



In sickness and in health™

IMPLEMENTATION STRATEGY PLAN CY 2017 - 2019

AMITA HEALTH ADVENTIST MEDICAL CENTER LA GRANGE

CONTENT OUTLINE

Executive Summary

Mission

Demographics & Methodology

Description of Region

Priority Issues

Implementation Plans

Contact Information



EXECUTIVE SUMMARY

The Adventist La Grange assessment was conducted by the Professional Research Consultants, Inc. in cooperation with MCHC and other partnering hospitals. It incorporates data from both quantitative and qualitative sources. The goals of the assessment were to:

- Engage public health and community stakeholders including low-income, minority and other underserved populations
- Assess and understand the community's health issues and needs
- Understand the health behaviors, risk factors and social determinants that impact health
- Identify community resources and collaborate with community partners
- Make the Community Health Needs Assessment widely available
- Use Assessment findings to develop and implement a 2017-2019 Community Health Plan (implementation strategy) based on the Hospital's prioritized issues

The information in this presentation is not exhaustive or conclusive, rather an overview of the issues most prominent in the primary and secondary services areas. In addition, the strategies presented are focal points, but do not represent all supporting education, contributions, and collaborations with the general community or partnering agencies on a wide-range of community needs.

The mission of AMITA Health is to extend the healing ministry of Jesus.

Our Community Benefit Program is Integral to our Mission.

It Responds to identified needs in the community.

It Empowers local organizations serving the most vulnerable populations.

It Supports the government's efforts to enhance population health.

It Helps families living in poverty to access affordable healthcare.

It Improves the health of the communities we live in.

PRIORITY ISSUES

The key issues to be addressed as determined by the CHNA are Mental Health, Diabetes and Nutrition, Physical Activity and Weight. These are the areas which were identified by community stakeholders, and confirmed by internal observation, as the most critical issues. Each of the identified priorities overlap with other Community Health issues as identified below.

Mental Health (including but not limited to Family Violence, Substance Abuse, Community Violence, Dementia)

Diabetes (contributing factor in Heart Disease/Stroke , Chronic Kidney Disease)

Nutrition, Physical Activity and Weight (preventing Diabetes, Heart Disease, Stroke)

Adventist Medical Center La Grange addresses other priorities identified as issues in the community on a continuous basis through screenings, education and treatment. Cancer, Respiratory Diseases, Infant and Child Health, Unintentional Injury, Arthritis and Osteoporosis; HIV/AIDS and Immunizations are amongst those conditions which we routinely provide services and outreach to members of the community.

Priorities which we have chosen not to specifically address in our community include Family Planning, Sexually Transmitted Diseases, Oral Health/Dental Care and Hearing and Vision Problems. Family Planning is a service which is provided in our community by private physicians, FQHCs and social service agencies, and are easily accessible to the general public. Sexually Transmitted Diseases are also covered by social service agencies and physicians in the community. Oral Health/Dental Care was explored as a potential community benefit. However, it was determined that local FQHCs provide dental services and members of the community have access to these services. The lowest priority, Hearing and Vision Problems, has not been identified by our community partners as an unmet need.

DEMOGRAPHICS & METHODOLOGY

In the La Grange Hospital service area, the population is slightly older and 31.7% of the population is Hispanic, a high percentage as compared to 16.7% in Illinois and 17.4% in the US. The community's social determinants are challenging, having more poverty, more unemployment and a less educated community than average in comparison to the MCHC region and the State. Nearly 17% of the population lives at or below 100% of the poverty level and 36% are at or below the 200% of the poverty level, representing 1,845,816 individuals. The service area for the hospital is comprised of 35 residential zip codes based on patient origin. A complete description of sample size and survey design is available on the website at amitahealth.org/communityneeds.

SURVEYS

An Online Key Informant Survey was conducted as part of this assessment. Key informants comprised those individuals who have a broad interest in the health of the community. There was a total of 55 stakeholders participants for this region. A list of stakeholders was provided by MCHC member hospitals participating in the overall assessment process

INTERVIEWS

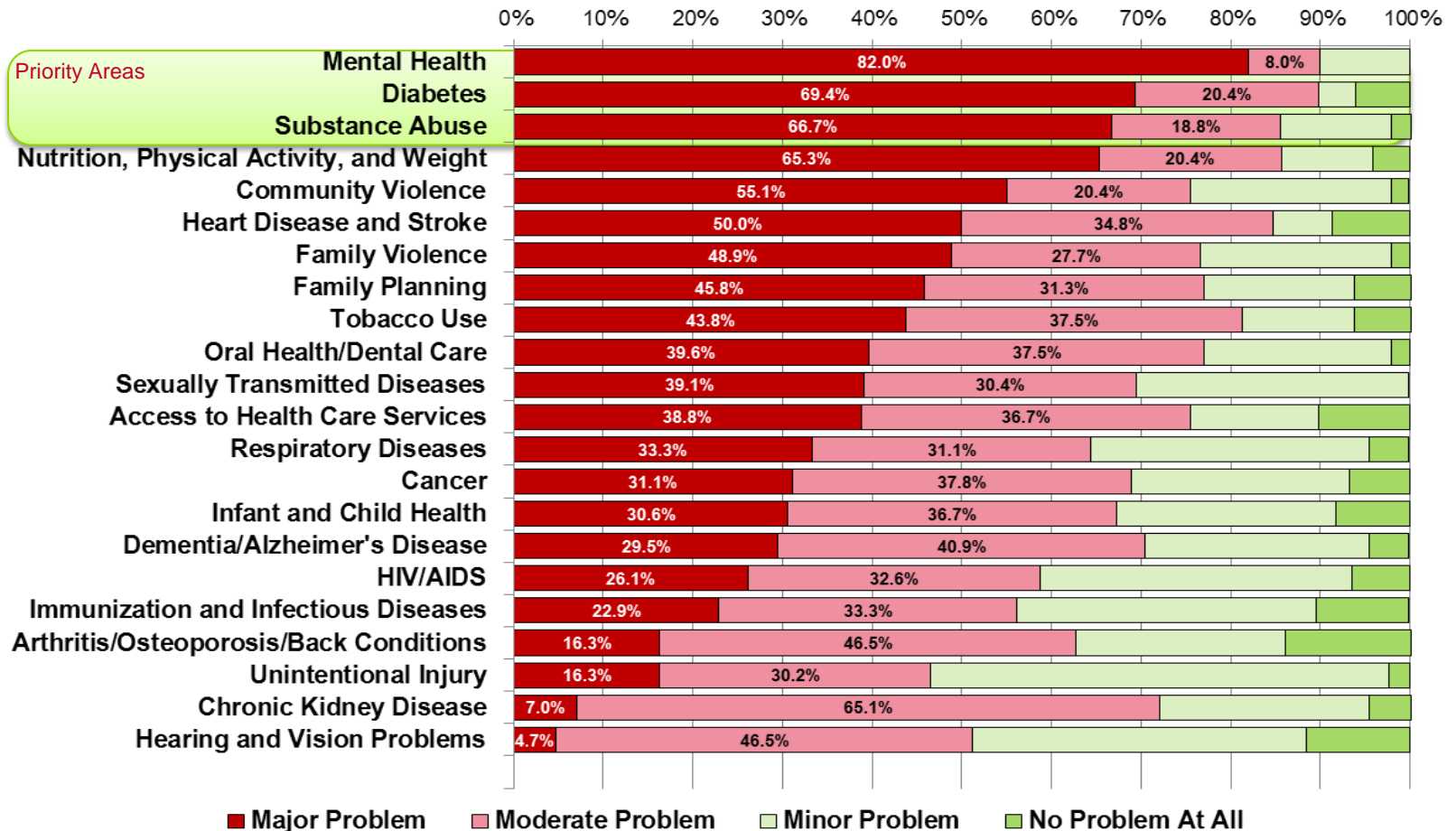
The strategy used for this assessment entailed a telephone interview methodology of 411 individuals age 18 and older in the Total Service Area. The surveys were distributed to individual hospitals that were part of the larger assessment thus involving multiple regions and hospital service areas.

DATA

This assessment incorporates a selection of secondary data from 17 sources in order to support the research quality. Benchmark data was collected from the Centers for Disease Control and the U.S. Department of Health and Human Services. The nationwide risk factor data was taken from the 2013 PRC National Health Survey and Healthy People 2020.

PRIORITY ISSUES cont

The chart below reveals the substantial areas of opportunity as it relates to community benefit. There is a special emphasis placed on priority areas although many community health issues are being supported. The key issues to be addressed determined by our CHNA are Mental Health, Nutrition, Physical Activity, and Weight, Substance Abuse, and Community Violence.



IMPLEMENTATION PLAN: MENTAL HEALTH

Goal: Contracting and credentialing with a second psychiatrist who treats patients age 15 and older to increase psychiatry availability by 4 hours per week

Strategy: Financial support for external community mental health agencies to protect the mental health services for the underinsured and insured.

Community Partner: Community Nurse Health Center

Public Policy: Advocate for state and federal funding for our community mental health centers.

Expected Impact:

1. Access to psychiatry services is done in an intentionally integrated manner to assure that these limited services are available to those most in need.
2. The psychiatrist and PCP jointly manage medication issues, and the protocol further calls for a patient to be engaged in both psychiatry and behavioral health therapy and counseling, unless there are exigent or emergent circumstances requiring otherwise.
3. The Psychiatrist participates in monthly integrated care team meeting with the medical providers, the SBIRT counselor and the Pillars counselors to coordinate care for jointly managed patients.

IMPLEMENTATION PLAN: DIABETES

Goal: That 22% or less of the diabetics have A1Cs higher than 9 by the end of the grant project period.

Strategy: Invest community programs throughout DuPage County that provide affordable and accessible services to low-income diabetic patients.

Community Partner: Community Nurse Health Center

Public Policy: Advocate for expansion and sustainability of the Diabetes Prevention Program with our federal representatives.

Expected Impact:

1. Patients with uncontrolled diabetes, or those diabetics who have multiple referrals to specialists or who have depression are referred to the PCMH team's care coordinator to assist with treatment plans and goals.
2. Medical providers to work with patients to develop individualized medication plans, screen for possible complications, and ensure access to self-monitoring blood testing.
3. The medical and dental teams to work together as an integrated care project to assure that patients under diabetic management are accessing quarterly follow-up visits in both the Medical and Dental Centers. The baseline for patients accessing both services was 30.7%. Our goal is to increase to 36% in 6 months.

IMPLEMENTATION PLAN: NUTRITION, PHYSICAL ACTIVITY, AND WEIGHT

Goal: Reduce the childhood obesity prevalence which is at 29.5% for our target service area, to the at the national average of 14.8%.

Strategy: Engage with elementary schools in DuPage County so that they have a comprehensive learning tool for students and teachers.

Community Partner: Community Nurse Health Center

Public Policy: Support the efforts of local elected officials for long-term and sustainable programs designed to prevent childhood obesity.

Expected Impact:

1. BMI calculation at every visit, with nutritional and exercise counseling by the provider and a referral to a nutrition counselor if needed.
2. When working with Hispanic families, nutrition information and education is provided to complement Hispanic diet regarding low fat, low salt, and low sugar substitutions for meal preparation.
3. Maintain affiliation agreement with Dominican University who provides free on-site nutritional counseling and education to patients.



AMITA Health Website: <http://www.amitahealth.org>

**Community Benefit Webpage:
<http://www.amitahealth.org/communityneeds>**

**Contact: Sendy Soto
Director of Community Benefit & Advocacy
(847) 590-2681
Sendy.Soto@amitahealth.org**