Healthy People 2020: Who’s Leading the Leading Health Indicators?
Welcome to the first installment of the monthly series, “Who’s Leading the Leading Health Indicators?”

Each month, this series will highlight an organization that is using evidence-based approaches to address one of the Healthy People 2020 Leading Health Indicator (LHI) topics.
Webinar Agenda

■ Don Wright, MD, MPH
  HHS Deputy Assistant Secretary for Health

■ Howard K. Koh, MD, MPH
  HHS Assistant Secretary for Health

■ Kenneth Munson
  HHS Region V Director

■ Daniel Johnson, MD
  Director, Community Health Sciences
  Urban Health Initiative

■ Kimberly Hobson, MPH
  Interim Director, South Side Healthcare Collaborative
What is Healthy People?

- A comprehensive set of national 10-year health objectives
- A framework for public health priorities and actions
- Roadmap for prevention
What are the Leading Health Indicators (LHIs)?

Leading Health Indicators are:

- Critical health issues that, if addressed appropriately, will dramatically reduce the leading causes of preventable deaths and illnesses.
- Linked to specific Healthy People objectives.
- Goal: motivate action to improve the health of the entire population.
LHI Topics

- Access to Health Services
- Clinical Preventive Services
- Environmental Quality
- Injury and Violence
- Maternal, Infant, and Child Health
- Mental Health
- Nutrition, Physical Activity, and Obesity
- Oral Health
- Reproductive and Sexual Health
- Social Determinants
- Substance Abuse
- Tobacco
Howard K. Koh, MD, MPH
Assistant Secretary for Health
Access to Health Care: An Administration Priority

- Access to health care has been one of this Administration’s signature issues.

- To improve the health of all Americans, it is critical that more Americans have access to both routine medical care and medical insurance.
  - Our new health reform law has expanded coverage to millions of Americans.
  - Ensuring that all Americans have access to high quality, affordable health care is central to the new health care reform law.
Access to health services has a profound effect on every aspect of a person’s health.

People without medical insurance are more likely to lack a usual source of medical care and are more likely to skip routine medical care due to costs, increasing their risk for serious and disabling health conditions.
Leading Health Indicators: Access to Health Services

“Indicators” for access to health services:

- Whether one has medical insurance.
- Whether one has usual primary care provider.

How America looks on the access front:

- One in four Americans has no primary care provider.
- One in six Americans lacks medical insurance.
Improving Access: Federal Actions

- HRSA supports a network of more than 1,100 community health centers.
- The health reform law is increasing the number of people who have medical insurance and access to health services.
- It is also increasing access to affordable care, by providing free access to many preventive services – such as vaccinations and cancer screenings.
- 2.5 million young adults in the 19-25 age bracket are now being covered by health insurance, thanks to new law.
South Side Healthcare Collaborative

The Urban Health Initiative of the University of Chicago Medical Center

Uniting to Build a Healthy Community

January 25, 2012
Urban Health Initiative

- The Urban Health Initiative (UHI) is the University of Chicago Medical Center’s collaboration with civic leaders, community organizations, health care providers and residents to improve health for the more than 800,000 residents of the 34 communities that comprise the South Side of Chicago.
- The UHI convened the SSHC and provides continuous support.
South Side Healthcare Collaborative (SSHC)

- Established in 2005
- A network of more than 30 federally qualified community health centers, 2 free clinics, and 5 local hospitals
- Connects South Side Chicago families and patients with a primary care doctor to get the health care they need
**SSHC Goals**

- Build ongoing relationships between South Side residents and community-based primary care doctors
- Focus on wellness, routine care, and prevention
- Prevent disease and detect illnesses and health conditions earlier, before they turn into emergencies
- Build a network of care that will meet primary and subspecialty care needs
Medical Home Connections

• The Medical Home Connection Program is designed to connect South Side Chicago residents to community health centers and doctors who can provide:
  – Preventive care
  – Regular treatment for non-emergency health conditions
  – Long-term management of chronic disease
  – Referrals to specialists
Patient Advocates

- Connect patients to primary care physicians at health centers in the community so they receive timely and appropriate care.
- Educate patients on their ability to receive faster and more appropriate care at community clinics.
- Share information about resources and locations to address health care needs.
- Connect patients to subspecialty care as recommended by the ER and coordinated with their primary care site.
# Patient Advocate Hours

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of Patient Advocates</th>
<th>Days</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult ER</td>
<td>2 Patient Advocates</td>
<td>M-F</td>
<td>8 a.m.–4:30 p.m.</td>
</tr>
<tr>
<td></td>
<td>1 Patient Advocate</td>
<td>M-F</td>
<td>3 p.m.–11:30 p.m.</td>
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<tr>
<td></td>
<td>1 Patient Advocate</td>
<td>Sa &amp; Su</td>
<td>10 a.m. – 6:30 p.m.</td>
</tr>
<tr>
<td>Pediatric ER</td>
<td>1 Patient Advocate</td>
<td>M-F</td>
<td>8 a.m. – 4:30 p.m.</td>
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</table>
Recent Medical Home Connection Data

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<thead>
<tr>
<th>Period</th>
<th>Show Rate</th>
<th># Appointments Made</th>
<th># Patients Approached by Patient Advocates</th>
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</thead>
<tbody>
<tr>
<td>2/2009-1/2010</td>
<td>38%</td>
<td>3,649</td>
<td>6,741</td>
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<tr>
<td>2/2010-1/2011</td>
<td>37%</td>
<td>2,424</td>
<td>4,368</td>
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<tr>
<td>(11 months)</td>
<td></td>
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</table>

# Patient Advocates

|                     | 6  | 4  | 4  |
Evaluation

Completed & Ongoing:
- Monitoring of patients educated and connected
- Regression analysis of types of patients likely to keep their appointments
- Regression analysis of effect of MHC Program on returns to ED

Planned:
- Tracking primary care medical home stickiness
- Evaluating new ways to help ED patients who choose not to set up a clinic appointment
Lessons Learned

• Show rates remain low for this population despite our efforts to improve it
  – Postcards, reminder calls, conversations focused on importance of follow-up care

• Funding is challenging

• Communication of ER patient information to collaborative sites
  – The Portal

• Getting people into subspecialty care in a timely manner is a challenge, so change the landscape
  – ECHO; Cook County Health and Hospitals System Partnerships-IRIS for Kids, Provident; Grand Boulevard Subspecialty Partnership, Diabetic Retinopathy Program
Plans to Sustain & Expand

• Continue institutional support to sustain current model
  – Will need to identify external support for long term sustainability

• Potential opportunities
  – Expand MHC program to other South Side Emergency Departments
  – Expand MHC program to inpatient floors and outpatient specialty clinics at University of Chicago Medical Center
  – Add additional community-based clinics to the SSHC roster
Contact Information

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Question & Answer Session

Please take a moment to fill out our brief survey.
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