Health Needs Addressed:** Mental Health, Obesity, Diabetes, Cardiovascular Conditions, Cost of Care, Provider Availability, Health Education and Information, Health Behaviors and Food Environment.

In this program, Lakeland staff will provide health education, information, training and preventive screenings to men, many of whom would not otherwise have access to health resources, at Elite Barbershop located in Benton Harbor. The intent is to use a barbershop as a venue for helping African American men overcome institutional, social and cultural barriers to accessing healthcare.

Lakeland staff, including CHW registered nurses and a registered dietitian, Lakeland University's health educators (e.g., diabetes and respiratory specialists), and Medical Residents from the Graduate Medical program (e.g., Family Medicine and Emergency Medicine), will provide health education and information through open, patron and barber-led discussions about health issues such as stress management and mental health; obesity and weight control; diabetes and kidney disease; hypertension, stroke and heart attacks; and nutrition and health behaviors. Other topics include sleep apnea and smoking. In addition, privately conducted preventive screenings for high blood pressure and cholesterol combined with health coaching and lifestyle modification classes (e.g., nutrition, fitness and stress management) will be offered.



## Goals

- 1 Build and cultivate an ongoing relationship between community residents and Lakeland.
- 2 Develop relationships between Elite barbers, their patrons, community residents, Lakeland and other organizations in Berrien County.
- 3 Establish an easily-accessible health home in a neighborhood setting with a focus on residents of census tract 4.
- 4 Develop a system of mutual support and collective accountability for health behaviors among patrons and barbers at Elite Barbershop by building the capacity and KABs of barbers to support and promote the health of their clients.

## Objectives

- 1 Provide twice-monthly, four-hour health education, information, coaching and screening programming to patrons and barbers at the Elite Barbershop in Benton Harbor.
- 2 Increase by 25% the number of people coming to the barbershop for health education and information from census tract 4 in year two (2018).
- 3 Increase by 25% presentations on health topics requested by residents of census tract 4 by the end of year three (2019).
- 4 Twenty-five percent (25%) of patrons will report holding themselves or others accountable for positive health behaviors.
- 5 Each barber will report increased interactions with patrons around health-related issues.

**Table 10.** *A Neighborhood-Based Health Home – Elite Barbershop – Goals and Objectives*

### Anticipated Impacts:

#### Trust

- Lakeland staff will create a safe and supportive environment built upon empathy and care, whereby sensitive information can be shared and personal needs addressed.
- The trust between Elite Barbershop's patrons and barbers and on-site Lakeland staff will increase.
- Lakeland staff will have increased confidence that patrons and barbers will adhere to collaboratively established health goals.

#### Capacity

- Elite Barbershop's patrons and barbers will be able to provide guidance to Lakeland staff regarding their health interests and health, and program design and delivery models.
- Elite Barbershop's patrons and barbers will be better able to address their health needs and the health needs of their friends and families.
- Lakeland staff will learn how to more effectively engage with and serve people who are culturally and socially distinct from themselves, and who suffer from health disparities.
- Lakeland staff will gain greater understanding and insight into the social and economic context of the lives of individuals whose health needs are underserved by the health system.

## Knowledge, Attitudes and Behaviors

- Elite Barbershop's patrons and barbers will have an increased knowledge of the causes of health conditions such as mental health, obesity, cardiovascular disease and diabetes, and how best to address those conditions.
- Elite Barbershop's patrons and barbers will know more about preventive care, such as the importance of regular health checks, healthy eating habits and physical activity.
- The health behaviors of Elite barbers will improve.
- Elite Barbershop's patrons and barbers will have a more positive attitude towards Lakeland staff.
- Lakeland staff will shed preconceptions regarding African American men in the barbershop.
- Lakeland staff will seek guidance on relevant programming content and delivery models from the patrons and barbers, in contrast to the traditional model of directing the content and delivery models.

**Programs and resources that Lakeland will commit to Elite Barbershop.** Lakeland programs include the Wellness Workshops and Community Flu Shot Clinics; classes on topics, such as stress, breast and prostate cancer; early heart attack care; MHFA; HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome); Sexually Transmitted Infections; respiratory health; mindful eating; cholesterol; and sleep apnea. Lakeland resources include the allocation of Community Benefits to underwrite the cost of staff salaries (including Health Educators and Medical Residents) and the acquisition of equipment, supplies and food (for nutrition classes). Lakeland will also provide the staff time to support program implementation and evaluation procedures.

### **Planned collaborations between Lakeland and other facilities or organizations for Elite Barbershop.**

Elite Barbershop will provide physical space and assist with program promotion. The Berrien County Health Department and the Community AIDS Resource and Education Services (CARES) will provide programming about HIV/AIDS, Sexually Transmitted Infections, Hepatitis C, and Sickle Cell Disease. Additional partnerships will be added as the program evolves.





## Activity Category 4: Community Health Education

### Activity 7: Neighborhood-Based Health Home - Community Food Network

**Priority Health Needs Addressed:** Mental Health, Obesity, Diabetes, Cost of Care, Provider Availability, Health Education and Information, Health Behaviors and Food Environment.

Lakeland staff, including CHW registered nurses and a registered dietitian, Lakeland University's health educators (e.g., diabetes and respiratory specialists) and Medical Residents from the Graduate Medical program (e.g., Family Medicine and Emergency Medicine), will provide health education and information about priority and other health needs identified in the CHNA, such as stress management and mental health; obesity and weight control; diabetes and kidney disease; hypertension, stroke and heart attacks; and nutrition and health behaviors. The program will also include other topics of interest to members of the Community Food Network (CFN). In addition, preventive screenings for high blood pressure and cholesterol combined with health coaching and lifestyle modification classes (e.g., nutrition, fitness and stress management) will be offered.

#### Goals

- 1 Build the relationship between members of the CFN and Lakeland.
- 2 Establish an easily-accessible health home in a neighborhood setting.
- 3 Develop a system of mutual support and collective accountability for health behaviors among members of the CFN.
- 4 Increase input into program design by members of CFN.

#### Objectives

- 1 Provide twice-monthly education, information, coaching and screening programming to members of the CFN in Benton Heights.
- 2 Increase by 20% annually (2017 to 2019), those served who reside in census tracts with the highest age-adjusted mortality rates (census tracts within the 3<sup>rd</sup> or 4<sup>th</sup> quartiles).
- 3 Design programming that addresses the health-related needs of members of CFN.
- 4 Twenty-five percent (25%) of CFN members will report holding themselves or others accountable for positive health behaviors.
- 5 Increase by 25% presentations on health topics requested by residents of census tract 23 by the end of year three (2019).

**Table 11.** *A Neighborhood-Based Health Home – Community Food Network – Goals and Objectives*





## Anticipated Impacts:

### Trust

- A trusting relationship between members of the CFN, and the Lakeland staff that provide the programs and services, will be developed.

### Capacity

- Members of the CFN will be better able to identify and address their health needs and the health needs of their friends and families.
- Lakeland's ability to serve people who reside in areas with high mortality rates (census tracts within the 3rd or 4th quartiles) will increase.
- Lakeland staff will learn how to more effectively engage with and serve people who are culturally and socially distinct from themselves, and who suffer from disparities which Lakeland seeks to narrow.
- Lakeland staff will gain greater understanding and insight into the social and economic context of the lives of individuals whose health needs are underserved by the health system.

### Knowledge, Attitudes and Behaviors

- Members of the CFN will have an increased knowledge of the causes of health conditions such as mental health, obesity, cardiovascular disease and diabetes, and how best to address those conditions.
- Members of the CFN will know more about preventive care such as regular health checks, healthy eating habits and physical activity.
- The health behaviors of members of the CFN will improve.
- Members of the CFN will have a more positive attitude towards Lakeland staff.
- Lakeland staff will shed their preconceptions regarding low income people in rural settings.
- Lakeland staff will seek guidance on relevant program content and delivery models from the members of the CFN, in contrast to the traditional model of directing the content and delivery models.

**Programs and resources that Lakeland will commit to CFN.** Lakeland will provide Wellness Workshops and Community Flu Shot Clinics; classes on topics, such as stress management, breast and prostate cancer; early heart attack care; MHFA; HIV/AIDS; Sexually Transmitted Infections; respiratory health; mindful eating; cholesterol; and sleep apnea. Lakeland resources include the allocation of Community Benefits to underwrite the cost of staff salaries (including Health Educators and Medical Residents) and the acquisition of equipment, supplies and food (nutrition classes). Lakeland will also provide the staff time to support evaluation procedures.

**Planned collaborations between Lakeland and other facilities or organizations for Community Food Network.** First Church of God in Benton Heights will provide the physical space and assist in program development and promotion. Additional partnerships will be added as the program evolves. Other collaborators will emerge as the program evolves.

## Activity Category 4: Community Health Education

### Activity 8: Neighborhood-Based Health Home - Harbor Towers

**Priority Health Needs Addressed:** Mental Health, Health Education and Information, and Health Behaviors.

Harbor Towers is an independent living community located in Benton Harbor, for low income individuals who are either disabled or elderly. In 2015-16, Lakeland introduced an on-site nurse and outreach coordinator at the facility to assist residents in managing their physical, mental and social health. The nurse provides basic health education, information, coaching and screenings, while the outreach coordinator facilitates the growth and development of an on-site support group for residents to provide mutual support and encouragement to better manage their health and the health of their community. Due to the particularly high incidence of emotional trauma experienced by this population, a trauma-informed approach to care will be central to this activity.



#### Goals

- 1 Increase social cohesion among residents at Harbor Towers.
- 2 Increase the number of residents with health-related problems who use on-site services provided by Lakeland.

#### Objectives

- 1 Establish one resident-run support group annually (2017 to 2019).
- 2 A nurse and outreach coordinator will be on-site at least twice weekly to provide basic healthcare services and support the development and growth of support groups.
- 3 Increase residents' knowledge and understanding of incorporating trauma-informed practices in peer support.
- 4 Increase meaningful communication and interaction among the residents.
- 5 Increase by 25% annually (2017 to 2019) the number of residents who access on-site nursing services.
- 6 Seventy-five percent (75%) of residents identified with chronic medical needs (e.g., hypertension, diabetes or obesity) will access ongoing care from the on-site nurse.
- 7 Fifty percent (50%) of residents who attend support groups will attend the meetings at least 50% of the time.

**Table 12.** *A Neighborhood-Based Health Home – Harbor Towers – Goals and Objectives*

## Anticipated Impacts:

### Trust

- Harbor Towers' residents will exhibit growing trust in Lakeland staff by increasing their use of the on-site nursing services.

### Capacity

- Harbor Towers' residents will have an increased capacity to identify their own experiences of trauma, and the impacts on their physical, mental and social health and the health of others.
- Harbor Towers' residents will have an increased capacity to manage their own health through the use of on-site services.
- Lakeland staff will be better equipped to understand and meet the needs of this underserved population.

### Knowledge, Attitudes and Behaviors

- Lakeland staff will have an increased knowledge of the causes of health conditions such as mental health, obesity, cardiovascular disease and diabetes, and how best to address those conditions.
- Harbor Towers' residents and Lakeland staff will have an increased understanding of what emotional trauma is and how it impacts physical, mental and social health.
- Harbor Towers' residents and Lakeland staff will understand the connection between trauma, negative health behaviors, coping strategies and health outcomes.
- Harbor Towers' residents and Lakeland staff will work to de-stigmatize and breakdown stereotypes related to mental illness.

**Programs and resources that Lakeland will commit to Harbor Towers.** Resources provided by Lakeland include an insurance navigator, nurse and community outreach coordinator. CHW staff will provide training in MHFA, Adverse Childhood Experiences, trauma, and trauma-informed approaches to care. Lakeland has provided furniture (e.g., tables and chairs) and equipment (e.g., a projector and laptop) to outfit on-site office space. Lakeland also provides supplies such as snacks, paper products, cleaning supplies and toiletries, as needed. Lakeland will also provide the staff time to support evaluation procedures. Lakeland will allocate Community Benefit resources, as needed.

### **Planned collaborations between Lakeland and other facilities or organizations for Harbor Towers.**

Collaborators include Sacred Heart Rehabilitation Center who will provide peer coaching and other services; the Benton Harbor Housing Authority will provide office space, janitorial services and supplies, such as snacks, toiletries, paper products and cleaning supplies; the Benton Harbor Public Safety and Benton Harbor Housing Authority will support efforts to address safety and security concerns; and Harbor Towers Management will support and encourage program participation. New collaborators will emerge as the program evolves.

## Activity Category 4: Community Health Education

### Activity 9: Community Health Screenings and Other Services

**Priority Health Needs Addressed:** Mental Health, Obesity, Diabetes, Heart Disease, Cost of Care, Health Education and Information, Food Environment and Health Behaviors.

First on Friday and Walk In Wednesday are preventive screening programs offered to those 18 years of age or older. First on Friday occurs on the first Friday of each month at the Niles-Buchanan YMCA, and Walk In Wednesday occurs on the first Wednesday of each month at the Lakeland Center for Outpatient Services in St. Joseph. Screenings offered include, blood pressure, fasting cholesterol lipid panel with glucose, body composition analysis (body fat percentage) and bone density screening for women. Health education and coaching are provided at each screening by a Clinical Educator. Lakeland clients that attend the Cardiac Rehabilitation Program are offered free heart health screenings through these two programs as part of their follow-up care and wellness program.

Wellness Workshops are free community preventive health screenings offered quarterly at different community locations throughout Lakeland's service area. The screening includes fasting cholesterol lipid panel with glucose, blood pressure, body mass index, waist measurement, and health education and health coaching to those 18 years of age and older.

Annual Flu Shot Clinics are offered to those 18 years of age and older starting in October of each year. Community clinics are held at churches, senior centers, preventive health screenings and neighborhood-based health home locations. Medicare billing is offered at these clinics.



## Goals

- 1 Decrease Emergency Room admissions of community health screening clients.
- 2 Develop community support by engaging residents and other community partners in volunteer activities at community health screenings.

## Objectives

- 1 Fifty percent (50%) of clients will adopt one additional preventive action over the course of a 12-month period.
- 2 Fifty percent (50%) of clients will attend any two community health screenings annually (2017 to 2019) while maintaining their existing preventive care actions.
- 3 Identify 10 community volunteers annually (2017 to 2019) to support community education and screenings at locations where the age-adjusted mortality rates are high (census tracts within the 3<sup>rd</sup> or 4<sup>th</sup> quartiles).
- 4 Increase by five annually (2017 to 2019) the number of collaborators involved with Community Health Screenings and other Services.
- 5 Increase by 50% annually (2017 to 2019) the number of clients served who reside in areas with the highest age-adjusted mortality rates (census tracts within the 3<sup>rd</sup> or 4<sup>th</sup> quartiles).

**Table 13.** *Community Health Screenings and Other Services – Goals and Objectives*

### Anticipated Impacts:

#### Trust

- The trust between Lakeland staff and clients served in the program, especially those who reside in underserved areas, will increase.

#### Capacity

- Community health screening clients will be better equipped to address their health needs.
- Lakeland will have a greater ability to serve people who reside in areas with high age-adjusted mortality rates.
- Lakeland staff will learn how to more effectively engage with and serve people who are culturally and socially distinct from themselves, and who suffer from disparities which Lakeland seeks to narrow.
- Lakeland staff will gain greater understanding and insight into the social and economic context of the lives of individuals whose health needs are underserved by the health system.

#### Knowledge, Attitudes and Behaviors

- Community health screening clients will have an increased knowledge of the causes of health conditions such as mental health, obesity, cardiovascular disease and diabetes, and how best to address those conditions.
- Community health screening clients will know more about preventive care such as the importance of regular health checks, better eating habits and more physical activity.
- The health behaviors of screening clients will improve.



**Programs and resources that Lakeland will commit to Community Health Screenings and Other Services.**

CHW will provide education; conduct screenings; secure equipment (e.g., blood pressure cuffs, Cholestech instruments, QA solution, pipettes, plungers, gloves, Band-Aids, flu vaccine, gauze, alcohol swabs, chux, and materials such as handouts and models); supply space; and provide time to support evaluation procedures. Lakeland Health Foundations will provide financial support. Lakeland's Cardiac Rehabilitation Program will make referrals and assist with marketing. Lakeland's Marketing Department will assist with promotions. Lakeland's Parish and Senior Center nurses will assist by securing space, promoting and marketing the program. Lakeland University will provide support through Expectation Management and Medical Information (EMMI) education programming. Lakeland Community Benefit resources will be allocated, as needed.

**Planned collaborations between Lakeland and other facilities or organizations to address Community Health Screenings and Other Services.** Community organizations, yet to be determined, will provide the space for the programming. Partnerships include, the Elite Barbershop, The Fair Housing Commission, the Ferry Street Resource Center, the Boys and Girls Club, the Niles-Buchanan YMCA and the Salvation Army. New collaborators will emerge as the program evolves.





## Activity Category 4: Community Health Education

### Activity 10: Community CPR

**Priority Health Needs Addressed:** Heart Disease and Health Education and Information.

The American Heart Association's Heartsaver® CPR-AED (Cardiopulmonary Resuscitation-Automated External Defibrillator) is a video-based, instructor-led course that teaches adult and child CPR and AED use, infant CPR, and how to relieve choking in adults, children and infants. This course teaches skills with the American Heart Association's research-proven, practice-while-watching technique, which allows instructors to observe the students, provide feedback and guide the students' learning of skills. This course is for individuals with limited or no medical or clinical training and will be available free of charge.



#### Goals

- 1 Improve participant knowledge of key CPR skills, and their ability to perform them.
- 2 Increase the number of partners involved in CPR training.

#### Objectives

- 1 One hundred class participants will successfully complete the course in year one (2017).
- 2 Increase successful course completion by 10% in 2018 and 2019.
- 3 Fifty percent (50%) of certified CPR class participants return to keep their certifications current.
- 4 Increase by five annually (2017 to 2019) the number of locations in which CPR trainings occur. Two locations will serve residents who live in areas with high age-adjusted mortality rates (census tracts within 3<sup>rd</sup> or 4<sup>th</sup> quartiles).
- 5 One public school district, with which Lakeland collaborates, will incorporate CPR certification in their health-related class each year beginning in the 2017-18 school year.
- 6 Seventy-five percent (75%) of certified CHW instructors will continue as instructors in subsequent years (2018 and 2019).

**Table 14.** *Community CPR – Goals and Objectives*

## Anticipated Impacts:

### Trust

- Program participants will return for additional training and certifications in subsequent years (2018 and 2019).
- More local schools and community organizations will seek to host CPR courses.

### Capacity

- More community residents will have successfully completed the CPR class.
- More CPR classes will be held in areas with high mortality rates.
- Program participants will return for re-certification in subsequent years (2018 and 2019).
- More local schools and a greater diversity of community organizations will host CPR courses.
- More school-aged children will know how to administer CPR.
- More instructors will administer classes for more than one year.

### Knowledge, Attitudes and Behaviors

- There will be more residents across the Lakeland service area that have the knowledge and skills to administer CPR.
- Program participants will return for additional training and certifications in subsequent years (2018 and 2019).
- More community residents, including school-aged children, will know how to administer CPR.
- More residents in areas with high mortality rates will be equipped with CPR knowledge and skills.

**Programs and resources that Lakeland will commit to Community CPR.** CHW will provide class instructors, equipment and supplies (e.g., books, valves, lungs, cleaning supplies, equipment and certification cards) and space, as needed. CHW will also be responsible for the overall administration of the classes (e.g., registration, securing locations and staff time to support evaluation procedures). Lakeland University will provide curricular updates and make referrals to the program. Lakeland Care will provide additional instructors as needed and make referrals to the program. Community Benefit resources will be allocated, as needed.

### **Planned collaborations between Lakeland and other facilities or organizations in providing Community CPR.**

Local schools will provide space and instructional time. Neighborhood-based health homes (e.g., Elite Barbershop, Harbor Towers and the CFN) and other community entities will provide space and assist with recruiting participants. Additionally, efforts will be made to recruit and train community members to become certified instructors. New collaborators will emerge as the program evolves.

## Activity Category 4: Community Health Education

### Activity 11: Babysitting with Confidence

**Priority Health Needs Addressed:** Health Education and Information, Food Environment and Health Behaviors.

This free community education program was created specifically for adolescents seeking to learn about caring for infants, toddlers and small children. It covers a variety of topics including, questions to ask before taking a babysitting job, expectations of a babysitter, what to do and who to contact in case of an emergency, home and fire safety, first aid, CPR, how to help a child that is choking, discipline, food preparation and feeding. Many parents request that sitters receive this basic training, therefore, this class serves as an entry into the world of work.



## Goals

- 1 Provide babysitting education to youth in locations with high age-adjusted mortality rates (census tracts within the 3<sup>rd</sup> or 4<sup>th</sup> quartiles).
- 2 Build knowledge and skills in youth to help them become responsible and safe sitters.

## Objectives

- 1 Serve at least 200 youth in year one (2017).
- 2 Increase by 10% annually the number of youth served in years two and three (2018 and 2019).
- 3 Add one new delivery location annually (2017 to 2019) in an area with high age-adjusted mortality rates.
- 4 Increase by 20% the knowledge and skills demonstrated by youth.

**Table 15.** *Babysitting with Confidence – Goals and Objectives*

### Anticipated Impacts:

#### Trust

- The trust between Lakeland staff and the community will increase.

#### Capacity

- Youth capacity to care for infants, toddlers and small children will be enhanced, especially in medically underserved areas.
- Former program participants will be able to instruct part of the course in subsequent years (2018 and 2019).

#### Knowledge, Attitudes and Behaviors

- Youth will be equipped with skills and knowledge to provide unsupervised care to infants, toddlers and small children.

**Programs and resources that Lakeland will to commit to Babysitting with Confidence.** Lakeland associates in CHW (e.g., registered nurses, a registered dietitian and clinical educators) will execute the program, market the class, print class materials (e.g., books and checklists), and provide supplies (e.g., dolls) for hands-on activities and snacks. Lakeland also contributes space and staff time to support evaluation procedures. Community Benefit resources will be allocated, as needed.

### **Planned collaborations between Lakeland and other facilities or organizations for Babysitting with Confidence.**

The St. Joseph, Niles, Benton Harbor and other local public safety departments will assist with marketing the program and providing education regarding home security and safety. The Niles Women's Service League will provide marketing support and snacks for the classes that take place in Niles. The BCHD will provide educational material regarding "Safe Sleep." Great Start Collaborative will craft developmentally appropriate education (e.g., activities for kindergarten readiness for toddlers). Local schools will also assist with the marketing of the program. New collaborators will emerge as the program evolves.

Activity Category 5: Organizational Infrastructure

**Priority Health Needs Addressed:** Mental Health, Obesity, Diabetes, Cost of Care, Provider Availability, Health Education and Information, Health Behaviors and Food Environment.

In order to effectively execute the IS, it will be necessary to marshal a range of technical, human, financial and other resources.

Goals	
1	Secure financial, human, technical and other resources to support the IS.
2	Build the capacity of CHW at Lakeland to improve population health in the Lakeland service area.
Objectives	
1	Solicit grant support from local, state and federal funders.
2	Re-align and re-prioritize community benefit allocations to reflect PHN and the goals, objectives and intended outcomes of the IS.
3	Leverage existing human resources to support the work of CHW.
4	Ensure the CHW team has the proper technology needed to implement IS projects.
5	Engage in continuous learning to support the IS by attending trainings, conferences, and other educational activities to stay current on state-of-the-art thinking in the field of population health and health promotion.
6	CHW staff will build internal capacity to evaluate the IS and make programmatic and strategic adjustments by engaging with iEval.

Table 16. Organizational Infrastructure – Goals and Objectives

Anticipated Impacts:

Capacity

- CHW associates will generate resources needed to effectively develop, implement, evaluation and sustain the IS activities.

Knowledge, Attitudes and Behaviors

- CHW associates will develop the knowledge and skills, and acquire the behaviors needed to effectively develop, implement, evaluation and sustain the IS activities.

**Programs and resources that Lakeland will to commit to Organizational Infrastructure.** CHW `staff time to prepare and submit grant proposals, and to engage in training and other educational programs.

**Planned collaborations between Lakeland and other facilities or organizations for Organizational Infrastructure.** Local, regional and national foundations, and other funders and professional organizations, including colleges, and other credentialing, educational or training bodies.



## Appendices

### Evaluation Plan

CHW engaged iEval, the external evaluation team, early in the process of developing the IS. Involving trained evaluators at the beginning of the planning process exemplifies best practices identified by organizations like the American Evaluation Association, Centers for Disease Control. Bradley Cousins, authority on the participatory approach to evaluation, said that involving evaluators early in the process and having joint ownership of the process by the client and evaluators leads to mutual ownership of the data, deeper understandings, and increased opportunities for meaningful use of findings (<http://www.hfrp.org/evaluation/the-evaluation-exchange/issue-archive/participatory-evaluation/participatory-evaluation-enhancing-evaluation-use-and-organizational-learning-capacity>).

iEval will provide ongoing technical assistance for the IS based on the CHNA, including its overall outcome evaluation, the process and outcome evaluations of its constituent activities and its monthly dashboard process. In this first year, the evaluation plan will be informed by the ToC (illustrated in Image 2 below), focusing both at the **initiative level** (i.e., evaluating trust, capacity, and knowledge, attitudes and behaviors) as well as the **activity level** (i.e., evaluating the implementation of the activities that will lead to changes in environmental conditions and the degree to which these activities support the overall initiative).

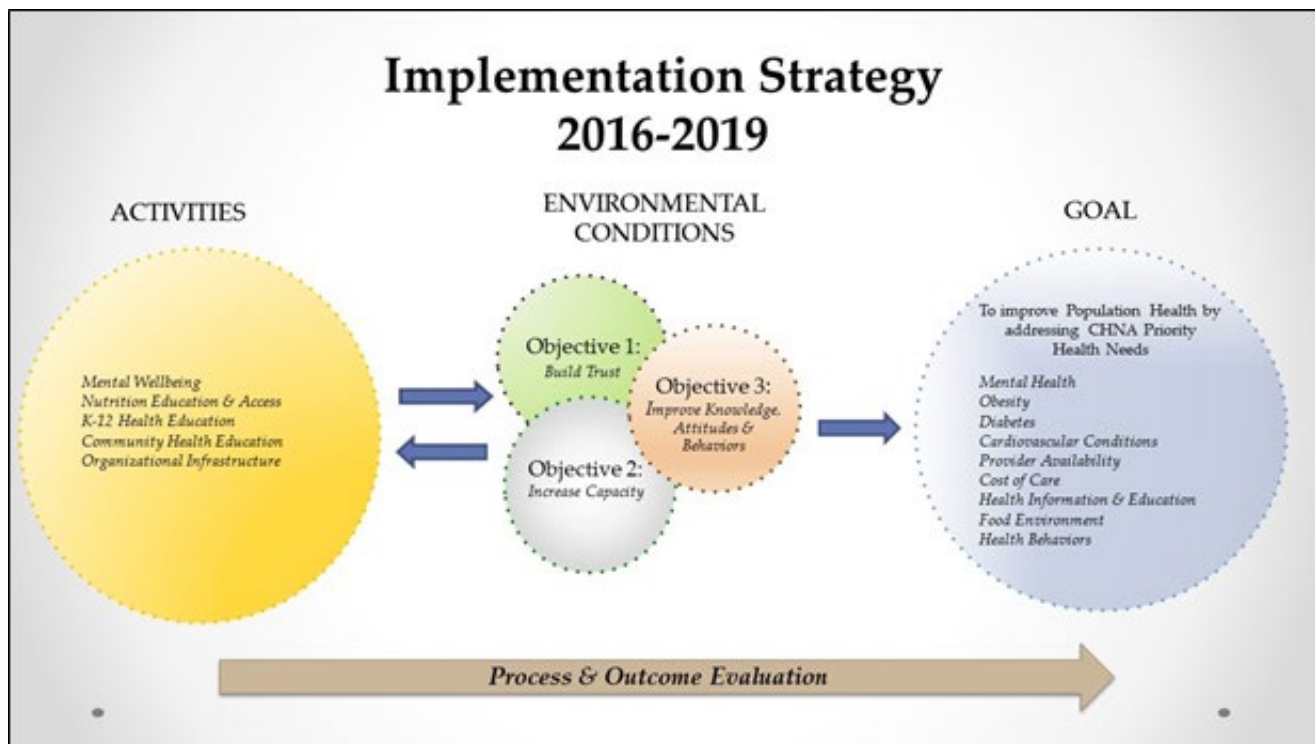


Image 2. Theory of Change

iEval will support this initiative in the development and execution of a comprehensive evaluation plan that will focus first on establishing baselines for each activity and then supporting ongoing data collection to answer key questions that will assess the outcomes and processes of the IS. Interviews, surveys, focus groups and program observations will be used to gather primary data as part of the analyses.



**Outcome Evaluation.** The outcome evaluation will focus on developing metrics for the activity-level outcomes and the initiative-level measures of trust, capacity, and changes in knowledge, attitudes and behaviors along with tools for collecting associated data. The data collection will begin with establishing a baseline so change over time can be evaluated in future years. The key evaluation questions, which are subject to revision and refinement as the IS is executed, focuses on both the initiative-level outcomes and the activity-level implementation and will include the following:

1. To what extent have the activities undertaken in the IS (i.e., Mental Wellbeing, Nutrition Education and Access, K-12 Health Education, Community Health Education and Organizational Infrastructure) impacted the trust that community members have in Lakeland?
2. To what extent have activities undertaken in the IS impacted the trust that Lakeland has in the community it serves?
3. To what extent have activities undertaken in the IS impacted the internal capacity of Lakeland to improve population health (e.g., training, materials and partnerships)?
4. To what extent have activities undertaken in the IS impacted the capacity of the community to improve population health (e.g., train-the-trainer models, skill-building and partnerships)?
5. To what extent have activities undertaken in the IS impacted the health-related (broadly defined) knowledge, attitudes and behaviors of Lakeland associates?
6. To what extent have activities undertaken in the IS impacted the health-related (broadly defined) knowledge, attitudes and behaviors of community residents?

**Process Evaluation.** Process indicators and associated measures for each of the activities that comprise the IS were developed in April 2017. A monthly dashboard, with key process indicators and associated measures, will be created as a way to focus formatively on each of the activities. The dashboard will be used in facilitated monthly discussions to inform refinements to the activities related to the IS with the aim of optimizing its outcomes. Key process questions (which are subject to revision and refinement as the IS is executed) include the following:

1. How has each activity been implemented (e.g., number of sessions, duration of sessions, type of sessions and location)?
2. What has been the community participation in each activity (e.g., number of participants, people from targeted areas and referrals)?
3. What is the level of community engagement or ownership in each activity (e.g., community-initiated work, change in community organizational policies or practices because of the activity)?
4. What are the strengths of each activity? How can these strengths be augmented, leveraged or more effectively utilized?
5. What are the challenges of each activity? How can challenges be mitigated or eliminated?
6. To what degree have the twelve different activities interacted, worked together or created any synergy in services to residents or the community?
7. To what extent has each activity served the residents of those census tracts that have high mortality rates?

## Evaluation Design

The evaluation design is multi-layered, focused on answering the evaluation questions outlined on page 44:

1. At the **initiative level**, the evaluation design addresses how the aggregation of the work done through all of the activities contribute to environmental changes (i.e., trust, internal or external capacity building, and knowledge, attitudes and behaviors) while addressing the PHN (i.e., health conditions, healthcare system, and social determinants of health).
2. At the **activity level**, the evaluation design addresses if each activity is being implemented as it is designed and what baseline outcome measures are available.

The table below illustrates how each activity contributes to the overall PHN and/or environmental changes:

Categories and Activities	Priority Health Needs									Environmental Change		
	Health Conditions				Healthcare System			Social Determinants of Health		Environmental Change		
	Mental Health	Obesity	Diabetes	Heart Conditions	Cost of Care	Provider Availability	Health Education and Information	Health Behaviors	Food Environment	Trust	Capacity	Knowledge, Attitudes and Behaviors
Mental Wellbeing (e.g., Adult Mental Health First Aid, Mental Health Youth Theatre, Youth Mental Health First Aid)												
Nutrition Education and Access (e.g., Benton Harbor Farmers Market, Community Kitchen Club)												
K-12 Health Education (e.g., Babysitting with Confidence, Coordinated School Health)												
Community Health Education (Neighborhood-based Health Homes: Elite Barbershop, Community Food Network and Harbor Towers; Community Health Screenings and Other Services; Community CPR and Babysitting with Confidence)												
Organizational Infrastructure												

**Table 17.** *Implementation Strategy Activities – Impact on Priority Health Needs and Environment*

**Initiative Level.** The evaluation design addresses how the aggregation of the work done through all of the activities contribute to environmental changes (i.e., trust, internal or external capacity building, or knowledge, attitudes and behaviors) while addressing the priority health needs (i.e., health conditions, healthcare system and social determinants of health). This section highlights how the environmental changes will be evaluated. All of the evaluation components below address more than one category, but they are described in more detail under the category with which they most closely align. The table illustrates how the various evaluation components address multiple categories.

Evaluation Component	Trust		Capacity		Knowledge, Attitudes and Behaviors	
	Lakeland Trust Community	Community Trust Lakeland	External	Internal	Residents	Lakeland
CHW team survey						
Small group or one-on-one interviews with partners and residents						
CHW team track capacity building evidence						
Activity level surveys						
Activity level metrics (e.g., program dosage and outcomes)						

**Table 18.** *Categories Addressed by Evaluation Components*

## IS Evaluation Plan

### Activity Category 1: Mental Wellbeing

Lakeland Health Key Contact: *Terri Albers* | iEval Key Contact: *Dr. Kristin Everett*

#### Activity 1: Mental Health First Aid (Youth)

##### Goals

Increase participant knowledge of the signs, symptoms and risk factors for mental illness and addiction.

Improve participants' attitudes and perceptions regarding mental illness and addiction, thereby reducing stigma surrounding mental illness.

Increase participant knowledge of local, professional, peer and social resources available to those experiencing mental illness and addiction.

##### Objectives

Conduct 15 YMHA trainings (serving between 6 and 15 people per training) by December 31, 2017, and a minimum of 24 trainings annually in subsequent years (2018 and 2019).

Demonstrate at least a 50% increase in participant knowledge of the signs, symptoms and risk factors for mental illness and addiction.

Demonstrate at least a 50% improvement in participants' attitudes and perceptions regarding mental illness and addiction.

Demonstrate at least a 50% increase in participant knowledge of local resources, including professional, peer and social supports available to those experiencing mental illness and addiction.

Conduct at least 50% of YMHA trainings in locations with high age-adjusted mortality rates (census tracts within the 3<sup>rd</sup> or 4<sup>th</sup> quartiles).

##### Measures

Record of training locations, dates and attendance.

Pre/post opinion quizzes for YMHA participants.

Follow-up surveys with trainees after six months to ask about use of training.

##### Lakeland Support

Record training locations, dates and attendance.

Administer, enter data and analyze pre/post quizzes.

Develop follow-up survey for trainees.

Administer, enter data and analyze follow-up surveys of trainees.

##### iEval Support

Assist with data collection and analysis.

##### Timeline

Data collection and analysis ongoing through 2019.

*Table continued on next page.*

Activity 1: Mental Health First Aid (Youth) <i>(continued)</i>	
<b>Goal</b>	
Create a post-training support system for Youth Mental Health First Aiders.	
<b>Objectives</b>	
A minimum of one school or youth-serving organization will make a change in policy or practice to improve youth mental health and emotional wellbeing annually (2017 to 2019).	
Develop a database of trained Youth Mental Health First Aiders (including name, email address, mailing address, phone number, etc.) to aid post-training communication, program evaluation, and continued education and trainings by December 31, 2017.	
<b>Measures</b>	
Change(s) in school policy.	
Follow-up surveys with trainees after 6 months to ask about counseling referrals and support.	
Development of a YMHFA database of trained adults.	
<b>Lakeland Support</b>	
Record any policy changes.	
Enter and maintain data.	
Send out surveys.	
<b>iEval Support</b>	
Assist with data collection and analysis.	
<b>Timeline</b>	
Data collection and analysis ongoing through 2019.	

**Table 19.** *Evaluation Table – Mental Health First Aid (Youth)*



## IS Evaluation Plan

### Activity Category 1: Mental Wellbeing

Lakeland Health Key Contact: *Margaret Clayborn* | iEval Key Contact: *Dr. Kristin Everett*

#### Activity 1: Mental Health First Aid (Adult)

##### Goals

Increase participant knowledge of the signs, symptoms and risk factors for mental illness and addiction

Improve participants' attitudes and perceptions regarding mental illness and addiction, thereby reducing stigma surrounding mental illness.

Increase participant knowledge of local, professional, peer and social resources available to those experiencing mental illness and addiction.

##### Objectives

Conduct between 18 and 20 AMHFA trainings (serving between 5 and 15 people per training) by December 31, 2017, and a minimum of 24 trainings annually in subsequent years (2018 and 2019).

Demonstrate at least a 50% increase in participant knowledge of the signs, symptoms and risk factors for mental illness and addiction.

Demonstrate at least a 50% improvement in participants' attitudes and perceptions regarding mental illness and addiction.

Demonstrate at least a 50% increase in participant knowledge of local resources, including professional, peer and social supports available to those experiencing mental illness and addiction.

##### Objectives

Conduct at least 50% of the AMHFA trainings in locations with high age-adjusted mortality rates (census tracts within the 3<sup>rd</sup> or 4<sup>th</sup> quartiles).

A minimum of one organization will make a change in policy or practice to improve adult mental health and emotional wellbeing annually (2017 to 2019).

##### Measures

Pre/post quizzes for AMHFA participants.

Survey.

Schedule of training dates.

A record of attendance.

##### Measures

List of training locations.

Change in organizational policy or practice.

Survey.

##### Lakeland Support

Administer, enter and analyze pre/post quizzes and surveys (section 3).

Create and maintain a record of training locations and dates.

Create and maintain a record for attendance.

##### Lakeland Support

Record training locations.

Compare training locations to target areas based on CHNA.

Work with organizations to answer questions and develop policies.

##### iEval Support

Assist with data collection and analysis.

##### Timeline

Data collection and analysis ongoing through 2019.

*Table continued on next page.*

### Activity 1: Mental Health First Aid (Adult) *(continued)*

#### Goal

Create a post-training support system for Adult Mental Health First Aiders.

#### Objective

Develop a database of trained Adult Mental Health First Aiders (including name, email address, mailing address, phone number, etc.) to aid post-training communication, program evaluation, and continued education and trainings by December 31, 2017.

#### Measures

Surveys.

AMHFA database of trained adults.

#### Lakeland Support

Create and administer surveys.

Enter and maintain data.

#### iEval Support

Assist with data collection and analysis.

#### Timeline

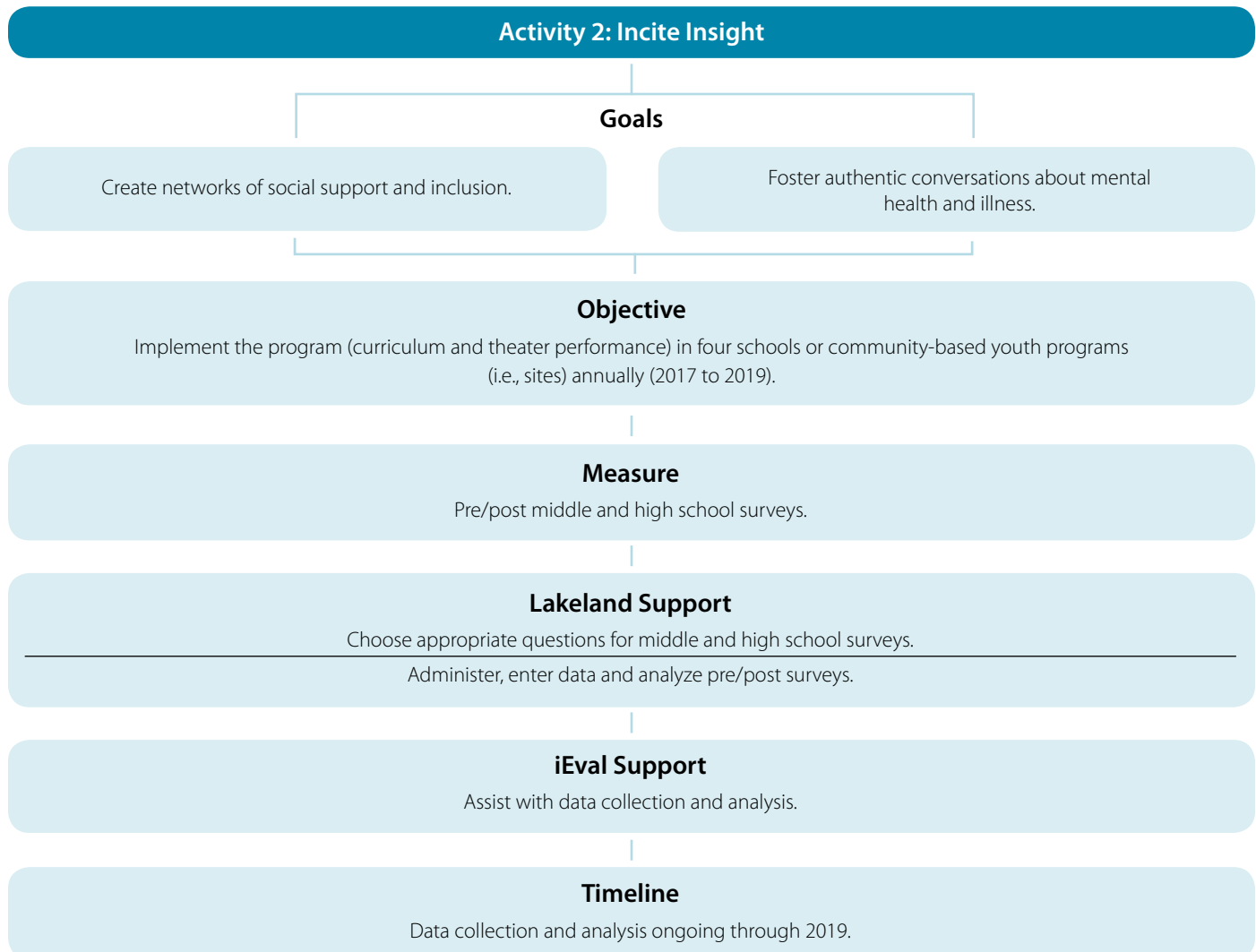
Data collection and analysis ongoing through 2019.

**Table 20.** *Evaluation Table – Mental Health First Aid (Adults)*

## IS Evaluation Plan

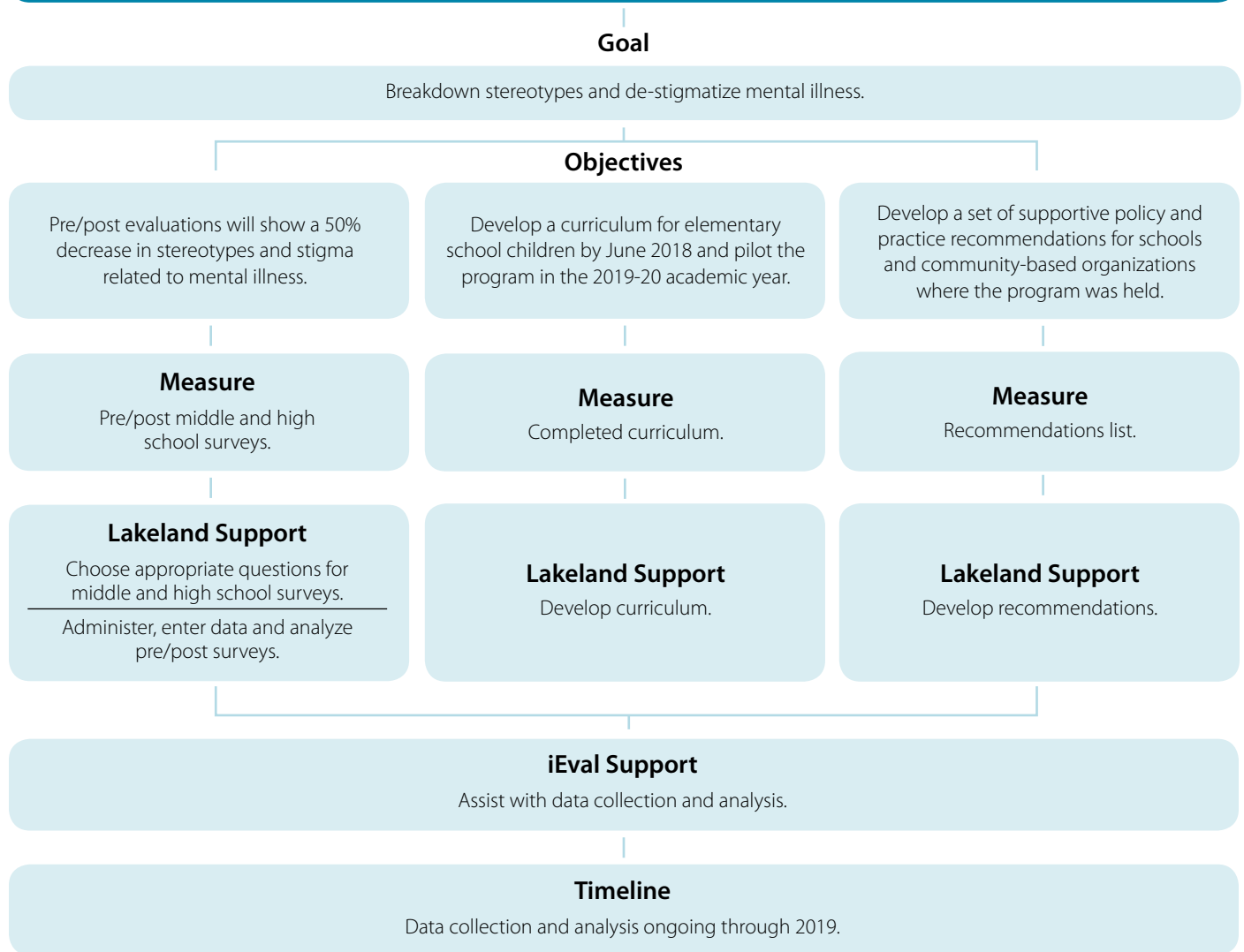
### Activity Category 1: Mental Wellbeing

Lakeland Health Key Contact: *Leah Tirado* | iEval Key Contact: *Dr. Kristin Everett*



*Table continued on next page.*

## Activity 2: Incite Insight *(continued)*



*Table continued on next page.*

## IS Evaluation Plan

### Activity Category 1: Mental Wellbeing

Lakeland Health Key Contact: *Leah Tirado* | iEval Key Contact: *Dr. Kristin Everett*

#### Activity 2: Incite Insight (continued)

##### Goal

Build capacity within schools and community-based youth programs to sustain Incite Insight.

##### Objectives

Execute a staged implementation and capacity building process that produces 12 independently operating sites in 2020.

Between 80 and 100 youth will complete the curriculum, and between 40 and 60 youth will participate in a performance in each year of the project period (2017 to 2019).

Identify two champions (one adult and one student) at each school to become implementers of the program.

##### Measures

Sessions held each year.  
Record of student attendance.

##### Measures

Number of sessions held each year.  
Record of student attendance.  
Number of champions identified.

##### Lakeland Support

Record number of sessions held.  
Record student attendance.

##### Lakeland Support

Record number of sessions held.  
Record student attendance.  
Record information about champions.

##### iEval Support

Assist with data collection and analysis.

##### Timeline

Data collection and analysis ongoing through 2019.

**Table 21.** *Evaluation Table – Incite Insight*



# IS Evaluation Plan

## Activity Category 2: Nutrition Education and Access

Lakeland Health Key Contact: *Heather Rudnik* | iEval Key Contact: *Corey Smith*

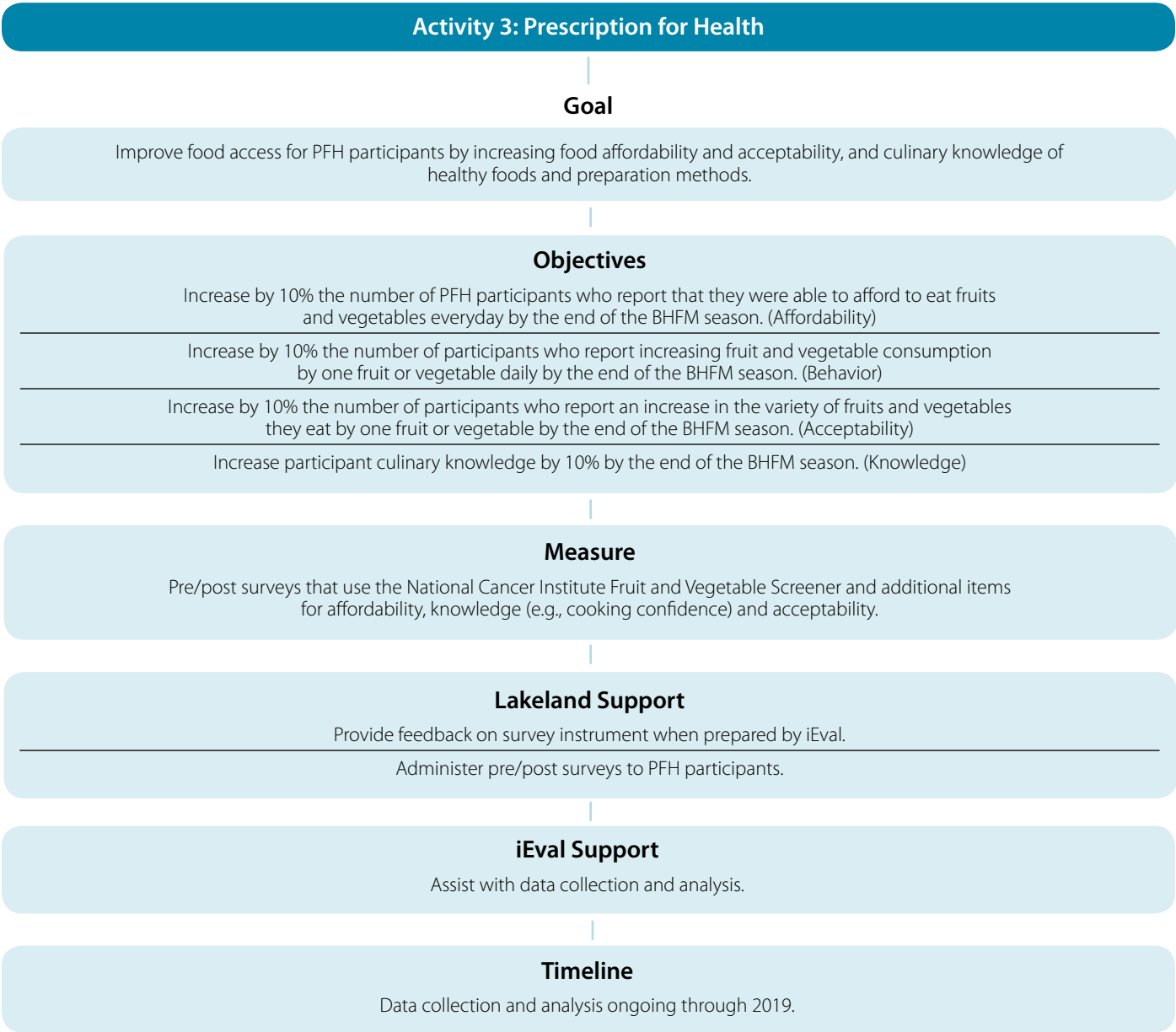
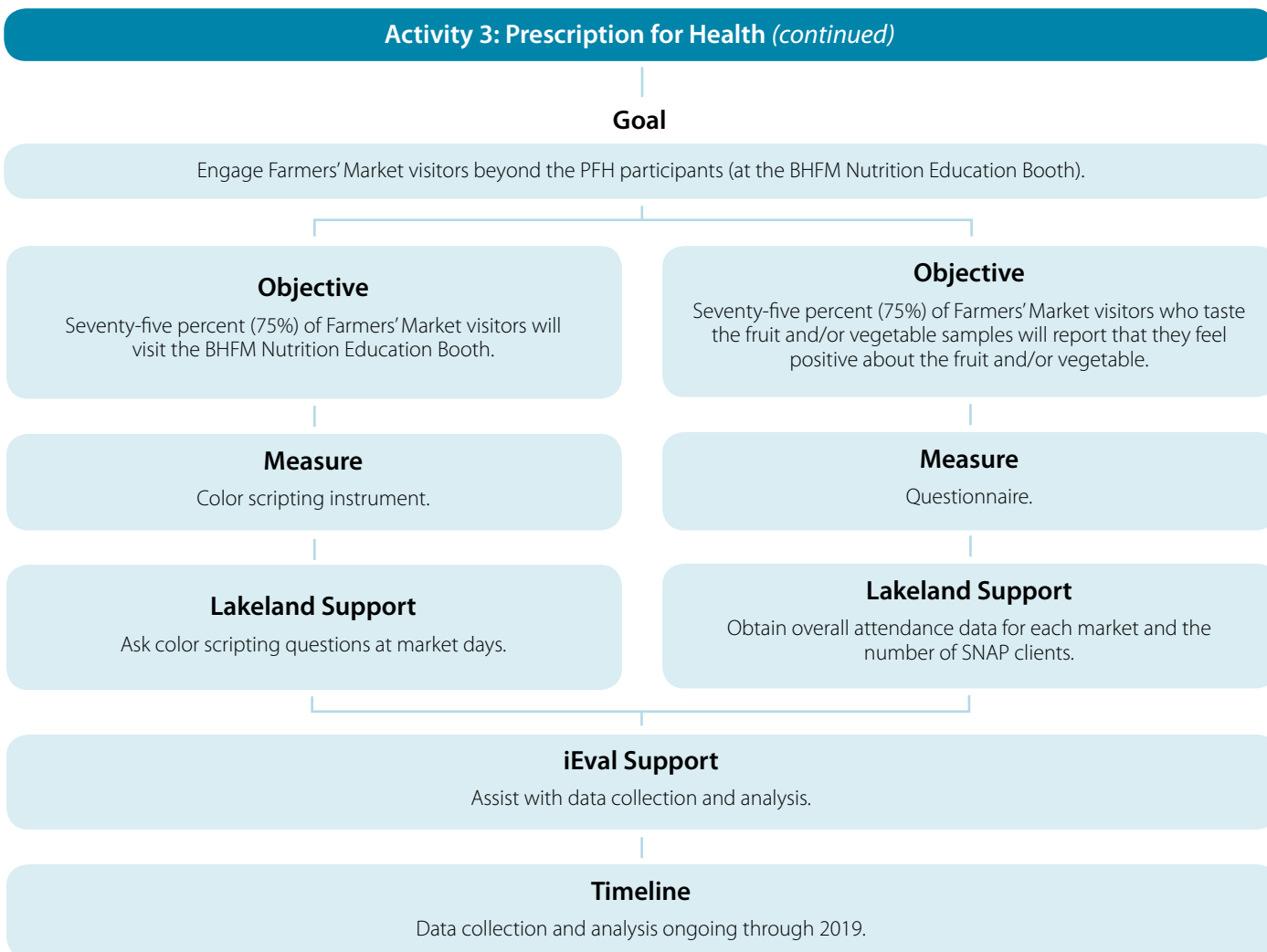


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## IS Evaluation Plan

### Activity Category 2: Nutrition Education and Access

Lakeland Health Key Contact: *Heather Rudnik* | iEval Key Contact: *Corey Smith*



**Table 22.** *Evaluation Table – Prescription for Health*

## IS Evaluation Plan

### Activity Category 2: Nutrition Education and Access

Lakeland Health Key Contacts: *Becky Carpio-Fonseca and Soraya Fish* | iEval Key Contact: *Dr. Kristin Everett*

#### Activity 4: Taller Comunitario de cocina y nutrición (Community Kitchen Club)

##### Goal

Improve diet related health behaviors among program participants in Benton Harbor and Stevensville.

##### Objectives

Increase by 25% participant knowledge of basic nutrition concepts.

Increase by 25% participant knowledge of making healthy recipes at home.

##### Measures

Pre/post-tests.

Color scripting.

Record of attendance.

##### Lakeland Support

Administer, enter data and analyze pre/post surveys/tests.

Administer and analyze color scripting questions at the end of each series of classes.

Identify food resources in the community.

Track attendance.

##### iEval Support

Assist with data collection and analysis.

##### Timeline

Data collection and analysis ongoing through 2019.

*Table continued on next page.*

## IS Evaluation Plan

### Activity Category 2: Nutrition Education and Access

Lakeland Health Key Contacts: *Becky Carpio-Fonseca and Soraya Fish* | iEval Key Contact: *Dr. Kristin Everett*

#### Activity 4: Taller Comunitario de cocina y nutrición (Community Kitchen Club) (continued)

##### Goal

Increase participant awareness of food resources to increase access to food.

##### Objectives

Fifty percent (50%) of participants will have accessed one new local food resource by the end of one session.

Increase by 25% participants' consumption of fruits, vegetables and whole grains.

##### Measures

Pre/post-tests.

Color scripting.

Record of attendance.

##### Lakeland Support

Administer, enter data and analyze pre/post surveys/tests.

Administer and analyze color scripting questions at the end of each series of classes.

Identify food resources in the community.

Track attendance.

##### iEval Support

Assist with data collection and analysis.

##### Timeline

Data collection and analysis ongoing through 2019.

*Table continued on next page.*

#### Activity 4: Taller Comunitario de cocina y nutrición (Community Kitchen Club) *(continued)*

##### Goal

Increase participant confidence in their ability to prepare nutritionally balanced meals.

##### Objective

Increase participants' ability to cook with locally available foods.

##### Measures

Pre/post-tests.

Color scripting.

Record of attendance.

##### Lakeland Support

Administer, enter data and analyze pre/post surveys/tests.

Administer and analyze color scripting questions at the end of each series of classes.

Identify food resources in the community.

Track attendance.

##### iEval Support

Assist with data collection and analysis.

##### Timeline

Data collection and analysis ongoing through 2019.

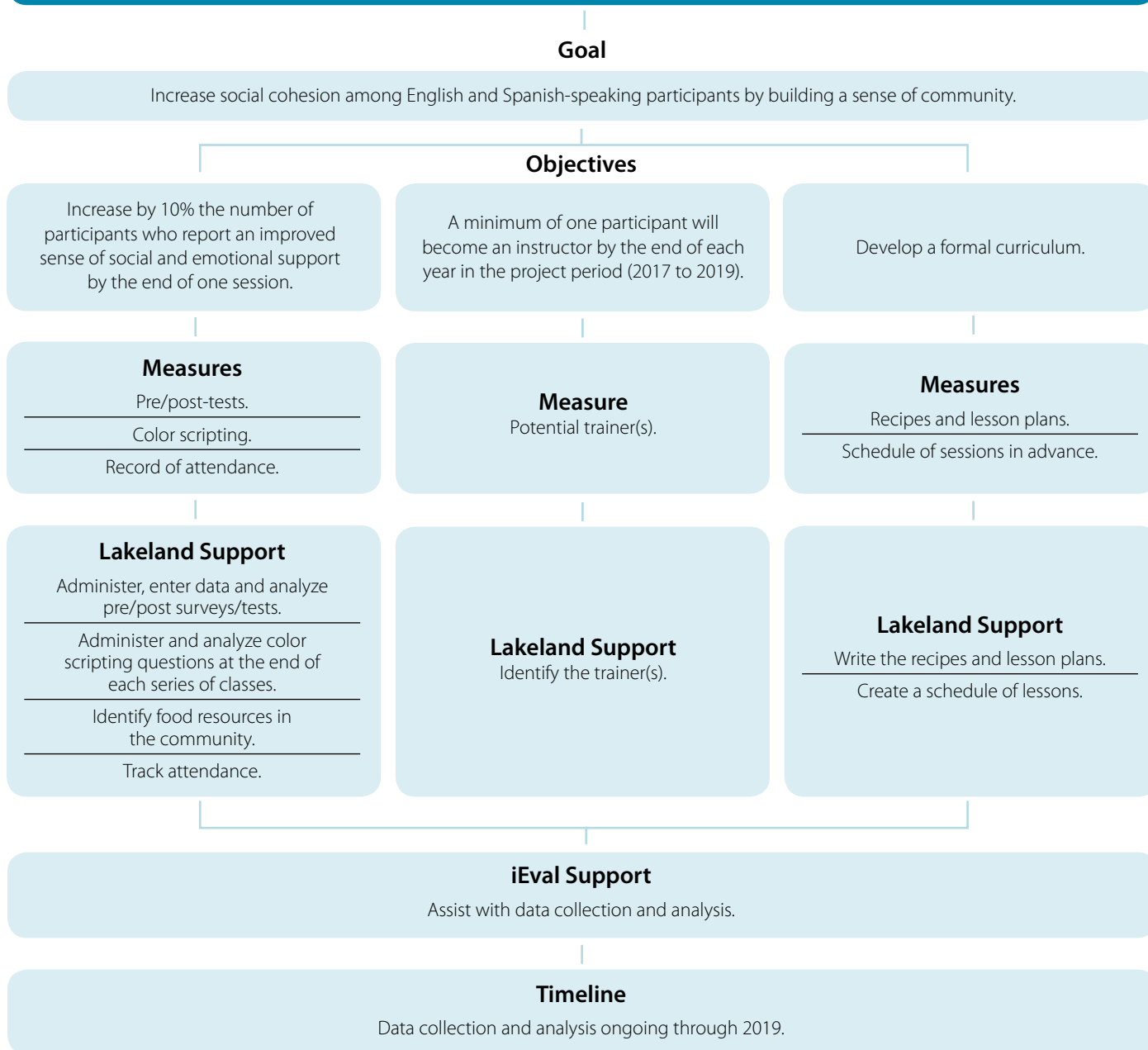
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## IS Evaluation Plan

### Activity Category 2: Nutrition Education and Access

Lakeland Health Key Contacts: *Becky Carpio-Fonseca and Soraya Fish* | iEval Key Contact: *Dr. Kristin Everett*

#### Activity 4: Taller Comunitario de cocina y nutrición (Community Kitchen Club) (continued)



**Table 23.** Evaluation Table – Taller Comunitario de cocina y nutrición (Community Kitchen Club)

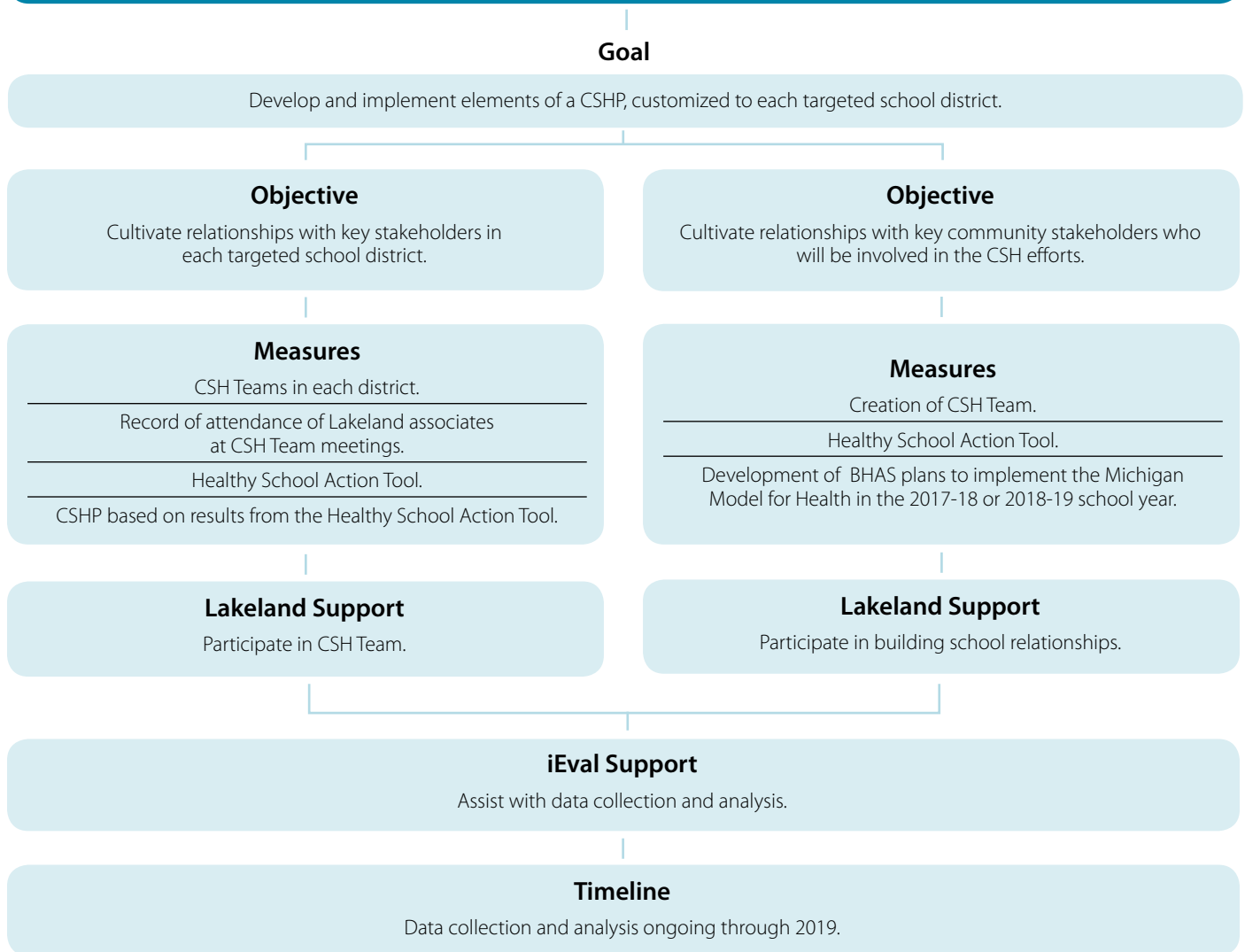


## IS Evaluation Plan

### Activity Category 3: K-12 Health Education

Lakeland Health Key Contact: *Ashlee Offord* | iEval Key Contact: *Dr. Wendy Tackett*

#### Activity 5: Coordinated School Health



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IS Evaluation Plan

Activity Category 3: K-12 Health Education

Lakeland Health Key Contact: Ashlee Offord | iEval Key Contact: Dr. Wendy Tackett

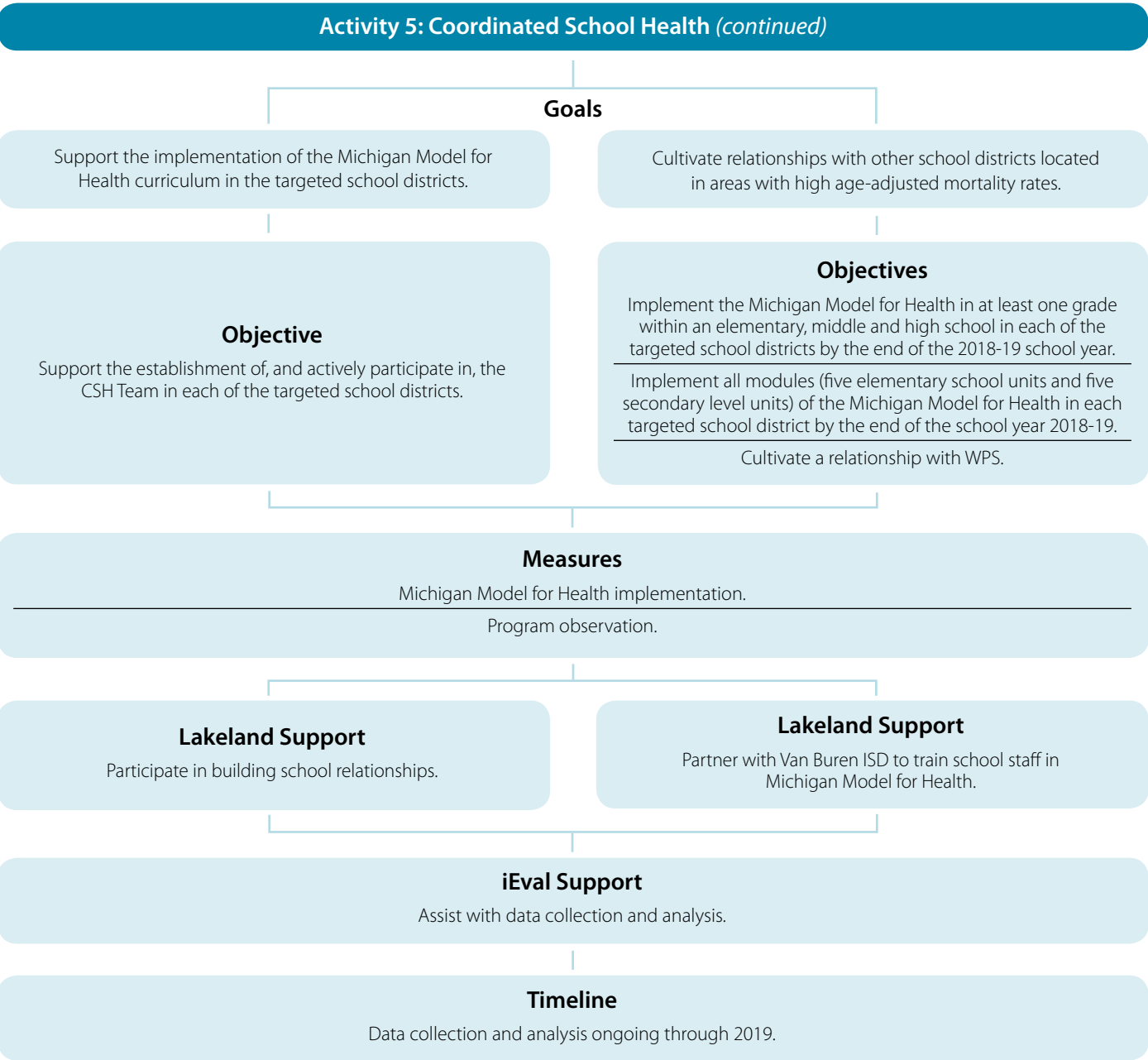


Table 24. Evaluation Table – Coordinated School Health

## IS Evaluation Plan

### Activity Category 4: Community Health Education

Lakeland Health Key Contacts: *Dr. Lynn Todman and Tami Goslee* | iEval Key Contact: *Corey Smith*

#### Activity 6: Neighborhood-Based Health Home - Elite Barbershop

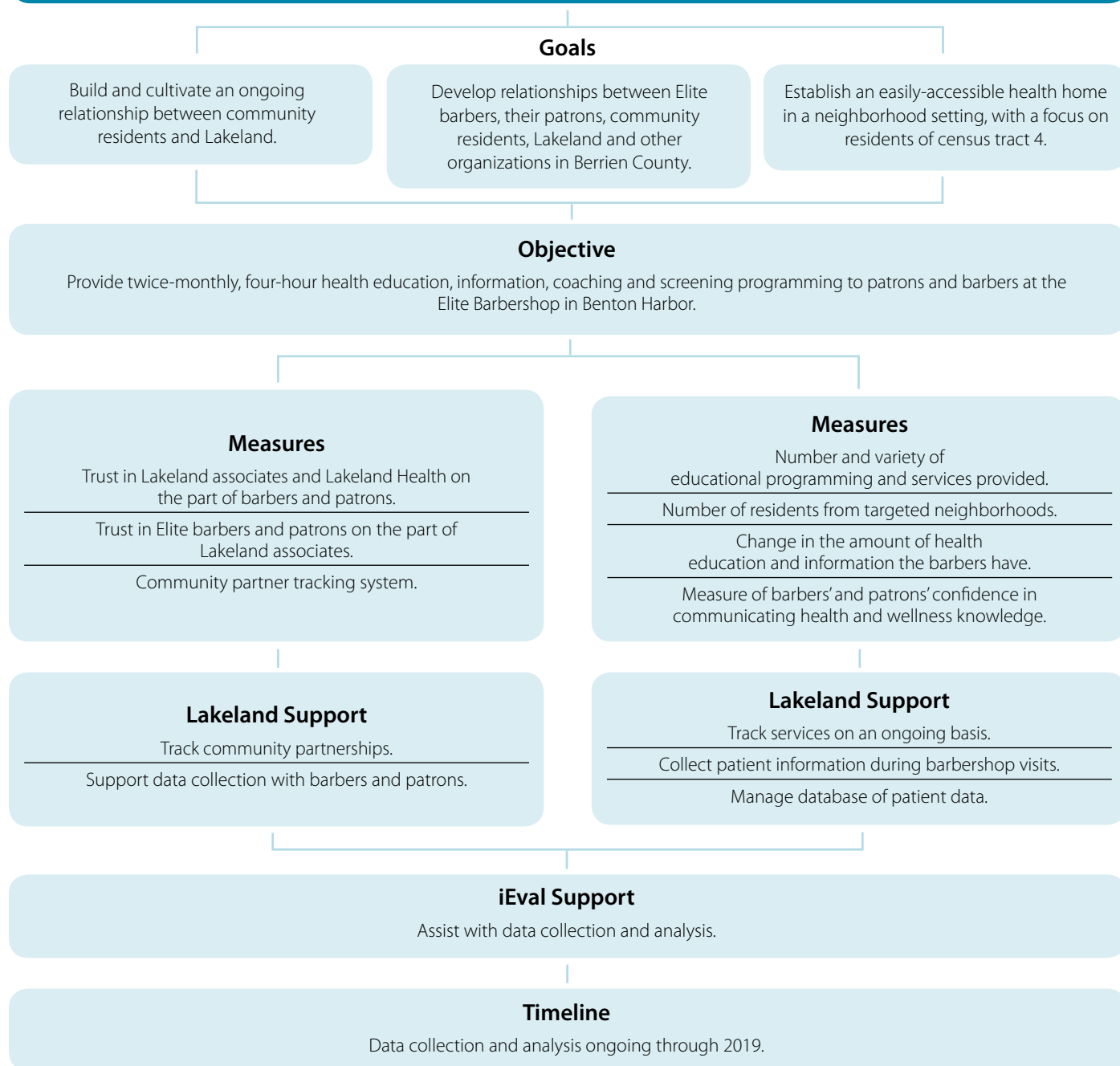


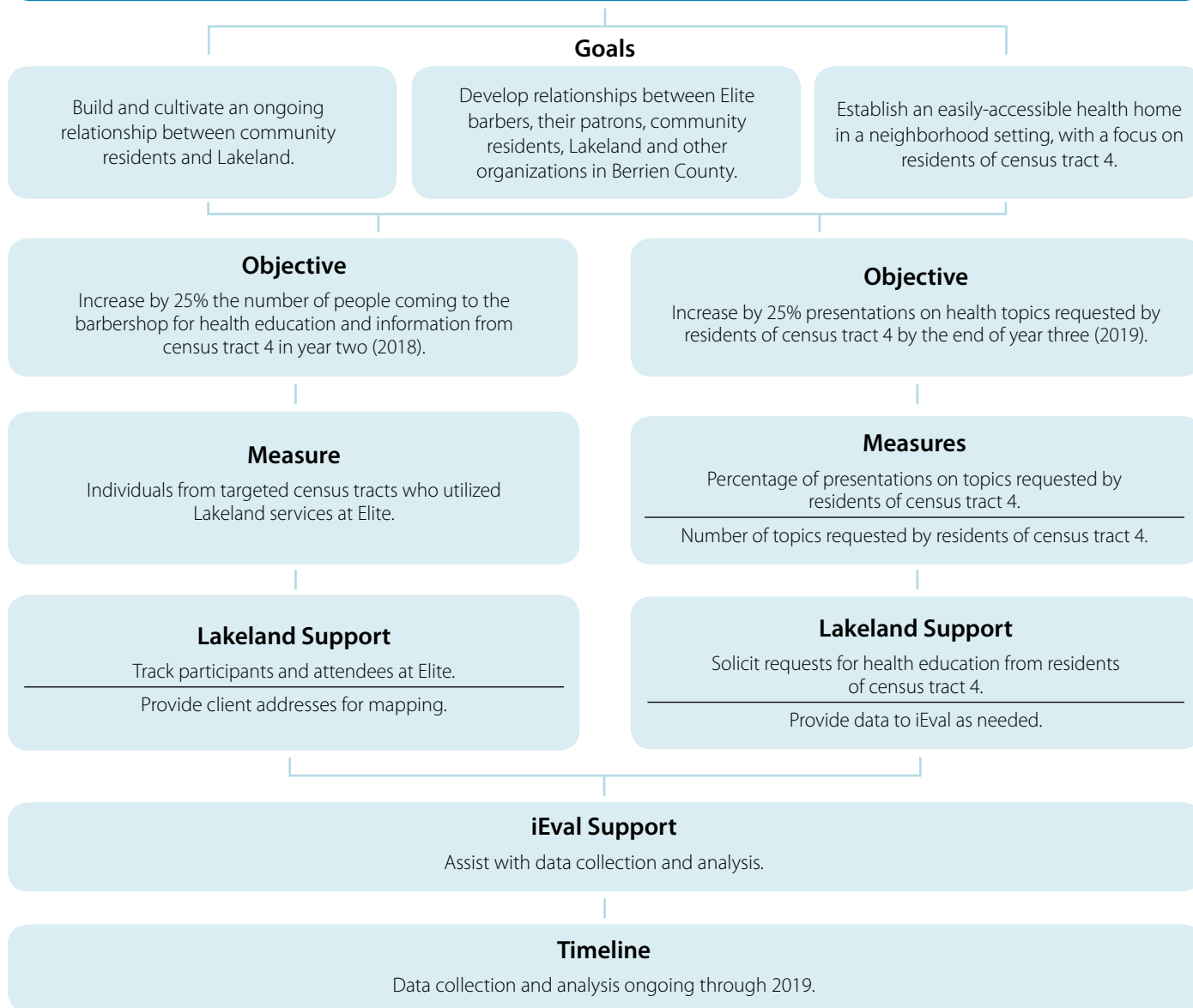
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## IS Evaluation Plan

### Activity Category 4: Community Health Education

Lakeland Health Key Contacts: *Dr. Lynn Todman and Tami Goslee* | iEval Key Contact: *Corey Smith*

#### Activity 6: Neighborhood-Based Health Home - Elite Barbershop (*continued*)



*Table continued on next page.*

### Activity 6: Neighborhood-Based Health Home - Elite Barbershop *(continued)*

#### Goal

Develop a system of mutual support and collective accountability for health behaviors among patrons and barbers at Elite Barbershop by building the capacity and KABs of barbers to support and promote the health of their clients.

#### Objectives

Twenty-five percent (25%) of patrons will report holding themselves or others accountable for positive health behaviors.

Each barber will report increased interactions with patrons around health-related issues.

#### Measures

Instances where individuals held themselves or others accountable.

Interviews conducted with barbers.

#### Lakeland Support

Administer a data collection tool.

#### iEval Support

Assist with data collection and analysis.

#### Timeline

Data collection and analysis ongoing through 2019.

**Table 25.** *Evaluation Table – Neighborhood-Based Health Home - Elite Barbershop*

IS Evaluation Plan

Activity Category 4: Community Health Education

Lakeland Health Key Contact: *Erin Salvagione* | iEval Key Contact: *Corey Smith*

Activity 7: Neighborhood-Based Health Home - Community Food Network

Goal
Build the relationship between members of the CFN and Lakeland.
Objective
Provide twice-monthly education, information, coaching and screening programming to members of the CFN in Benton Heights.
Measures
Educational programming and services provided.
Residents from targeted neighborhoods who used educational programming and health coaching or monitoring services.
Amount of health education and information members have as a result of this program.
Members' confidence in communicating health and wellness knowledge to neighbors, family members and friends.
Lakeland Support
Track services on an ongoing basis.
Collect patient information during educational sessions.
Manage database of patient data.
iEval Support
Assist with data collection and analysis.
Timeline
Data collection and analysis ongoing through 2019.

Table continued on next page.



## Activity 7: Neighborhood-Based Health Home - Community Food Network *(continued)*

### Goal

Establish an easily-accessible health home in a neighborhood setting.

### Objective

Increase by 20% annually (2017 to 2019), those served who reside in census tracts with the highest age-adjusted mortality rates (3<sup>rd</sup> or 4<sup>th</sup> quartiles).

### Measure

Individuals from targeted census tracts who utilized services provided by the CFN.

### Lakeland Support

Track participants and attendees at CFN.

Provide client addresses for mapping.

### iEval Support

Assist with data collection and analysis.

### Timeline

Data collection and analysis ongoing through 2019.

*Table continued on next page.*

IS Evaluation Plan

Activity Category 4: Community Health Education

Lakeland Health Key Contact: *Erin Salvagione* | iEval Key Contact: *Corey Smith*

Activity 7: Neighborhood-Based Health Home - Community Food Network (continued)

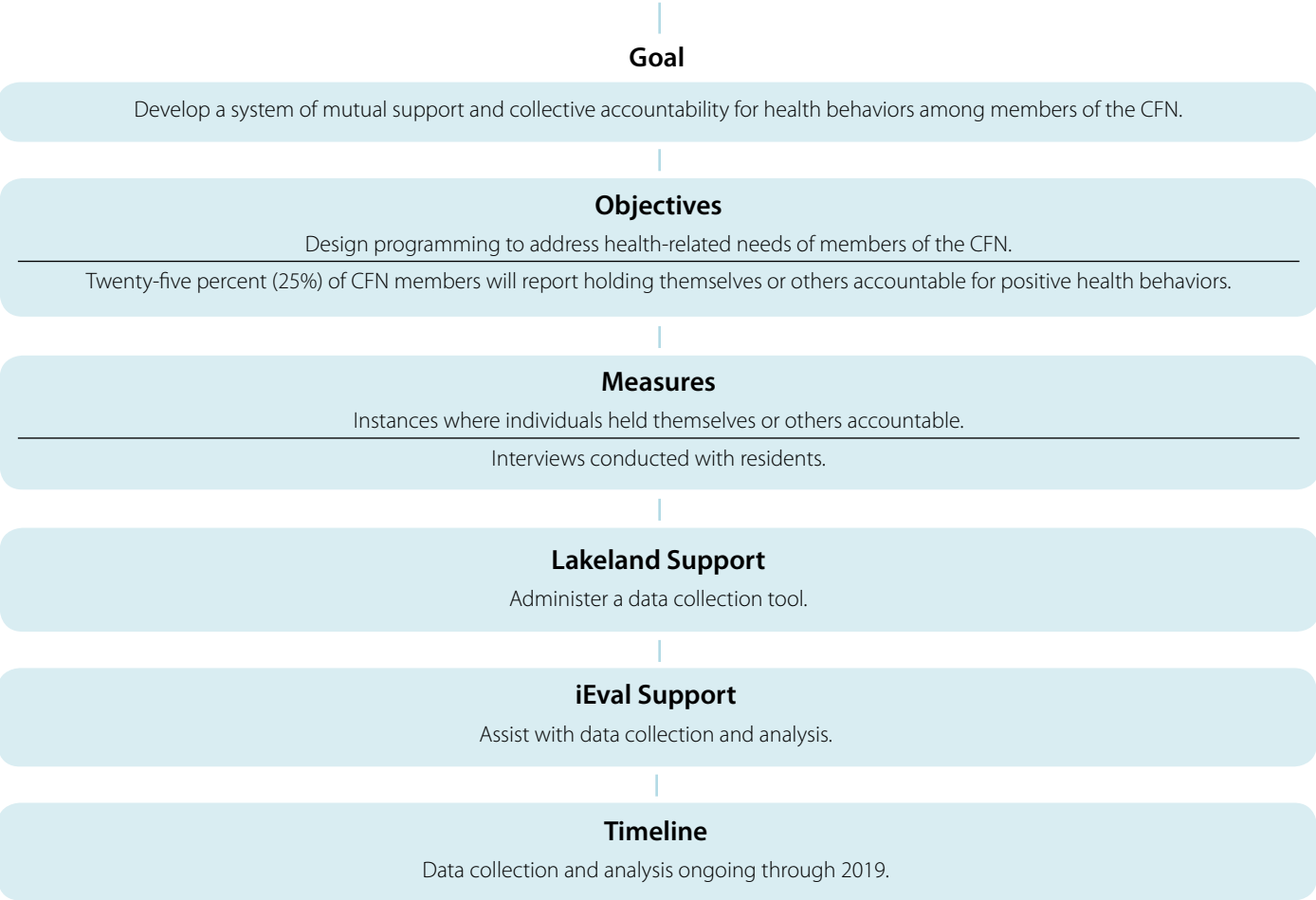


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**Activity 7: Neighborhood-Based Health Home - Community Food Network** *(continued)*

**Goal**

Increase input into program design by members of the CFN.

**Objective**

Increase by 25% presentations on health topics requested by residents of census tract 23 by the end of year three (2019).

**Measures**

Presentations on topics requested by residents of census tract 23.

Topics requested by residents of census tract 23.

**Lakeland Support**

Solicit requests for health education from residents of census tract 23.

Provide data to iEval as needed.

**iEval Support**

Assist with data collection and analysis.

**Timeline**

Data collection and analysis ongoing through 2019.

**Table 26.** *Evaluation Table – Neighborhood-Based Health Home – Community Food Network*

## IS Evaluation Plan

### Activity Category 4: Community Health Education

Lakeland Health Key Contacts: *Margaret Clayborn and Paula Rutland* | iEval Key Contact: *Dr. Wendy Tackett*

#### Activity 8: Neighborhood-Based Health Home - Harbor Towers

##### Goal

Increase social cohesion among residents at Harbor Towers.

##### Objectives

A nurse and outreach coordinator will be on-site at least twice weekly to provide basic healthcare services and support the development and growth of support groups.

##### Objectives

Establish one resident-run support group annually (2017 to 2019).

##### Measures

Tracking system that includes, dates, times and types of basic health services provided at Harbor Towers.

Record of participation in Lakeland services at Harbor Towers.

##### Measures

Support groups led by residents.

Resident-led support group meetings held annually.

##### Lakeland Support

Maintain service calendar.

Maintain resident participation data in spreadsheet.

Distribute survey (e.g., door-to-door or at community meetings) and collect surveys (e.g., drop-off boxes or personal connections).

Identify survey incentives.

Maintain survey data in spreadsheet.

##### iEval Support

Assist with data collection and analysis.

##### Timeline

Data collection and analysis ongoing through 2019.

*Table continued on next page.*

## Activity 8: Neighborhood-Based Health Home - Harbor Towers (continued)

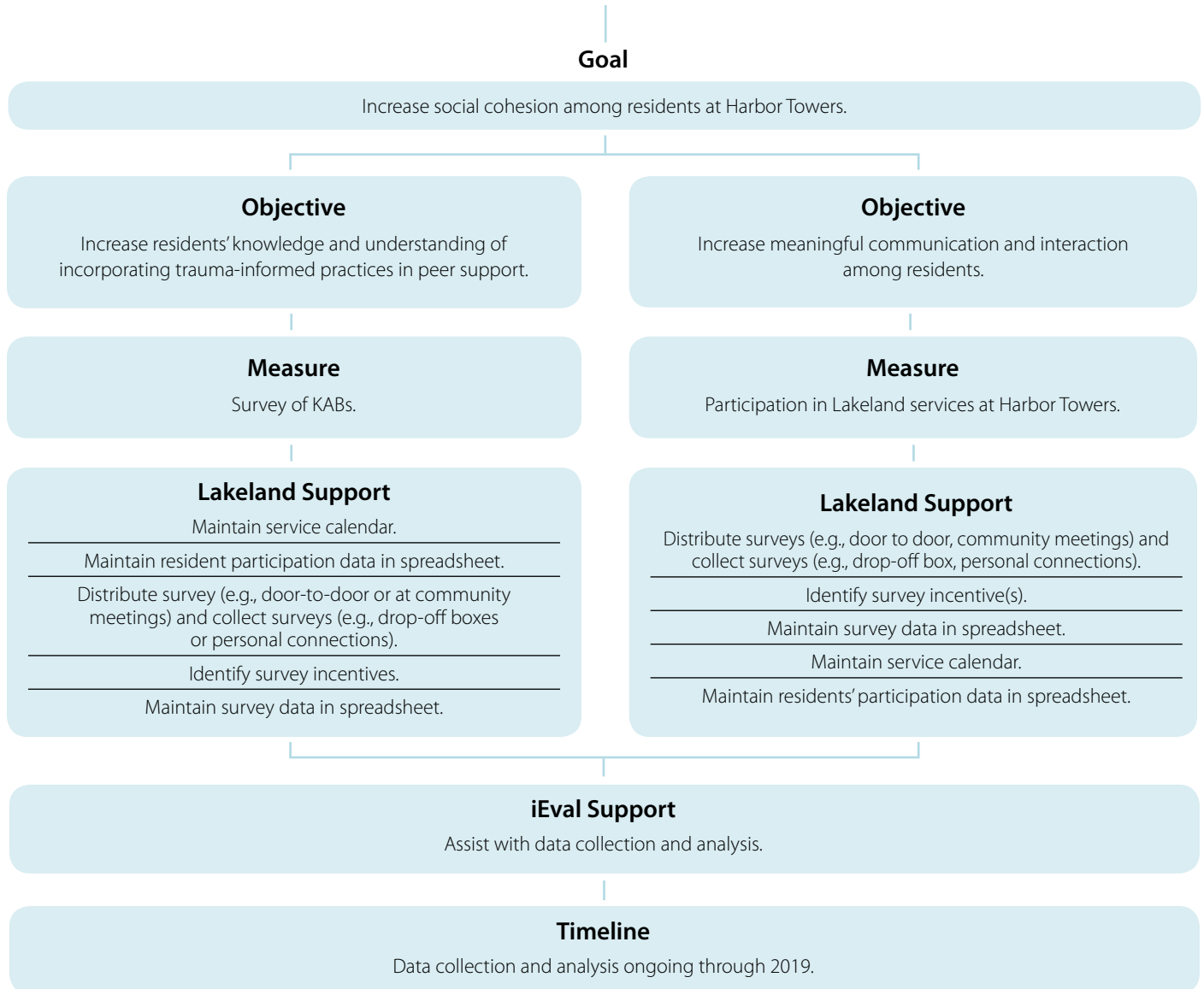


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## IS Evaluation Plan

### Activity Category 4: Community Health Education

Lakeland Health Key Contacts: *Margaret Clayborn and Paula Rutland* | iEval Key Contact: *Dr. Wendy Tackett*

#### Activity 8: Neighborhood-Based Health Home - Harbor Towers (continued)

##### Goal

Increase the number of residents with health-related problems who use on-site services provided by Lakeland.

##### Objectives

Increase by 25% annually (2017 to 2019) the number of residents who access on-site nursing services.

Seventy-five percent (75%) of residents identified with chronic medical needs (e.g., hypertension, diabetes or obesity) will access ongoing care from the on-site nurse.

##### Objective

Fifty percent (50%) of residents who attend support groups will attend the meetings at least 50% of the time.

##### Measure

N/A

##### Measures

Resident-led support group meetings held per year.

Participation in support groups.

##### Lakeland Support

Distribute surveys (e.g., door to door, community meetings) and collect surveys (e.g., drop-off box, personal connections).

Identify survey incentive(s).

Maintain survey data in spreadsheet.

Maintain service calendar.

Maintain residents' participation data in spreadsheet.

##### Lakeland Support

Maintain data in spreadsheet.

##### iEval Support

Assist with data collection and analysis.

##### Timeline

Data collection and analysis ongoing through 2019.

**Table 27.** Evaluation Table – A Neighborhood-Based Health Home – Harbor Towers

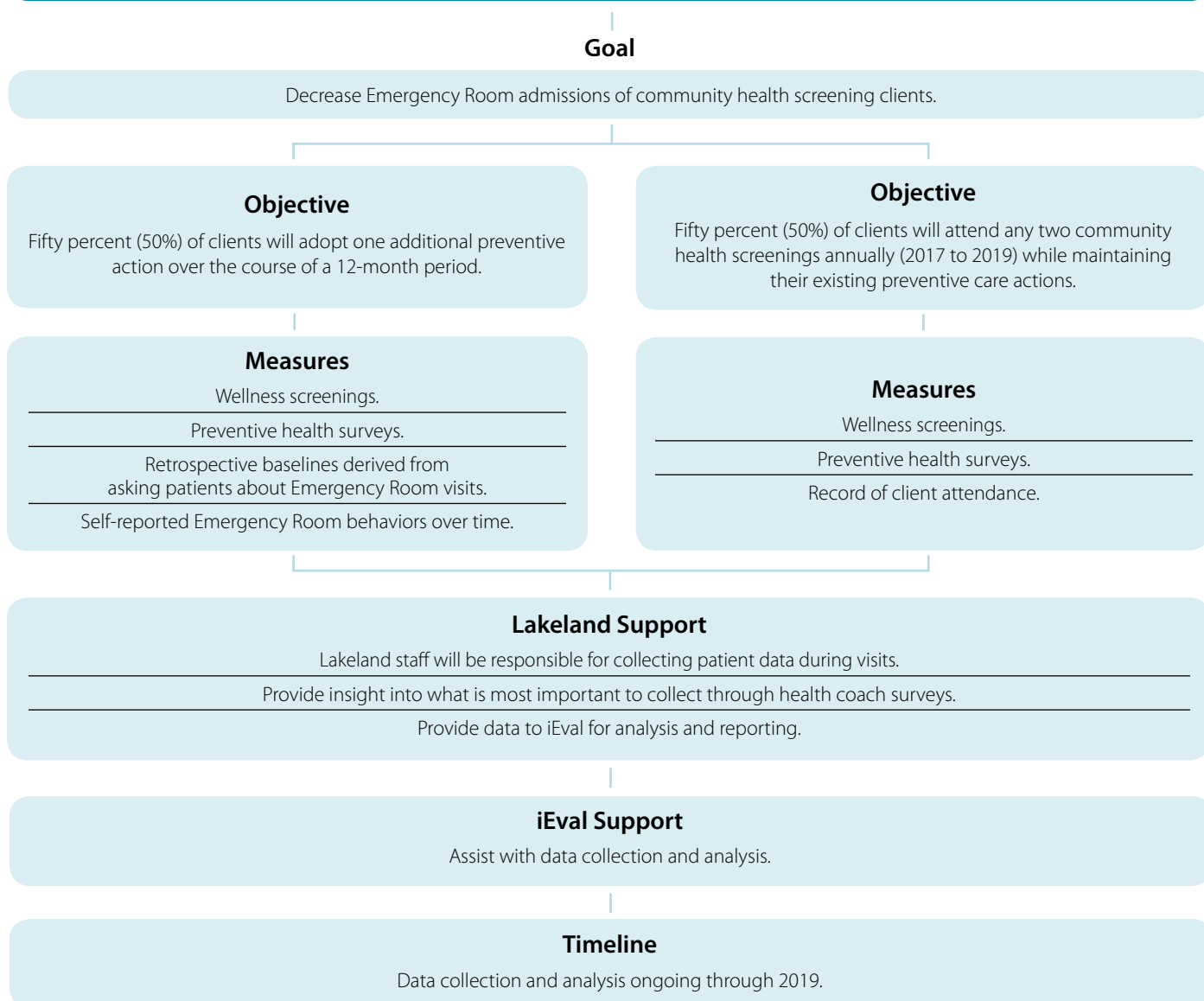


## IS Evaluation Plan

### Activity Category 4: Community Health Education

Lakeland Health Key Contacts: *Tami Goslee and Ashlee Offord* | iEval Key Contact: *Corey Smith*

#### Activity 9: Community Health Screenings and Other Services



*Table continued on next page.*

IS Evaluation Plan

Activity Category 4: Community Health Education

Lakeland Health Key Contacts: Tami Goslee and Ashlee Offord | iEval Key Contact: Corey Smith

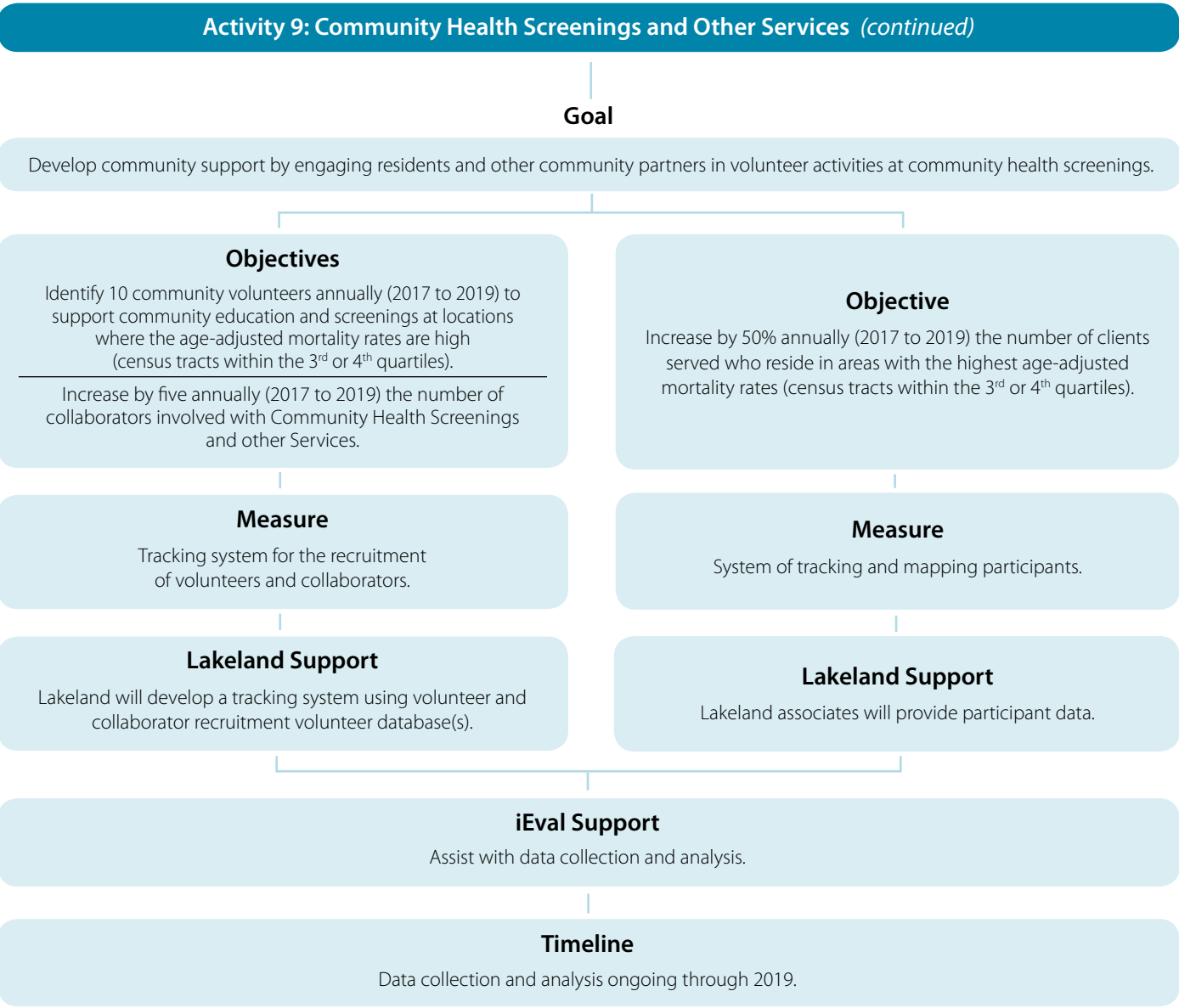


Table 28. Evaluation Table – Community Health Screenings and Other Services

## IS Evaluation Plan

### Activity Category 4: Community Health Education

Lakeland Health Key Contacts: *Tami Goslee and Ashlee Offord* | iEval Key Contact: *Dr. Wendy Tackett*

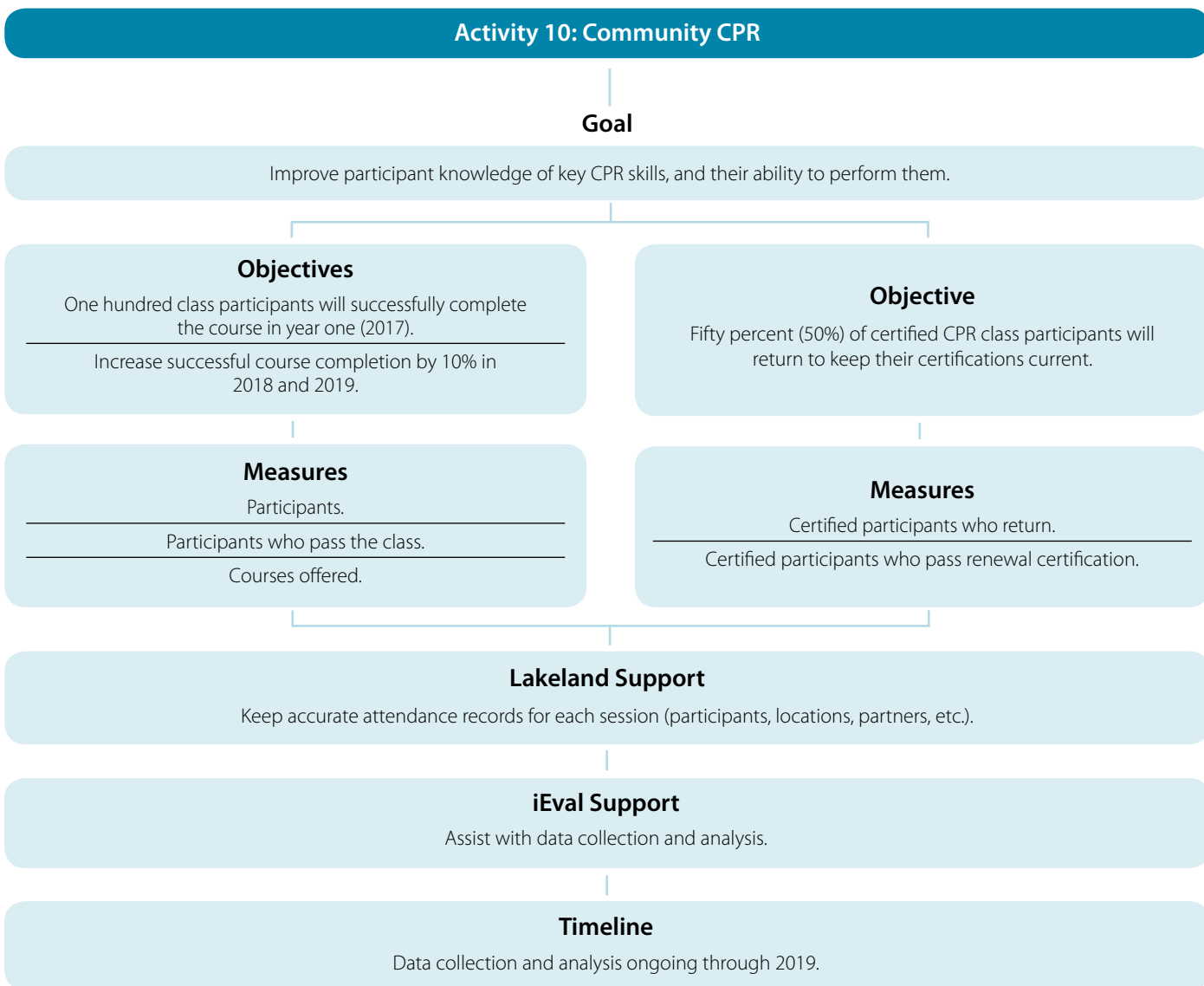


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**Table 28.** Evaluation Table – Community Health Screenings and Other Services

## IS Evaluation Plan

### Activity Category 4: Community Health Education

Lakeland Health Key Contacts: *Tami Goslee and Ashlee Offord* | iEval Key Contact: *Dr. Wendy Tackett*

#### Activity 10: Community CPR (continued)

##### Goal

Increase the number of partners involved in CPR training.

##### Objectives

Increase by five annually (2017 to 2019) the number of locations in which CPR trainings occur. Two locations will serve residents who live in areas with high age-adjusted mortality rates (census tracts within 3<sup>rd</sup> or 4<sup>th</sup> quartiles).

One public school district, with which Lakeland collaborates, will incorporate CPR certification in their health-related class each year beginning in the 2017-18 school year.

Seventy-five percent (75%) of certified CHW instructors will continue as instructors in subsequent years (2018 and 2019).

##### Measures

Schools or organizations who met with CHW to potentially offer new CPR courses.

Changes in certification requirements by schools or organizations.

New sites for CPR training.

Annual survey of partners.

##### Measures

Instructors who continue working for more than one year.

Annual survey of instructors.

##### Lakeland Support

Lakeland representatives work to build new relationships, starting with Watervliet's CPR certification requirements.

Maintain data in spreadsheet.

Administer annual survey.

##### Lakeland Support

Maintain data in spreadsheet.

Administer annual survey.

##### iEval Support

Assist with data collection and analysis.

##### Timeline

Data collection and analysis ongoing through 2019.

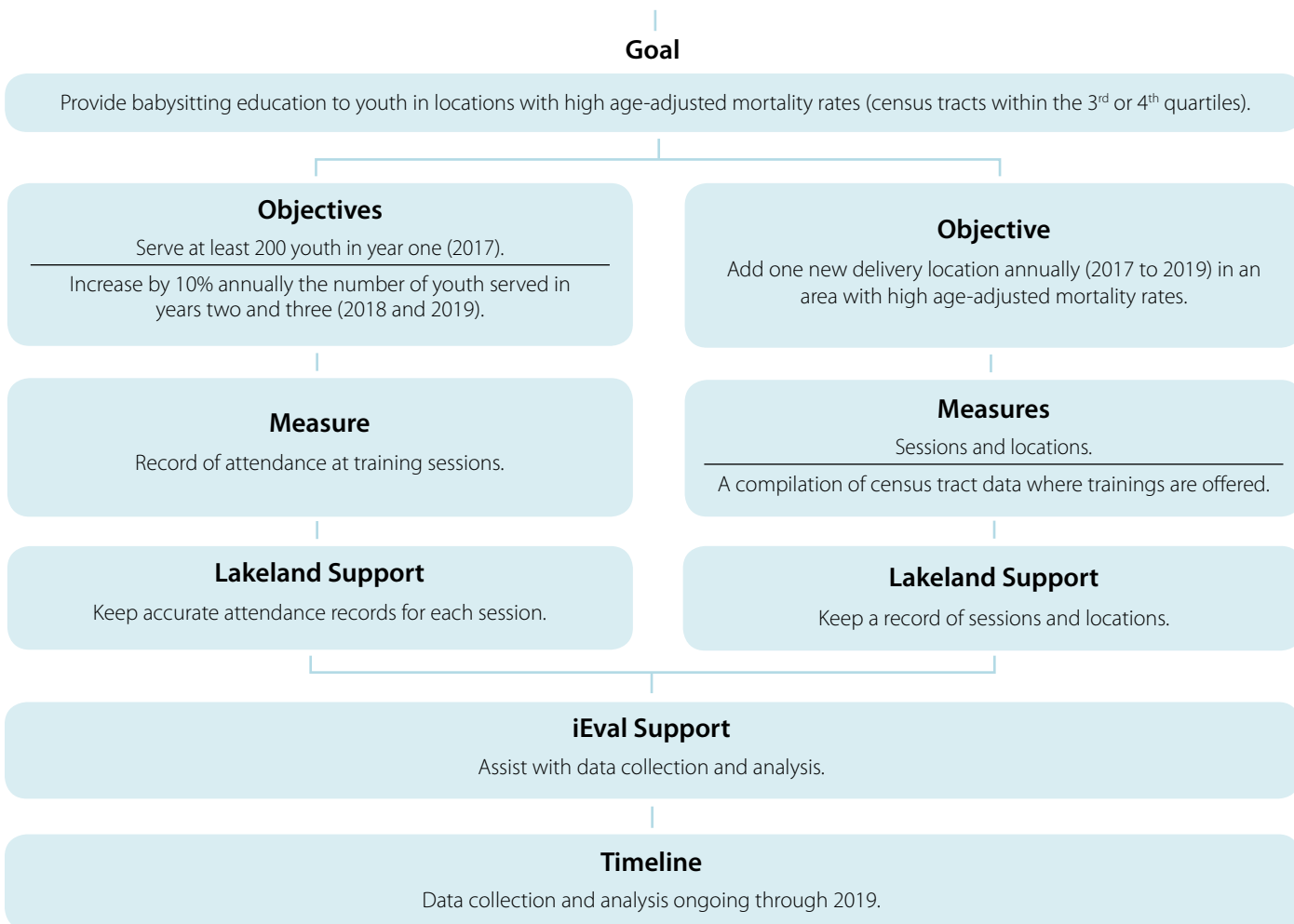
**Table 29.** *Evaluation Table – Community CPR*

## IS Evaluation Plan

### Activity Category 4: Community Health Education

Lakeland Health Key Contacts: *Tami Goslee and Ashlee Offord* | iEval Key Contact: *Corey Smith*

#### Activity 11: Babysitting with Confidence



*Table continued on next page.*

## IS Evaluation Plan

### Activity Category 4: Community Health Education

Lakeland Health Key Contacts: *Tami Goslee and Ashlee Offord* | iEval Key Contact: *Corey Smith*

#### Activity 11: Babysitting with Confidence (*continued*)

##### Goal

Build knowledge and skills in youth to help them become responsible and safe sitters.

##### Objective

Increase by 20% the knowledge and skills demonstrated by youth.

##### Measures

Pre/post tests for youth in training programs.

Color scripting.

Follow-up surveys from participants.

##### Lakeland Support

Provide feedback to iEval on pre/post tests and color scripting question(s).

Administer pre/post tests at each session.

Ask color scripting question(s) during stations in trainings and record responses.

Administer follow-up surveys with youth and parents.

Data entry for surveys and color scripting.

##### iEval Support

Assist with data collection and analysis.

##### Timeline

Data collection and analysis ongoing through 2019.

**Table 30.** *Evaluation Table – Babysitting with Confidence*



## IS Evaluation Plan

### Activity Category 5: Organizational Infrastructure

Lakeland Health Key Contacts: *Dr. Lynn Todman* | iEval Key Contact: *Dr. Wendy Tackett*

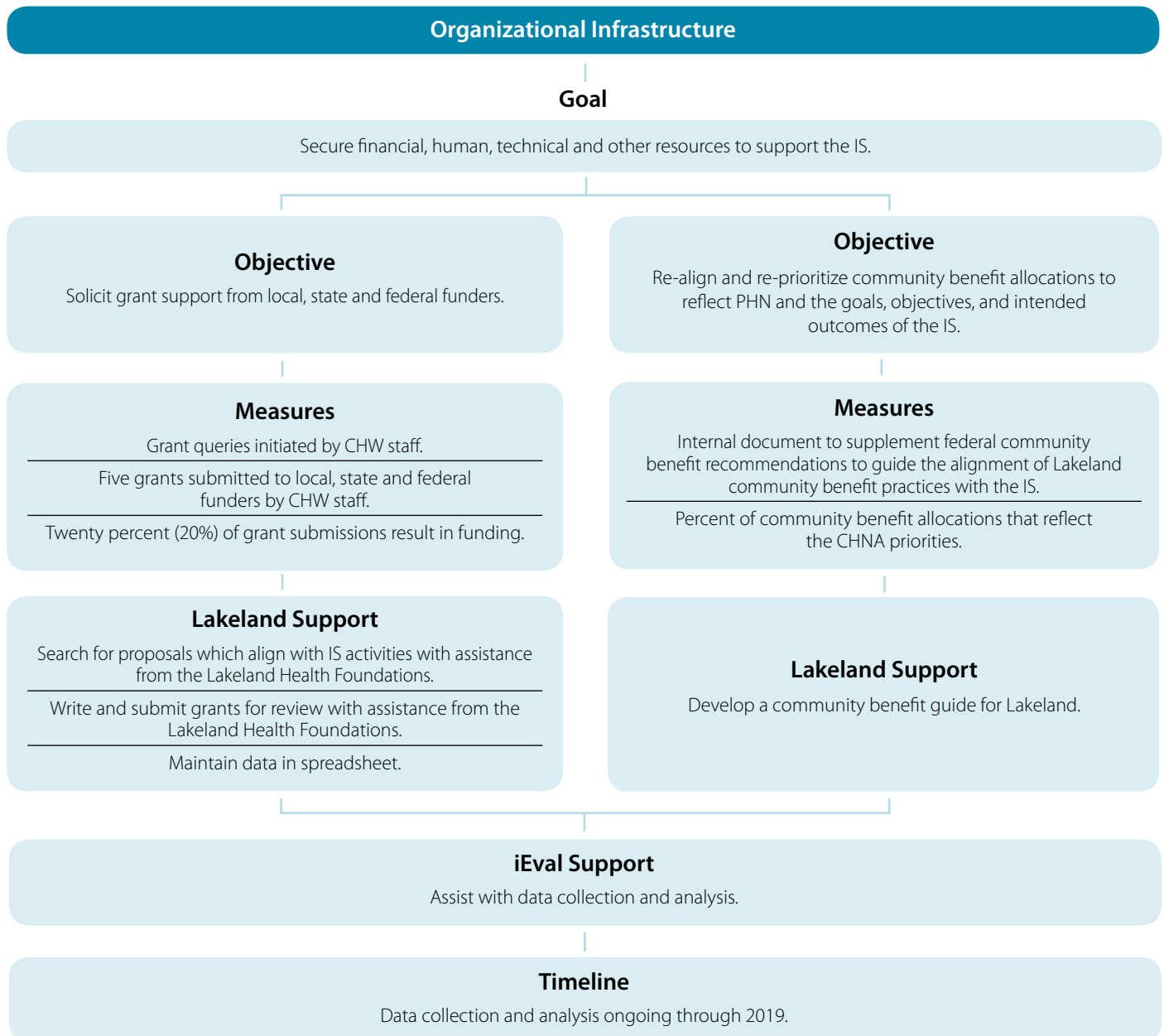


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## IS Evaluation Plan

### Activity Category 5: Organizational Infrastructure

Lakeland Health Key Contact: *Dr. Lynn Todman* | iEval Key Contact: *Dr. Wendy Tackett*

#### Organizational Infrastructure (continued)

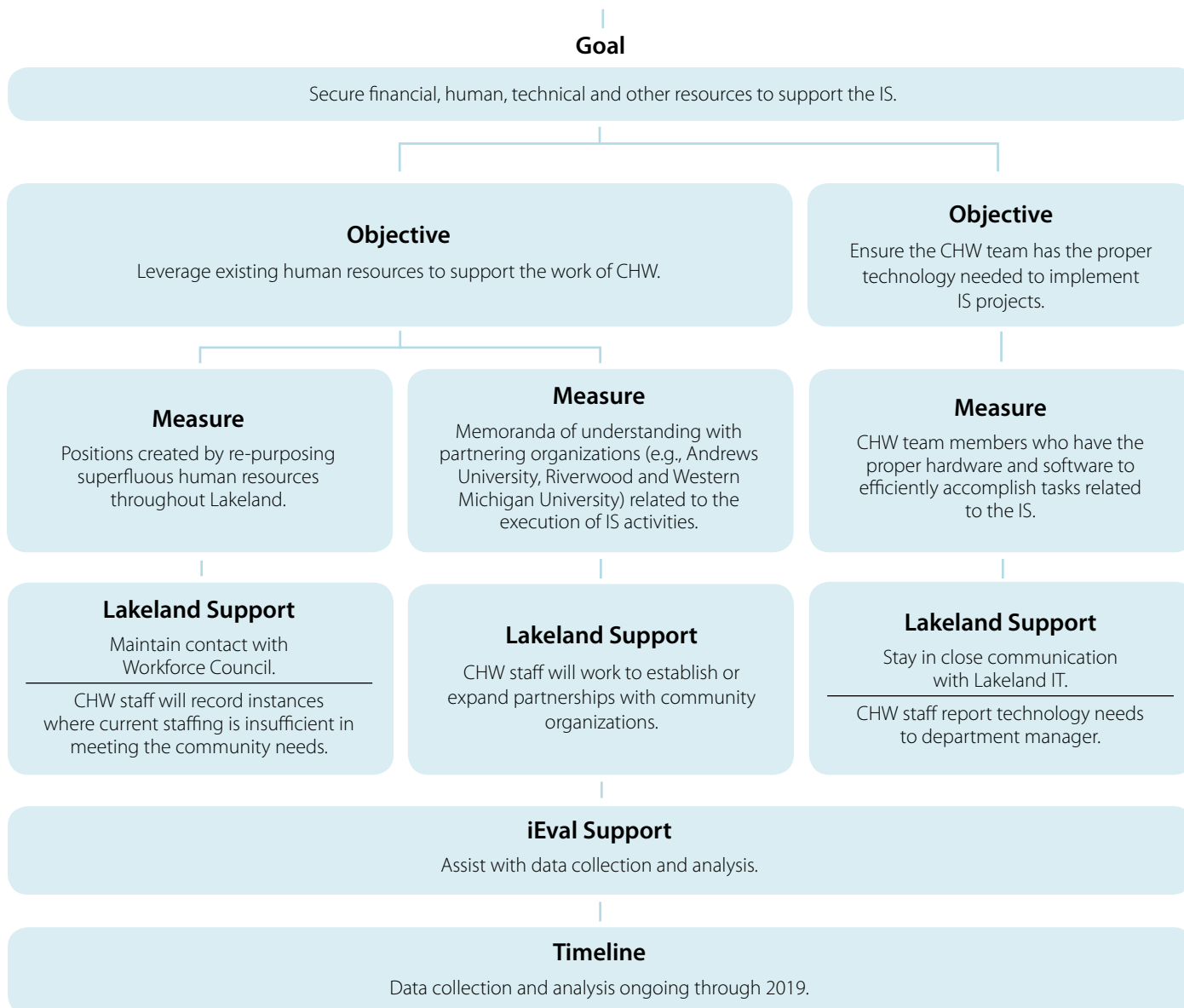
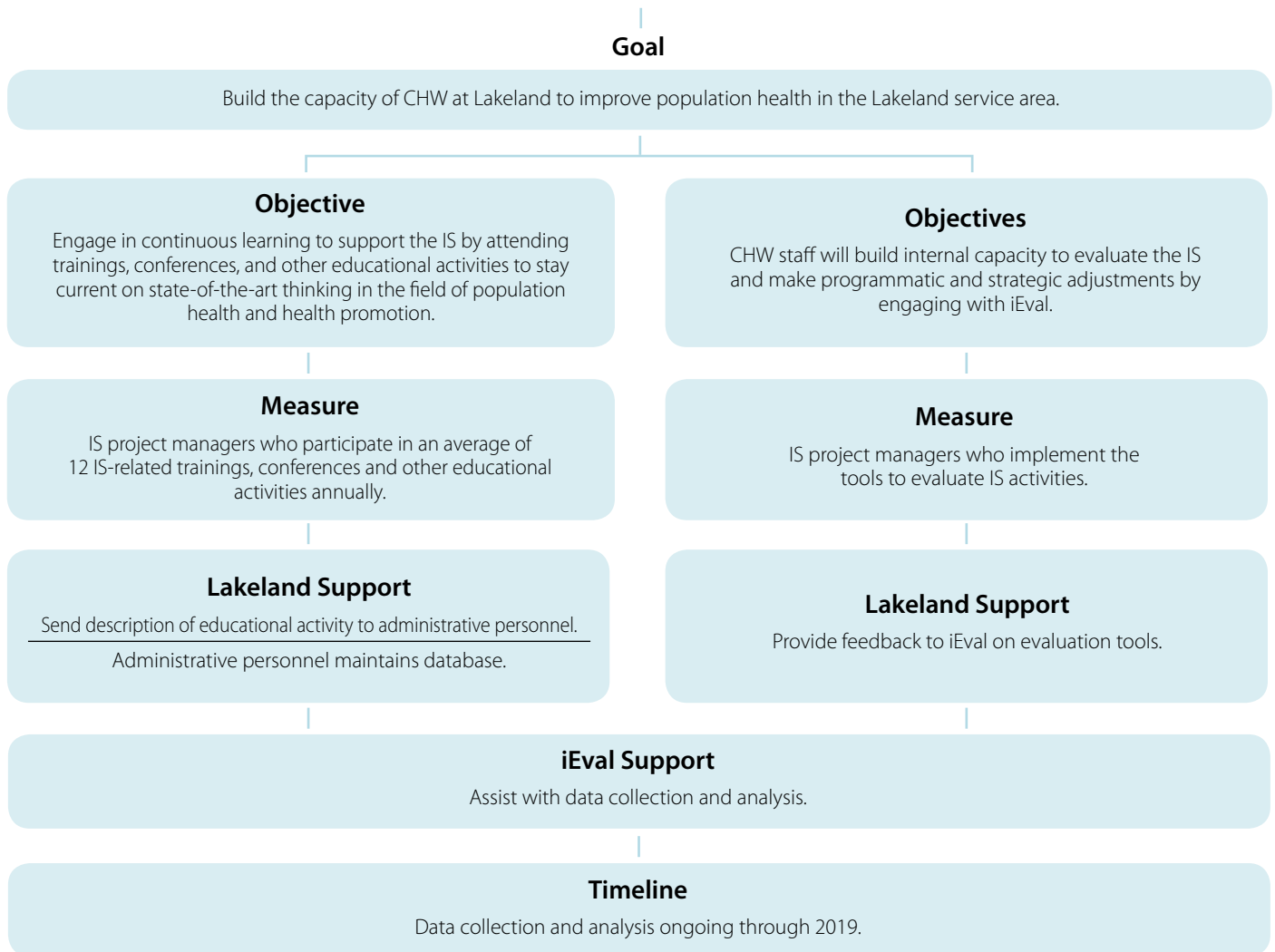


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## Organizational Infrastructure (continued)



**Table 31.** Evaluation Table – Organizational Infrastructure

## Evaluation Team

An external evaluator – iEval – has been engaged by CHW at Lakeland to provide evaluation services for the IS which is in response to Lakeland’s CHNA. The iEval team, led by Wendy Tackett, PhD, believes in conducting evaluation in a participatory manner, working with clients as part of the evaluation team. iEval will embed evaluation in the execution of the IS, which will allow for:

- a deeper understanding of evaluation findings,
- a higher probability of using the findings to improve programming,
- an increased opportunity for sustaining integrated evaluation activities after the engagement has ended, and
- an opportunity to increase the rigor of the evaluation design and, ultimately, the validity of the evaluation findings.

iEval, which was founded by Dr. Tackett in 2002, focuses on providing useful evaluation data and findings, implementing a friendly evaluation process, building internal evaluation capacity and creating reports that are straightforward and accurate. The work through iEval has primarily been with educational institutions (evaluating early childhood education, after school programming, teacher professional development, math-science partnerships, college access, school-based health and nutrition programs), healthcare organizations (evaluating federally qualified health centers, prevention programs, community-based health, neonatal abstinence syndrome prevention and pregnancy care services), and non-profit organizations (conducting organizational assessments, evaluating community wide collaborations, substance abuse prevention programs, advocacy and services for the developmentally disabled). The iEval team, comprised of Dr. Tackett, Dr. Kristin Everett and Corey Smith, collectively has almost 30 years of evaluation experience.



 **Lakeland Health**

[www.lakelandhealth.org](http://www.lakelandhealth.org)