Advocate Health Care

Community Health Needs Assessment Implementation Plan 2017-2019

Advocate Sherman Hospital

Date Created: May 2017 Date Reviewed/Updated:

PRIORITY AREA: Diabetes and Kidney Disease

GOAL: Reduce the long term complications related to Diabetes and Kidney Disease for residents living in Carpentersville (60110) and Elgin (60120 and 60123).

LONG TERM INDICATORS OF IMPACT		
	Baseline Value, Date and Source	**Frequency**
1. Reduce the age-adjusted, per 100,000 population kidney disease death rate for Kane County and McHenry County	18.9/100,000 Kane County (2013-2015) 18.0/100,000 McHenry County (2013-2015) Healthy Communities Institute, Centers for Disease Control and Prevention, 2017	Annual
2. Decrease the age-adjusted hospitalization rates due to diabetes for Carpentersville (60110) and Elgin (60123 and 60120)	23.9/10,000 Carpentersville (60110) (2013-2015) 22.4/10,000 Elgin (60123) 21.3/10,000 Elgin (60120) (2013-2015) Healthy Communities Institute, Illinois Hospital Association COMPdata, 2016	Annual
3. Reduce the age-adjusted Emergency Room visit rates due to Diabetes in Carpentersville (60110) and Elgin (60123 and 60120)	25.4/10,000 Carpentersville (60110) (2013-2015) 24.5/10,000 Elgin (60120) (2013-2015) 28.2/10,000 Elgin (60123) (2013-2015) Healthy Communities Institute, Illinois Hospital Association, COMPdata, 2016	Annual
4. Decrease the Age-Adjusted Hospitalization rates due to Long term Complications of Diabetes in Carpentersville (60110) and Elgin (60120 and 60123)	13.6/10,000 Carpentersville (60110) (2013-2015) 11/10,000 Elgin (60120) (2013-2015) 12.7/10,000 (60123) (2013-2015) Healthy Communities Institute, Illinois Hospital Association, COMPdata 2017	Annual

STRATEGY #1: Increase the percentage of adults who are screened to identify pre-diabetes and diabetes and are referred for follow up to a Primary Care Provider.	**TYPE: Clinical Intervention**

PARTNERS: Elgin Fresh Market, Centro de Informacion, National Kidney Foundation of Illinois, Sherman Hospital Dietitians, YWCA English as a Second Language classes

BACKGROUND ON STRATEGY:
Evidence of effectiveness: U.S. Preventive Services Task Force Abnormal Blood Glucose Screening

The United States Preventive Services Task Force is an independent, volunteer group of national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medicines. The recommendations apply to people with no signs or symptoms of the disease. To develop a recommendation statement, Task Force members consider the best available science and research on a topic. For each topic, the Task Force posts draft documents for public comment, including a draft recommendation statement. All comments are reviewed and considered in developing the final recommendation statement.

The Task Force recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. Risk factors for abnormal glucose metabolism include overweight and obesity or a high percentage of abdominal fat, physical inactivity, and smoking. Abnormal glucose metabolism is also frequently associated with other cardiovascular risk factors, such as hyperlipidemia and hypertension. Glucose abnormalities can be detected by measuring hemoglobin A1C or fasting plasma glucose or with an oral glucose tolerance test. The Task Force found that measuring blood sugar levels and treating those who have high blood sugar with intensive lifestyle change programs may reduce their chances of developing diabetes. The Task Force also found that intensive lifestyle changes can lead to fewer cases of diabetes and its related complications.
https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/screening-for-abnormal-blood-glucose-and-type-2-diabetes (click here)

As part of the Latino Diabetes Program Sherman Hospital will implement screening for abnormal blood glucose in the Elgin and Carpentersville Latino communities, and refer individuals to a primary care provider if they do not have a medical home. Additionally, the hospital will provide education sessions to introduce the concept of diabetes as a chronic disease.

SHORT TERM INDICATORS

	Annual Targets by December 31		
Process Indicators	**2017**	**2018**	**2019**
1. Number of individuals screened for blood glucose levels	100	150	200
2. Percentage of individuals screened who present with a normal blood glucose level (lower than 140 mg/dL)	Baseline	TBD	TBD
3. Percentage of individuals screened who present with a pre-diabetes blood glucose level (between 140 mg/dL and 199 mg/dL)	Baseline	TBD	TBD
4. Percentage of individuals screened who present with a blood glucose level that may indicate diabetes (200 mg/dL or higher)	Baseline	TBD	TBD
5. Percentage of individuals screened as pre-diabetic or diabetic who are referred to a Primary Care Provider(PCP)	100%	100%	100%
6. Percentage of individuals referred to PCP who secure an appointment with PCP	Baseline	TBD	TBD
7. Number of individuals who complete an “introduction to diabetes” education session	Baseline	TBD	TBD

Impact Indicators	2017	2018	2019
1. Percentage change in knowledge-level for individuals receiving diabetes education as measured by pre- and post- test	5%	10%	10%
2. Percentage of individuals referred to PCP who keep appointment with PCP	Baseline	TBD	TBD

STRATEGY #2: Implement the Stanford School of Medicine Diabetes Self-Management Program in Elgin	TYPE: Counseling and Education; Long-term Protective Intervention

PARTNERS: Churches, YWCA, Gail Borden Library, other Latino Diabetes Program partner organizations

BACKGROUND ON STRATEGY

Evidence of effectiveness: The Diabetes Self-Management workshop is given 2½ hours once a week for six weeks, in community settings such as churches, community centers, libraries and hospitals. Workshops are facilitated from a highly detailed manual by two trained leaders, one or both of whom are peer leaders with diabetes themselves. Subjects covered include: 1) techniques to deal with the symptoms of diabetes, fatigue, pain, hyper/hypoglycemia, stress, and emotional problems such as depression, anger, fear and frustration; 2) appropriate exercise for maintaining and improving strength and endurance; 3) healthy eating 4) appropriate use of medication; and 5) working more effectively with health care providers. Participants will make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management program.

Six months after the workshop, participants had significant improvements in depression, symptoms of hypoglycemia, communication with physicians, healthy eating, and reading food labels. They also had significant improvements in patient activation and self-efficacy. At 12 months, participants continued to demonstrate improvements in depression, communication with physicians, healthy eating, patient activation, and self-efficacy. Stanford School of Medicine, Stanford Patient Education Research Center http://patienteducation.stanford.edu/programs/diabeteseng.html (click here)

Sherman Hospital will implement the Diabetes Self-Management Program (DSMP) in conjunction with the existing Diabetes Program for the Latino Community in Elgin. The hospital will work with members of the Latino Advisory Committee to recruit additional individuals in the community with diabetes, who will become trainers in the DSMP program. Self-management classes will be held in locations in the Elgin community to provide easy access to the multi-series educational program.

SHORT TERM INDICATORS

	Annual Targets by December 31		
Process Indicators	2017	2018	2019
1. Number of community members who complete the Diabetes Self-Management training to become a trainer	2	4	6
2. Number of six-week self-management programs that are conducted	2	4	8
3. Number of participants who start the six-week self-management program	30	60	90
4. Number of participants who complete the six-week self-management program	15	30	45

Impact Indicators	2017	2018	2019
1. Average percentage change in participants who rate their health as good as measured pre- and post- test	Baseline	TBD	TBD
2. Average percentage change in participants' A1C level pre and post DSMP	Baseline	TBD	TBD
3. Average percentage change in participants' depression level as measured by PHQ-2 or PHQ-9 tool	Baseline	TBD	TBD
4. Average percentage change in participants' healthy eating as measured by pre- and post- test	Baseline	TBD	TBD
5. Average percentage change in self-reported physical activity level as measured by a pre- and post- test	Baseline	TBD	TBD

STRATEGY #3: Increase the access points to fresh produce for residents living within Carpentersville (60110) and Elgin (60120 and 60123)	**TYPE:**

PARTNERS: Downtown Neighborhood Association, Faith communities, Elgin Fresh Market

BACKGROUND ON STRATEGY
Evidence of effectiveness: California Latino 5 a Day Program

The "California Latino 5 a Day Campaign" aims to increase the fruit and vegetable consumption among Spanish-speaking Latino adults and their families through the use of media and community-based interventions. The program uses various types of media as a medium to share information about eating healthy. It is facilitated by the California Department of Public Health and locally managed by regional agencies. The program reaches Latinos through the top-rated Spanish speaking radio stations, television, and community-based approaches, such as billboard advertisements placed at Latino festivals, farmers markets, and neighborhood grocery stores. Moreover, samples of healthy recipes from the cookbook called "Healthy Latino Recipes Made with Love" and educational brochures are distributed during the community events and flea markets. The program's website provides useful information on healthy eating, tips on how to stay active, and resources on buying food through various food assistance programs. The program achieved their goals of spreading awareness, positively changing individual's intentions to eat more fruits and vegetables, and increasing consumption of fruits and vegetables in the Spanish-speaking intervention community.
California Department of Public Health and National Cancer Institute and the Centers for Disease Control and Prevention.
https://wwwn.cdc.gov/CHIdatabase/items/california-latino-5-a-day-program (click here)

Advocate Sherman Hospital will implement the Latino 5 a Day Campaign in the Elgin and Carpentersville area, building on the Diabetes in the Latino community media campaign launched in 2016. The hospital will work with Elgin Fresh Market to launch cooking demonstrations and recipe cards to prepare typical meals in a Latino household using fresh and healthy ingredients. A program tracking card will be provided to program participants to track their access to fresh produce available at participating locations throughout Carpentersville and Elgin. Program incentives will be provided for redeemed tracking cards.

SHORT TERM INDICATORS

	Annual Targets by December 31		
Process Indicators	**2017**	**2018**	**2019**
1. Number of individuals who access fresh produce at specified locations, including farmers markets, food pantries and neighborhood grocery stores as measured through the program tracking card	50	100	150
2. Number of community events where educational brochures are distributed about the program	15	30	45

Impact Indicators	2017	2018	2019
1. Percentage change in participants' consumption of five servings of fruits and vegetables daily as measured through pre- and post- test	0	5%	10%
2. Percentage change in participants' awareness of community locations and resources for buying fresh produce as measured through a pre- and post- test	5%	10%	10%

ALIGNMENT WITH COUNTY/STATE/NATIONAL PRIORITIES			
Strategy	**County IPLAN**	**SHIP (State Health Improvement Plan)**	**Healthy People 2020**
1, 2 & 3	Nutrition By 2030, reduce chronic disease in Kane County (Kane County Community Health Improvement Plan, March 2015)	Goal 4: Increase community-clinical linkages to reduce chronic diseases Strategy: Reduce out-of-pocket costs to increase preventive screenings for chronic diseases (Healthy Illinois 2021 State Health Improvement Plan, April 2016)	Diabetes D-1: Reduce the annual number of new cases of diagnosed diabetes in the population D-15 Increase the proportion of persons with diabetes whose condition has been diagnosed
2	By 2020, reduce the proportion of McHenry County adults diagnosed with Diabetes to 5% (McHenry County Healthy Community Study, 2014)	Goal 4: Increase community-clinical linkages to reduce chronic diseases Measurable Objectives: Reduce the percentage of adults reporting diabetes Reduce the rate of emergency department discharges for type 2 diabetes Strategy: Expand self-management programs like the Chronic Disease Self-Management Program, the Asthma Self-Management Education Program, and the National Diabetes Prevention Program, and ensure that those types of programs are implemented in communities with a high burden of chronic disease (Healthy Illinois 2021 State Health Improvement Plan, April 2016)	Diabetes D-5 Improve glycemic control among persons with diabetes D-5.1 Reduce the proportion of persons with diabetes with an A1c value greater than 9 percent D-5.2 Increase the proportion of the diabetic population with an A1c value less than 7 percent D-14 Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education
3	Increase the percentage of Kane County adults consuming 5 + servings of fruits and/or vegetables a day (Kane County Health Department Community Health Improvement Plan, March 2015	Chronic Disease Goal 2: Increase opportunities for healthy eating (Healthy Illinois 2021 State Health Improvement Plan, April 2016)	Diabetes D-16.3 Increase the proportion of persons at high risk for diabetes with prediabetes who report reducing the amount of fat or calories in their diet

Advocate Sherman Hospital has developed this implementation plan to meet a prioritized need identified through a community health needs assessment process. The hospital may refocus resources if necessary to best address the needs of its community.

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