Office of Disease Prevention and Health Promotion
Healthy People 2020: Who's Leading the Leading Health Indicators?
Access to Health Services Webinar, January 25, 2012, 10:00am EST

OPERATOR: Good morning and thank you for registering to the webinar on the Leading Health Indicators. I would now like to introduce Dr. Don Wright, Deputy Assistant Secretary for Health at the Department of Health and Human Services.

DR. DON WRIGHT: Thank you very much. Next slide. 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 evidenced-based approaches to address one of the Healthy People 2020 leading health indicator topics. Next slide. During today's webinar, you will hear from four distinguished speakers, Assistant Secretary for Health Dr. Howard Koh will introduce this month's leading health indicator topic, Access to Health Services. Health and Human Services Regional Director of Region V, Kenneth Munson, will give a snapshot of access to health services in HHS Region V. And finally, for this month's featured organization, Chicago South Side Health Care Collaborative, Kimberly Hobson and Dr. Daniel Johnson will discuss how they are increasing access to health services in their community. Next slide.

First, let me give you some background on Healthy People, the initiative that introduced the leading health indicators. For four decades, Healthy People has provided a comprehensive set of national ten-year objectives that has served as a framework for public health activities at all levels and across the public health community. The Healthy People Initiative has evolved as the nation's public health priorities have changed.

Often referred to as a roadmap for national health promotion and disease-prevention efforts, Healthy People is about understanding where we are now and taking informed actions to get where we want to go over a ten-year period of time. Next slide.

You may be interested, what are the leading health indicators. Well, the leading health indicators are critical health issues that, if addressed appropriately, will dramatically reduce the leading causes of preventable death and illnesses. These indicators are critical health issues are linked to specific Healthy People objectives. They've been selected to communicate high priority health issues to the public along with actions that can be taken to address them with the overall goal of improving the health of the entire population. Next slide.

Well, as you can see, there are twelve LHI topics. We intend to highlight one of these topics every month in 2012. This month, the leading health indicator will be focusing on access to health services. We are showcasing the South Side Health Care Collaborative which has made significant advances in improving access to primary care services for residents of Chicago's South Side. At this point, I'd like to now welcome Dr. Howard Koh.

DR. HOWARD KOH: Thank you, Dr. Wright. Thank you for your leadership, and I'm absolutely delighted to be here to help launch this very exciting monthly series. Healthy People 2020 and the Leading Health Indicators offers our country a 2020 vision for a healthier nation. So we're thrilled to have so many people joining us for this launch.

Allow me to give you a brief overview on this month's LHI topic, Access to Health Services. We chose this topic to lead off our series because access to health services has been one of this Administration's top priorities. And we all know that to improve the health of all Americans, it is critical that more Americans have access to both routine medical care and medical insurance.

Access to health services has a profound impact on every aspect of a person's health, and we understand that 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 cost, increasing their risk for serious and disabling health conditions.

The leading health indicator access to health services is divided into two parts, first, whether or not there's access to medical insurance and, secondly, whether or not people have a usual primary care provider. Unfortunately right now in America, one in four people has no primary care provider or health center where they can receive regular medical services, and approximately one in six Americans has no medical insurance.

But fortunately our new health reform law has already begun expanding coverage to millions of Americans. And we at the Department of Health and Human Services are committed to this effort in a number of ways. For example, our Health Resources and Services Administration supports a network of more than 1,100 community health centers that provide quality care to underserved communities.

Also, the health reform law is increasing access to affordable care by providing free access to many preventive services such as vaccinations and cancer screening. And just recently, we have learned that the number of people in the 19-25 age bracket who are being covered by health insurance has increased by about 2.5 million compared to 2010 figures. That's because the new health care law now allows children to stay on their parents' health plan until their 26th birthday.

So thanks to this new law, we are truly making progress to reach our Healthy People 2020 leading health indicator goal of increasing access to health care for all Americans. So at this point, I'd like to turn the program over to our Regional Director of Region V, Kenneth Munson, who will add a few words.

MR. KENNETH MUNSON: Thank you, Dr. Koh. Well, it's a real privilege for me to be here with you all today. And I'm really proud that today's webinar also will highlight some of the great work being done here in Region V. Region V is the six states in the Upper Midwest, and this program we'll be talking about is in the Chicago area. And I'll echo Dr. Koh in saying that access to primary care is

critical and having a medical provider who knows you, who can help you manage your chronic conditions and your emerging health challenges, we know that increasing access to quality primary care saves lives, reduces suffering and by the way also saves money. And as Dr. Koh said, here in Region V, we're certainly aware that the health reform law signed by the President in 2010 really invests in many ways in promoting and providing and expanding access to primary care. One way is the investment in the National Health Service Program which funds the primary care work force in underserved communities. Illinois alone here, that program is funded in just 2011 about 300 new providers, doctors, nurses and others who will be providing primary care in the most underserved areas in this state, and that's taking place across the whole country.

And also the health reform law invests, as Dr. Koh, in new and expanded community health centers. Here in our six state region, Region V, again but I'd say over $100 million has been invested in new and existing community health centers just since that law was signed in October -- in March of 2010 across our six-state region. And, of course, that's also taking place across the country. That builds on about $2 billion invested in health centers all across the country since the – over the last three years.

Now that discussion of community health centers being expanded helps lead me to our next speakers, and I'm really gratified to build a spotlight and example of really effective collaboration across health care institutions, across organizations, across facilities -- in this case, community health centers, academic medical centers, hospitals all working together to provide great primary care to those who need it most.

So I'm honored to be able to highlight the South Side Health Collaborative, and I have the pleasure of introducing the leadership of the Collaborative today. Now established in 2005, the South Side Health Collaborative represents more than 30 community-based health centers in five local hospitals that are increasing

access to care by building really strong and ongoing relationships between our South Side Chicago residents, our Chicago area residents and community-based primary care doctors and by focusing on those things that are most important –- wellness, routine care and prevention so that we can work to prevent disease and detect illness before they turn into life threatening emergencies.

They're doing just tremendous work and having a great impact across our Metropolitan region here. And I'd like to be able to have you hear their successes firsthand. So rather than steal their thunder, please join me as we welcome the Interim Director of the South Side Health Care Collaborative, Ms. Kimberly Hobson and Dr. Daniel Johnson who's Director of Community Health Sciences at the Urban Health Initiative at the University of Chicago Medical Center.

DR. DANIEL JOHNSON: Thank you very much, Mr. Munson. It's a true honor to have the opportunity to kick off the Leading Health Indicators webinar series as we are this morning. I'm joined today, as you indicated, by Kim Hobson who's our Executive Director for the Collaborative along with Elana Kaufman who is our extraordinary data manager and data analyst who has helped us understand so much better the successes and accomplishments that we are seeing with the programs of the Collaborative. Next slide.

You can go back one. Thank you. So the South Side Health Care Collaborative is a program of the Urban Health Initiative, and the Urban Health Initiative is a collaboration with the University of Chicago and the communities that make up the South Side of Chicago. As you can see from the map, the University of Chicago sits in those communities, and we are trying to work together in order to create a system of care that allows patients to be seen at the right time in the right location for the right reasons, and our goal is to try and make the South Side of Chicago a model of urban health by 2025.

Under the auspices of the Urban Health Initiative, one of our first programs was the creation of the South Side Health Care Collaborative in partnership with our community partners. Next slide.

As Mr. Munson mentioned, we were established in 2005, and at that time we were a relatively small collaborative that now has grown to include 30 federally qualified health centers, free clinics and safety net hospitals. We represent as a collaborative many of the health care needs of the South Side of Chicago, and we advocate on behalf of the population.

One of our main goals is to bring people into care. As you indicated, that aligns very nicely with the leading health indicators of trying to ensure that there's access to service as part of the 2020 goals. Next slide.

So we are building ongoing relationships between South Side residents and the providers that provide primary care as well as those that are providing subspecialty care for this very needy population. We are focusing on wellness through routine care and prevention as well as prevention of diseases and building a network that will meet primary care and subspecialty care needs.

The map shows the sites that are distributed across the South Side. The two at the bottom of the map include some of the suburban areas of the South Side.

What we've shown on the map is the greater Chicago land area with specifically the South Side communities –- the 34 communities that make it up as we have defined the South Side shown in yellow. Next slide.

Our Medical Homes Connection Program is designed to connect residents to community health centers and to providers in order to receive the array of services that generally speaking are provided in a primary care setting. And we are linked to fairly qualified health centers in particular because of the large number of people living in poverty representing the South Side of Chicago. The

South Side of Chicago is a very vibrant community and is represented by all stratas of socioeconomic levels. But we do have a large number of patients who are in need of services that are provided through the FQHC System. And so we're very thankful to have this large number of partners that are interested in working with us to try and meet the needs of the population. Next slide.

As part of our program, what we chose to do is set up a patient advocate system which is our Community Connections Program, and they work with patients who come into the emergency room who are in need of a primary care medical home. We educate patients on the value of community clinics. We share information about those resources, and we connect patients to services including both primary care as well as subspecialty care. Next slide.

Our advocates are not there around the clock. You can see the hours that they're posted as well as the days of week that they work, and they're split between our Adult ER and our Pediatric ER. Those ERs are in adjacent buildings. In fact, they're across the street from each other, and we're fortunate at the University of Chicago to have a free standing children's hospital in addition to our adult hospital.

The patients who come in during those hours that the patient advocates are in place will have the opportunity to be seen by an advocate, and the patients are connected to those advocates through either the direction of the ER physician or based on the acute needs that the patient has when they're assessed at the time of entry into the emergency room. If patients need those services in hours that the patient advocates are not posted, then there's follow up through the advocates the next morning. Next slide.

You'll see the number of patients that have been contacted through the program, the number of appointments made and the number of approaches by the patient advocates. The percent represents some of the show rate which is our ability to

be able to have made that appointment and then follow through and determine whether or not the patient came. Of course, we're not happy with that show rate. We would love to see higher. But it is in keeping with the kind of follow up rates that's seen with emergency rooms that are similar to our own working with high risk populations such as those using services and using our ER often for what could be handled by a primary care medical home. Next slide.

Oh, wait, could you come back to that slide just for one moment? I just want to point out the number of advocates has varied over the course of the program. And, of course, this shows one of the challenges that any program like this has which is to try and ensure that we have steady funding over the course of the program. Next slide.

So we are doing evaluation, and that evaluation includes monitoring of data. We look at patients educated and connected. We've done our regression analysis on the types of patients likely to keep their appointments as well as a regression analysis on the impact of the program on the emergency department. And as part of that, we're also doing a financial analysis to try and understand the impact. So far, our initial data suggests that we're seeing as a consequence of this program about a 4 percent reduction in recidivism – that is, the number of patients who return for ongoing care in that low acuity profile.

We've also seen that the impact on the program –- the financial impact of the program is substantial if we were just to look at those programs who –- rather those patients who have Medicaid or those patients who are in a no-pay status currently, so self-pay. If we add in those patients who have private insurance, then the financial impact at this point is a wash because of the dollars represented by those private pay patients. This program is open to both public, private, and self-pay patients.

We plan to track the medical home stickiness meaning those patients who not only show up for an appointment at a medical home but then stay there because clearly that's one of the major goals of the project is to get patients into their primary care medical home permanently. And we're looking at ways to try and improve our success rates at getting patients to keep their appointments. Next slide.

So, of course, we've learned things through this process, and we've tried a lot of different things as you can see listed there to try and improve the rate at keeping appointments. And we really have not seen a substantial change over the course of the program. So we're now trying to understand who keeps appointments and who doesn't so maybe we can do a better job of directing our efforts. And we're also starting a texting program to see if perhaps sending text messages to people will further improve the show rates.

I already mentioned that funding is a challenge and it's part of the reason why we want to look at the financial impact so that way we hope that going forward we will be able to use that to continue to attract appropriate funding for the program. We know that communication of information out to the collaborative sites is critical to continuity of care, and we've built a portal which allows us to actually direct information to the sites that the patients agreed to go so that way they can look at the information that's been generated in the emergency room directly rather than having to depend on a faxing or mailing system which we found did not accomplish the task which was often that information was lost in process.

And then finally getting people to subspecialty care is certainly a challenge. We know from data that's specific to the South Side as well as national data that trying to get patients into care who are public pay or are self-pay is a true challenge. And we are trying to change the landscape in terms of both addressing need and as well as trying to improve the finances of institutions that are interested in providing service to this population.

So through that, we've developed what we call Project ECHO which actually is a up-training program, taking the example from New Mexico and applying it into an urban center. We're the first university and in fact we're the first program to do that. And then we're working very closely with our community partners including the Cook County health and hospital systems, and we've developed with them a system called IRIS for Kids which helps to move patients in a more seamless way into an appointment at the county health facility for follow-on care depending on the timing of that care and the availability both at our own institution as well as through a subspecialty partnership program that we've developed with one of our federally qualified health centers which is the Grand Boulevard Health Center of the Access Community Health Network.

And then finally, we've developed a Diabetic Retinopathy Program which allows FQHC to be able to send a picture of the retina of patients to our retina specialists for review and then, based on that review, determination is made about whether or not it's necessary to make an appointment to see the subspecialist. In this way, we can more effectively use the time of our subspecialty of providers. Next slide.

So we plan to sustain and expand this program. We are continuing to receive internal support. But, of course, we believe that sustainability is going to be tied to external funding. And we continue to look for opportunities to expand our program including encouraging other South Side emergency departments to take up the Medical Home Connect Program as well as to expand it to our inpatient force and outpatient specialty clinics because often we find that there are patients who need a medical home from those locations. We're finding that those sites that are within our own institution are using our patient advocates even now to help with identifying a primary care medical home. Next slide.

So here is contact information. We're very happy to talk further. We recognize that this format allows time for questions. But we assume that there will also be

other questions or information desired, and we're very happy to continue this conversation with you in that fashion should there not be enough time for questions.

DR. DON WRIGHT: Thank you, Dr. Koh, Mr. Munson, Dr. Johnson and Ms. Hobson for your outstanding presentations. If you've not already done so, I invite participants to send their questions through the WebEx chat feature. During the question and answer period, you will prompted to fill out a survey about your experience with this webinar. We strongly encourage you to complete the survey so that we can continue to improve the quality of these webinars in the future. Thanks in advance for your feedback.

We have a limited amount of time for question and answer. But the first question I'll direct to Dr. Koh. What are the unique features of the Leading Health Indicators, and why should stakeholders use them?

DR. HOWARD KOH: Well, the Leading Health Indicators represent a set of five priority health areas representing major opportunities for action for the country. So we view the LHI as a way to align efforts for people who care about health across the country, drive action and then, as you saw through this presentation today, serve as an opportunity to share lessons learned from the field. So this is a great way to bring us together as a public health community going forward.

DR. DON WRIGHT: Thank you, Dr. Koh. We have a number of questions for the South Side Health Care Collaborative. The first question from one of our participants, how are you establishing these ongoing relationships.

DR. DANIEL JOHNSON: So we have regular meetings of the Collaborative, and we also have subcommittees or working groups of the Collaborative as well. And so that, of course, brings us together and helps us stay unified with the goals. In

addition, we ask sites to sign a memoranda of understanding so that way there's some definition of what our responsibilities are.

DR. DON WRIGHT: Thank you. Another question for the same group, can the patients look at their own data via a PHR of some sort or health record?

DR. DANIEL JOHNSON: And so the answer is right now no. But many of our sites that are in the Collaborative are moving of course towards EMR. And as part of some of the EMRs, it will be possible for a MyChart kind of function for individuals to be able to look at their charts on their own.

DR. DON WRIGHT: Great. One more question. How are patients paired up with the primary care doctor?

DR. DANIEL JOHNSON: Well, there are criteria that are used. But, of course, first and foremost we start with the patient. We show them a list of the various sites that are available. They are then able to see a map which shows the true graphic location of them. And then finally the State of Illinois, as part of its Medicaid Program, assigns providers to patients. As a consequence, some of the time what we're doing is so to speak introducing that provider to the patient. Of course, they're able to make change, and we would never get in the way of that. So we just explain to people how they can go about doing that if they wanted to change their provider, and so all of those wrap together in terms of leading to that kind of connection.

DR. DON WRIGHT: Thank you, Dr. Johnson. I'll fill the next question. The question is will the presentation be available after the session, and the answer is yes. The slides will be emailed to all the attendees, and the webinar will also be archived on the Healthy People website.

Unfortunately, this session is coming to an end. I want to thank you for joining today's webinar. This webinar is part of a series, and we hope that you'll continue to join us. To receive notices about upcoming events, please sign up for our email announcements on the Healthy People website, that is healthypeople.gov. You can also check HealthyPeople.gov for a recording of today's presentation.

Let me end by saying that on behalf of HHS, I would like to thank all of you, the presenters as well as everyone that's been involved with the planning and implementing of Healthy People 2020. Thank you.

OPERATOR: Ladies and gentlemen, thank you for joining the first of the LHI Webinar Series. Your session is now ending.

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