Advocate Health Care

Community Health Needs Assessment Implementation Plan 2017-2019

Advocate Christ Medical Center

Date Created: May 2017 Date Reviewed/Updated:

PRIORITY AREA: Asthma
GOAL: Reduce the incidence of uncontrolled asthma among adults and children in the hospital's service area with a focus on high risk communities.

LONG TERM INDICATORS OF IMPACT		
	Baseline Value, Date and Source	**Frequency**
1. Reduction in Emergency Room (ER) visits due to adult asthma in zip codes 60620, 60629, and 60453	Primary Service Area (PSA): 56.8 ER visits/10,000 population 60620: 175.6 ER visits/10, 000 population 60629: 69.8 ER visits/10,000 population 60453: 19.6 ER visits/10,000 population; Healthy Communities Institute (HCI), Illinois Hospital Association (IHA), COMPdata, 2013-2015	Annual
2. Reduction in ER visits due to pediatric asthma in zip codes 60620, 60629, and 60453	60620: 230.4 ER visits/10,000 population under 18 years 60629: 101.9 ER visits/10,000 population under 18 years 60453: 39.7 ER visits/10,000 population under 18 years; HCI, IHA, COMPdata, 2013-2015	Annual

STRATEGY #1: Partner with Metropolitan Tenants Organization (MTO) to expand the Healthy Homes Initiative to support people living with asthma in the service area.	**TYPE: Education and Counseling; Long-term Protective Intervention**

PARTNERS: Metropolitan Tenant Organization, Community Based Organizations, Centers for Disease Control and Prevention (CDC), Greater Auburn Gresham

BACKGROUND ON STRATEGY

Evidence of effectiveness: Environmental conditions within the home can exacerbate asthmatic children's symptoms. To improve health outcomes among this population, researchers in Lansing Michigan implemented an in-home environmental public health program—Healthy Homes University—for low-income families from 2005 to 2008. Families received four visits during a six-month intervention. Program staff assessed homes for asthma triggers and subsequently provided products and services to reduce exposures to cockroaches, dust mites, mold, tobacco smoke and other triggers. They also provided asthma education that included identification of asthma triggers and instructions on specific behaviors to reduce exposures. Based on self-reported data collected from 243 caregivers at baseline and six months, the impact of asthma triggers on these children was substantially reduced, and the proportion who sought acute unscheduled health care for their asthma decreased by more than 47%. The part of the strategy that will be used is to offer community Healthy Home Workshops to identified community partners. *Largo TW, Borgialli M, Wisinski CL, Wahl RL, Priem WF. Healthy Homes University: A Home-Based Environmental Intervention and Education Program for Families with Pediatric Asthma in Michigan. Public Health Reports. 2011;126 (Suppl 1):14-26.*

MTO's Healthy Homes Program educates tenants on common asthma triggers in the home. A recent study conducted by Sinai Urban Health Institute found that when Community Health Educators and Housing Advocates worked together to manage asthma symptoms, Emergency Department (ED) visits were cut by 72% (Metropolitan Tenants Organization, no date, www.tennants-rights.org (click here)

SHORT TERM INDICATORS

	Annual Targets by December 31		
Process Indicators	**2017**	**2018**	**2019**
1. Develop a process with MTO to train hospital staff in the healthy homes initiative	Fall 2017/ Spring 2018	TBD	TBD
2. Number of hospital staff provided training for Healthy Homes Initiative by MTO	2	TBD	TBD
3. Number of Healthy Home workshops offered to the community in collaboration with MTO	4	6	7
4. Number of healthy homes inspections completed by MTO	25	45	60
Impact Indicators	**2017**	**2018**	**2019**
1. Percentage of community participants with increased knowledge regarding identification of asthma triggers in their residence as measured by comparison of pre- and post-tests	50%	50%	50%
2. Percentage of community participants who agree to have a Healthy Home inspection	25%	30%	35%
3. Percentage of homes that receive remediation services as a result of referral from Healthy Home Inspections	Baseline	TBD	TBD

STRATEGY #2: Partner with community organizations and faith communities to provide asthma self-management training to adults who experience asthma in Auburn Gresham (60620) and Englewood (60629).	**TYPE: Counseling and Education**

PARTNERS: Community Partners, Faith Communities, Christ Medical Center Respiratory Department

BACKGROUND ON STRATEGY

Best practice asthma education focuses on self-management, a collaborative relationship between the provider and patient, and includes a written action plan. A Cochrane review of 36 trials that compared customary care to self-management with regular review plus an action plan found: (1) more regular physician visits; (2) fewer emergency department visits and hospital admissions; (3) slightly better lung function and peak flow measurements; (4) fewer medications overall; and (5) less use of rescue medication. (Gibson PG, Powell H, Coughlan J, Wilson AJ, Abramson M, Haywood P, et al. Self-management education and regular practitioner review for adults with asthma. Cochrane Database System Revue, 2003; (1):CD001117; Gibson PG, Powell H. Written action plans for asthma: an evidence based review of the key components. Thorax 2004; 59(2):94-99).
http://www.rcjournal.com/contents/06.08/06.08.0778.pdf (click here)

SHORT TERM INDICATORS

	Annual Targets by December 31		
Process Indicators	**2017**	**2018**	**2019**
1. Develop a community asthma self-management program using the Allergy and Asthma Meeting in a Box program	Fall 2017/ Spring 2018	TBD	TBD
2. Number of community organizations hosting the community self-management program series of 3 classes	1 organization	4 organizations	5 organizations
3. Number of community participants attending the 3-class community self-management series	15 participants	30 participants	45 participants
Impact Indicators	**2017**	**2018**	**2019**
1. Percentage of adults who attend 3 of 3 classes	80% of adults	80% of adults	80% of adults
2. Percentage of adults who have developed an Asthma Action Plan post program	65% of adults	65% of adults	65% of adults
3. Average percentage of increased knowledge as measured by posttest over pretest score	60% increase	60% increase	60% increase

STRATEGY #3: Collaborate with the Advocate Children's Hospital Oak Lawn to provide the "Kickin Asthma" education program in identified schools in the PSA.	**TYPE: Counseling and Education**

PARTNERS: Advocate Children's Hospital–Oak Lawn, American Lung Association, partner schools, Advocate Children's Hospital Respiratory Therapy Department, AmeriCorps

BACKGROUND ON STRATEGY

Evidence of effectiveness: In urban communities with high prevalence of childhood asthma, school-based educational programs may be the most appropriate approach to deliver interventions to improve asthma morbidity and asthma-related outcomes. A study was conducted in Oakland CA to evaluate the implementation of Kickin' Asthma, a school-based asthma curriculum designed by health educators and local students, which teaches asthma physiology and asthma self-management techniques to middle and high school students. Of the 8,488 students surveyed during the first 3 years of the intervention (2003-2006), 15.4% (n = 1309) were identified as asthmatic; approximately 76% of eligible students (n = 990) from 15 middle schools and 3 high schools participated in the program. Comparison of baseline to follow-up data indicated that students experienced significantly fewer days with activity limitations and significantly fewer nights of sleep disturbance after participation in the intervention. For health care utilization, students reported significantly less frequent Emergency Department visits or hospitalizations between the baseline and follow-up surveys.

CONCLUSION: A school-based asthma curriculum designed specifically for urban students has been shown to reduce symptoms, activity limitations, and health care utilization for intervention participants.
http://onlinelibrary.wiley.com/doi/10.1111/j.1746-1561.2008.00362.x/full (click here)

SHORT TERM INDICATORS

	Annual Targets by December 31		
Process Indicators	**2017**	**2018**	**2019**
1. Number of schools	2 schools	3 schools	5 schools
2. Number of students enrolled in Kickin' Asthma program	20 students	30 students	50 students
3. Number of students who complete all 4 sessions	10 students	15 students	25 students
Impact Indicators	**2017**	**2018**	**2019**
1. Percentage of students who self-report a decrease of daytime symptoms frequency post-survey (71% from 2005–2006)	60% of students	70% of students	70% of students
2. Percentage of students who self report a decrease of night time symptoms frequency post survey (79% from 2005–2006)	60% of students	70% of students	70% of students
3. Percentage of students who increased knowledge of asthma as measured by pre- and post-test	80% of students	80% of students	80% of students
4. Number of students who demonstrate appropriate utilization of asthma control medicine through observation or by post-survey	25 students	35 students	45 students

ALIGNMENT WITH COUNTY/STATE/NATIONAL PRIORITIES			
Strategy	**County IPLAN**	**SHIP (State Health Improvement Plan)**	**Healthy People 2020**
1	Chronic Disease – To reduce inequities and the burden of chronic disease by cultivating environments, healthcare systems and a culture that promote health. In the months and years ahead, staff will work to implement and/ or monitor progress on strategies in all three priority areas to advance health equity throughout suburban Cook County.	Expand access to comprehensive asthma control services through home-based and school-based strategies by offering asthma self-management education resources for patients, caregivers and health care providers. Home- and school-based services will include the implementation of practice or evidence-based programs and should include information on how to control exposure to asthma triggers.	Reduction of asthma deaths, hospitalizations due to asthma, emergency room visits, and reduce the number of work days and school missed due to asthma
2	Same as Above	Strategies are being designed to promote effective, evidence-based asthma self-management programs targeted to areas previously identified as having a disproportionate asthma burden (e.g., provide education in clinic/ primary care/community/ school/ home settings).	Increase the proportion of persons with current asthma who receive appropriate asthma care according to National Asthma Education and Prevention Program (NAEPP) guidelines
3	Same as Above	Current SHIP in Illinois has an Asthma goal that targets Implementing home- and school-based Services	Increase the proportion of persons with current asthma who receive formal patient education; Reduce the proportion of children aged 5 to 17 years with asthma who miss school days

Advocate Christ Medical Center has developed this implementation plan to meet a prioritized need identified through a community health needs assessment process. The medical center may refocus resources if necessary to best address the needs of its community.