Franciscan
ST. ANTHONY HEALTH
Crown Point

FRANCISCAN ST. ANTHONY HEALTH CROWN POINT

COMMUNITY HEALTH NEEDS ASSESSMENT

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FRANCISCAN ST. ANTHONY HEALTH CROWN POINT - EXECUTIVE SUMMARY

The Community Health Needs Assessment (CHNA) is designed to provide an understanding of the current health status and needs of the residents of the Franciscan St. Anthony Health-Crown Point (FSAH-CP) campus service area. This service area includes Southern Lake County. The information and findings from the CHNA was used to prioritize the identified needs and how to plan and act upon these health needs. The CHNA also recognizes community strengths, assets and resources to address these needs.

Beyond the educational and informative aspect, the CHNA is a newly required legal document for tax-exempt health care organizations around the country in order to be compliant with new Patient Protection and Affordable Care Act of 2010 (PPACA).

In order to better understand the health needs of the community and population FSAH-Crown Point serves, there was substantial primary and secondary research. This CHNA incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research through a survey produced by the CHNA advisory committee and secondary research (vital statistics, Healthy Communities Institute (HCI) and other existing health-related data). These quantitative components allow for comparison to benchmark data against state and national levels. Interviews of opinion-leaders in the community also allowed for input from specific fields and interests to help shape and support primary and secondary research.

Franciscan St. Anthony Health's primary service area (PSA) includes Southern Lake County. Physical health issues including affordability and access to health, substance abuse, and access to healthy food and wellness programs can be linked to a variety of social issues including unavailability of jobs, poverty, and transportation issues. The main findings from primary and secondary research show:

- The number one cause of death in our PSA is Major Cardiovascular disease.
- High rates of hospitalizations due to congestive heart failure.
- Cancer is the second cause of all mortality in our PSA.
- High Rates of ER and Hospitalizations due to poor respiratory health especially due to asthma (in both children and adults)
- High Rates of ER and Hospitalization due to diabetes.
- High rates for low birth weights and pre-term birth deaths.
- High rates and population percentage of adult obesity.
- High percentage of adults who smoke.
- High Rate of preventable Hospital Stays

The findings from the CHNA have helped to identify the priorities on which Franciscan St. Anthony Health – Crown Point will focus their efforts. These priorities include:

- Cardiovascular Health
- Diabetes

FRANCISCAN ST. ANTHONY HEALTH CROWN POINT (FSAH-CP)

The Franciscan St. Anthony Health-Crown Point

Community Health Needs Assessment Advisory Committee

NAME	TITLE	
John Kessler	Regional V.P. Mission Services and NWI CHNA Coordinator	
Dave Ruskowski	President, Franciscan St. Anthony (Ex Officio)	
Agnes Seitz	Mission Integration Director-CHNA Chair	
Kevin DeBraal	V.P. Administrative Services-CHNA Co-Chair	
Joe Dejanovic	Regional VP Public Relations/Community Relations	
Sr. Rene` Duplessis	Spiritual Care Service Chaplin	
Daniel Netluch, M.D.	Emergency Department Director	
Rose Clemons	Case Management Director	
Carolyn Davis	Case Management Discharge Planner	
Kris Quirk	Case Manager Emergency Department	
Becky Grove	Regional Director Service Line Marketing	
Jacque Hamers	Employee Assistance Regional Director	
Julie Kissee	Employee Assistance Regional Therapist	
Michael Olson	Regional Director Pharmacy	
Kendra Schuett	On-Site Financial Analyst	
Tammy Byers	Admitting Financial Counselor	
Kathy Horn	Admitting Director	
Kathy Damjanovic	Admitting Manager	
Angie Denton	Women's Health Services/Breast Center Manager	
Cindy Mako	Diabetes Nurse Clinician & Educator	
Julie Mallers	St. Clare Clinic Manager	
Kathy Copak	PreNatal Assistance Program Manager	

COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

INTRODUCTION

In the spring of 2012, Franciscan St. Anthony Health Crown Point (FSAH-CP) embarked on a comprehensive Community Needs Assessment (CHNA) process to identify and address the key health issues for our community.

Franciscan St. Anthony Health (FSAH-CP), based in Crown Point, Indiana, is a not-for-profit, 280 bed hospital serving Lake County, Indiana. FSAP-CP is part of Franciscan Alliance, a 13 hospital Catholic system based in Mishawaka, IN. With 1,400 employees, FSAH-CP provides service primarily to residents of the southern half of Lake County, but also serves those in neighboring cities and towns. FSAH-CP is accredited by Healthcare Facilities Accreditation Program (HFAP).

The doctors and employees of Franciscan St. Anthony Health, along with Franciscan Alliance hospitals, work to live our hospital's mission: "Continuing Christ's Ministry in Our Franciscan Tradition". In following our mission we live and work by a set of common values that include respect for life, fidelity to our mission, compassionate concern, joyful service and Christian stewardship. Franciscan St. Anthony Health provides the following services:

- Anticoagulation Clinics
- Behavioral Health
- Breast Health
- Cancer Care
- Colon and Rectal Surgery
- daVinci® Robotic Surgery
- Diabetes Care
- Dietitians
- Ear, Nose and Throat
- Electrophysiology Lab
- Emergency Medicine
- Employee Assistance Program
- Family Doctor
- Franciscan Express Care
- Franciscan Point
- Heart & Vascular
- Home Health Care
- Hospitalists
- Imaging
- Incontinence Care
- Infusion Services
- Intensive Care Unit
- Interventional Radiology
- Laboratory Services
- Lymphedema Services
- Mammography
- Message Therapy
- Nuclear Medicine
- Ob-Gyn
- Occupational Health
- Orthopedics
- Outpatient Services
- Palliative Medicine
- Pediatrics
- Primary Care Physicians
- Pulmonary Medicine
- Registered Dietitians
- Rehabilitation Services
- Respiratory Care
- Robotic Surgery
- Senior Services
- Sleep Disorders
- Sports Medicine
- Stroke Care
- Surgical Services
- Urgent Care
- Women's Health/Ob-Gyn
- Working Well
- Wound Care

CHNA PURPOSE

The purpose of the Community Health Needs Assessment (CHNA) is to provide an understanding of the current health status and needs of the FSAH-CP service area. This service area includes sections of Lake County, Indiana. This information will be used to prioritize the identified needs, and to plan and act upon these health needs. The CHNA will also recognize community strengths, assets and potential resources to address those needs.

Beyond the educational and informative aspect - the CHNA is a new legal requirement for tax-exempt health care organizations around the country. Other forms of assessments of community health have been a function that FSAH-CP has been involved in for many years. The CHNA must be conducted in order to be compliant with new Affordable Care Act (ACA) requirements. The Internal Revenue Service (IRS) has drafted guidelines of what must be included in the assessment. These guidelines state:

A community health needs assessment must:

- Be conducted every three years.
- Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.
- Be made widely available to the public.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how addressing the needs identified in the CHNA and a description of needs that are not being addressed with the reason why such needs are not being addressed.

The community survey and focus group aspects of this assessment were conducted on behalf of FSAH-CP by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994. The PRC community survey work on this CHNA was done in collaboration with Community Health System and Methodist Hospital, two other area hospital systems.

The 2013 CHNA Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in Franciscan St. Anthony's primary service area. The information may be used to make informed decisions and guide efforts to improve community health and wellness.

The CHNA Assessment provides information so communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. The 2012 PRC/HCI Community Health Needs Assessment serves as a tool toward reaching three basic goals:

- To improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and/or injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.
- To increase accessibility to preventive services for all community residents within the hospital's primary service area. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventative care.

OBJECTIVES

The objectives of this CHNA are to:

1. Develop a comprehensive profile of health status, quality of care, and care management indicators overall and by county for those residing within the FSAH-CP primary service area.
2. Identify the priority health needs (public health and healthcare) within the FSAH-CP primary service area.
3. Serve as a foundation for developing subsequent detailed recommendations on implementation strategies that can be utilized by healthcare providers, communities and policy makers in order to improve the health status of persons residing in the FSAH-CP primary service area.
4. Supply public access to the CHNA results in order to inform the community and provide assistance to those invested in the transformation to the community's healthcare network
5. Improve access to health services, enhance population health, advance general knowledge and relieve or reduce the burden of government to improve health of persons living in the FSAH-CP primary service area.

METHODOLOGY

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research via the PRC community survey and focus groups and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at state and national levels. Qualitative data input includes primary research gathered through a series of Key Informant Focus Groups. To guide the CHNA process, evaluate information and develop final priorities and selected strategies to implement, an Advisory Committee was established. Its members are listed on pages 5 and 6.

Analytic Methods

The survey instrument used for this PRC survey was based largely on the Centers for Disease Control and Preventative (CDC) Behavioral Risk Factor Surveillance system (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by PRC, with input from FSAH-CP, Indiana, and other community sponsors.

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology—one that incorporates both landline and cell phone interviews—was employed. The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

The complete PRC Community Survey can be reviewed by using this link:
http://www.franciscanalliance.org/community/community-needs-assessment/Documents/2012_PRC_CHNA_Report-FSAH-CP.pdf

Data Sources

In addition to the PRC Survey, a variety of existing (secondary) data sources were consulted to complement the research quality of this Community Health Needs Assessment. Specifically, the newly adopted Healthy Community Institute (HCI) helped to aggregate and report data at the county-level for the hospital's primary service area. These were obtained from a variety of sources included but not limited to:

- Center for Disease Control & Prevention
- National Center for Health Statistics
- U.S. Census Bureau
- U.S. Department of Health and Human Services
- U.S. Department of Justice, Federal Bureau of Investigation
- Indiana State Department of Health
- Local Health Departments if data was available

An additional source of information was the previously identified focus groups. Five Focus Groups were held on November 27 and 28, 2012, comprised of 50 informants in the community. These key informant focus groups allowed for input from persons with special knowledge of/or expertise in public health, as well as others who represent the broad interests of the community served by Franciscan St. Anthony Health-CP. Participants included representation from:

- Social Services
- Other Health Care Providers
- Community Leaders
- Physicians
- Business Leaders

Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall. Participants included several individuals who work with low-income, minority and other medically underserved populations, and those who work with persons with chronic disease conditions.

Healthy Community Institute (HCI)

Another source of ongoing information is Healthy Community Institute (HCI), a third-party resource that Franciscan Alliance purchased in order to better understand and address the health of our community. This resource aggregates national, state and county data into one convenient area that allows its users and their community to understand the environment in which they live. HCI has been recently recognized by the Health Data Initiative Forum III in Washington, D.C. and awarded the Best Community Health App. This resource allows its users to measure community health, share best practices, identify new funding sources while improving community health. One of the visually appealing aspects of HCI is their use of the colored gauge. The colored gauge, as defined by HCI, "gives a visual representation of how our community is doing in comparison to other communities. The three-colored dial represents the distribution of values from the reporting regions (e.g. counties in the state) ordered from those doing the best to those doing the worst (sometimes lower values are better and in other cases higher values are better). From that distribution, the green represents the top 50th percentile, the yellow represents the 25th to 50th percentile, and the red represents the "worst" percentile."

Information Gaps

While this Community Health Needs Assessment is quite comprehensive, Franciscan St. Anthony Health Crown Point recognized that it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups—such as homeless, institutionalized persons, or those who only speak a language other than English or Spanish—are not represented in the survey data. Other population groups might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly some medical conditions that are not specifically addressed. To attempt to close the information gap qualitatively, FSAH-CP conducted one-on-one interviews with a number of Opinion Leaders in the community to help gain a better understanding of what they are observing firsthand.

Vulnerable Populations

The CHNA analysis and report yielded a wealth of information about the health status, behaviors and needs for our population. A distinct advantage of the primary quantitative (survey) research is the ability to segment findings by geographic, demographic and health characteristics to identify the primary and chronic disease needs and other health issues of vulnerable populations, such as uninsured persons, low-income persons, medically underserved and racial/ethnic minority groups.

Collaborating Entities

As previously described, the PRC Community survey and Focus Groups was the consequence of collaboration among FSAH-CP (and other Franciscan Alliance hospitals in the region) and Community Healthcare System and Methodist Hospitals – all serving in contiguous or overlapping markets.

Existing Health and Social Service Organizations

Hospitals

- Pinnacle Hospital – Merrillville
- Methodist Hospital – Merrillville
- Franciscan St. Margaret Health – Dyer
- Franciscan Health Munster – Munster
- Community Healthcare – Munster

Home Health

- Franciscan Home Health
- Visiting Nurse Association of Porter County

Long Term Care

- St. Anthony Home
- Wittenburg Village
- Chicagoland Christian Village

Mental and Behavioral Health

- Samaritan Counseling Center
- Regional Mental Health Center
- Franciscan St. Margaret Health

Community and Social Service

- American Red Cross
- Boys and Girls Clubs
- Brothers' Keepers Shelter
- Caring Place
- Catholic Charities
- United Way
- Lake County Health Department
- Lutheran Social Services of Indiana

The above organizations represent resources that now address a number of the identified concerns in this CHNA and which have the potential to address community health concerns in collaborative ways – a direction FSAH-CP supports.

Public Dissemination

Franciscan Alliance has recently purchased the Healthy Communities Institute (HCI) web-based product that measures community health, shares best practices, identifies new funding sources and drives improved community health. This can be found at the below link for each of the hospitals and their specific service areas within the Franciscan Alliance System.

This Community Health Needs Assessment is available to the public using the following URL: http://www.franciscanalliance.org/community/community-needs-assessment/pages/default.aspx

This site:

- Informs readers that the CHNA Report is available and provides instructions for downloading it;
- Offers the CHNA Report document in a format that, when accessed, downloaded, viewed and printed in hard copy, exactly reproduces the image of the report;
- Grants access to download, view and print document without special computer hardware or software required for that format (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital organization or facility or another entity maintaining the website.

FSAH-CP will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. FSAH-CP will also maintain at its facilities a hardcopy of the CHNA report that may be viewed by any who request it.
If you would like more information or have questions regarding the Community Health Needs Assessment, please contact Kevin DeBraal at kevin.debraal@franciscanalliance.org or 219-757-6298.

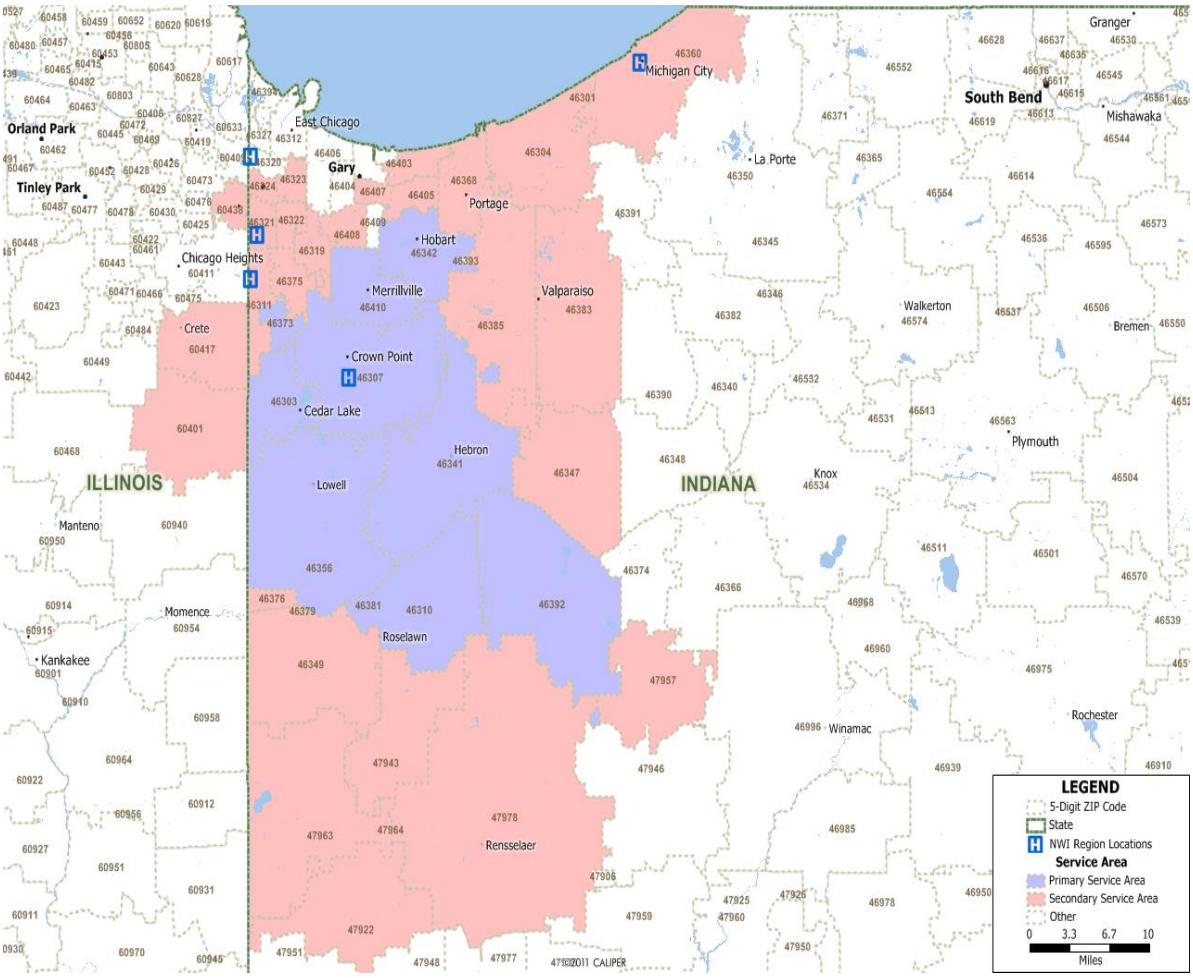
CHNA Community Definition

Franciscan St. Anthony Health's community is defined for the purposes of the Community Health Needs Assessment as having a primary service area as described in the Zip Code map below. This community definition was determined because >80% of FSAH-CP's patients originate from this area.

The communities comprising the primary service area of FSAH-CP include:

City	Zip Code
Crown Point	46307
Cedar Lake	46303
Demotte	46410
Hebron	46341
Hobart	46342
Lowell	46356
St. John	46373
Thayer	46381
Wheatfield	46380
Wheeler	46393
Merrillville	46310

Graphic view of Primary Service Area



Demographics of the Community

The population of the hospital's primary service area is estimated at 208,338 people. It is predominately non-Hispanic White with only two of eleven communities having less than 91% Caucasian, only one community having more than 6% African-American and three communities having more than 8% Hispanic. To a large degree, this group of communities does not have the challenges of poverty and unemployment that is more typical of communities in the mid and northern areas of Lake County **(1).**

Areas of Opportunity

To determine the top health priorities for our service area we engaged Healthy Communities Institute (HCI) to provide publicly reported health and social data and Professional Research Consultants (PRC) to perform focus groups and a phone survey of our community at large. We also worked with our community partners to get their input regarding community health needs.

The following chart is a summary of the top ten priorities identified through this process.

Areas of Opportunity Identified Through This Assessment	
Access to Health Services	• Top Focus Group Concern o *Barriers to Access (Health Literacy; Poverty; Insurance Issues; Cost of Care; Medicaid; Hours of Operation; Use of the ER; Transportation;* o *Need for a Local Trauma Center*
Cancer	• Cancer Death Rate
Chronic Kidney Disease	• Kidney Disease Death Rate
Diabetes	• Diabetes Mellitus Death Rate
Family Planning	• Teen Births
Heart Disease & Stroke	• Heart Disease Death Rate • Stroke Death Rate
Injury & Violence Prevention	• Firearm-Related Death Rate • Homicide Rate
Maternal, Infant & Child Health	• Low Birth weight • Infant Mortality
Mental Health & Mental Disorders	• Top Focus Group Concern o *Inadequate Treatment Options* o *Self-Medication (See Also "Substance Abuse")* o *Stigma*
Nutrition, Physical Activity & Weight Status	• Fruit/Vegetable Consumption • Top Focus Group Concern o *Lack of Nutrition & Physical Activity* o *Cost of Healthy Foods* o *Food Deserts* o *Education*
Substance Abuse	• Top Focus Group Concern o *Prevalence of Drug Use* o *Easy Access/Parental Complacency* o *Limited Treatment Programs* o *Inadequate Funding*

Integration with Operational Planning

Community Benefit Planning has been a part of FSAH-CP approach to operations for several years. The CHNA Report and Strategic implementation Plan will be made an integral part of the FSAH-CP Operational and Strategic Plans to assure continuity of practices already in place.

Prioritization Process

After reviewing the Community Needs Assessment findings, the CHNA Advisory Committee established at FSAH-CP met in the Spring of 2013 to determine the health needs to be prioritized for action in FY2014-FY2016. During a detailed presentation of the CHNA findings, the CHNA Advisory Committee members and Senior Management engaged in a process of understanding key local data findings (Areas of Opportunity) and ranked identified health issues against the following established, uniform criteria:

- Magnitude. The number of persons affected, also taking into account variance from benchmark data and Healthy People 2020 targets.
- Impact/Seriousness. The degree to which the issue affects or exacerbates other quality of life and health-related issues.
- Feasibility. The ability to reasonably impact the issue given available resources
- Consequences of Inaction. The risk of not addressing the problem at the earliest opportunity.

Priority Health Issues Selected

In acknowledging the wide range of priority health issues that emerged from the CHNA process, FSAH-CP determined that it could effectively focus on those which it deemed most pressing, most under-addressed and most within its ability to influence.

Health Priorities Chosen for Action	Reason
Cardiovascular Disease	Heart disease is the number one cause of death in Indiana. According to the American Heart Association, in 2008, 18,244 or 32.2% of deaths statewide were related to cardiovascular disease (CVD). In Lake County Indiana, the number is even higher at 34.6% or one in every 3 people will die because of CVD. In 2011, according to the Indiana State Department of Health, 33% of all adults had high blood pressure, 40% of all adults had high cholesterol and 470,000 adults with diabetes. Tobacco is the agent most responsible for avoidable illness and death in America today. Tobacco use brings premature death to almost half a million Americans each year, and it contributes to profound disability and pain in many others. Approximately one-third of all tobacco users in this country will die prematurely because of their dependence on tobacco. Areas with a high smoking prevalence will also have greater exposure to second hand smoke for non-smokers. Tobacco use is the most preventable cause of morbidity and mortality **(6).** Smoking cessation is one of the most cost effective preventable services. Smoking cessation reduces the risks of cardiovascular disease, respiratory complications, stroke, kidney disease, lung cancer and other types of cancer **(8).**
Adult Type II Diabetes	Type II Diabetes is one of the most common chronic diseases per 10,000 population in those 18 years and older. Type II Diabetes continues to be an increasing burden on the health of our community. Type II Diabetes accounts for approximately 95% of all diabetes. Reports indicate that medical expenses are nearly doubled for a diabetic patient as a non-diabetic patient. Individuals with Type II Diabetes have increased risk for multiple comorbidities, shorter life span and decreased quality of life **(2,3).** The prevalence of diagnosed Type II Diabetes increased six-fold in the latter half of the last century. Diabetes risk factors such as obesity and physical inactivity have played a major role in this dramatic increase. Age, race and ethnicity are also important risk factors. The CDC estimates the direct economic cost of diabetes in the United States to be about $100 billion per year. This figure does not take into account indirect economic costs attributable to potential work time lost to diabetes-related illness or premature death. In response to this challenge, Franciscan St. Anthony Health-CP has identified goals that aim to reduce the disease, economic burden of diabetes, and improve quality of life for all persons who have or are at risk for diabetes. Goals include improved diabetes education, improved compliance with recommended care and screening procedures, and reduced rates of serious complications.

Priority Health Issues That Will Not Be Addressed & Why

Rationale for Health Priorities Not Chosen

Access to Health Services	Increased number of Federally Qualified Clinics (FQHC) available in Lake and surrounding counties. St. Clare Health Clinic (operated by FSAH-CP) serves the uninsured individuals that would endure hardship to access quality healthcare. St. Clare Health Clinic accepts referrals from the hospital, emergency room, and the St. Jude House.
Cancer	The Breast Care Center at Franciscan St. Anthony-Crown Point offers comprehensive breast care with diagnostic procedures, treatment and education. The Burrell Cancer Center also offers interdisciplinary teams of experts using advanced technology to provide excellent cancer care and prevention. The St. Clare Health Clinic is a Breast and Cervical Cancer Program (BCCP) and Indiana Breast Care Awareness Trust (IBCAT-HOPE) provider to screen women without healthcare free for breast and cervical cancer. Franciscan St. Margaret Health in Hammond, Indiana, offers lung scans at reduced rates
Chronic Kidney Disease (CKD)	The most common cause of CKD is diabetes; therefore this is addressed through diabetes prevention. Franciscan St. Anthony-Crown Point offers a comprehensive diabetic program for education. The Franciscan Hammond Clinic has offers free diabetic classes. St. Clare Health Clinic has an indigent program for diabetic patients to get testing meters and strips.
Family Planning (Teen Births)	Franciscan St. Anthony Crown Point supports the efforts of the prenatal assistance program which helps women with screening for pregnancy, Medicaid application, home visits, and prenatal and postpartum education. An outpatient lactation consultant is also being established for the women. The women also receive donations for food, clothing and baby items such as diapers, wipes, and car seats.
Injury and Violence Protection	The Regional Mental Health Facility of Merrillville offers men, women, and children opportunity for mental health services, addiction counseling and substance abuse intervention. The Crown Point Fire Department hosts educational in-services on fire safety, proper car seat installation and other community awareness. DARE is a drug awareness program that is active within the school systems.
Mental Health and Mental Disorders	The Regional Mental Health Facility, Community Health Net, Health Link, and Wabash Mental Health facility offer mental health services and has a sliding scale fee for services and take referrals for our service area.
Nutrition, Physical Activity and Weight Status	All of these are examined within Cardiovascular Health Prevention and therefore are addressed within our plan of action.
Substance Abuse	Alcoholic Anonymous (AA), Regional Mental Health, and Wabash Valley Mental Health offer drug rehabilitation along with the Christian Drug Rehab Center Crown Point IN.

Implementation Strategies & Action Plans

Cardiovascular Disease and Diabetes were selected as the needs to be addressed. The following describes the FSAH-CP plan to address those priority health issues chosen for action in the FY2014 - FY2016 period.

Cardiovascular Disease	
Reason for Program (Sources available in CHNA Report)	Heart disease is the number one cause of death in Indiana. According to the American Heart Association, in 2008, 18,244 or 32.2% of deaths statewide were related to cardiovascular disease (CVD). In Lake County Indiana, the number is even higher at 34.6% or one in every 3 people will die because of CVD. In 2011, according to the Indiana State Department of Health, 33% of all adults had high blood pressure, 40% of all adults had high cholesterol and 470,000 adults with diabetes. Tobacco is the agent most responsible for avoidable illness and death in America today. Tobacco use brings premature death to almost half a million Americans each year, and it contributes to profound disability and pain in many others. Approximately one-third of all tobacco users in this country will die prematurely because of their dependence on tobacco. Areas with a high smoking prevalence will also have greater exposure to second hand smoke for non-smokers. Tobacco use is the most preventable cause of morbidity and mortality **(6).** Smoking cessation is one of the most cost effective preventable services. Smoking cessation reduces the risks of cardiovascular disease, respiratory complications, stroke, kidney disease, lung cancer and other types of cancer **(8).**
Community Partners	Primary site for implementation: St. Clare Health Clinic Partners for Potential Screening sites: • Southlake YMCA, Crown Point, IN • St. Mary's and St. Matthias Churches, Crown Point, IN • Strack & Van Til, Lowell and Demotte, IN Partners for Community Referrals: • St. Jude House • City of Crown Point • Crown Point Community Foundation • Franciscan Physician Network ACO Coordinators • Purdue University • University of St. Franciscan Alliance • Libraries of Cedar Lake, Crown Point and Lowell, IN
Goal	Offer the community a Cardiovascular Disease program with a focus on disease prevention and health promotion, specifically targeting prevention through quarterly screenings with community partners, and six (6) month education and treatment programs that will potentially reduce health inequalities for the FSAH-CP community service areas.
Time Frame	FY2014-2016

Scope	The screening events will be open to adults 18 years of age or older that reside within the primary FSAH service area. The focus group will track 100 participants that have been diagnosed by St. Clare Health Clinic providers with Cardiovascular Disease, and/or risk factors for Cardiovascular Disease through evidence based guidelines of the American Heart Association. The 100 tracked participants will meet qualification guidelines for St. Clare Health Clinic that include residence in FSAH-CP service area, at or below 200% federal poverty level and 18 years of age or older.
Strategies & Objectives	**Objective:** To reduce the risk of community residents developing and dying from cardiovascular disease by making major improvements in diet, physical activity, control of high blood, pressure, diabetes **(7)** and cholesterol, and smoking cessation. **Strategy #1: Raise awareness of benefits of early detection and prevention through quarterly cardiovascular screenings, nutrition and exercise counseling, and smoking cessation programs.** • Establish community partnerships to assist in reaching at risk population and increase participation in smoking cessation. Collaborate with public relations to put program information in local city calendars, websites, mailings, flyers and postings. • Identify staff and volunteers with specific roles and duties to the program including: physicians, nurse practitioners, registered nurses, registered dietician, respiratory therapist, medical assistants and social workers. • Hold quarterly screenings in various community settings to offer baseline screening for: o BMI/Weight o Blood Pressure o A1C o Lipid panel o Tobacco Use **Strategy #2: Reduce health disparities related to Cardiovascular Disease by incorporating evidence based research findings in treatment and six (6) month education programs.** • Establish quarterly screenings through utilization of brief motivational interviewing. • Implement evidence based 6 month educational program that may include a combination of medication therapy, counseling, behavioral and psychosocial interventions **(9).** **Strategy #3: Evaluation of the program** • Establish pre and post program participant surveys to establish benchmarks for annual reporting related to participation and patient outcomes. • Continue to monitor tracked participants BMI, weight, blood pressure, life style modifications, and Lipid panel and tobacco use quarterly. • Relate overall engagement in smoking cessation and understanding of health. • Utilize database to gather and report statistical results **Strategy #4: On-Going Commitment** • Budget for continuation of the program through grant or other financial support. • Address barriers with plans to continue participation.
Anticipated Outcome	At the time of the final survey, 25% of the participants who have completed the program will have an overall better understanding of their personal health. • 25% of the participants who have completed the program will experience

and Impact	positive behavior modification toward healthy eating, increased exercise and smoking cessation. • Of the tracked participants completing the program, document the improvement efforts of participants toward healthy eating, increased exercise and smoking cessation. o BMI 28% or less o Blood pressure below 140/90 o Reduction/Cessation in smoking o Cholesterol below 200 o LDL 160 or lower o HDL at least 40 or higher o Exercise at least 3 times weekly for 30 minutes • At the end of the 2016 program, the number of screened participants will increase by 10%
Results	Pending

Adult Type II Diabetes	
Reason for Program (Sources available in CHNA Report)	Type II Diabetes is one of the most common chronic diseases per 10,000 population in those 18 years and older. Type II Diabetes continues to be an increasing burden on the health of our community. Type II Diabetes accounts for approximately 95% of all diabetes. Reports indicate that medical expenses are nearly doubled for a diabetic patient as a non-diabetic patient. Individuals with Type II Diabetes have increased risk for multiple comorbidities, shorter life span and decreased quality of life **(2,3).** The prevalence of diagnosed Type II Diabetes increased six-fold in the latter half of the last century. Diabetes risk factors such as obesity and physical inactivity have played a major role in this dramatic increase. Age, race and ethnicity are also important risk factors. The CDC estimates the direct economic cost of diabetes in the United States to be about $100 billion per year. This figure does not take into account indirect economic costs attributable to potential work time lost to diabetes-related illness or premature death. In response to this challenge, Franciscan St. Anthony Health-CP has identified goals that aim to reduce the disease, economic burden of diabetes, and improve quality of life for all persons who have or are at risk for diabetes. Goals include improved diabetes education, improved compliance with recommended care and screening procedures, and reduced rates of serious complications.
Community Partners	Primary site for implementation: St. Clare Health Clinic Partners for Potential Screening sites: • Southlake YMCA, Crown Point, IN • St. Mary's and St. Matthias Churches, Crown Point, IN • Strack & Van Til Lowell and Demotte, IN Partners for Community Referrals: • St. Jude House • City of Crown Point • Crown Point Community Foundation • Franciscan Physician Network ACO Coordinators • Purdue University • University of St. Franciscan Alliance • Libraries of Cedar Lake, Crown Point and Lowell, IN
Goal	To reduce the health burden of Type II diabetes through improved diabetes education, improved compliance with recommended care and quarterly screening procedures with community partner sites, and reduced rates of serious complications.

Time Frame	FY2014 - 2016
Scope	The screening events will be open to adults 18 years of age or older that reside within the primary FSAH service area. The focus group will track 100 participants that have been diagnosed by St. Clare Health Clinic providers with Type II Diabetes, and/or risk factors for Type II Diabetes through evidence based guidelines of the American Diabetes Association. The 100 tracked participants will meet qualification guidelines for St. Clare Health Clinic that include residence in FSAH-CP service area, at or below 200% federal poverty level and 18 years of age or older.
Strategies & Objectives	**Objective:** The proportion of public residing in the hospital service area who engages in diabetic health promotion/disease prevention behaviors compared to level of engagement prior to program as reflected by the anticipated outcomes. **<u>Strategy #1</u>: Raise awareness of Type II diabetes prevention through community outreach through quarterly screenings and education programs.** 1. Establish community partnerships to assist in reaching at risk population and increase participation in quarterly screening events. Collaborate with public relations to put program information in local city calendars, websites, mailings, flyers and postings. 2. Identify staff and volunteers with specific roles and duties to the program including: physicians, nurse practitioners, registered nurses, registered dietician, diabetic educator, medical assistant and social works or case managers. 3. Establish screening methods for AIC, weight, BMI, blood pressure and behaviors. 4. Develop handouts for prevention of Type II Diabetes to focus on annual screening, regular physical activity, weight reduction, nutrition education and behavior modification **(4).** **<u>Strategy #2:</u> Reduce health disparities in those diagnosed with Type II Diabetes by incorporating evidence based research findings into healthcare practices and education.** • Establish six (6) month educational programs for diagnosed Type II Diabetic individuals through the American Diabetic Association (ADA) guidelines with emphasis on medication management, weight loss, regular physical activity, diet and life style modification **(5).** • Assessment guidelines of psychosocial evaluation, lipid screening and management, smoking cessation, cardiovascular screening, nephrology screening, retinopathy screening, neuropathy screening and foot care. **<u>Strategy #3:</u> Evaluation of the program** • Participants with an active diagnosis of type II Diabetes and who have completed the program will have a reduction of HgbA1c levels toward a goal of **7%** during the evaluation period. • Participants who have completed the program will have an overall increased knowledge of their personal health in relation to their diabetes management measured through pre and post program surveys, along with review meal recall diaries and review self-monitoring blood glucose logs. • Participants who have completed the program will have met one or two personal health goals. • Screening events will capture Type II Diabetes and increase community participation **<u>Strategy #4:</u> On-Going Commitment**

	• Budget for continuation of the program through grant or other financial support. • Address barriers with plans to continue participation.
Anticipated Outcome and Impact	**Use ADA Screening Standards of Medical Care for Diabetes. Document the results and expect individual results to move toward these standards.** • HgA1C < 7% • Blood pressure < 130/80 • LDL < 100 mg/dl • HDL Male > 40 mg/dl • HDL Female > 20 mg/dl • Triglycerides < 150 mg/dl Expect daily self-monitoring blood sugar to move closer to targets: • Fasting blood sugar < 120 • Postprandial (2 hrs after meal) < 180 At the end of the 2016 program, the number of screened participants will increase by 10%
Results	Pending

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