Advocate Health Care

Community Health Needs Assessment Implementation Plan 2017-2019

Advocate South Suburban Hospital

Date Created: May 2017 Date Reviewed/Updated:

PRIORITY AREA: Asthma
GOAL: Reduce the incidence of uncontrolled asthma among children in zip codes 60411, 60426, 60428, 60429, 60478.

LONG TERM INDICATORS OF IMPACT		
	Baseline Value, Date and Source	**Frequency**
1. Reduce age adjusted ER rate due to pediatric asthma in zip codes 60411, 60426, 60428, 60429, 60478	60411 = 149.4 ER visits/10,000 population under 18 years 60426 = 230.9 ER visits/10,000 population under 18 years 60428 = 206.2 ER visits/10,000 population under 18 years 60429 = 185.2 ER visits/10,000 population under 18 years 60478 = 194.3 ER visits/10,000 population under 18 years; Healthy Communities Institute (HCI), Illinois Hospital Association (IHA), COMPdata, 2013-2015	Annual
2. Reduce age adjusted hospitalization rates due to pediatric asthma in zip codes 60411, 60426, 60428, 60429, 60478	60411 = 10.2 hospitalizations/10,000 population under 18 years 60426 = 28.4 hospitalizations/10,000 population under 18 years 60428 = 20.3 hospitalizations/10,000 population under 18 years 60429 = 15.1 hospitalizations/10,000 population under 18 years 60478 = 16.4 hospitalizations/10,000 population under 18 years; HCI, IHA, COMPdata, 2013-2015	Annual

STRATEGY #1: Expand the *Kickin' Asthma* program into the following zip codes: 60411, 60426, 60428, 60429, 60478.	**TYPE: Counseling and Education**
PARTNERS: Schools nurses in zip codes identified	
BACKGROUND ON STRATEGY **Evidence of effectiveness:** *Kickin' Asthma* was designed by the American Lung Association of California as a school-based curriculum that addresses the needs of children ages 11 to 16 with asthma. The program promotes individual responsibility, self-management and early action among adolescents. In a study published in 2008, 990 students with asthma who participated in *Kickin' Asthma* from 2003-2006 were evaluated. Following completion of the program, researchers found that students experienced significantly fewer days with activity limitations and significantly fewer nights of sleep disturbance. Students also reported significantly less frequent emergency department (ED) visits or hospitalizations after program completion. http://onlinelibrary.wiley.com/doi/10.1111/j.1746-1561.2008.00362.x/full (click here)	

SHORT TERM INDICATORS			
	Annual Targets by December 31		
Process Indicators	**2017**	**2018**	**2019**
1. Number of school partners	5 partners	7 partners	10 partners
2. Number of students participating in *Kickin' Asthma* classes	35 students	56 students	80 students
Impact Indicators	**2017**	**2018**	**2019**
1. Percentage of students who have at least one ED visit for asthma within 3 months of program completion as measured by phone calls to parents 3 months after program completion (Comparison: 4%, 2015)	6% of students	5% of students	4% of students
2. Percentage of students who score 75% or above on the *Kickin' Asthma* post test (Comparison: 87%, 2013-2015)	75% of students	80% of students	85% of students

STRATEGY #2: Continue to work with internal South Suburban Hospital committee to improve disease self-management skills for patients and families with asthma.	**TYPE: Clinical Intervention; Counseling and Education**

PARTNERS: South Suburban Hospital Asthma Task Force

BACKGROUND ON STRATEGY

Evidence Base: National Asthma Control Initiative

Health care providers are the first line of defense when it comes to diagnosing and treating asthma patients. Failure to control asthma inflicts a considerable burden on patients, families, and health care systems. For health care professionals who deliver care to individuals with asthma and their families, unplanned acute-care visits for asthma also disrupt practice schedules, and shift patient care out of primary care settings and into emergency rooms and hospital beds.

How providers communicate with patients, families, and caregivers will influence how well patients follow the treatment plan. The Physician Asthma Care Education (PACE) program showed that physicians educated in basic communication strategies to help put guidelines into practice improved patient outcomes and satisfaction without spending more time during visits.
https://www.nhlbi.nih.gov/health-pro/resources/lung/naci/audiences/healthcare-professionals.htm (click here)

Asthma affects approximately 6.8 million children in the U.S., is the third leading cause of preventable hospitalizations and the leading health-related cause of school absenteeism. Children with asthma miss twice as many school days as other children, on average. Other symptoms also may restrict activities and impair the quality of life for a child with asthma. Keeping asthma under control can be expensive; it causes financial burdens including lost work days; reduced productivity; lost income; low quality of life for persons with asthma; and disruption to family and caregiver routines.
http://www.dph.illinois.gov/sites/default/files/publications/publicationsohpmillinois-asthma-state-plan.pdf (click here)

SHORT TERM INDICATORS – Emergency Department			
	Annual Targets by December 31		
Process Indicators	**2017**	**2018**	**2019**
1. Number of task force meetings (Baseline: 4, 2016)	4 meetings	4 meetings	4 meetings
2. Number of members who attend at least 50% of meetings annually	14 members	14 members	14 members
3. Percentage of pediatric (PEDS) patients, age 5-17 years, with a diagnosis of asthma symptoms in the ED who receive an Asthma Action Plan (No baseline, measure changed)	80% of pediatric patients	85% of pediatric patients	90% of pediatric patients
4. Percentage of pediatric patients, age 5-17 years, with a diagnosis of asthma symptoms in the ED who receive asthma education as documented in the chart (No baseline, measure changed)	80% of pediatric patients	85% of pediatric patients	90% of pediatric patients
5. Percentage of pediatric patients with a diagnosis of asthma symptoms in the ED that are discharged home with steroids (Baseline: 89%, 2016)	80% of pediatric patients	85% of pediatric patients	90% of pediatric patients
Impact Indicators	**2017**	**2018**	**2019**
1. Percentage of pediatric patients with a primary diagnosis of asthma symptoms in the ED who have filled prescriptions by the time of the discharge call (Baseline: 95%, 2016)	80% of pediatric patients	85% of pediatric patients	90% of pediatric patients
2. Percentage of ED pediatric visits for asthma that represents readmissions for asthma for the calendar year will decrease 3% annually (Baseline: 17% 2016)	20% of pediatric ED visits	17% of pediatric ED visits	14% of pediatric ED visits

STRATEGY #3: Provide asthma education through partnerships with community organizations that teaches participants what adults should do in case a child experiences an asthma attack.	**TYPE: Counseling and Education; Changing the Context**

PARTNERS: Local community organizations, i.e., park districts, physical education teachers, day care centers/nurseries, church health ministries, etc.

BACKGROUND ON STRATEGY

Evidence Base: National Asthma Control Initiative

Reducing the public health burden of asthma through improved asthma control is a goal shared by state and local leaders, patients and their families, and other community stakeholders. Moreover, asthma has a disproportionate impact on children, low-income persons, and ethnic and racial minority populations. These groups experience above-average rates of asthma and asthma-related hospitalizations and emergency department visits.

Asthma-friendly communities champion improvements that put evidence-based asthma guidelines into practice by health care professionals, community organizations, and larger networks, environments, and care systems. Locally, it means increasing the capacity of clinics, medical offices, hospitals, emergency departments, pharmacies, homes, and schools and child care settings, to educate patients, families, and caregivers to monitor asthma control, use asthma medications, manage environmental triggers, and prevent or control asthma flare-ups.
https://www.nhlbi.nih.gov/health-pro/resources/lung/naci/audiences/communities.htm (click here)

SHORT TERM INDICATORS			
	Annual Targets by December 31		
Process Indicators	**2017**	**2018**	**2019**
1. Number of community partners participating in the asthma education (Baseline: 4, 2016)	5 partners	7 partners	10 partners
2. Number of asthma education hours per year for community partners (Baseline: 16, 2016)	16 hours	20 hours	25 hours
3. Number of participants in the asthma education programs	20 participants	25 participants	30 participants
Impact Indicators	**2017**	**2018**	**2019**
1. Percentage of people who increase their knowledge of asthma in post test score	20% of people	20% of people	30% of people

ALIGNMENT WITH COUNTY/STATE/NATIONAL PRIORITIES			
Strategy	**County IPLAN**	**SHIP (State Health Improvement Plan)**	**Healthy People 2020**
1-3	Chronic Disease: Participants at the January 21, 2016, WePLAN Community Health Partner Committee meeting worked together to identify priority health issues for the Community Health Improvement Plan as part of WePLAN2020. The group's goal is to reduce inequities and the burden of chronic disease by cultivating environments, healthcare systems and a culture that promotes health. Asthma is categorized as a chronic disease.	The Illinois State Asthma Plan (2015-2020) is a framework for action, collaboration and communication. There are three priority areas within the plan with goals and objectives that have been developed by the Illinois Asthma Partnership (IAP). Each priority area addresses specific concerns and needs using a public health approach to reflect the plan's overarching goal to reduce the burden of asthma.	Healthy People 2020 has numerous objectives to reduce emergency department (ED) visits and hospitalizations for asthma among children and adults ages 5 to 64 years. Risk factors for asthma currently being monitored include: having a parent with asthma; sensitization to irritants and allergens; respiratory infections in childhood; and overweight.

Advocate South Suburban 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.