Advocate Trinity Hospital Community Health Implementation Strategy

January 1, 2023 – December 31, 2025

Community health improvement is an effective tool for creating a shared vision and supporting a planned and integrated approach to improving health outcomes. The basic premise of community health improvement is that entities identify community health issues, prioritize those that can be addressed, and then develop, implement, and evaluate strategies to address those issues. Tax-exempt hospitals are required to conduct a community health needs assessment (CHNA) and develop an implementation strategy to document how the hospital will address prioritized community health needs. The following outlines a summary of the CHNA process and provides details on Advocate Trinity Hospital's plans to address their prioritized community health needs.

SUMMARY OF ADVOCATE TRINITY HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT 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 a review of hospital data, data from the Alliance for Health Equity (AHE), and Metopio platform, the overarching health issues were summarized and presented to the hospital's Community Health Council (CHC) for prioritization on June 24, 2022. Data presented to the council targeted the following health conditions identified as important in Advocate Trinity's primary service area:

- Heart disease
- Obesity
- Diabetes
- Mental health & Substance abuse
- Maternal, Fetal, Infant Health
- Respiratory
- Sexually Transmitted Infections (STI)

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 issue
- 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 instructed to vote on the top two greatest health needs in the community by using the Zoom voting poll system. During the prioritization session, CHC members were asked to place their votes in any distribution, weighting any health condition with one, more than one, or all votes based on the selection criteria. At the end of the voting session, the numbers were calculated and the health issues with the highest percentage of votes were chosen as the priority areas to focus on during the 2022 CHNA and the community health improvement implementation cycle. The council members selected two chronic diseases as priority areas to focus on for the coming 2023-2025 implementation plan cycle—mental health and diabetes.

SIGNIFICANT HEALTH NEEDS IDENTIFIED AND SELECTED FOR IMPLEMENTATION STRATEGY AND WHY

As mentioned above, the CHC members selected mental health and diabetes as the top priorities. In addition, food insecurity was identified as the SDOH which aligns with The Alliance's social determinant priorities for a more collective impact. Therefore, as a result of the 2022 CHNA process, Advocate Trinity selected two priorities for implementation planning: Behavioral Health/Mental Health and Diabetes.

HEALTH PRIORITY: BEHAVIORAL HEALTH/MENTAL HEALTH

IMPACT:

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

DESCRIPTION OF HEALTH NEED DATA:

- In the hospital PSA, the ED rate due to mental health is 1,315.3 ED visits per 100,000 residents, The PSA rate is higher than both Cook County (917.1 ED visits per 100,000 residents) and Illinois (988.6 ED visits per 100,000 residents).
- Within the PSA, young adults ages 18-39 years (2,096.2 ED visits per 100,000 residents) and middle-aged adults ages 40-64 years (1,293.4 ED visits per 100,000 residents) have higher ED rates due to mental health compared to other age groups. The males in the PSA also have a higher rate due to mental health (1,566.7 ED visits per 100,000 residents)
- Three zip codes in the hospital's PSA exceed the overall PSA rate of 1,315.3 visits per 10,000 population for age-adjusted ER rates due to mental health. These zip codes are Roseland 60628 (1,604.0), South Shore 60649 (1,487.0), and Grand Crossing 60619 (1,432.5) per 100,000 population.

Source: Metopio, Illinois Hospital Association, 2016-2020.

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL:

- Access to Behavioral Health Services
  - 211 Metro Chicago access helpline – connecting people to referral sources for: food, housing, utility payment assistance, health care, transportation, childcare, employment, **mental health,** disaster information and assistance, and more services
- Mentalhealth.Chicago.gov

STATE:

- linois crisis intervention and response teams
  - Mobile units and BH triage

NATIONAL:

- Health Conditions: Mental and Behavioral Health, Improve Mental Health
  Mental Health and Mental Disorders - Healthy People 2030 | health.gov
- 988 Suicide and Crisis Lifeline - **three-digit, nationwide phone number to connect directly to the 988 Suicide and Crisis Lifeline.**

HEALTH PRIORITY: BEHAVIORAL HEALTH/MENTAL HEALTH cont.

STRATEGY #1: Increase knowledge and reduce stigma related to mental/behavioral health

SPECIFIC INTERVENTIONS	COLLABORATIVE PARTNERS	OBJECTIVES
• Offer educational speaking engagements to reduce behavioral health stigma and increase mental health awareness • Continue offering upon request Mental Health First Aid (MHFA) trainings to educate individuals on how to identify, understand and respond to signs of mental illness. • Offer Healing Circle sessions to local High schools	• Faith-Based Institutions • Local High schools and Colleges/ Universities • Community-Based Organizations • Local libraries • Fraternities and Sororities • Barbershops & Hair Salons • Rich Township • AAH Faith & Health Partnerships • Chicago Family Health Center • Metropolitan Family Services	• Increase knowledge related to mental health illness • Establish access to mental health resources • Provide three-point BH screening questionnaire

MEASURING OUR IMPACT

- Number of attendees and BH workshops offered in high-risk community areas
- Number of collaborating partners who implement education
- Pre and Post program assessment

STRATEGY #2: Provide AAH teammates BH workshop trainings; including ED nurses, CHWs, and nursing new hires.

SPECIFIC INTERVENTIONS	COLLABORATIVE PARTNERS	OBJECTIVES
• Work with hospital leadership to provide workshops and referral resources during hospital onboarding orientation.	• AAH Faith & Health Partnerships team • AAH Behavioral Health Department team • ATH nursing leadership and education department team • AAH employee assistants program • National Alliance on Mental Illness Chicago (NAMI)	• Increase knowledge related to mental health illness • Access to mental health resources

MEASURING OUR IMPACT

- Number of behavioral health workshops offered
- Number of teammates that participate in the Advocate Trinity hospital sponsored workshops.
- Pre and post evaluation percentage of teammates who are adequately prepared to address mental health issues during patient care.

HEALTH PRIORITY: Diabetes

IMPACT:

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

DESCRIPTION OF HEALTH NEED DATA:

- Approximately 993,082 people (10 percent of the adult residents) in Illinois have been diagnosed with diabetes and there are 3,393,000 people (34 percent of the adult residents) in Illinois, who have prediabetes.
- The ED rate due to diabetes in the Advocate Trinity PSA is 457.02 ED visits per 100,000 residents. Non-Hispanic Blacks have a disproportionately higher rate of ED visits due to diabetes at 451.8 ED visits per 100,000 residents than any other race. The hospital's PSA rate is higher than the Illinois rate at 239.7 ED visits per 100,000 residents (Metopio, Illinois Hospital Association, 2016-2020).
- The following communities have the highest ED visit rates due to Diabetes in the PSA: Roseland(60628) with 622.2 ED visits per 100,000 residents, South Shore (60649) with 485.8 ED visits per 100,000 residents, and Grand Crossing (60619) with 459.0 ED visits per 100,000 residents.

Source: Metopio, IHA COMPdata, 2022

ALIGNMENT WITH EXISTING STRATEGIES

LOCAL:

- Access /Primary Medical Homes
- Improve Diabetes Management to patients by engaging Community Health Workers

STATE:

- Illinois Medicare Diabetes Prevention Program (MDPP)

NATIONAL: HEALTHY PEOPLE 2030

- Healthy People 2030 https://health.gov/healthypeople
- CDC Prevent Type 2 Diabetes Program

HEALTH PRIORITY: Diabetes cont.

STRATEGY #1: Offer Prevent T2 Lifestyle change program to at-risk pre-diabetic individuals

SPECIFIC INTERVENTIONS	COLLABORATIVE PARTNERS	OBJECTIVES
• Offer the evidence-based CDC National Diabetes Prevention Program (DPP) to residents of the Advocate Trinity PSA with pre-diabetes https://www.cdc.gov/diabetes/prevention/index.html • Establish an all-male DPP cohort with a fraternity group or from local barbershops. • Offer Lifestyle Health Coach training or become an ambassador to AA and Hispanic men in the community.	• CDC, Faith Based Institutions, Senior Housing Centers, Community Centers • Fraternities and Sororities • Claretian Associates-Chicago • South 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 • Increased Physical Activity

MEASURING OUR IMPACT

- Number of participants who lose 4-5% 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

STRATEGY #2: Offer Medicare Diabetes Prevention Program to Advocate Medical Group at risk pre-diabetic patients & offer cooking classes

SPECIFIC INTERVENTIONS	COLLABORATIVE PARTNERS	OBJECTIVES
• Apply to become MDPP supplier • Recruit a Physician Champion • Provide Medicare Diabetes Prevention Program to Advocate Medical Group(AMG) patients. • Bill Medicare • Offer cooking class sessions	• AMG Physicians in Trinity PSA • Imani Village Providers • Restoration Ministries (The Kitchen)	• Improved hemoglobin A1C levels • Prevention of Type-2 • Increase physician referrals • Encourage healthy eating habits

MEASURING OUR IMPACT

- Number of participants who lose 4-5% of their body weight
- Number of patient referrals and enrolled in the program by their doctor
- Number of participants with improved Hemoglobin A1C levels post program
- Number of referrals for DPP participants who are food insecure

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.