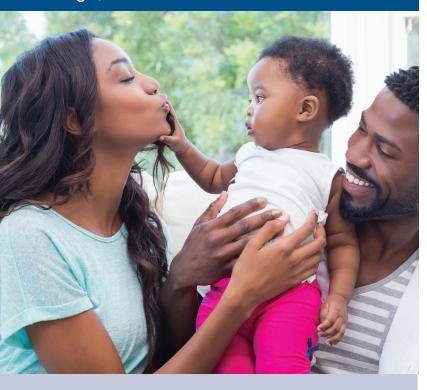## COMMUNITY SPOTLIGHT

CHP SUBJECT MATTER EXPERT COMMUNITY
THE UNIVERSITY OF CHICAGO MEDICINE
Chicago, IL

"We use data to evaluate the effectiveness of our programs and we have expanded, ended, and re-engineered programs to have greater impact on improving the health of populations we serve."

COMMUNITY OVERVIEW

The University of Chicago Medicine (UCM) will provide expertise in data integration and multi-organization collaboration to the Community Health Peer Learning (CHP) Program. As the anchor health care institution on the south side of Chicago, they convened and collaborated with community partners to address critical health issues in their communities. Through their Medical Home Connection program, they leveraged partnerships with community health centers to educate emergency department utilizers on the value of using medical homes for ongoing care. Patient Advocates scheduled follow up medical home visits for patients who were discharged from the emergency room. With the adoption of an electronic patient information portal integrated with the electronic information system, the program expanded. With the use of data from multiple sources the collaborating partners have implemented several additional population health management programs.

KEY INSIGHTS & LESSONS

From years of work with the South Side Health Collaborative (SSHC), the University of Chicago Medicine has learned many lessons from its past endeavors:

- **Learn early what the community partner's main priorities are.** While implementing programs in SSHC partners' facilities, UCM found that some of the programs had no direct connection to the organization's needs or priorities, or were more of a burden for the organization than help. The collaboration should support the strategic imperatives of all of the partners.

- **Enter into the collaboration without biases or preconceived notions.** Biases or preconceived notions about partners can sometimes be perceived as a one-sided dependency. UCM and their collaborative partners experienced the nuances of "they need me to do this" attitude, which sometimes created conflict in the success of the partnership.

- **Partnerships/collaborations are interdependencies.** In a collaboration, both sides have to learn that they are interdependent. Neither can accomplish the goals without the other. Each partner brings resources, without which the project would not be effective.

- **Know when it is time to re-evaluate the process and be flexible.** The 2014 SSHC strategic planning process revealed a clear need to address pressing environmental issues (ACA, reduced reimbursement, health disparities, etc.). Not a single organization could address these without other collaborators, and members suggested a multi-year focus on these critical issues vs. non-related issues.

- **Take an asset based approach.** Recognize that all parties in a collaboration have assets of value to bring to the project. Be sure to identify each entity's skill set and onboard expertise (e.g., staff, location, infrastructure) and then leverage what each brings to further the process.

COMMUNITY SNAPSHOT

Site Type	Hospital
Areas of Expertise	Multi-organization Collaboration • Formed the South Side Health Collaborative Data Integration • Established the Medical Home and Specialty Care Connection Program and adopted an electronic information system • Used data from multiple sources to expand the focus to additional population health management programs • Set up a real-time automated system to link the patients of 33 health care sites and 27 community health centers

KEY ACHIEVEMENTS

- **Medical Home Connection.** UCM and its partners implemented the Medical Home Connection program to help patients connect or establish with a primary medical home. Patient Advocates meet with low acuity patients in the adult and pediatric emergency departments to educate them on the value of utilizing a primary medical home, ask the patient for permission to connect them with a primary medical home, and if permitted schedule the patient for a follow-up appointment at their new/existing medical home within 3-7 days after the ED visit. When the Medical Home Connection program began, the show-rate for patients to follow-up appointments after an ED visit was 35 percent. Today the show rate is 60 percent. The program was expanded to include follow-up appointments to specialists, and renamed the **Medical Home and Specialty Care Connection Program** (MHSCCP).

- **The Medical Home Network System.** The system provides easy transmission of real time emergency department utilization and EMR data, expediting notification to the primary medical home and cutting down the time for the Patient Advocate to schedule the follow-up appointment. As a result, the program has seen a 60 percent increase in the number of patients achieving follow-up appointments after hospital admission and a collective impact on reducing the readmission rate for Cardiology Heart Failure patients by two percent.

- **Community Rx Program.** The CommunityRx system is a continuously updated electronic database of community health resources that is linked to the electronic health records of local safety net providers. In real time, the system processes patient data and prints out a "HealtheRx" for the patient, including referrals to community resources relevant to the patient's condition and health status. The program served 200,000 beneficiaries of the South Side of Chicago with ambulatory care sensitive and chronic conditions by providing a prescription of community resources within patients' neighborhoods that could help them stay healthy and manage their disease.

- **ECHO-Chicago.** ECHO-Chicago is an evidence based telementoring program designed to expand access to best practice health care for vulnerable populations. ECHO-Chicago leverages existing resources - University of Chicago specialists and community primary care providers (PCPs) – to expand PCP capacity to treat chronic disease through case based interactive telehealth training series delivered via high quality videoconferencing technology. ECHO-Chicago is involved with all member organizations of the SSHC and beyond with training of >450 primary care providers.

LEAD AGENCY

- **University of Chicago Medicine (UCM)** (http://www.uchospitals.edu/) is an academic medical center and the anchor health care institution on the South Side of Chicago. In 2004, UCM implemented the Urban Health Initiative as a community health department, tasked with identifying innovative ways in which UCM could interface with its surrounding community and execute its population health management strategies.

PARTNERS/COLLABORATORS

- **South Side Health Collaborative (SSHC):** Formed by the University of Chicago Medicine in 2005, SSHC is a network comprised of federally qualified health centers – 30 sites, four community-based hospitals, and two free clinics. The SSHC was formed to improve access to health care for residents on the Chicago's South Side.

MEET THE PROJECT TEAM!

Brenda Battle, R.N., B.S.N., M.B.A.
VP of Care Delivery Innovation, Urban Health Initiative and Chief Diversity and Inclusion Officer
CHP Role: Project Lead
Contact: brenda.battle@uchospitals.edu

Ask her about:
- Population health management
- Care delivery innovation
- Value-based care
- Community engagement
- Health care equity
- Community benefit

Sweta Basnet, M.S.
Project Manager, Population Health
CHP Role: Project Manager
Contact: sweta.basnet@uchospitals.edu

Ask her about:
- Program evaluation
- Epidemiologic research methods
- Data analysis
- Population health management

Daniel Johnson, M.D.
Chief, Section of Academic Pediatrics
CHP Role: Advisor to Learning Collaborative
Contact: djohnson@peds.bsd.uchicago.edu

Ask him about:
- Population health management
- Community engagement
- ECHO-Chicago
- Capacity building

Kimberly Hobson, M.B.A.
Director, Strategic Hospital Affiliations and South Side Healthcare Collaborative
CHP Role: Advisor to Learning Collaborative
Contact: kimberly.hobson@uchospitals.edu

Ask her about:
- Community engagement
- Building strategic affiliations
- External relationship management
- Population health management

Nadia Salibi, M.P.H.
Manager, Community Benefit at University of Chicago Medicine
CHP Role: Evaluation and Reporting
Contact: nadia.salibi@uchospitals.edu

Ask her about:
- Program evaluation and design
- Program implementation
- Strategic planning
- Community benefit

COMMUNITY HEALTH PEER LEARNING PROGRAM www.academyhealth.org/CHPhealthIT