
Indiana University Health

# IU Health White Memorial

# Nutrition and Active Living

**Goal: Providing education and resources to our all ages that are at-risk for diabetes or obesity will help them lead a healthier lifestyle. Also, through A1C screenings, trying to catch those at risk or already diabetic but unaware. Our approach targets children, families, low income community members and individuals who are at-risk for diabetes.**

| Identified Need | Implementation Strategy | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| More community resources to promote physical activity | •Community walking programs | •Increase physical activity<br>•Reduce BMI | • Increase physical activity through completion of their Walking Journal<br>• Reduce BMI in at least 15% of participants |
| Need community education regarding obesity prevention, nutrition and physical education | •Nutrition education at Farmer's Markets (4H Fairs or local Farmer's Markets)<br>•Health & Safety Fair<br>•Educational programs at local senior residences | •Increase awareness of overall well-being and health for families and children. | •Record # of screenings and number of participants<br>o H&SF<br>o Education programs |

# Access to Healthcare

**Goal: By physically and financially supporting our community, we'll increase healthcare access to low income or minority community members. Additional resources made available to patients will allow them to continue receiving required medication or healthcare services**

| Identified Need | Implementation Strategy | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| Need to expand clinic hours and improve primary care access | • Walk - in clinic (expanded hours)<br>• Nurse Family Partnership (Goodwill)<br>• Certified Patient Centered Medical home | • Our goal is to provide care to the White County area by appointment and by walk-in appointment 7 days a week, increasing access to local health care.<br>• Our goal is to provide prenatal and postnatal care to the residents in the White County area<br>• Better outcomes with asthmatic and diabetic patients. Provide better and more coordinated care through CPCMH. | • Success will be measured by the number of patients served through the clinic.<br>• Success will be measured by the numbers of OB patients served in the community<br>• Patient outcomes |
| Ability to pay for healthcare services | • IU Health White Memorial Financial Assistance policy<br>• Financial Navigators<br>• Prescription Discount cards | • Provide financial assistance and information on prescription/healthcare insurance assistance to those in need. | • The number of patients who received charity care per year will be measured.<br>• We will measure the number of patients who received charity care vs. the number of admitted patients to look for trends. |
| Need more community events to provide health education. | • Car Seat Safety<br>• CPR Classes for Public<br>• Safe Sitter Classes<br>• Support Groups | • Ensure safety of child passengers<br>• Be a community resource. Continuing to educate and increase awareness.<br>• Provide a community for patients/family members to discuss health concerns | •Record number of car seat safety checks<br>•Record number of people participating in classes and support groups.<br>•Record the number of attendees certified in CPR. |

# Behavioral Health

*Goal: Providing education and resources to all ages who have behavioral health issues helping them lead a healthier lifestyle. Our approach targets children, families, low income community members and individuals who may be suffering with behavioral health issues.*

| Identified Need | Implementation Strategy | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| Lack of mental health services in the West Central Region | SBIRT Training | •Identify patients who need intervention for drug/alcohol abuse | •Number of referrals to treatment |
| Lack of mental health services in the West Central Region | MHA QPR Training / NAMI training | •Allow community members to know the warning signs of those in mental crisis. | •Number of participants going through training |
| Lack of mental health services in the West Central Region | Teen Texting Program | •Awareness for high school kids/teachers on how to get help for crisis situations. | •Number of activations in schools<br>•Number of texts received |
| Lack of mental health services in the West Central Region | Tobacco Cessation / 1.800.QUIT NOW | •Reduce number of smokers in the community | •Number of referrals to IUHA program<br>•Number of referrals to Quit Now |
| Lack of mental health services in the West Central Region | New Behavioral Health program in primary setting | •Provide outpatient access to community members requiring behavioral health services<br>•Work in collaboration with Sycamore Springs, River Bend Hospital and NAMI to serve community members in need of inpatient behavioral health services. | •Number of patients treated |

# Chronic Disease Management

*Goal: Providing education and resources to all ages who are at-risk or living with a chronic disease, learn to manage the disease and lead a healthier lifestyle. Through screenings we are trying to catch those at risk but unaware. Our approach targets children, families, low income community members and individuals who are at risk.*

| Identified Need | Implementation Strategy | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| Need more community events to provide health education. | • Blood Pressure<br>• Cholesterol screenings<br>• Sleep Quiz<br>• Support Groups<br>• Diabetes Education | •Increase health knowledge of all attendees | •Measure the number of people served through health screenings and support groups.<br>•Measure the number of people found at risk<br>•Work to provide follow up with these patients to find a PCP<br>•Measure how many followed through on referral forms |
| Dementia Care | • Aging Brain Program | • Provide support for patients/family members supporting those with dementia | • Number of enrolled patients |