Live Well Lake County

2014 Annual Report

Preview

LakeCounty
Health Department and
Community Health Center

Live Well Lake County

We are pleased to present an annual update of "Live Well Lake County," the Lake County Health Department/Community Health Center's 2013-2016 Strategic Plan. This update presents our annual report in a new format showing the alignment between our plans and the work we accomplish. It details how programs met specific 2014 strategic plan goals, and includes efforts that are ahead of schedule toward meeting 2015 and 2016 goals.

Tony Beltran

As you will see in the following pages, the Health Department has made substantial strides toward meeting the goals. We reduced barriers to healthcare by opening a school-based health center at Round Lake High School. We helped numerous patients reduce their tobacco use. We trained police officers to use a product that reverses opioid overdoses, which is reducing the number of substance abuse related emergency room visits and deaths. We also applied for accreditation through the Public Health Accreditation Board (PHAB).

During 2014, we established numerous baseline measures to help determine the progress our programs are making toward responding to the county's public health challenges. For example, we established baselines for the number of persons who experience a delay in obtaining necessary primary care, for the patient population who knows their HIV serostatus, and for asthma rates in the African American population served by LCHD/CHC.

"Live Well Lake County" is a part of a big picture focused on improving the quality of life of Lake County. We are continuing to build partnerships with a wide variety of organizations including hospitals, academic institutions and community organizations to meet our goals. The Strategic Plan is aligned with the Health Department's program performance measures and the Lake County Community Health Improvement Plan (CHIP), which has four strategic priorities:

- Coordination of care: access to medical home and behavioral health; coordinated network of health and human services
- Emphasis on prevention/access to prevention and wellness
- Reduction in health disparities/increased health equity in Lake County
- Adequate and diverse public health system workforce

Our overall goal is to achieve the highest level of health for all in Lake County. We hope you will join us as we work diligently to meet that goal.

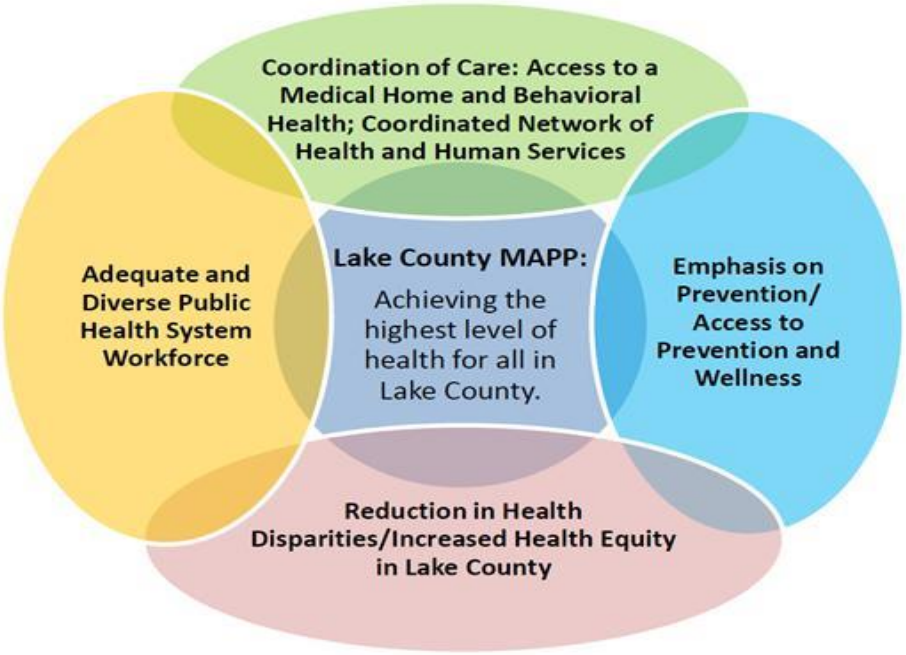
Sincerely,

Chief Timothy Sashko
President
Lake County Board of Health

Robert Tarter
Chair
Lake County Community Health Center Governing Council

Tony Beltran
Executive Director
Lake County Health Department/ Community Health Center

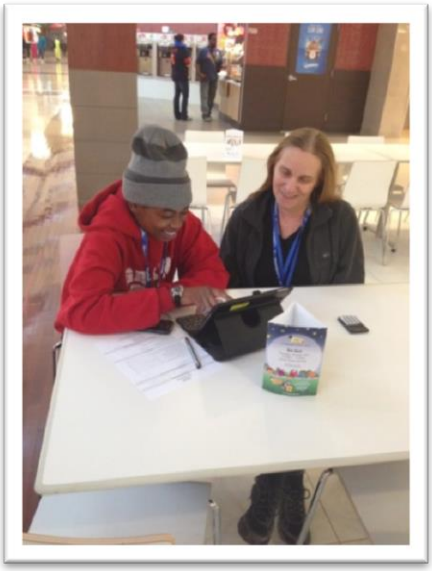
Live Well Lake County



The Lake County Community Health Improvement Plan's Strategic Priorities

Coordination of Care: Access to a Medical Home and Behavioral Health Home; Coordinated Network of Health and Human Services

Goal: Increase the number of residents in Lake County who have health insurance.



By June 30, 2014, "Enroll Lake County" will educate 40,000 individuals and enroll 21,800 residents of Lake County in health insurance coverage.

Progress: 2014 Goal Met

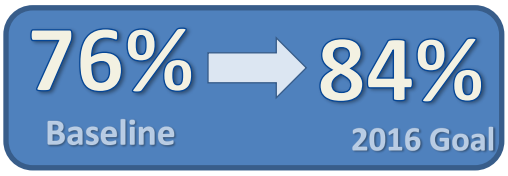
Launched in July of 2013, the Enroll Lake County! (ELC!) initiative is a countywide effort to help residents access new forms of health insurance made available through the Affordable Care Act (ACA). As of October 31, 2014, the program had educated over 41,474 individuals about the ACA. It also played a major role in the overall enrollment of 26,717 residents in healthcare coverage. Lake County now has the third highest enrollment rate for Medicaid in the state after

Cook and DuPage counties. There continue to be individuals who are unaware of health insurance options that are available to them. This group is a key target of ELC!'s outreach and education efforts for 2015.

Goal: Increase the Proportion of Persons Who Have a Consistent Source of Ongoing Care

By June 30, 2014, establish a baseline for the proportion of persons in Lake County with a consistent primary care provider. By December 31, 2016, increase the proportion of persons with a consistent primary care provider by 10%.

Progress: 2014 Goal Met



Patients with a consistent primary care provider have greater access to needed services, better quality of care, and greater focus on prevention and early management of health problems. Using Medicaid data provided by the state of Illinois, we determined that 76% of Lake County residents receiving Medicaid assistance had a routine medical visit in the prior year. As one of the largest healthcare providers for Medicaid eligible residents in Lake County, we want to increase the number of Medicaid recipients who have had a routine medical visit in the previous year by 10%. Since 10% of the 76% baseline is 7.6%, 7.6% was added to the 76% baseline to establish the 2016 goal of 84%.

Goal: Assess and Reduce Barriers to Care and Covered Services

By June 30, 2014, establish a baseline of the proportion of persons who are unable to obtain or experience a delay in obtaining necessary primary care, mental health, substance abuse or dental care using LCHD/CHC patient population data.

and

By June 30, 2014 establish a baseline of the availability of core standard services (includes primary care, mental health, substance abuse and dental care) as measured by decreased time to the next appointment. By December 31, 2016, decrease the time to the next appointment by 10%, from the established baseline.

Progress: 2014 Goals Met

A nurse practitioner checks the blood pressure of a student at the Round Lake High School Health and Wellness Center.

An example of the Health Department's efforts to increase access to care is the school-based health center, which the Department opened with a group of local partners at Round Lake High School in October of 2014. The Center's goal is to improve the physical and emotional health of students attending the high school and to teach them life-long, positive health behaviors by providing quality, comprehensive primary healthcare. The Center grew out of the Round Lake Area School District and a group of concerned citizens wanting to address growing healthcare needs and barriers to healthcare access. Of particular concern was the impact health issues were having on academic achievement. School-based health centers historically have helped children stay in school by identifying and addressing health problems that may affect their ability to learn.

A $500,000 grant from the U.S. Department of Health and Human Services funded the construction of the center. The Healthcare Foundation of Northern Lake County funded an initial feasibility study and continues to provide support.

Through the Center, students now have access to a comprehensive range of medical and behavioral health services provided by both the Health Department and Nicasa Behavioral Health Services. The services were determined by certification requirements established by the Illinois Department of Human Services, with input from the community through information sessions, community open houses, and surveys organized in 2012 and 2013. All students, regardless of their ability to pay, are eligible for these services.

Another way the Health Department is increasing access to care is by decreasing wait times for appointments. New patients seeking a primary care medical home need to be able to access care in our LCHD/CHC system in a timely fashion. To decrease the time to the next available appointment, we are implementing several strategies. These include increasing the number of provider teams at health center sites, altering scheduled clinic hours to add more early morning, evening and weekend hours, and adding more "immediate access" appointments in the schedule to allow for patients, either new or existing, to get in for care sooner.

New Patients	Average Days to Third Next Available Appointment*
New Well Baby Initial Exam	12 days
New Adult Initial Appointment	19 days
Dental	18 days
Outpatient Psychiatry	41 days

*The third next appointment is the industry standard for determining appointment availability.

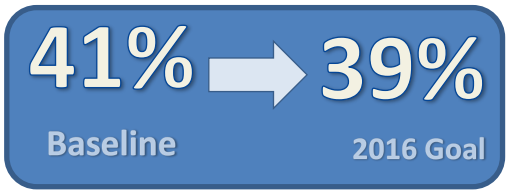
New Patients	Wait Time Prior to Program Admission
Addictions Treatment Program Detox	10 days
Addictions Treatment Program Rehab	21 days
Women's Residential Services	21 days
Substance Abuse Intensive Outpatient Services	18 days

Emphasis on Prevention/Access to Prevention and Wellness

Goal: Reduce Illness, Disability and Death Related to Tobacco Use and Second Hand Smoke Exposure

By June 30, 2014, establish a baseline of how many Behavioral Health Services (BHS) clients use tobacco. By June 30, 2016, reduce by 5 percentage points the number of Behavioral Health Services clients who use tobacco.

Progress: 2014 Goal Met



Tobacco dependence among individuals with mental health disorders and/or substance addiction is a tremendous problem that goes largely ignored. Persons with chronic mental illness die 20-25 years earlier than the general population and tobacco usage is a major reason why. The Health Department found that 41% of its Outpatient Mental Health Services patients used tobacco. (In comparison, 20% of the general population uses tobacco.) Since 5% of 41% is 2.05%, 2.05% was subtracted from the 41% baseline to determine the 2016 goal of 39%. Despite popular belief, persons with mental illness and addictions want to quit smoking, want information on cessation services and resources, and, most importantly, they can successfully quit using tobacco. One study found that 52% of individuals addicted to cocaine, 50% of those who abuse alcohol, and 42% of individuals addicted to heroin were interested in quitting smoking at the time they started treatment for their other addictions.

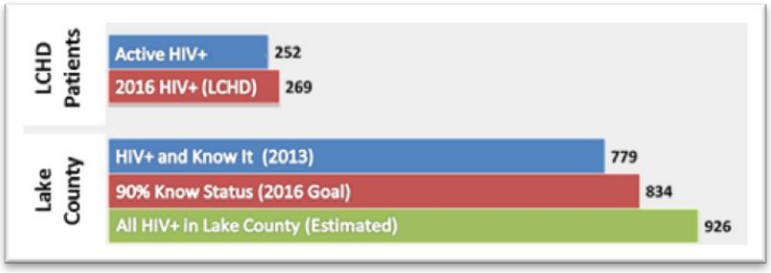
To meet its 2016 goal, the Department has begun offering tobacco cessation classes at several programs, including Williams Consent Decree, Women's Residential Services and the Addictions Treatment Program.

BHS will continue to work with the Tobacco Free program to expand services to other behavioral health programs. The model for the programs is "Harm Reduction," a model designed to reduce the harmful consequences associated with tobacco use. Staff is identifying clients who have the desire to quit smoking and offering them Nicotine Replacement Therapy free of charge. Patients are being monitored through self-reports, assessments and carbon-monoxide readings. From July 2013 to present, Women's Residential Services clients reduced the amount of cigarettes they smoked per day by 75%. Additionally, 58% decreased their carbon-monoxide levels and 11 clients stopped smoking. Nine out of 15 Park City clustered apartments clients reduced their carbon-monoxide levels. At the William's Consent Decree Program, of the 19 clients who were identified as wanting to quit smoking, 37 percent reduced their carbon monoxide levels. BHS will continue to work with all clients who are using tobacco to decrease their use of tobacco products.

Goal: Reduce the Incidence of Infectious Diseases

By June 30, 2014, establish a baseline of the LCHD/CHC patient population who knows their serostatus. By December 31, 2016, increase the proportion of persons living with HIV who know their serostatus from the established baseline to 90% to be consistent with the National HIV/AIDS Strategy and increase the number of LCHD/CHC patients who have an undetectable viral load (<200) by 10% from 16%.

Progress: 2014 Goal Met



The Health Department currently provides care for one in three individuals living with HIV or AIDS in the county. The Sexually Transmitted Infections (STI) Program is working to increase the percent of persons living with HIV and know it to 90%, in line with the National HIV/AIDS Strategy goals. If the Health Department continues to provide care for one in three HIV or AIDS patients and the number of individuals learning their status increases to 90%, the number of patients in the Health Department's care should increase from 252 patients in 2014 to 269 clients in 2016.

The STI Program staff continued to provide comprehensive wrap-around care and prevention services for individuals at-risk for and/or infected with STIs and HIV in Lake County. This year, the Program:

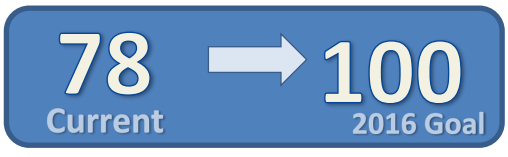
- Increased its HIV testing efforts across Lake County through the use of marketing, events and expanded testing availability.
- Continued to work to promote Routine HIV Testing in all six Primary Care FQHC health center sites, the Lake County Jail, and the TB Clinic, providing over 7,000 free HIV tests to patients receiving services.
- Conducted nearly 9,400 HIV tests through the end of November 2014, in conjunction with Primary Care Services, the TB Clinic, the Lake County Jail, Behavioral Health Services and NICASA.
- Out of the tests completed, identified 27 new positives, yielding a 0.3% overall positivity rate and a 6.7% positivity rate with targeted high risk HIV testing.
- Strengthened outreach and linkage to care services for all HIV positive individuals residing in Lake County, including Surveillance-Based Linkage to Care and Partner Services interventions, which links identified, out-of-care HIV-positive individuals with needed services.

Linkage to care and early initiation of antiretroviral medication not only support the health of HIV positive individuals, but lowering "community viral load" reduces virus transmission and prevents new HIV infections.

Goal: Protect and Improve Surface and Groundwater Resources

By June 30, 2016, establish a public awareness campaign and identify at least 100 abandoned wells and assure 100% are sealed.

Progress: Ahead of Schedule Toward Meeting 2016 Goal



This objective is ahead of schedule with 78 abandoned wells identified and sealed as of the end of 2014. In most areas of Lake County substantial amounts of clay exist between the ground surface and the aquifers. These favorable geological conditions are effective at protecting the groundwater that provides the drinking water for over 200,000 county residents. Abandoned water wells, however, provide

a direct pathway from the ground surface to the aquifers. This potential threat is the reason why identifying and assuring the sealing of abandoned water wells is a high priority, and why these efforts are a part of the Health Department's strategic plan. Water Well Program staff will continue to enhance their efforts to identify and assure the sealing of abandoned water wells by increasing public and community awareness and by stepping up investigation and enforcement activities.

Goal: Reduce the Percentage of Adults and Children in Lake County Who are Overweight or Obese

By October 1, 2014, work with collaborative partners to develop a countywide active living brand and plan to increase physical activity, healthy eating and quality of life.

Progress: Goal Met

This objective began as an idea in the Mobilizing for Action through Planning and Partnerships (MAPP) Active Living subcommittee. Board of Health member and Forest Preserve District President Ann Maine and County Board Chairman Aaron Lawlor expanded this objective to reflect additional concepts to the Lake County branding effort named "Lake County Life". In 2014, three meetings were held between County Administration, Lake County Partners, Lake County Tourism Bureau, Lake County Forest Preserves, Lake County Stormwater Management Commission and the Lake County Health Department. The branding objectives were as follows:

- Create unified message that brands life in Lake County.
- Promote collective benefits of stakeholders to all Lake County residents, visitors and business prospects.
- Develop Lake County communications strategy.
- Build collaborative effort among stakeholders and community partner groups to spread message of benefits of life in Lake County.
- Tailor key messages/themes that fit within stakeholder vision/strategic planning efforts and campaigns, and that meet marketing best practices.

The group identified key messages/themes and created a colorful infographic, logo brand and interactive video. In January of 2015, the group launched the "Lake County Life" branding on a new website (lakecountylife.org) along with other communication and marketing strategies.

Goal: Reduce the Number of Substance Abuse Related Emergency Room Visits and Deaths

By June 30, 2016, reduce the number of opiate-related overdoses by 20%, from 22 deaths.

Progress: Baseline Updated. In Progress Toward Meeting 2016 Goal

The goal has been updated to read: By June 30, 2016, reduce the number of opiate-related overdoses by 20%, from 46 deaths in 2012.

Deaths related to opioid abuse, an illness that is particularly affecting young people, are a growing concern in Lake County. Due to opioid overdoses, 46 people in 2012 and 49 people in 2013 died in Lake County. The Health Department, along with other local partners, is addressing this issue through its membership with the Lake County Opioid Initiative, which is working to prevent opioid use, abuse, misuse, addiction, overdose and death.

As part of this initiative, the Health Department trained 90 police officers from 32 police departments to use Naloxone, a product that can swiftly reverse opioid overdose. These police officers, who are often the first responders to overdoses, are in turn training their peers to use it. The Health Department played a role in securing donations of Naloxone product, including a $1.4 million contribution of EVZIO, the auto-injectable version of Naloxone, to equip the police officers. Officers trained by the Health Department have successfully used Naloxone to save the lives of two people who had overdosed. The Health Department continues to train program staff, patients and their families on the use of Naloxone.

Reduction in Health Disparities/Increased Healthy Equity

Goal: Improve Health Equity and Reduce Chronic Disease in Target Populations in Lake County

By June 30, 2014, determine rates of adults with hypertension (HTN) in five (5) targeted communities (North Chicago, Waukegan, Zion, Round Lake Area and Highwood) using LCHD/CHC patient population data.

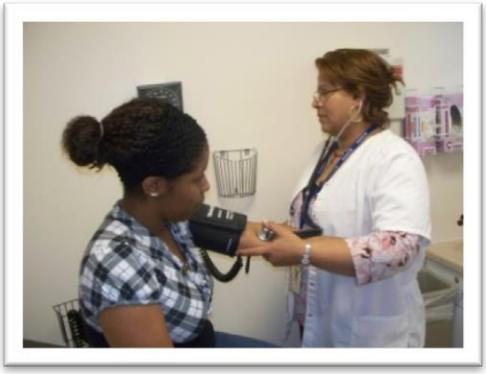
Progress: 2014 Goal Met

High blood pressure (hypertension) can quietly damage a person's body for years before symptoms develop. Left uncontrolled, hypertension can lead to disabilities, poor quality of life or even heart attacks. With treatment and lifestyle changes, people can control their high blood pressure to reduce the risk of life-threatening complications.

Community	Percentage of Patients with Hypertension
Highland Park	26%
North Chicago	39%
Round Lake	22%
Waukegan	41%
Zion	38%
Total	35%

By June 30, 2014, establish baselines for tobacco use, obesity and hypertension for the severely mentally ill population served by LCHD/CHC.

Progress: 2014 Goal Met



People who live with mental illness are often at higher risk for heart illness and much of that risk is preventable. People who live with mental illness are more likely to have classic heart risk factors such as cigarette smoking, obesity, diabetes, elevated cholesterol and hypertension (high blood pressure)—all of which can be exacerbated by some antipsychotic medications. These risk factors can be modified. Mental health patients who are addressing them can live longer and enjoy a higher quality of life.

Risk Factor	Percentage
Tobacco Use	41.2%
Obesity	44.2%
Hypertension	17.6%*

*The percentage rate for hypertension is very low compared to the national average. This is due in part to the fact that psychiatrists typically do not make the diagnosis of hypertension. The majority of these cases in mental health have existing diagnoses of hypertension or they are on medication supporting the management of their hypertension. If a mental health client has an elevated blood pressure rate at the time of service, appropriate referrals are made to a primary care provider.

By June 30, 2014, establish baselines for diabetes rates in the African American and Hispanic populations served by LCHD/CHC.

Progress: 2014 Goal Met

Compared to the general population, African Americans and Hispanics are disproportionately affected by diabetes. A major cause of blindness, renal failure, amputation and cardiovascular disease, diabetes also increases the risk of cancer and dementia and more than doubles individual health care costs. However, diabetes is a manageable disease. Through learning how to control it, patients can live longer and can improve their quality of life.

Patient Population	Percentage with Diabetes
African Americans	11%
Hispanics	14%

By June 30, 2014, establish a baseline for asthma rates in the African American population served by LCHD/CHC.

Progress: 2014 Goal Met

African Americans have one of the highest rates of asthma compared to other racial/ethnic groups. Access to healthcare and proper treatment are important issues facing African Americans with asthma, as wide disparities in care exist between them and Caucasian asthma patients. Research has shown that African Americans have a poorer quality of life, more asthma control problems and a greater risk of emergency hospital visits compared with Caucasians.

Percentage of African American children with Asthma in three specific Lake County school districts in 2010.*	**25%**

*In 2010 the Health Department conducted an Asthma Intervention Project funded by the Health Care Foundation of Northern Lake County. The Health Department cooperated closely with the school districts in North Chicago, Waukegan, and Zion to distribute the Brief Pediatric Asthma Survey (BPAS) to pre-school and school age children in those communities. The BPAS is a validated survey tool that can be used to estimate the prevalence of asthma. A total of 4,726 surveys were returned. The results of the survey responses were that 25% of the African American respondents answered "yes" to the question "Has a doctor or nurse ever told you that your child has asthma?"

By August, 2015, reduce the rate of adolescents and adults who have a reportable sexually transmitted infection (chlamydia or gonorrhea) in the three (3) targeted communities (North Chicago, Waukegan and Zion). Reduce chlamydia by 5%, from 401.8/10,000 in North Chicago; 256.9/10,000 in Waukegan; and 307.7/10,000 in Zion. Reduce gonorrhea by 5% from 181.7/10,000 in North Chicago; 70.4/10,000 in Waukegan; and 108.3/10,000 in Zion.

Progress: Baseline Updated

The goal has been updated to read: By August, 2015, reduce the rate of adolescents and adults who have a reportable sexually transmitted infection (chlamydia or gonorrhea) in the three (3) targeted communities (North Chicago, Waukegan and Zion). Reduce chlamydia by 5%, from 80.4/10,000 in North Chicago; 62.1/10,000 in Zip Code 60085; 29.6/10,000 in Zip Code 60087; and 61.2/10,000 in Zion. Reduce gonorrhea by 5% from 34.1/10,000 in North Chicago; 16.2/10,000 in Zip Code 60085; 6.1/10,000 in Zip Code 60087; and 19.0/10,000 in Zion. Rates are five-year averages based on 2009-2013 Illinois Department of Public Health reports.

Chlamydia Rates per 10,000		2009	2010	2011	2012	2013
North Chicago	**60064**	78.5	78.5	72.7	88.3	83.7
Waukegan	**60085**	59.5	55.1	56.6	68.5	70.7
Waukegan	**60087**	17.8	21.5	24.5	40.4	43.7
Zion	**60099**	56.6	51.8	64.3	61.7	71.7

Gonorrhea Rates per 10,000		2009	2010	2011	2012	2013
North Chicago	**60064**	38.3	24.0	40.9	29.9	37.6
Waukegan	**60085**	20.2	13.1	14.5	13.9	19.1
Waukegan	**60087**	4.1	3.7	6.7	7.8	8.2
Zion	**60099**	19.3	14.5	20.3	20.6	20.6

The Health Department's STI Program staff continued to provide comprehensive wrap-around care and prevention services for individuals at-risk for and/or infected with STIs and HIV in Lake County. The STI

Program has been diligently increasing its STI prevention efforts across Lake County while concentrating on the priority communities of Waukegan, North Chicago and Zion. Through its participation in the MAPP Coordination of Care Subcommittee's Gonorrhea Action Team, the STI Program collaborates with community partners to reduce gonorrhea rates and transmission of antibiotic resistance. In addition, the STI Program has reached out to 54 private providers in Lake County to educate and increase awareness of proper treatment, screening, and partner notification for STIs. The STI Program, in partnership with the Gonorrhea Action Team, continues its efforts to decrease STI rates in the priority communities.

Adequate and Diverse Public Health System Workforce

Goal: Attract and Retain a High Performing Public Health System Workforce

By December 31, 2014, design and implement a workforce succession and sustainability program for LCHD/CHC.

Progress: In Progress

Human Resources has researched potential models and is in the process of developing a model workforce succession and sustainability program. In order to continue achieving our vision and mission as an agency, we must invest in developing our staff and preparing the agency to minimize the impact of employee departures. Risk analysis for retirement eligible employees has begun, which will be followed up with knowledge transfer plans. Overall development planning to assess and improve competency gaps within the agency to have a stronger and more ready internal pipeline of talent is also underway.

By December 31, 2014, LCHD/CHC will apply for Public Health Accreditation through the Public Health Accreditation Board.

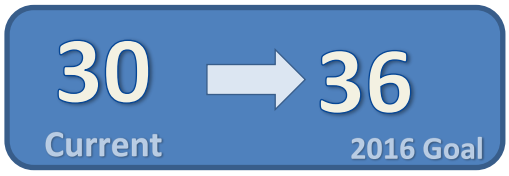
Progress: 2014 Goal Met

On March 26, 2014, LCHD/CHC submitted an application for Public Health Accreditation. The application was accepted by the Public Health Accreditation Board (PHAB) and approved on the same day. On May 13-14, 2014, the LCHD/CHC accreditation coordinator attended an in person training on the specifics of collecting, providing, and submitting evidence to the accrediting body. A multidisciplinary accreditation team, consisting of 28 LCHD/CHC staff was created to collect and review evidence. The team met on a regular basis through the summer and into the fall of 2014. On December

11, 2014, a PHAB mock site visit was conducted and overall the site reviewers were positive about the evidence submitted.

By June 30, 2014, establish a baseline of how many strategically aligned continuous education offerings there are available to LCHD/CHC partners. By December 31, 2016, increase the amount of offerings by 20%, from the established baseline.

Progress: 2014 Goal Met



Continuous improvement is not only a matter of evaluating our processes, but also ensuring the on-going development and continued education of our staff. This allows for the maintaining of licenses and credentials as well as staying on top of emerging issues in public health. In 2014 we evaluated our in-house offerings for continued education and determined a baseline of 30 activities. By December 31, 2016 we will increase this number by 20%.

Goal: Strengthen the Public Health System Workforce and Future Workforce Pipeline to Improve the Public's Health

By December 31, 2014, establish a baseline of activities and promotion events with schools and partners to promote public health career choices. By December 31, 2015, increase the number of activities and promotions by 3% from the established baseline.

Progress: 2014 Goal Met

The need for a diverse and high performing public health workforce continues to grow. To help ensure an on-going pipeline of professionals for years to come as well as overall promotion of the public health field, the Health Department is actively engaged in partnerships and promotional activities with school-aged children. These include activities such as participating in career days, talking to classes, being interviewed by students, and work experience programs. In 2014, we completed five of these activities, and plan to continue growing these activities throughout 2015.

Goal: Ensure the Appropriate Number of well-trained Health Care Providers to Provide Care to All Residents

By December 31, 2014, establish a baseline of how many providers are enrolled in multiple managed care plans. By December 31, 2016, increase the number of enrolled providers by 5% from the established baseline.

and

By December 31, 2015, establish a baseline of how many primary care and specialty care providers accept multiple managed care plans. By December 31, 2016, recruit additional providers to meet increased demand by 2%, from the established baseline.

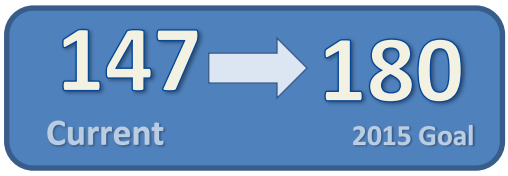
Progress: Baseline Updated

The goals have been combined and updated to read: By June 30, 2015, establish a baseline of how many providers are enrolled in Medicaid Managed Care Plans. By December 31, 2016, increase the number of providers by 5% from the established baseline if needed.

The goal was narrowed to Medicaid Managed Care only as almost all Lake County providers currently participate in Commercial Managed Care. We could not establish the baseline by the previously established date (December 31, 2014) as the Medicaid Managed Care plans are behind in entering their provider contracts into their computer systems. The Medicaid Managed Care Plans that operate in Lake County should have their systems updated by June 30, 2015.

By December 31, 2015, double the number of trained, mass medical distribution site managers, from 90 site managers.

Progress: In Progress Toward Meeting 2015 Goal



Emergency Management has worked to increase the number of site managers from 90 to 147 in the past year by developing and rolling out a new site manager recruiting program. New recruitment of Health Department staff for the site manager role occurs through quarterly *Preparedness Awareness Campaign* events that will continue through the end of 2015. Other new recruitment efforts have been successfully extended out to the Community Emergency Response Teams (CERTs) of Lake County. Additionally, we have added incentives for the role by not only educating site managers on personal preparedness, but providing them with essential equipment to start home emergency kits.

Live Well Lake County