# 2018 Community Health Needs Assessment

## Implementation Plan for Northwestern Medicine Delnor Hospital

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# Introduction

Northwestern Medicine Delnor Hospital (NMDH) has a rich history of caring for its community. NMDH, an acute-care facility located in Geneva, Illinois, offers emergency care and inpatient specialty care in medical and surgical services, obstetrics, pediatrics, neurology and oncology to the residents of Central Kane County and surrounding areas.

NMDH continues to uphold its promise to provide Kane County residents convenient and affordable access to high-quality, advanced healthcare services. More than 450 physicians are on the medical staff at NMDH, and are trained in more than 80 medical specialties. NMDH continues to uphold the prestigious Magnet® recognition from the American Nurses Credentialing Center. This recognition is considered the gold standard for nursing excellence and demonstrates an organizational commitment to quality care.

NMDH sponsors numerous programs to promote health and wellness, healthcare career training, youth mentoring, language assistance and a multitude of additional programs to enhance the quality and accessibility of health care. Services are carefully designed and structured to meet the needs of our growing and changing communities.

In 2018, NMDH completed a comprehensive Community Health Needs Assessment (CHNA) to identify the highest-priority health needs of residents in our community. We will use this information to guide new and enhance existing efforts to improve the health of our community. The goal of the CHNA was to implement a structured, data-driven approach to determine the health status, behaviors and needs of all residents in the NMDH service area. Through this assessment, we identified health needs that are prevalent among residents across all socioeconomic groups, races and ethnicities, as well as issues that highlight health disparities or disproportionately impact the medically underserved and uninsured.

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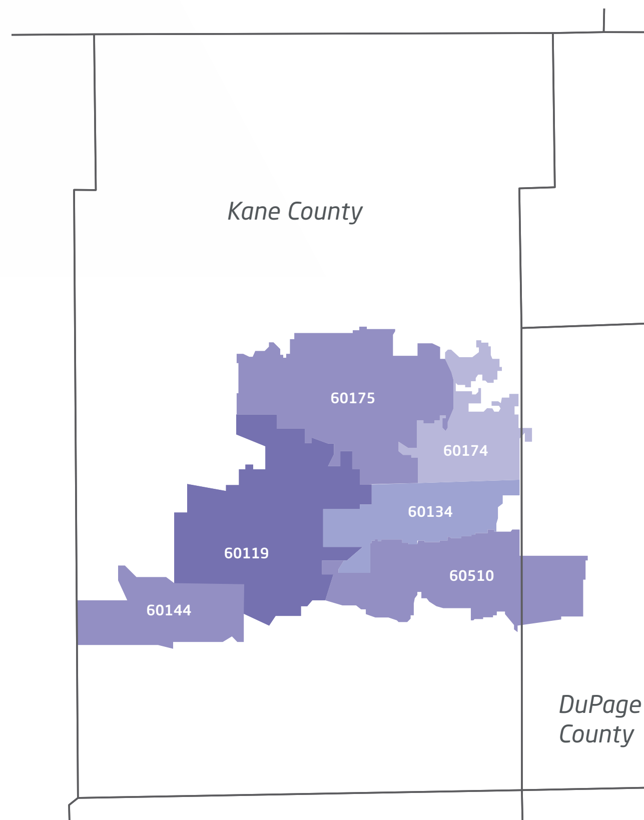
# Community defined for the assessment

The study area for the survey effort was defined as the NMDH service area and analyzed at the ZIP code level. It included the following ZIP codes:



# Overview of the assessment process

A comprehensive CHNA was commissioned on behalf of Northwestern Medicine by Professional Research Consultants, Inc. (PRC). PRC is a nationally recognized healthcare consulting firm with extensive experience in conducting CHNAs in hundreds of communities across the United States since 1994.

The CHNA framework consisted of a systematic, data-driven approach to determine the health status, behaviors and needs of residents in the service area of NMDH. The CHNA provided information to enable hospital leadership and key community stakeholders to identify health issues of greatest concern among all residents and decide how best to commit the hospital's resources to those areas, thereby achieving the greatest possible impact on the community's health status.

The CHNA incorporated data from both quantitative and qualitative sources. Quantitative data input included primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data). These quantitative components allowed for trending and comparison to benchmark data at the state and national levels. Qualitative data included a telephone survey randomly administered to residents in the community and a survey of key community stakeholders. Once the data was reviewed by NMDH community health experts, executive leadership and key community stakeholders identified priority areas of need in which NMDH was uniquely positioned to address and respond.

The entire CHNA process included:

A comprehensive identification and prioritization of needs;

the identification of priority needs that NMDH was most uniquely suited to address;

a framework for the development of a comprehensive Community Health Improvement Plan (CHIP) designed to guide NMDH in addressing and responding to the identified priority needs via a process-driven methodology including goal development, strategies, measurable outcomes; and

a plan to partner with other key community stakeholders to support the remaining needs.

Following completion of the CHNA, NMDH leadership convened an External Steering Committee (ESC) to review the findings. This multidisciplinary committee was made up of key stakeholders who were selected based on strong collaborative efforts to improve the health of the community, including the medically underserved, minority and low-income populations. The varied backgrounds of the committee members provided diverse insight into prioritizing identified health indicators.

# Prioritization process

A planned and structured process was used to facilitate prioritization of the identified health needs. Tools and data utilized in the process included the CHNA data, Kane County IPLAN data, an organizational asset inventory and alignment with guiding principles for response to community need.

The prioritization process included an analysis of:

**Importance of the problem to the community**
Is there a demonstrated community need?
Will action impact vulnerable populations?
Does the identified health need impact other community issues?

**Availability of tested approaches or existing resources to address the issues**
Can actionable goals be defined to address the health need?
Does the defined solution have specific and measurable goals that are achievable in a reasonable timeframe?

**Opportunity for collective impact**
Can the need be addressed in collaboration with community or campus partners to achieve significant, long-term outcomes?
Are other organizations already addressing the health issue?

**Applicability of NMDH as a change agent (such as acting as a partner, researcher or educator, or in a position to share knowledge or funding)**
Does NMDH have the research or education expertise/resources that address the identified health need?
Does NMDH have clinical services or other expertise/resources that address the identified health need?

**Estimated resources, timeframe and size of impacted population**

NMDH developed a survey tool to formally solicit input from ESC members and identify their organizations' priority health needs (defined as health needs that could be impacted the most by the work of NMDH and partner organizations participating on the ESC). NMDH leaders and ESC members were asked to identify top priorities from among the areas of opportunity identified by PRC using the following prioritization criteria:

**Magnitude:** How many people in the community are/will be impacted?

**Seriousness and impact:** How does the identified need impact health and quality of life?

**Feasibility:** What capacity/assets currently exist to address the need?

**Consequences of inaction:** What impact would inaction have on the population health of the community?

**Trend:** How has the need been changing over time?

The survey results were compiled and shared with the ESC. Together with the committee, the highest-priority health needs were determined, taking into account the findings of the CHNA, the survey findings, and discussion around the guiding principles and prioritization criteria.

Attention was also focused on assessment of internal and external capabilities. An asset analysis included a review of current initiatives and exploration of ways to better coordinate efforts. The potential for duplicative efforts and existing gaps were identified

# Identification of priority health needs

A CHNA provides information to assist hospitals in identifying health issues of greatest concern among residents within their service area. It also guides in the decision to best commit their resources to those areas, thereby resulting in the greatest possible impact on community health status. The NMDH CHNA was conducted with a data-driven approach, utilizing both online key informant surveys in addition to vital statistics and other existing health-related data. It spotlighted disparate/vulnerable populations including individuals experiencing mental health/substance abuse concerns, decreased access to affordable healthcare services and limited English-proficient individuals

Seven potential areas of opportunity for community health improvement were identified in the CHNA:

- Access to healthcare services
- Prevention and management of chronic disease
- Injury and violence
- Mental health
- Nutrition, physical activity and weight
- Substance abuse
- Tobacco use

Upon completion of this process, the 2018 NMDH priority health needs were identified as follows:

- Access to healthcare services
- Mental health and substance abuse
- Chronic disease

# Response to non-prioritized health needs

An identified need was not addressed as a 2018 priority health need if NMDH was not best positioned to help due to the following situations:

NMDH has limited expertise, services or resources in the identified area of need

Public health or other organizations typically address the need

Other organizations have infrastructure and plans already in place to better meet the need

Broader initiatives in the Implementation Plan will address or significantly impact the need

### Injury and violence

While injury and violence was not addressed as a priority need, NMDH partners with local police and EMS systems to respond to emergency needs. Additionally, NMDH has a strong Injury Prevention program which provides injury prevention education to hundreds of children and adolescents annually.

### Nutrition, physical activity and weight

The problems and responses related to poor nutrition, inadequate physical activity and overweight/obesity are included within the broader category of chronic disease within our Implementation Plan. These factors are considered key root causes of chronic disease and were included in the causal analysis and response.

### Tobacco abuse

Tobacco abuse is incorporated into the substance abuse component of the Implementation Plan.

# Implementation Plan development

It is widely recognized and accepted that the gold standard for community benefit planning and the response to community need is largely dependent upon the support of organizational leadership and the integration and alignment of community benefit planning into the organization's mission and strategic plan. To that end, Northwestern Medicine (NMHC) has developed a set of guiding principles that are in alignment with the organization's strategic plan.

| Implementation Plan Development | | |
|---|---|---|
| **Deliver Exceptional Care** | **Develop People, Culture and Resources** | **Advance Medical Science and Knowledge** |
| **NMHC Strategic Plan Alignment** | | |
| Ensure that residents of our defined communities have access to high-quality, medically necessary healthcare services in the most appropriate setting, in response to assessed needs | Create pathways to healthcare professions and ensure a well-trained healthcare workforce is in place for our communities<br>Support community-based partners through collaboration, and providing tools and resources | Support the discovery of new knowledge through research that can prevent, detect, and cure disease and reduce suffering |
| **NMHC Community Benefit Plan Alignment** | | |
| Develop and support culturally competent clinical and educational programs to prevent disease, promote health and wellness and address disparities in health | Provide youth with education, mentoring and exposure to healthcare professions<br>Provide support for community-based healthcare and wellness programs by collaborating, convening, leading and funding | Provide support for the research and education efforts of Northwestern Medicine |
| Develop and support models of care that ensure adequate primary care capacity and access to medically necessary diagnostic and specialty care, especially for the medically underserved | Train healthcare students and professionals in the classroom and clinical settings<br>Share technical, fundraising and management expertise to foster a culture of quality among our community-based healthcare partners | Provide clinical settings for research at our care locations and through partnership with community healthcare organizations |
| Develop and maintain programs to address affordability of and accessibility to healthcare services | Develop programs to address current and projected healthcare workforce shortages<br>Support continuing education to ensure a well-trained healthcare workforce is in place | Promote access to clinical trials<br>Disseminate knowledge of clinical discoveries to the medical science community, our communities, and within our system<br>Engage and support community partners in conducting research in response to identified healthcare needs |

These guiding principles were utilized in the development of the Implementation Plan for each of the priority health needs discussed below.

# Priority health need: Access to healthcare services

## Introduction and need overview

Access to health services has a profound effect on every aspect of a person's health, yet almost one in four Americans does not have a primary care provider (PCP) or health center where he or she can receive regular medical services. Increasing access to both routine medical care and medical insurance is vital for improving the health of all Americans.[1] Access to health services affects a person's health and well-being.

Regular and reliable access to health services can:

- Prevent disease and disability
- Detect and treat illnesses or other health conditions
- Increase quality of life
- Reduce the likelihood of premature (early) death
- Increase life expectancy[2]

### Insurance

Approximately one in five Americans (children and adults under age 65) does not have medical insurance. People without medical insurance are more likely to lack a usual source of medical care, such as a PCP, and are more likely to skip routine medical care due to costs, increasing their risk for serious and disabling health conditions. When they do access health services, they are often burdened with large medical bills and out-of-pocket expenses.

Among CHNA survey respondents age 18 to 64, 3.7 percent reported having no insurance coverage for healthcare expenses. This was down from 6.3 percent in 2015 and is notably lower than state (10.7 percent) and national (13.7 percent) reports.

### Barriers to access

A total of 35.4 percent of service area respondents reported some type of difficulty or delay in obtaining services in the past year, as compared to 31.6 percent in 2015. Difficulties were reported more often among women and adults age 18 to 39. These findings were similar to both regional (38.3 percent) and national (43.2 percent) findings.

Notable barriers to healthcare access included:

- Inconvenient office hours
- Difficulty obtaining a provider appointment
- Cost of a doctor visit
- Cost of prescriptions
- Difficulty finding a doctor
- Lack of transportation

1 Healthy People 2020
2 Healthy People 2020, Leading Health Indicators

Only 5.3 percent reported difficulty obtaining medical care for children in the past year, as compared to 5.1 percent in 2015.

Access to healthcare services was identified as a moderate/major problem in the community by 67.8 percent of respondents and key stakeholders who noted the following concerns:

Barriers to care for refugee and immigrant populations, including access, transportation, language barriers and difficulty navigating the system

A growing minority population affected by income, lack of education and multiple other disparities

Personal finances

Lack of providers who accept all Medicaid plans

Transportation for seniors

Additionally, key informants identified the types of medical care most difficult to access:

Substance abuse treatment

Chronic disease care

Mental health

Specialty care

## Access to primary care

Despite the collaborative efforts of NMDH, the Kane County Health Department and multiple health/human service organizations, service area residents have less access to PCPs than throughout the state or nation. Kane County reports 44.8 PCPs per 100,000 population, as compared to between 80 and 95 PCPs at the state and national level.

A specific source of primary care was acknowledged by 83.5 percent of survey respondents.

A total of 71.7 percent have visited their healthcare provider for a checkup in the past year, up from 67.0 percent in 2015.

A total of 95.7 percent of respondents' children have visited a PCP for a routine checkup in the past year, up from 82 percent in 2015.

Use of the emergency room more than once in the past year was acknowledged by 2.7 percent of survey respondents for the following reasons:

Emergency situations (52.1 percent)

Weekend/after-hours situations (30.8 percent)

Lack of a PCP (12.3 percent)

## Access to specialty care

A total of 56.7 percent of respondents reported the need to see a specialist within the past year – an increase from 52.1 percent in 2015. Those individuals noted obtaining specialty care was:

A major problem (8.6 percent)

A moderate problem (8.2 percent)

A minor problem (12.5 percent)

No problem at all (70.7 percent)

## Access to dental care

A total of 81.8 percent of survey respondents acknowledged a source of dental care, exceeding state (65.5 percent), national (59.7 percent) and Healthy People (HP 2020) targets (49 percent or higher).

Additionally, 76.3 percent of respondents had insurance coverage for all or part of dental care costs, an increase from 66.1 percent in 2015.

Among key informants, 16.7 percent identified oral health as a major problem and 44.7 percent noted it as a moderate problem.

Concerns noted by key informants included:

Access to dental care by refugee population

Lack of access

Inadequate number of dentists who accept Medicaid reimbursement

## Access to vision care

A total of 67.2 percent of respondents acknowledged having a dilated eye exam within the past two years.

### Analysis of access to care concerns

People without medical insurance are more likely to lack a usual source of medical care, such as a PCP. They are also more likely to skip routine medical care due to costs, increasing their risk for serious and disabling health conditions.

When they do access health services, they are often burdened with large medical bills and out-of-pocket expenses. Increasing access to both routine medical care and medical insurance are vital steps in improving the health of all Americans.[3] Access to health services affects a person's health and well-being. As discussed previously, regular and reliable access to health services can:

- Prevent disease and disability
- Detect and treat illnesses or other health conditions
- Improve quality of life
- Reduce the likelihood of premature (early) death
- Increase life expectancy

Social determinants of health include factors such as socioeconomic status, education and employment. These factors significantly affect an individual's ability to access health care. Individuals with minimal or no health insurance are the least likely to access health care until their conditions become severe and costly. Lack of routine care and preventive screening may result in poor outcomes and decreased life expectancy.

A lack of knowledge regarding how to access affordable health care contributes to limited access to health care. It is incumbent upon healthcare providers to not only provide financial assistance, but it is also critical to develop pathways and safety nets to facilitate access to care.

## Community assets

The Kane County Health Department works closely with its community partners to assess current health needs within the county. NMDH is one of over 60 partners having participated in the county's recent community health assessment. This newest cycle of the health assessment, completed in 2018, utilizes the MAPP process – Mobilizing Action through Planning and Partnerships. MAPP is a community-wide strategic planning process for improving community health and strengthening local public health systems. MAPP provides a framework that helps communities prioritize public health issues, identify resources for addressing them, and develop and implement community health improvement plans. The Kane County Health Department, in collaboration with the hospitals and other community partners, is in the process of completing a 2020 CHIP based on the newest community health assessment. Additional data and information is available through www.KaneHealthCounts.org. The site contains data gathered from the 2018 MAPP Assessment, and will provide additional information regarding the county's upcoming 2020 CHIP. Data and priorities noted in this report are adapted from the county's 2017-2020 CHIP.

3 Healthy People 2020

## Existing NMDH hospital programs

NMHC and its affiliates, including NMDH, are committed to meeting the healthcare needs of those within the NMHC community who are unable to pay for medically necessary or emergency care. When needed, NMHC provides medically necessary care free of charge or at discounted rates ("financial assistance").

To manage its resources and responsibilities, and to provide financial assistance to as many people as possible, NMHC has established program guidelines for providing financial assistance. However, NMHC will always provide emergency care, regardless of a patient's ability to pay.

## Range of possible interventions

A broad range of interventions exists to address the problem of access to care. Kane County has four major community-based, federally qualified health centers (FQHCs) offering cradle to grave primary and specialty care to the underserved in Kane County. These FQHCs work closely with local hospitals to ensure a seamless continuum of care.

## Benchmarks

National–HP 2020

## Goal

Improve access to comprehensive, quality healthcare services

## Related objectives

AHS-1: Increase the proportion of persons with medical insurance

AHS-3: Increase the proportion of persons with a usual PCP

AHS-4: Increase the number of practicing PCPs

AHS-5: Increase the proportion of persons who have a specific source of ongoing care

AHS-6: Reduce the proportion of persons who are unable to obtain or are delayed in obtaining necessary medical care, dental care or prescription medicines

AHS-7: Increase the proportion of persons who receive appropriate evidence-based clinical preventive services

## Local–Kane County 2017-2020 CHIP

### Priority Two–Increase access to high-quality, holistic preventive and treatment services across the healthcare system.

2-1: Increase the proportion of residents of all ages that have regular, ongoing sources of medical and dental care.

2-2: Increase the proportion of residents of all ages who receive appropriate, evidence-based clinical services.

2-3: Focus culturally appropriate outreach and engagement efforts to eliminate disparities in health outcomes, especially related to infant mortality.

### Implementation strategy

NMDH will offer a comprehensive financial assistance program to patients who are unable to afford the cost of necessary medical care.

NMDH will continue to support efforts to increase access to care by providing leadership, investing resources and working collaboratively with other community organizations throughout the county.

NMDH will support the maintenance and expansion of an efficient and effective continuum of care offering medical homes (including primary and specialty care), pharmaceuticals, inpatient, outpatient and emergent care to uninsured adult residents of Kane County.

NMDH will also seek to engage and maintain a multicultural workforce of PCPs, specialists, mid-level practitioners, registered nurses and other medical professionals committed to working in an evidence-based practice setting.

## Implementation plan

# Strategy #1

NMDH will offer a comprehensive financial assistance program to patients who are unable to afford the cost of necessary medical care.

| Methodology | Resources/Programs/ Partnerships | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| 1. NMDH will offer financial assistance policies that are easily accessible, user-friendly, respectful, and meet all regulatory requirements. | 1. Leadership and staff from NMDH | 1a. NMDH will conduct an internal audit of financial assistance policies, procedures and application materials annually.<br>1b. NMDH will conduct an internal audit of signage, website and compliance with all regulatory requirements. | 1a-b. NMDH staff will report annually to leadership the results of an internal review of website, policies, forms and signage to ensure accessibility, user-friendliness and compliance with all regulatory requirements. |
| 2. NMDH will continue to provide medically necessary inpatient and outpatient hospital services to uninsured and underinsured patients in accordance with the hospital's financial assistance policies. | 2. Leadership and staff from NMDH | 2. NMDH will promote access to needed healthcare services by offering financial assistance to qualified individuals who were unable to afford the cost of their medical care. | 2a. NMDH staff will track and report the number of individuals rendered financial assistance annually.<br>2b. NMDH staff will track and report the amount of financial assistance rendered annually. |
| 3. NMDH will continue to address the needs of individuals identified as potentially eligible for public health insurance by facilitating their application for government-sponsored healthcare coverage. | 3. NMDH financial services and HJQ – an outside vendor that assists patients in applying for government-sponsored healthcare coverage | 3. NMDH and outside vendor will assess and refer eligible patients for public benefits. | 3. NMDH financial services staff will report the number of patients referred annually along with an annual quantitative summary of costs related to the use of HJQ services. |

## Strategy #2

NMDH will continue to support efforts to increase access to care by providing leadership, investing resources and working collaboratively with other community organizations throughout the county.

| Methodology | Resources/Programs/ Partnerships | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| 1. NMDH leadership will continue representation on various task forces and work groups related to the collaborative work occurring on access-to-care issues. | 1. NMDH leadership, local FQHCs, Tri City Health Partnership | 1. NMDH will create and/or participate in programs and initiatives focused on meeting the county's IPLAN and safety net objectives to promote access to care. | 1. NMDH will prepare an annual summary of activities and work completed towards responding to this strategy. |
| 2. NMDH Foundation will provide operational grants to Tri City Health Partnership in support of their coordination of care for patients without insurance. | 2. NMDH Foundation leadership, Tri City Health Partnership | 2. Provision of an operational grant to Tri City Health Partnership will enable low-income county residents to afford and receive needed care. | 2. Tri City Health Partnership will track and review information related to the following metrics:<br>2a. Number of patients accessing services and number of visits annually. |
| 3. NMDH will continue to offer the NM *Parent Review* on-line support program for new families. | 3. NMDH staff | 3. The program will offer educational information and access to support information for new families. | 3. NMDH staff will track and report software utilization and costs related to the program. |

## Strategy #3

NMDH will support the maintenance and expansion of an efficient and effective continuum of care offering medical homes (including primary and specialty care), pharmaceuticals, inpatient, outpatient and emergent care to uninsured adult residents of Kane County.

| Methodology | Resources/Programs/ Partnerships | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| 1. NMDH will continue to provide free inpatient and outpatient care to Tri City Health Partnership clients in accordance with presumptive eligibility and existing NMDH financial assistance policies. | 1. NMDH and Tri City Health Partnership | 1. Access to free inpatient and outpatient care will enable presumptively eligible, low-income residents to receive needed services in a timely, coordinated and efficient manner. | 1a. NMDH staff will track and report the cost of free inpatient care rendered to Tri City Health Partnership clients.<br>1b. NMDH staff will track and report the cost of free outpatient care and other services rendered to Tri City Health Partnership clients. |
| 2. NMDH will continue to work with VNA Healthcare to promote access to primary and specialty care to Medicaid recipients in the service area. | 2. NMDH and VNA leadership | 2. NMDH staff will work collaboratively with VNA staff to promote a seamless continuum of primary, specialty and emergency care to underserved residents in the hospital's service area. | 2a. NMDH will track and report on the number of individuals referred to VNA as well as NMDH and Northwestern Medicine Regional Medical Group (NMRMG).<br>2b. NMDH and NMRMG will track and report the costs associated with providing specialty care to patients referred from VNA. |

## Strategy #3 (continued)

| Methodology | Resources/Programs/ Partnerships | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| 3. NMDH will offer vaccine clinics that are easily accessible, user-friendly, respectful, and meet all regulatory requirements. | 3. NMDH Vaccine Clinic staff, Vaccines for Children program | 3. NMDH staff will work to provide a vaccine clinic to children that are eligible for the Vaccines for Children program.<br>NMDH will also increase the number of Tdap vaccinations to parents and caregivers as part of the vaccine clinic, in response to the growing incidence of pertussis in the community. | 3a. A random audit of vaccine compliance for children entering kindergarten will be completed bi-annually:<br>- (4) or more doses of DTaP vaccine<br>- (2) or more doses of MMR vaccine<br>- (3) or more doses of polio vaccine<br>- (3) or more doses of Hepatitis B vaccine<br>- (2) or more doses of varicella vaccine<br>3b. A random audit of vaccination compliance for adolescents will be completed bi-annually.<br>- (1) dose Tdap booster<br>- (2) doses of varicella vaccine<br>- (1) dose meningococcal vaccine<br>- (3) doses of HPV vaccine for females<br>3c. NMDH staff will track the number of Tdap vaccinations provided for adult caregivers. |

## Strategy #4

NMDH will also seek to engage and maintain a multicultural workforce of PCPs, specialists, mid-level practitioners, registered nurses and other medical professionals committed to working in an evidence-based practice setting.

| Methodology | Resources/Programs/ Partnerships | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| 1. NMDH will serve as a training center for nursing and other allied health professions. | 1. NMDH staff and local nursing and allied health professions training programs | 1. Serving as a training center demonstrates an ongoing commitment towards the provision of a highly competent, culturally sensitive and diverse future workforce. | 1. NMDH staff will track and report a quantitative summary detailing number and types of internships and staff time commitment. |
| 2. NMDH will provide trained professional healthcare interpreters and offer language assistance programs. | 2. NMDH staff and phone line language assistance services | 2. Utilization of trained professional healthcare interpreters will decrease barriers to care, promote access and ensure high-quality, culturally competent care. | 2. NMDH staff will track and report a quantitative summary detailing types of interpretive services and related costs. |

# Priority health need: Mental health and substance abuse

## Introduction and need overview

Data from the CHNA revealed that poor mental health and access to mental health treatment were issues of concern for Kane County residents as evidenced by:

A total of 62.6 percent of residents reported their mental health as “excellent” or “very good,” with 23.6 percent reporting “good” and 13.8 percent reporting “fair” or “poor.”

Additionally, 25.8 percent of respondents in the NMDH service area reported 3 or more days of poor mental health in the past month, as compared to 14.7 percent in 2015.

A total of 22.5 percent of adults reported being diagnosed with a depressive disorder (an increase from 8.3 percent in the 2015 CHNA).

A total of 31.9 percent of respondents reported 3 or more days of feeling sad, blue or depressed in the past month, as compared to 16.0 percent in 2015. 62.9 percent of those reporting fell between 18 and 39 years of age.

Between 2014 and 2016, the annual average age-adjusted suicide rate was 8.5 deaths per 100,000 population in Kane County (essentially unchanged from 2013-2015 data).

Among respondents with children age 2 to 17 years of age within the NMDH service area, 21.5 percent rated their child’s mental health as “poor or fair,” as compared to 7.3 percent in 2015.

A total of 39.3 percent of respondents reported ever having sought help for a mental or emotional problem, as compared to 30.8 percent nationally.

A total of 19.3 percent of respondents reported either currently taking medication or receiving mental health treatment, as compared to 13.9 percent nationally.

Lack of access to mental health care within the past 12 months was reported by 21.0 percent of individuals 18 to 39 years of age.

A total of 65.0 percent of survey respondents acknowledged awareness of local mental health resources.

A total of 61.0 percent of key informants identified mental health as a major problem in the community citing reasons such as lack of access, availability, affordability, insufficient funding and number of psychiatrists in Kane County, significant prevalence of anxiety and depression, ongoing treatment and insufficient capacity.

Additionally, CHNA data related to substance abuse and tobacco use included:

### Substance abuse

Age-adjusted deaths from cirrhosis/liver disease rose from 8.9 deaths per 100,000 population in 2015 to 9.5 in 2016, exceeding state rates.

Age-adjusted, drug-induced deaths remained lower than state and national rates.

A total of 28.1 percent of respondents reported excessive drinking. This was higher than the national rate of 22.5 percent.

A total of 4.0 percent of respondents acknowledged driving after having consumed too much alcohol in the last month – up from 1.4 percent in 2015.

Illicit drug use in the past month was acknowledged by a total of 3.7 survey respondents. While this exceeded the U.S. rate (2.5 percent), it also reflected an increase from 0.7 percent in the 2015 survey.

A total of 4.0 percent of respondents acknowledged seeking professional help for a drug/alcohol related problem up from 2.8 percent in 2015.

Substance abuse was characterized as a "major" problem in the community by 44.7 percent of key informants. Education, denial/stigma, cost/insurance, and access to affordable care were cited as barriers to treatment and ease of access to opiates noted as a contributing factor.

Key informants who rated substance abuse as a "major" problem most often identified alcohol, cocaine, heroin/opioids, prescription medications and marijuana as the most problematic substances in the community.

### Tobacco use

A total of 8.2 percent of NMDH service area adults currently smoke cigarettes, representing a decrease from 13.2 percent in 2015.

Among households with children, 4.0 percent have someone who smokes cigarettes in the home.

Additionally, 13.9 percent of service area adults use some type of smokeless/vaping products, representing an increase from 8.6 percent in 2015.

A total of 33.5 percent of respondents were aware of the Illinois Tobacco Quit-Line program.

Tobacco use was identified as a "moderate problem," by 47.1 percent of key informants, while an additional 11.0 percent identified it as a "major" problem, citing concerns such as lack of education, peer pressure and high stress environments.

## Analysis of mental health and substance abuse concerns

Mental health and substance abuse are associated with many other root causes and social determinants including poverty, education and unemployment. HP 2020 identified mental health risk factors, such as decreased resiliency and lack of treatment for mental health conditions. Substance abuse risk factors included high stress and community norms. Contributing factors to both issues included poor coping skills, stressors, social and self-stigma, lack of access to treatment, adverse life events, perceived low risk of substance abuse, inadequate policies and easy access to substances.

Public policies impacting substance abuse include absent and/or unenforced social host ordinances and lack of regulation on e-cigarettes and hookah bars. Current budget stalemates at the state level have resulted in substantial cutbacks in mental health and related human services. Key programs for people with mental illness are also facing reductions in the state's proposed budget.

## Community assets

NMDH is an active partner in the Mental Health Council developed by the Kane County Health Department. NMDH community health and behavioral health leadership works collaboratively with community resources to ensure a continuum of care in support of mental health wellness in Kane County.

## Existing NMDH hospital programs

NMDH works collaboratively with Northwestern Medicine Central DuPage Hospital (NMCDH) to offer immediate help, providing short-term psychiatric care for adults and teens (13 years of age and older) in a hospital setting. Short-term inpatient care is provided in three secure hospital psychiatric units to help people who pose a risk to themselves or others and those who are unable to care for themselves.

Following stabilization, NMCDH offers a full range of treatment including outpatient partial hospitalization, individual and family therapy, group therapy and follow-up services in the community. NMCDH also offers a full range of substance abuse services including inpatient detoxification, residential treatment and rehabilitation services, along with continued counseling to support long-term recovery. NMCDH works closely with mental health and substance abuse programming in Kane County to ensure a seamless continuum of care.

## Benchmarks

National – HP 2020

## Mental health goal

Improve mental health through prevention and by ensuring access to appropriate, quality mental health services

## Related objectives

MHMD-1: Reduce the suicide rate

MHMD-4: Reduce the proportion of persons who experience major depressive episodes

MHMD-5: Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral

MHMD-9: Increase the proportion of adults with mental health disorders who receive treatment

MHMD-10: Increase the proportion of persons with co-occurring substance abuse and mental health disorders who receive treatment for both disorders

### Substance abuse goal

Reduce substance abuse to protect the health, safety and quality of life for all, especially children

### Related objectives

SA-1: Reduce the proportion of adolescents who report that they rode with a driver who had been drinking alcohol during the previous 30 days

SA-2: Increase the proportion of adolescents never using substances

SA-3: Increase the proportion of adolescents who disapprove of substance abuse

SA-4: Increase the proportion of adolescents who perceive great risk associated with substance abuse

SA-8: Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year

SA-9: Increase the proportion of persons who are referred for follow-up care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department

SA-10: Increase the number of Level I and Level II trauma centers and primary care settings that implement evidence-based alcohol screening and brief intervention

SA-14: Reduce the proportion of persons engaging in binge drinking of alcoholic beverages

SA-19: Reduce the past-year nonmedical use of prescription drugs

## Local – Kane Health Counts Action Plan

Goal: By August 31, 2021, reduce the number of emergency department visits related to behavioral health by 5.0%.

Impact Objectives:

1. Increase the proportion of adults aware of mental health resources by 15%
2. Reduce the proportion of adults who could not get mental health resources when needed in the past year to 2.5% (or by 11%)
3. Reduce the proportion of adults that experience “fair” or “poor” mental health by 15%

## Implementation strategy

In support of national and local mental health service objectives, NMDH will continue to provide leadership, invest resources and work collaboratively with community partners in a countywide mental health/substance abuse coalition. The purpose of the coalition will be to study the issues and needs, and develop planned responses that will ultimately improve the quantity, quality and continuity of mental health services available in the county.

## Implementation strategy

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| Methodology | Resources/Programs/ Partnerships | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| 1. NMDH will provide in-kind leadership and support to the implementation of the Mental Health Council that has been developed by the Kane County Health Department. | 1. Leadership from Behavioral Health will supply support and direction in the implementation of the objectives identified in the CHIP. | 1. Leadership from Behavioral Health will supply support and direction in the implementation of the objectives identified in the CHIP. 1. NMDH staff will work towards supporting the development of one or more innovations to increase pipeline capacity of quality providers. | 1. NMDH staff will report progress towards the increase in the proportion of adults aware of mental health resources. |
| 2. NMDH will offer evidence-based wellness programs in the areas of mental health and substance abuse via programmatic venues including but not limited to Dinner with the Doc series, clinician-led educational offerings, self-help groups, rehabilitation services programs, support groups and professional development. | 2. NMDH Community Health Outreach (CHO) staff will partner with Behavioral Health staff and community mental health and substance abuse partners to provide wellness programming in the areas not limited to alcohol, cocaine, narcotics abuse, overeating, attention deficit hyperactivity disorder, depression, suicide and bipolar disorders. | 2. Attendees will complete program evaluations validating that learner outcomes have been met via an increase in topic knowledge and awareness. | 2a. NMDH staff will track the number of programs offered and the number of attendees.<br>2b. NMDH staff will develop course objectives and learner outcomes while measuring learned behavior and planned change.<br>2c. Attendees will identify at least one learned outcome and articulate one planned behavior change.<br>2d. NMDH staff will work collaboratively with self-help and support group community contacts to ensure that best practices are used to assess participant impact of programming. |

## Implementation strategy (continued)

| Methodology | Resources/Programs/ Partnerships | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| 3. NMDH will offer community benefit grants targeted to address mental health needs in the NMDH service area. | 3a. Ecker Center for Mental Health: Psychiatry Services<br>Grant amount: $15,000<br>3b. Tri City Family Services: Counseling Access Program<br>Grant amount: $10,000 | 3a. Ecker Center for Mental Health will measure the success of the psychiatry services by utilizing the Medication Possession Ratio (MPR) and a client self-reported assessment.<br>Program outcomes include:<br>- To increase the MPR to over 0.90 consistently over time<br>- More than 75% of clients will report symptom improvement as a result of psychiatric services provided<br>3b. Tri City Family Services will measure the success of the Counseling Access Program by tracking outcomes through census data and treatment outcomes that measure skilled and changed behaviors/ attitudes, plus the level of functioning by utilizing the Columbia Impairment Scale and Ohio Outcome Scales.<br>Program outcomes include:<br>- To increase skills and changed behavior/attitudes, as indicated through improvement in treatment goals developed with their therapist.<br>- To improvement in functioning, as measured by the Columbia Impairment Scale and Ohio Outcome Scales. Expected to see increased skills, changed behaviors, attitudes and improvement in functioning. | 3a. A report on the identified program outcomes will be submitted to NMCDH staff by September 30, 2019.<br>3b. A report on the identified program outcomes will be submitted to NMCDH staff by September 30, 2019. |

## Implementation strategy (continued)

| Methodology | Resources/Programs/ Partnerships | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| 4. NMDH will continue the National Council for Behavioral Health's Mental Health First Aid (MHFA) Program and offer programming to members of the community.<br><br>Note: MFHA is an 8-hour course that teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders. | 4. NMDH CHO staff | 4a. NMDH staff will successfully develop and implement the NMDH MHFA Program.<br><br>4b. The NMDH MHFA Program will demonstrate an increased awareness of appropriate resources available in the community to address mental health concerns.<br><br>The program's impact will be measured in alignment with the following identified outcomes:<br><br>- Ninety percent of course participants will agree or strongly agree that they are able to describe the 5-step Action Plan (ALGEE).<br><br>-Ninety percent of course participants will agree or strongly agree that the MHFA course increased their confidence in recognizing and correcting misconceptions about mental health and mental illness.<br><br>-Ninety percent of MHFA course participants will score a minimum of 85 percent on the MHFA course exam. | 4a. Four NMDH staff will complete MHFA and MHFA for Youth facilitator training.<br><br>4b. NMDH staff will document and report program outcomes. |

# Priority health need: Chronic disease

## Introduction and need overview

### Cardiovascular disease

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing our nation today, accounting for more than $500 billion in healthcare expenditures. Healthy People 2020 (HP 2020) stresses that the risk of Americans developing and dying from cardiovascular disease would be substantially reduced if changes were made in diet, physical activity and management of high blood pressure, cholesterol and smoking. Fortunately, they are most preventable especially if intervention is provided across the lifespan of the disease — from early education, prevention and screening to early diagnosis, prompt treatment and comprehensive aftercare. In planning responses to the priority needs of their communities, hospitals can positively impact the health burdens of all chronic diseases by addressing the disease across the continuum of its lifespan.

Together, cardiovascular disease (heart disease and stroke) accounted for 26.9 percent of all deaths in Kane County in 2016.

A total of 4.9 percent of survey respondents acknowledged having been told by their healthcare provider that they either had heart disease or had a stroke.

A total of 31.3 percent of adults reported being told at some point that their blood pressure was high, exceeding the HP 2020 target of 26.9 percent or lower. This finding represented a decrease from 34.9 percent in our 2015 assessment.

A total of 87.4 percent of adults with multiple high blood pressure readings reported taking action to control their levels.

A total of 32.0 percent of adults reported a diagnosis of high cholesterol. This represents an increase from 30.1 percent in our 2015 assessment and a HP 2020 target of 13.5 percent or lower. 85.8 percent reported taking action to help control their cholesterol levels.

Regarding total risk of cardiovascular disease, 82.3 percent of respondents reported one or more risk factors including overweight, smoking cigarettes, physical inactivity, high blood pressure or high cholesterol levels.

A total of 77.7 percent of key informants rated heart disease and stroke as a moderate/major problem in the community

### Cancer

Continued advances in cancer research, detection and treatment have resulted in a decline in both incidence and death rates for all cancers. Yet cancer remains a leading cause of death within the NMDH service area. Once again, intervention across the lifespan of the disease poses an opportunity for hospitals to focus on prevention through education, and early diagnosis and treatment through access to routine screenings.

Between 2014 and 2016, the annual average age-adjusted cancer mortality rate was 142.3 deaths per 100,000 residents in Kane County. The rate has decreased from the 2012-2014 rate of 152.5 per 100,000 residents.

Lung cancer remains the leading cause of cancer deaths in Kane County, followed by female breast cancer, prostate cancer and colorectal cancer.

The incidence of female breast cancer ranked higher in DuPage County than in Illinois or in the U.S.

When queried regarding screenings:

- Among women age 50 to 74 years, 75.1 percent reported having had a mammogram in the past two years. This represented a decrease from 77.5 percent in 2015.
- Among women age 21 to 65 years, 80.6 percent reported having had a Pap smear within the past three years. This represented an increase from 71.1 percent in 2015.
- Among men age 40 and over, 56.4 percent reported having had a Prostate-Specific Antigen (PSA) test in the past two years. This rate remained relatively unchanged from 56.1 percent in 2015.
- Among adults age 50 to 75 years, 71.9 percent reported having a colorectal cancer screening. This represented an increase from 58.1 percent in 2015.
- A total of 24.0 percent of key informants rated cancer as a major problem in Kane County.

## Pulmonary disease

Asthma and chronic obstructive pulmonary disease (COPD) are also significant public health burdens. Annual healthcare expenditures for asthma alone were estimated by HP 2020 to be in excess of $20 billion dollars.

Currently, 7.3 percent of respondents reported suffering from COPD in 2018, as compared to 9.1 percent in 2015.

Additionally, 7.7 percent of adult survey respondents suffer from asthma – a significant increase from 3.9 percent in 2015.

Also, 5.4 percent of children within the NMDH service area were reported to have asthma. This represents a decrease from 8.7 percent in 2015.

A total of 55.6 percent of key informants rated respiratory disease as either a moderate or major problem in Kane County.

## Diabetes

Diabetes is another disease that continues to increase in both incidence and prevalence in the United States. Increasing numbers coupled with earlier onset of the disease pose a growing concern about the potential to overwhelm the existing healthcare system.

Between 2014 and 2016, the annual average age-adjusted diabetes mortality rate was 18.0 deaths per 100,000 residents in Kane County, slightly below state and national rates.

In 2018, a total of 9.5 percent of respondents reported having been diagnosed with diabetes, and an additional 5.3 percent reported having “pre-diabetes.” The prevalence of diabetes has increased from 8.4 percent in 2015.

Among individuals not having been diagnosed with diabetes, only 53.4 percent reported having had their blood sugar level tested within the past three years. This is a decrease from 62 percent in 2015.

Diabetes was identified as a major problem in Kane County by 41.8 percent of key informants.

## Factors contributing to chronic disease

### Diet and nutrition

A total of 23.1 percent of survey respondents reported eating five or more servings of fruits and/or vegetables per day.

Among respondents with children age 2 to 17 years, 33.7 percent reported child consumption of five or more servings per day. This was a significant downward trend from 59.5 percent in 2015.

Additionally, 11.1 percent of respondents reported little or no difficulty accessing fresh produce.

U.S. Department of Agriculture 2015 data reported that 21.0 percent (108,260 individuals) had low food access or live in a "food desert," meaning that they did not live near a supermarket or large grocery store.

### Physical activity

A total of 21.1 percent of respondents in the NMDH service reported no leisure-time physical activity in the past month; this trend was less favorable than regional, state and national findings.

Additionally, a total of 30.2 percent of respondents participate in regular, sustained, moderate or vigorous physical activity.

Among service area children age two to 17 years, 28.6 percent were reported to have had 60 minutes of physical activity on each of the seven days preceding the interview. These results were significantly lower than 2015 rate of 36.3 percent.

A total of 19.9 percent of service area children age 2 to 17 years were reported to have 3 or more hours of screen time on a typical day. This was an increase from 13.1 percent in 2015.

### Overweight/obesity

Based on self-reported heights and weights, 66.3 percent of survey respondents were overweight and 29.2 percent were obese. Current reports demonstrate an increase from 63.5 percent overweight and 23.0 percent obese in 2015 data.

Based on heights and weights reported by surveyed parents, 12.3 percent of children age five to 17 years were overweight or obese (> 85th percentile). This finding indicated a decrease from 15.3 percent in 2015.

Further, 10.0 percent of these children were obese (> 95th percentile); an increase from 9.2 percent in 2015.

Nutrition, physical activity and weight were perceived as major problems by 40.7 percent of key respondents who cited reasons including education, access to affordable healthy foods, school lunch menus and less opportunity for physical activity.

## Analysis of chronic disease concerns and impact on the healthcare system

It is widely recognized by public health experts that one the most effective methods of addressing chronic disease concerns is via the use of the Interventions Model of care, which considers the evolution of a chronic disease across its lifespan.

When addressing the problem of chronic disease, there are three points of intervention:

**Primary intervention** involves the provision of disease prevention and health promotion strategies focused on the prevention or delay of onset of the disease. This level of intervention focuses heavily on education and prevention.

**Secondary intervention** involves the strategies related to regular screening, and early diagnosis and prompt treatment of disease to limit or minimize its associated disability.

**Tertiary intervention** involves the provision of services to assist individuals with a chronic disease to live and function at an optimum state of wellness. This level of intervention focuses heavily on chronic disease management.

The successful management of chronic disease is heavily dependent upon timely access to health care – especially primary care. Root causes and social determinants such as poverty, limited income, lack of affordable healthcare insurance, illiteracy and inadequate education frequently prevent individuals from seeking routine primary care, which provides health education and screening. These same determinants also provide barriers to receiving sick or urgent care and adequate chronic disease management, thereby exacerbating the chronic disease and increasing the costs related to care and decreasing quality of life. In addition, inadequate nutrition, physical inactivity and obesity—while not considered chronic diseases—are also contributing factors and strategies to manage them will be addressed as part of this section.

## Community assets

Programs described in the previous sections of this document that respond to access to care are vital to the management of chronic disease. Access to PCPs ensures access to routine health care, screenings, specialty care, medications and medical homes.

## Existing NMDH hospital programs

NMDH offers a comprehensive financial assistance program to individuals unable to afford the cost of their acute medical care. In addition, the hospital offers a comprehensive array of community education programming and services to support both primary and tertiary interventions.

## Range of possible interventions

A broad range of intervention exists to address the issue of chronic disease including:

- Health education
- Health screenings
- Supporting linkages to medical homes
- Chronic disease management programs

## Benchmarks

National – HP 2020

## Cancer goal

Reduce the number of new cancer cases, as well as disability and death caused by cancer

### Related objectives

C-3: Reduce the female breast cancer death rate

C-4: Reduce the colorectal cancer death rate

C-18: Increase the proportion of adults who were counseled about cancer screening consistent with the current guidelines

## Diabetes goal

Reduce the disease burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM

### Related objectives

D-2: Reduce the diabetes death rate

D-5: Improve glycemic control among persons with diabetes

D-16: Increase prevention behaviors in persons at risk for diabetes – including weight loss (D-16.2)

## Heart disease goals

- Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke
- Early identification and treatment of heart attacks and strokes
- Prevention of repeat cardiovascular events
- Reduction in deaths from cardiovascular disease

### Related objectives

HDS-1: Increase overall cardiovascular health in the U.S. population

HDS-5: Reduce the proportion of persons in the population with hypertension

HDS-16: Increase the proportion of adults aged 20 years and older who are aware of the symptoms of, and how to respond to, a heart attack

HDS-17: Increase the proportion of adults aged 20 years and older who are aware of the symptoms of, and how to respond to, a stroke

HDS-24: Reduce hospitalizations of older adults with heart failure as the principal diagnosis

### Nutrition and weight status goal

Promote health and reduce chronic disease risk through the consumption of healthful diets, and achievement and maintenance of healthy body weights

#### Related objectives

NWS-2: Increase the proportion of schools that offer nutritious foods and beverages outside of school meals

NWS-8: Increase the proportion of adults who are at a healthy weight

NWS-9: Reduce the proportion of adults who are obese

NWS-13: Reduce household food insecurity and, in doing so, reduce hunger

### Local – Kane County Health Department 2015 IPLAN

Chronic care-related objectives are woven into the Kane County IPLAN priority objectives and are not specifically referenced as objectives.

## Implementation strategy

In support of national objectives to reduce the prevalence and burden of chronic disease, NMDH will continue to provide evidence-based care in the areas of primary interventions (disease prevention, health promotion), secondary interventions (screening), and tertiary interventions (education to individuals affected with a chronic disease in an effort to promote an optimum state of individual wellness). NMDH will also continue to bring leading-edge, chronic disease care to all individuals, regardless of ability to pay.

| Methodology | Resources/Programs/ Partnerships | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| 1. NMDH will host/offer evidence-based community health and wellness programming in the areas of cardiovascular and peripheral vascular disease. | 1. NMDH staff, physicians and clinicians<br>Program venues include Dinner with the Doc series, clinician-led educational offerings, self-help groups, rehabilitation services programs and support groups. | 1. Upon completion of the program, participants will identify signs/symptoms of the selected topic in addition to prevention and management strategies. Participants will also rate their perceived level of knowledge before and after the program. | 1. NMDH staff will track the type of offering, the number of individuals in attendance and the qualitative metrics identified for the particular program. |
| 2. NMDH will host/offer evidence-based community health and wellness programming in the area of cancer, including, but not limited to, the topics of breast and colon cancer, brain tumors, proton therapy, yoga for patients with cancer, palliative care and hospice. | 2. NMDH staff, physicians and clinicians<br>Program venues include Dinner with the Doc series, clinician-led educational offerings, self-help groups, rehabilitation services programs and support groups. | 2. Upon completion of the program, participants will identify signs/symptoms of the selected topic in addition to prevention and management strategies. Participants will also rate their perceived level of knowledge before and after the program. | 2. NMDH staff will track the type of offering, the number of individuals in attendance and the qualitative metrics identified for the particular program. |
| 3. NMDH will host/offer evidence-based community health and wellness programming in various other areas related to chronic disease including, but not limited to, obesity, injury prevention, arthritis, maternal and child health, joint replacement, fall prevention, chronic lung disease, epilepsy and Parkinson's disease. | 3. NMDH staff, physicians and clinicians<br>Program venues include Dinner with the Doc series, clinician-led educational offerings, self-help groups, rehabilitation services programs and support groups. | 3. Upon completion of the program, participants will identify signs/symptoms of the selected topic in addition to prevention and management strategies. Participants will also rate their perceived level of knowledge before and after the program. | 3. NMDH staff will track the type of offering, the number of individuals in attendance and the qualitative metrics identified for the particular program. |

## Implementation strategy (continued)

| Methodology | Resources/Programs/ Partnerships | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| 4. NMDH will offer a community-based heart failure (HF) program to all patients with an active diagnosis of HF who have not been referred for or are not receiving other nursing services.<br><br>The goal of the HF program is to empower patients with HF through a comprehensive, educational chronic disease management program designed to promote effective self-care behaviors aimed at decreasing hospital readmission rates while enhancing client-perceived quality of life. | 4. NMDH community health outreach (NMCHO) heart staff, including certified heart failure nurses, dietitians and exercise physiologists. The program also includes interfacement with NMDH specialty physicians and mid-level practitioners and staff nurses. | 4. Eligible patients with HF will receive inpatient education, home visits and follow-up telephone calls by certified HF nurses, dietitians and an exercise physiologist as indicated. Anticipated impact will include more effective self-management of the disease, enhanced quality of life and decreased hospital readmission. Established outcome measures include:<br><br>- Ninety percent of patients enrolled will describe compliance with symptom tracking.<br><br>- Ninety percent of patients enrolled will identify the appropriate necessary action in the event of a worsening of their condition.<br><br>- Ninety percent of patients enrolled will describe expected action and undesired side effects of two of their cardiac medications during a home visit.<br><br>- Eighty percent of patients will demonstrate use of an effective medication management system.<br><br>- Ninety percent of patients will complete a discharge follow-up appointment with the healthcare provider managing their HF within seven days of hospital discharge.<br><br>- Thirty-day, all-cause readmission rates for program participants will be less than 10 percent.<br><br>- Thirty-day HF readmission rates will remain at less than three percent. | 4. HF staff will collect and report annual data related to the number of patients enrolled in the program and program outcome measures. |

## Implementation strategy (continued)

| Methodology | Resources/Programs/ Partnerships | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| 5. NMDH will offer small community benefit grants targeted to enhance and promote health and minimize chronic disease and obesity. | 5. Well Child Center: Pediatric Dental Program – First Tooth Visit<br>Grant amount: $10,000 | 5. Well Child Center will measure the success of the Pediatric Dental Program: First Tooth Visit Program by tracking outcomes through administrative data, surveys and testimonials.<br>Program outcomes include:<br>- More than 62% of children will complete a preventive six-month follow up appointment.<br>- More than 64% of the children will have no decay.<br>- More than 76% of the children will follow up for six-month preventive care.<br>- More than 77% of the children will have no new decay.<br>- More than 90% of the patients/parents report positive experience with dentists, dental treatments, and the Pediatric Clinic.<br>- More than 90% of parent's confidence levels increase in preventive dentistry and knowledge of how to practice good daily dental care, including their understanding of the ADA recommended guidelines. | 5. A report on the identified program outcomes will be submitted to NMDH staff by September 30, 2019. |

## Implementation strategy (continued)

| Methodology | Resources/Programs/ Partnerships | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| 6. NMDH will work with local schools to implement the Coordinated Approach to Child Health (CATCH) program. Emphasis will be on parents and children attending the 4-year-old program and all preschool program teachers. | 6. NMDH staff and selected preschools in Kane and DuPage counties | 6. Teachers, parents and children will demonstrate:<br>- An increased awareness of healthy eating choices, including recognition of "Go" and "Whoa" foods.<br>- An increase in the amount of healthy snacks provided in the school setting.<br>- An increase in moderate to vigorous physical activity throughout the school day.<br>- Increased parental awareness of the importance of including physical activity in their child's life and including "Go" foods most often when providing snacks/meals. | 6. NMDH staff will submit an annual report addressing identified outcomes. |
| 7. NMDH will offer healthy cooking classes through the *Delnor Community Kitchen*. | 7. Community health outreach staff and NM dieticians | 7. A variety of cooking classes including but not limited to heart healthy cooking, allows participants to learn about nutrition in a fun and engaging environment. Participants experience how to prepare and eat healthy by increasing their consumption of vegetables, fruits, whole grains, healthy fats and protein foods under the direction of NM dieticians. | 7. NMDH staff will submit an annual report detailing the types of classes offered and the number of attendees. |
| 8. NMDH will provide "Kits for Kids," an educational program that may be utilized by parents, teachers, Scout leaders and other individuals to assist children in learning about hand-washing, bicycle safety and nutrition. | 8. NMDH staff working together with community members | 8. Each kit will be posted online and provide an educational program with tools to support a fun and engaging lesson. | 8. NMDH staff will track the number of downloads for each kit. |

## Implementation strategy (continued)

| Methodology | Resources/Programs/ Partnerships | Anticipated Impact | Evaluation Plan |
|---|---|---|---|
| 9. NMDH staff will continue efforts to promote referral patterns of physicians and ancillary staff to smoking cessation resources. | 9. NMDH staff | 9. NMDH staff will develop an additional screening component within Epic that will facilitate the identification and referral of potential patients. | 9. NMDH will track and report progress and outcomes related to the program. |
| 10. NMDH will offer the nationally recognized Think First Injury Prevention Program. | 10. NMDH staff and community organizations and local schools. | 10. NMDH staff will provide the community with an evidence-based program focusing on bike/helmet safety, child safety classes and car seat safety. | 10. NMDH staff will track and report the number of individuals who received education; the number of bike helmets provided and fitted; and the number of booster seats checked/distributed. |

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