Advocate Health Care

Community Health Needs Assessment Implementation Plan 2017-2019

Advocate Trinity Hospital

Date Created: May 2017 Date Reviewed/Updated:

PRIORITY AREA: Chronic Disease – Asthma
GOAL: To reduce the incidence of uncontrolled asthma among adults 18+ in Trinity Hospital Primary Service area zip codes 60617 and 60619.

LONG TERM INDICATORS OF IMPACT		
	Baseline Value, Date and Source	**Frequency**
1. Decrease age-adjusted Emergency Room (ER) rate due to adult asthma in zip codes 60617 and 60619	Baseline: Zip code 60617 124.0 ER visits/10,000 population Zip code 60619 166.4 ER visits/ 10,000 population; Healthy Communities Institute (HCI), Illinois Hospital Association (IHA), COMPdata, 2013-2015	Annual
2. Decrease age-adjusted hospitalization rate due to adult asthma in zip codes 60617 and 60619	Zip code 60617 31.7 Hospitalization/10,000 population Zip code 60619 42.7; Hospitalization/10,000 population HCI, IHA, COMPdata, 2013-2015	Annual

STRATEGY #1: Expand Project H.E.A.L.T.H (Healing Effectively after Leaving the Hospital) to engage patients admitted to Trinity hospital by conducting home visits to identify triggers and barriers to asthma management with a focus on patients in 60617 and 60619 zip code areas.	**TYPE: Long-lasting Protective Intervention**

PARTNERS: Partners for Faith and Health Network, Care Managers, Respiratory Department; Inpatient Physicians

BACKGROUND ON STRATEGY

Evidence of effectiveness: : The expansion of Project HEALTH will involve Community Health Workers using the Coleman Transitions Intervention (CTI) to engage patients in the hospital and through home visits. "A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served (American Public Health Association)." CTI is uniquely focused on providing patients and family caregivers with the skills, confidence, and tools they need to assert a more active role in their care and ensure that their needs are met. CTI was designed with patients and families and was evaluated using the most rigorous scientific approach—randomized control trial. Key findings show that patients who received CTI were significantly less likely to be readmitted to the hospital, and benefits were sustained for five months after the end of the one-month intervention. http://caretransitions.org/evidence-and-adoption/ (click here)

An integrative analysis of 24 studies showed that despite varying roles and functions, evidence indicates that community health workers are effective in increasing access to health services, increasing knowledge and promoting behavior change among ethnic minority women. A community health worker builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, such as outreach, community education, informal counseling, social support and advocacy.

Andrews, J. O., Felton, G., Wewehrs, M. E. and Heath, J. (2004), *Use of Community Health Workers in Research with Ethnic Minority Women*. Journal of Nursing Scholarship, 36: 358–365. doi:10.1111/j.1547-5069.2004.04064.x

SHORT TERM INDICATORS			
	Annual Targets by December 31		
Process Indicators	**2017**	**2018**	**2019**
1. Number of Asthma Control Tests (ACT) provided to hospital in-patients that reside in zip codes 60617 and 60619	60 tests	120 tests	180 tests
2. Number of home visits completed post discharge for patients that have an asthma diagnosis and that reside in zip codes 60617 and 60619	20 visits	60 visits	80 visits
3. Number of Asthma Action Plans completed	20 plans	60 plans	80 plans
Impact Indicators	**2017**	**2018**	**2019**
1. Percentage of home visit patients that demonstrate increased knowledge in identifying asthma triggers in the home at 3-month home visit as compared to the initial home visit as measured by pre- and post-tests	70% of patients	75% of patients	80% of patients
2. Percentage of patients that have made a reduction in at least one asthma trigger in the home at 3-month home visit	70% of patients	75% of patients	80% of patients
3. Percentage of patients that score >19 on their ACT at 3-month home visit as compared to their initial ACT score while a hospital patient	Baseline	75% of patients	80% of patients

STRATEGY #2: Expand project H.EA.L.T.H program to engage patients identified through Trinity Hospital Emergency Room staff by conducting home visits to identify triggers and barriers to asthma management with a focus on patients from zip codes 60617 and 60619.	**TYPE: Counseling and Education, Clinical Intervention**
PARTNERS: Nurses, care managers, community organizations, emergency room physicians	
BACKGROUND ON STRATEGY **Evidence of effectiveness:** See evidence for Strategy #1.	

SHORT TERM INDICATORS			
	Annual Targets by December 31		
Process Indicators	**2017**	**2018**	**2019**
1. Number of Asthma Control Test (ACT) tests provided to Trinity Hospital ER patients presenting with asthma symptoms that reside in zip codes 60617 and 60619	60 tests	80 tests	120 tests
2. Number of asthma action plans completed for Trinity Hospital ER patients presenting with asthma symptoms that reside in zip codes 60617 and 60619	30 plans	60 plans	90 plans
3. Number of home visits completed for ER patients identified by hospital staff as having an asthma diagnosis	40 visits	80 visits	120 visits

Impact Indicators	2017	2018	2019
1. Percentage of ER patients identified by staff as having an asthma diagnosis that have made a reduction in at least one asthma trigger in the home at 3-month home visit	70% of patients	75% of patients	80% of patients
2. Percentage of ER patients identified by staff as having an asthma diagnosis that indicate increased knowledge in identifying asthma triggers in the home at 3-month visit versus initial home visit as measured by pre- and post-test	70% of patients	75% of patients	80% of patients
3. Percentage of ER patients that score >19 on their ACT at 3-months post discharge as compared to their ER ACT score	Baseline	75% of patients	80% of patients

STRATEGY #3: Partner with community organizations by utilizing CHWs to educate community home owners to identify and remediate asthma triggers in the home.	**TYPE: Counseling and Education; Long-lasting Protective Intervention**

PARTNERS: Claretian Associates

BACKGROUND ON STRATEGY

Evidence of effectiveness: Asthma is one of the most common chronic diseases in children. It also affects 15.7 million non-institutionalized adults nationwide. Symptoms can include tightness in the chest, coughing, and wheezing. These symptoms are often brought on by exposure to inhaled allergens (dust, pollen, cigarette smoke, animal dander, etc.). Along with proper medical treatment, effective management of environmental triggers in the home can reduce the number and severity of an individual's asthma episodes. This reduction may result in fewer emergency room visits and hospitalizations, increasing a person's quality of life and reducing health plans' cost of care.

https://www.epa.gov/sites/production/files/2013-08/documents/implementing_an_asthma_home_visit_program.pdf (click here)

SHORT TERM INDICATORS

	Annual Targets by December 31		
Process Indicators	**2017**	**2018**	**2019**
1. Number of referrals received from community organizations to conduct home assessments for identifying asthma triggers in the home	20 referrals	20 referrals	25 referrals
2. Number of home assessments completed by CHWs for community members experiencing asthma as identified by community partners	20 assessments	20 assessments	25 assessments
Impact Indicators	**2017**	**2018**	**2019**
1. Percentage of community members with an increase in knowledge in identifying triggers at home at 3 month versus initial visit as measured by pre- and post-test	70%	75%	80%
2. Percentage of community members identified by community partners as experiencing asthma that report reduced number of asthma triggers in the home after receiving home assessment as measured by pre- and post-test	60%	70%	75%

ALIGNMENT WITH COUNTY/STATE/NATIONAL PRIORITIES			
Strategy	**County IPLAN**	**SHIP (State Health Improvement Plan)**	**Healthy People 2020**
1	Healthy Chicago 2.0 Review strategies to expand asthma self-management education programs for the Healthy Chicago 2.0 Continue to promote implementation of legislation around self-carry of asthma medication, and updates to asthma action plans for children with asthma. Promote policies to increase access to evidence-based asthma interventions with an environmental focus (e.g., reimbursement for home-based, multi-trigger, multi-component asthma interventions).	Current SHIP in Illinois has an Asthma goal that targets Implementing home and school-based services	Reduction of asthma deaths, hospitalizations due to asthma, emergency room visits, and the number of work days and school missed due to asthma. Increase the proportion of persons with current asthma that receive appropriate asthma care according to National Asthma Education and Prevention Program (NAEPP) guidelines

Advocate Trinity 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.