Community Health Implementation Plan

2020 - 2022

Advocate Trinity Hospital
Community Health Implementation Strategy Plan
January 1, 2020 – December 31, 2022

SUMMARY OF CHNA PROCESS

Advocate Trinity Hospital's (Advocate Trinity) community health team reviewed data from primary and secondary sources. The data highlighted the prevalent health issues within the hospital's primary service area (PSA). After review of hospital data, data from the Alliance for Health Equity (AHE) and the Conduent Healthy Communities Institute (HCI) platform, the overarching health issues were summarized and presented to the hospital's Community Health Council (CHC) for prioritization on July 17, 2019. Data presented to the council targeted the following health conditions identified as important in Advocate Trinity's PSA:

- Heart disease
- Cancer
- Diabetes
- Mental health
- Substance Abuse
- Asthma

The following criteria were also considered in making selections:

- Hospital and community resources available to address the health issue
- Hospital's capacity to address the health issues
- Importance of the health problem to the community

After discussion and review of significant data findings, the CHC members were instructed to rank the six health conditions by voting on those that they perceived to be the most important to addressing health needs for the communities within the hospital's PSA. A consensus model of prioritizations was utilized. Members were each provided five sticky dots and instructed to vote by placing the dots onto flip charts representing the greatest health need in the community. During the prioritization session, CHC members were asked to place their votes in any distribution, weighting any health condition with more than one vote or all votes based on the selection criteria mentioned earlier. At the end of the voting session the numbers were tallied and the health issues with the highest number of votes were chosen as the priority areas to focus on during the 2020-2022 CHNA cycle. The council members selected two chronic diseases as priority areas to focus on for the coming CHNA cycle—mental health and diabetes. In addition, food insecurity was selected as the social determinant of health issue the hospital will be addressing for the next three years in efforts to align strategies with the Alliance for Health Equity.

SIGNIFICANT HEALTH NEEDS IDENTIFIED BUT NOT SELECTED AND WHY

Cancer

Advocate Trinity did not select cancer as a health priority because the hospital has multiple programs and services in place to address this health issue. Advocate Trinity's Oncology Center programs are structured to facilitate a multidisciplinary environment that provides minimally invasive procedures and advanced surgical intervention to treat cancer. The Oncology Center includes advanced diagnostics, imaging services, interventional radiology and an infusion center. The hospital has a Cancer Committee to develop, approve and implement the strategic plans, goals and objectives of Advocate Trinity's cancer programs and to provide oversight for ongoing programs and outreach services. The Cancer Committee ensures that community outreach plans reflect the cancer experience at Advocate Trinity and that the defined community needs are addressed. Advocate Trinity's oncology nurse navigator, in collaboration with the community health department, works to implement outreach services in the community. Outreach activities include community education for breast cancer prevention, prostate cancer prevention and additional community health education, including healthy lifestyle education for cancer prevention.

Substance Abuse

A second health need identified but not selected is substance abuse. Advocate Trinity is a community hospital that does not have a psychiatric unit and does not provide ongoing treatment for substance abuse. However, in order to meet the immediate needs of its ED patients and inpatients, and provide for continuity of care, the hospital provides treatment options through Advocate Behavioral Health Services and the Family Care Network located at Advocate Christ Medical Center (Advocate Christ). Advocate Behavioral Health Services and Family Care Network provides an adult inpatient psychiatric program, older adult inpatient program to help older adults regain psychological stability, adolescent partial hospitalizations and substance abuse-partial hospitalization for short-term intensive treatment of chemical dependence. Upon treatment and prior to discharge, patients are connected to the behavioral health programs and provided resources to organizations that assist the patient based on the patient's unique needs (i.e., substance abuse facility or detox center).

Heart Disease

One of the health issues identified but not selected as a prioritized health need was heart disease. Advocate Trinity is addressing the heart disease needs of the community through the Advocate Heart Institute. The Advocate Heart Institute's services are comprehensive and range from cardiovascular diagnostics and detection to treatment and surgery, using the most advanced diagnostic and therapeutic tools available. The

institute also offers CPR training, a free heart risk assessment and an affordable heart CT scan. In 2015, Advocate Trinity opened a new cardiac catheterization lab that offers procedures to diagnose cardiovascular conditions. In addition to the new catheterization lab, the hospital developed a new state-of-the-art cardiac rehabilitation facility offering Phase I and II cardiac rehabilitation exercise and lifestyle education programs to the community. The hospital offers a number of community education programs both at the hospital and throughout the community. These educational programs include lectures, seminars and support group meetings for congestive heart failure, diabetes education, heart risk assessments and senior breakfast club lectures covering a range of topics pertinent to senior heart health. In addition to these services, Advocate Trinity provides access to health education, and cholesterol, glucose and blood pressure screenings.

Asthma

Asthma was another health issue identified but not selected as a prioritized health need during this CHNA cycle. Advocate Trinity's Asthma Program uses a unique, multi-disciplinary team approach to asthma care. The program offers board certified pulmonologists to develop and monitor treatment protocols and standing orders for care, and an asthma nurse educator who oversees the program, provides patient education and serves as a link to the community to ensure the patient's asthma is managed. Other team members include respiratory care practitioners who provide breathing treatments and teach patient education in the hospital and community. In addition, the Asthma Program offers many educational opportunities to help people better understand their condition and manage their asthma. Educational programs include one-on-one individualized education sessions for people encountering difficulties managing their asthma, and monthly asthma education classes covering self-management, peak flow monitoring and addressing environmental triggers.

SIGNIFICANT HEALTH NEEDS IDENTIFIED AND SELECTED FOR IMPLEMENTATION PLAN AND WHY

The CHC members selected mental health and diabetes as the top health priorities. In addition, food insecurity was identified as the SDOH which aligns with The AHE's social determinant priorities for a more collective impact. Therefore, as a result of the 2017-2019 CHNA process, Advocate Trinity selected three priorities for implementation planning:

- Mental Health
- Diabetes
- Food Insecurity (social, economic and structural determinants of health)

Mental Health

It was recognized by the council that mental health is a growing health issue in the hospital's PSA. The CHC selected mental health as the most pertinent health need priority due to the increase in ED and hospitalization rates, and the growing need for community services and resources. This is a health need that is also related to substance abuse, as many substance users/abusers also experience mental health issues and many individuals with mental health disorders experience substance abuse issues. The high rates of ED visits and hospitalizations due to mental health issues are preventable through employing coping mechanisms and resilience training. The hospital will investigate programs that prevent mental health emergencies and decrease ED visits and hospitalizations due to mental health issues.

Diabetes

The CHC and community health department voted for diabetes as a chronic condition that needs to continue to be prioritized as a result of secondary data outcomes within the PSA. Uncontrolled diabetes continues to be a factor in the hospital's PSA as well as in Cook County. Advocate Trinity has implemented the evidence-based CDC National Diabetes Prevention Program (DPP), Prevent T2, in the community and in partnership with community-based organizations and faith communities. Since 2017, the program has proven successful for participants who have completed the year-long series of classes. To establish the hospital as a designated DPP, the hospital will continue to implement this strategy, and data will be collected and submitted in accordance with the program guidelines. Diabetes affects people of different backgrounds, ages and ethnicities. Continuing this program empowers individuals to take control of their health.

Food Insecurity

Advocate Trinity will address food insecurity (FI) for the 2020-2022 CHNA implementation cycle as a commitment to addressing social determinants of health (SDOH) and health inequity. FI was also selected to align with efforts and strategies for diabetes prevention. FI is a household level factor of limited or uncertain access to adequate food that contributes to stress and poor nutrition, making individuals susceptible to chronic disease. The lack of access to adequate food can worsen health problems and increase financial strain through decreased employability due to chronic disease (The Alliance for Health Equity, Community Health Needs Assessment, 2019). Several community areas in Advocate Trinity's PSA are at risk for FI. The hospital will establish several strategies to enhance initiatives that increase access to healthy food choices within its PSA and patient population.

AAH COMMUNITY STRATEGY AND ADDRESSING ROOT CAUSES

Advocate Aurora Health (AAH) has a strong history of community engagement and service. Following the merger of Advocate Health Care and Aurora Health Care in 2018, a targeted strategy has been developed to build on this history—one that transforms Advocate Aurora's community facing work to provide even stronger support for patient health and to build community health. The AAH vision statement is: *We will build health equity, ensure access and improve health outcomes in our communities through evidence-informed services and innovative partnerships by addressing medical needs and social determinants.*

To execute on this vision, all community facing work has been aligned through a health equity lens. For Advocate Aurora's purposes, health inequity is defined as differences in health that are systemic, avoidable, unfair or unjust. The overarching aim of this strategy is to decrease the inequity gap in life expectancy across the Advocate Aurora footprint. Currently, there is a 26-year gap in life expectancy across the communities served by Advocate Aurora. The community strategy goal is to increase life expectancy by 5% in targeted low-income communities over a span of ten years. To that end, the Advocate Aurora community health, community relations, diversity and inclusion, and faith and health partnerships work has been aligned to focus on six areas, including: access/primary medical homes; access/behavioral health services; workforce development; community safety; housing; and food security. These six transformational focus areas are identified in current industry literature as being "game changers," having an upstream effect on health equity, and are also strongly confirmed by organization-wide CHNA data. A rigorous tracking and evaluation process is being developed to establish baseline and annual progress goals for each focus area and strategy.

HEALTH PRIORITY: Food Insecurity

DESCRIPTION OF HEALTH NEED DATA:

- **The food access rates for communities in the hospital's PSA were the following: Roseland (38.2 per 100,000 population), South Shore (32.0 per 100,000 population), Greater Grand Crossing (23.3 per 100,000 population), Morgan Park (12.6 per 100,000 population), South Chicago (12.2 per 100,000 population) and Auburn Gresham (10.7 per 100,000 population) for 2015.**

Source: Chicago Health Atlas, U.S. Dept. of Agriculture (USDA) Food Access Research Atlas, 2019

- **In the city of Chicago, the food access rate was 8.5 per 100,000 population in 2015.**

Source: Chicago Health Atlas, U.S. Dept. of Agriculture (USDA) Food Access Research Atlas, 2019

TARGET POPULATION: Low-income Food Insecure Individuals

GOAL: Decrease obesity, reduce food insecurity and prevent chronic disease in the Advocate Trinity PSA

ALIGNMENT WITH ADVOCATE AURORA COMMUNITY STRATEGY

- Food Access

ALIGNMENT WITH ADDITIONAL STRATEGIES

- **Healthy People 2020:**
  - Reduce the proportion of adults who are obese
- **Illinois State Health Improvement Plan (ISHIP) 2021:**
  - Reduce the percentage of obesity among adults

STRATEGY #1	COLLABORATIVE PARTNERS	INTENDED RESULTS
Implement programs to increase access to healthy food in the Advocate Trinity PSA **Specific Intervention** • Implement food insecurity screening for participants in Project HEALTH, Partners for Faith and Health Network and Diabetes Prevention Programs and refer to healthy food access points • Implement screening for additional social determinants and refer to resources needed (housing, utilities, etc.) *https://hungerandhealth.feedingamerica.org/2018/04/hospital-food-bank-partnerships-recipe-community-health/*	• Advocate Faith Nurse Department • Local Urban Garden • Alliance for Health Equity • Greater Chicago Food Depository • Local food pantries	• Increased access to healthy food • Reduced food insecurity in top three zip codes • Improved health outcomes (blood glucose, hypertension and BMI)

MEASURING OUR IMPACT

- Percent of participants who report behavior change through implementation of focus groups
- Percent of participants who screen positive for food insecurity

- Number of participants living in food insecure community areas in the PSA who are accessing healthy food items
- Percent of participants with improved clinical metrics (glucose, weight and blood pressure)
- Percent of participants referred to additional supportive resources
- Pounds of food distributed monthly

STRATEGY #2	COLLABORATIVE PARTNERS	INTENDED RESULTS
Improve health outcomes and food security for participants of the Healthy Living Food Farmacy **Specific Interventions** • Implement at least two food distributions per month of the Healthy Living Food Farmacy *https://www.geisinger.org/freshfoodfarmacy*	• Advocate Faith Nurse Department • Local urban gardens • Alliance for Health Equity • Greater Chicago Food Depository • Local food pantries • Advocate Medical Group medical providers	• Improved biometric measurements • Increased healthy lifestyle behaviors • Increased access to healthy produce and grains for food insecure participants

MEASURING OUR IMPACT

- Percent of participants who report behavior change through implementation of focus groups
- Percent of food insecure participants accessing healthy food items
- Percent of participants with improved biometric measurements (Glucose, Weight, Cholesterol & Blood Pressure)
- Percent of participants from food insecure zip codes accessing healthy food items

HEALTH PRIORITY: Diabetes

DESCRIPTION OF HEALTH NEED DATA:

- **The 2015-2017 ER rate due to diabetes for the Advocate Trinity PSA is 60.8 ER visits per 10,000 population, over two times higher than the Illinois rate of 27.7 ER visits per 10,000 population, and nearly double the Cook County rate of 33.2 ER visits per 10,000 population.**

Source: Conduent Healthy Communities Institute, Illinois Hospital Association, 2018

- **The communities in the PSA with the highest rates of ER visits due to diabetes include South Chicago (62.4 per 10,000 population), Grand Crossing (62.9 per 10,000 population) and Roseland (68.8 per 10,000 population).**

Source: Conduent Healthy Communities Institute, Illinois Hospital Association, 2018

TARGET POPULATION: Residents of the Advocate Trinity PSA with pre-diabetes and diabetes

GOAL: Improve the health status of Advocate Trinity PSA residents with pre-diabetes and diabetes through preventive strategies and increased access to support resources

ALIGNMENT WITH ADVOCATE AURORA COMMUNITY STRATEGY

- Access/Primary Medical Home

ALIGNMENT WITH ADDITIONAL STRATEGIES

- **Healthy People 2020**
  - Improve Diabetes Management to patients by engaging Community Health Workers
  - Reduce A1C levels in the prediabetic ranges
  - Increase physical activity of 150 minutes per week
  - Reduce 5% body weight loss

STRATEGY #1	COLLABORATIVE PARTNERS	INTENDED RESULTS
Offer diabetes prevention education for Advocate Trinity PSA residents with pre-diabetes **Specific Interventions** • Implement the evidence-based National Diabetes Prevention Program (DPP) to residents of the Advocate Trinity PSA *https://www.cdc.gov/diabetes/prevention/index.html*	• Faith Nurse • Our Lady of Guadalupe • Fraternity and Sorority Organizations • Compassion Baptist Church • Calvary Baptist Church • St. Sabina • Claretian Associates • Chicago Family Health Center	• Increased weight loss • Improved hemoglobin A1C levels • Increased access to community members at risk for type-2 diabetes • Prevention of Type-2 Diabetes • Increased Physical Activity

MEASURING OUR IMPACT
• Number of participants who lose 5-7% of their body weight • Percent of participants who complete a minimum of 150 minutes of exercise per week • Number of participants with improved Hemoglobin A1C levels post program • Number of referrals for DPP participants who are food insecure

STRATEGY #2	COLLABORATIVE PARTNERS	INTENDED RESULTS
• Offer the evidence-based Diabetes Empowerment Education Program (DEEP) curriculum for individuals with diabetes *https://mwlatino.uic.edu/deep-program/*	• Advocate Diabetes Educator • Healthy Living Food Farmacy • Fraternity and Sorority Organizations • Chicago CARES • Federally Qualified Health Centers • Advocate Medical Group Providers • Faith Institutions	• Increased access to resources • Improved access to healthy food items • Increased weight loss • Improved healthy lifestyle behaviors

MEASURING OUR IMPACT
• Number of cohort participants • Number of participants with weight loss post program • Number of improved glucose metrics • Number of participants accessing healthy food items • Rate of Hospital ER visits due to Diabetes

HEALTH PRIORITY: Mental Health

DESCRIPTION OF HEALTH NEED DATA:

- **In the hospital PSA, the age-adjusted ER rate due to mental health is 149.4 visits per 10,000 population in 2015-2017. This rate is higher than the Illinois rate of 95.3 per 10,000 population and the Cook County rate of 93.1 ER visits per 10,000 population.**

- **Three zip codes in the hospital's PSA exceed the overall PSA rate of 149.4 visits per 10,000 population for age-adjusted ER rates due to mental health. These zip codes are Auburn Gresham (157.8), Grand Crossing/Avalon (166.6) and South Shore (182.5) per 10,000 population.**

Source: Conduent Healthy Communities Institute, Illinois Hospital Association, 2018

TARGET POPULATION: Residents of the Advocate Trinity PSA

GOAL: Improve the mental health status of the Advocate Trinity PSA residents through prevention and by ensuring access to mental health services

ALIGNMENT WITH ADVOCATE AURORA COMMUNITY STRATEGY

- Access to Behavioral Health Services

ALIGNMENT WITH ADDITIONAL STRATEGIES

- **Healthy Chicago 2025**
  - Assistance in funding local health centers in expanding care in high-need neighborhoods regardless of patients' ability to pay or insurance status
  - Invest in crisis prevention and response teams
  - Coordinate the city's mental health system

STRATEGY #1	COLLABORATIVE PARTNERS	INTENDED RESULTS
Implement Mental Health First Aid (MHFA) trainings in priority service areas to educate individuals on how to identify, understand and respond to signs of mental illness **Specific Interventions** • Implement Mental Health First Aid courses in priority areas in the Advocate Trinity PSA *https://www.mentalhealthfirstaid.org/*	• Alliance for Health Equity • Metropolitan Family Services • National Alliance on Mental Health • Faith and Health Nurse • Advocate Behavioral Health • Community-Based Organizations • Faith Institutions • Advocate Licensed Clinical Professional	• Establish access to mental health resources • Increase knowledge related to mental health illness • Establish access to mental health education for professionals and community members

MEASURING OUR IMPACT
• Number of MHFA workshop participants in the Advocate Trinity PSA by community area, zip code, gender, race/ethnicity and age • Number of MHFA workshops implemented in the Advocate Trinity PSA by community area and zip code

STRATEGY #2	COLLABORATIVE PARTNERS	INTENDED RESULTS
• Implement an evaluation of the Mental Health First Aid training, three months post workshop	• Advocate Faith Nurse • Alliance for Health Equity	• Incorporated skills learned in the MHFA training to real life situations • Sustained MHFA education

MEASURING OUR IMPACT
• Percent of participants who utilized skills learned from the MHFA training • Percent of participants adequately prepared to address mental health issues

Note: Plans to address selected CHNA priorities are dependent upon resources and may be adjusted on an annual basis to best address the health needs of our community.