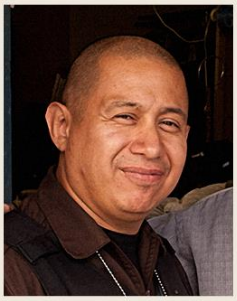
UNIVERSITY OF ILLINOIS
Hospital & Health Sciences System
Changing medicine. For good.



University of Illinois Community Assessment of Health Needs (UI-CAN)

2013 COMMUNITY HEALTH NEEDS ASSESSMENT REPORT

UNIVERSITY OF ILLINOIS
Hospital & Health Sciences System
Changing medicine. For good.

EXECUTIVE SUMMARY

In the last two years, the **University of Illinois Hospital & Health Sciences System (UI Health)** has significantly changed direction in two ways. First, we have moved toward an integrated system of care in which the **University of Illinois Hospital (UIH)** is tightly linked to the outpatient clinics, community health centers, dental clinics, and pharmacies that are also part of the University's clinical infrastructure. These units are inseparable, and work together to provide comprehensive services to our shared patient population.

Second, we have recommitted to serving the surrounding community and the entire state of Illinois, particularly in serving as a national model for our pursuit of the *elimination* of health disparities. These are unique messages compared with the standard missions of *education, research, and clinical care* that characterize the vast majority of academic health centers. We are proud of how we are different.

This mission makes us particularly focused on addressing the needs of our community. The UI Health primary service area contains many of the poorest communities in Chicago, and, as described in detail in this report, its residents have tremendous healthcare needs. We believe that our focused efforts can begin to reduce the disparities that exist and address many of our residents' unmet needs.

Conducting the **University of Illinois Community Assessment of Health Needs (UI-CAN)** provided an opportunity to systematically evaluate the needs in our community and define an implementation plan. Led by the Office of the Vice President for Health Affairs (OVPHA), which oversees the hospital and its related clinical components, this report sets a clear path for strategically deploying our resources in ways that stay closely linked to our mission.

After an extensive review of the myriad of needs in our community, we identified four broad high priority areas that will be our focus for the next three years:

- Access to healthcare services (including medical, mental health, oral health, and vision)

- Follow-up care
- Chronic conditions and factors
- Cancer screening

Our implementation plan for addressing these needs has three overarching 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 injuries. Intervention plans aimed at targeting these individuals may then be deployed to combat some of the socio-economic factors that have historically had a negative impact on residents' health.
- **To increase accessibility of preventive services for all community residents**. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

These concepts are used to develop targeted, specific goals related to the health needs we have prioritized. The strategies for achieving these goals focus on increasing service capacity (particularly at our community sites) and creating new service lines, better coordinating care, providing personalized care, and increasing outreach and awareness. Many of these efforts are underway, and will continue to develop in the coming months and years.

Although the data shown here represents a major step forward in understanding the needs of our communities, our commitment to our core mission requires that we think bigger. We have developed this report in concert with a longer-term effort to build the next iteration of UI-CAN. The result has been the **University of Illinois Survey of Neighborhood Health (UNISON Health)**, an ambitious, innovative community health needs assessment that will involve in-person interviews and biometric testing of a random sample of people who live in 24 Chicago neighborhoods that surround us. We will also be asking some of our own patients about several chronic conditions where we believe we can have a particularly large impact. Expected to launch later in 2013, UNISON Health will allow us to identify precisely where needs exist. We can then use this information to strategically grow service lines and programs that will address these needs, as well as ensure that members of our community are aware of and can access our services. In other words, this report is just the beginning.

OVERVIEW OF UI Hospital

The **University of Illinois Hospital & Health Sciences System (UI Health)** is an integrated academic health system that includes the **University of Illinois Hospital (UIH)**, over 60 outpatient care clinics (many embedded in the Outpatient Care Center), 12 Federally Qualified Health Centers (**Mile Square Health Center, MSHC**), and 7 health science colleges (Medicine, Applied Health Sciences, Dentistry, Pharmacy, Public Health, Nursing, Social Work). The hospital, an academic health center with 495 beds and 4,000 employees, is a critical component of UI Health.

UI Health is unique among U.S. academic medical centers in its focus on delivering personalized health to "at risk" populations. As the State's only health system, UI Health accounts for a significant proportion of the healthcare delivered to metropolitan Chicago's medically underserved populations (~1 million patient care encounters annually).

Key to UI Health's strategy for serving its communities is its own network of community health centers. We are one of the only academic health centers in the country to have our own **Federally Qualified Health Centers (FQHCs)**. MSHC includes 5 primary care clinics, which provided care to more than 18,000 patients in 2011, as well as 2 award-winning integrated healthcare clinics operated by the College of Nursing, and 5 on-site school health centers operated by the Office of Community Engagement and Neighborhood Health Partnerships. The majority of patients at MSHC are minority, women and children, live at or below the poverty line, and are publicly insured. These sites are located in some of the neediest communities in Chicago, and allow patients to access top-notch care in locations that are convenient. Mile Square also provides a "front line" for offering preventive services and primary care, and if needed, can send patients to the hospital or other clinical sites within UI Health for seamless transitions of care.

UI Health's Mission

The *mission* of UI Health is *"to leverage its unique combination of clinical care, health sciences education and biomedical research to provide high quality, cost effective healthcare for the people of the State of Illinois and to deliver 'personalized health' in pursuit of the elimination of racial and ethnic health disparities."* UI Health's mission emphasizes innovative research, health education, patient care and community outreach

and leverages the University's long-standing commitment to training a diverse healthcare workforce, research across the translational spectrum, and leadership in urban social sciences.

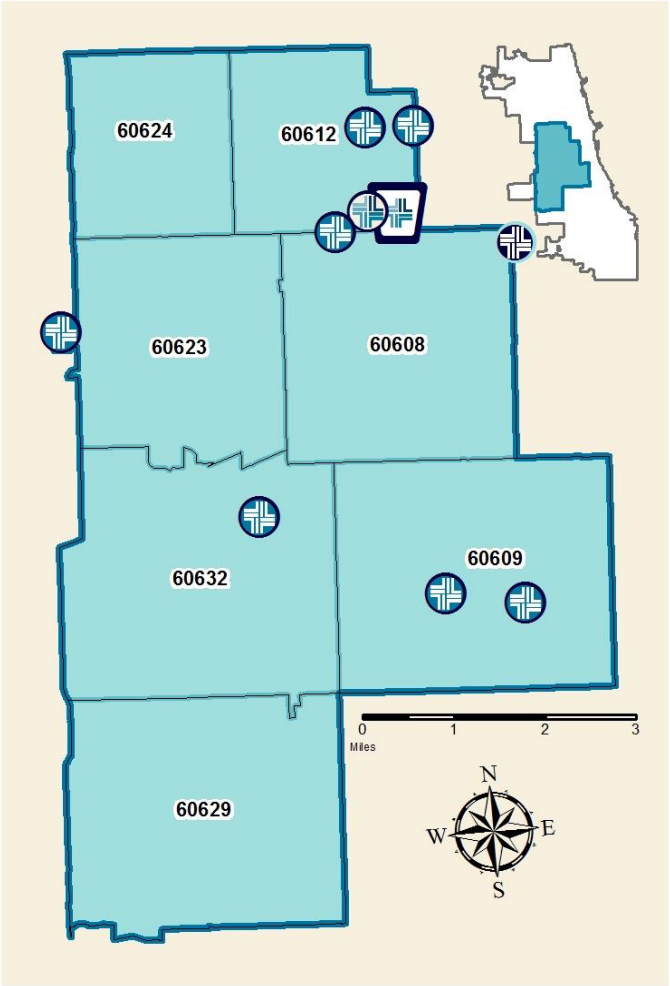
The UI Hospital is inseparable from its broader health system. The collective expertise of UI Health with its seven health science colleges brings a contemporary healthcare workforce to the task of changing healthcare delivery models. An academic environment allows performance of traditional investigation as well as community-based approaches to health identification, and health management. New members of the health care workforce can create awareness to advance programs outside of the traditional academic health center environment. UI Health has three core themes: *people, value-based care delivery, and inquiry*– each contributing to and driving health system sustainability and innovation to support the health of our community and the entire state of Illinois.

DEFINITION OF COMMUNITY SERVED

UI-CAN Community Definition

For the purposes of this community health needs assessment, UI Hospital focused on zip codes within our high Primary Service Area (PSA). UI Health's high PSA is defined as zip codes that account for more than 3% of the health system's encounters, and includes 60608, 60609, 60612, 60623, 60624, 60629 and 60632 (Figure 1).

Figure 1. UI Hospital High Primary Service Area



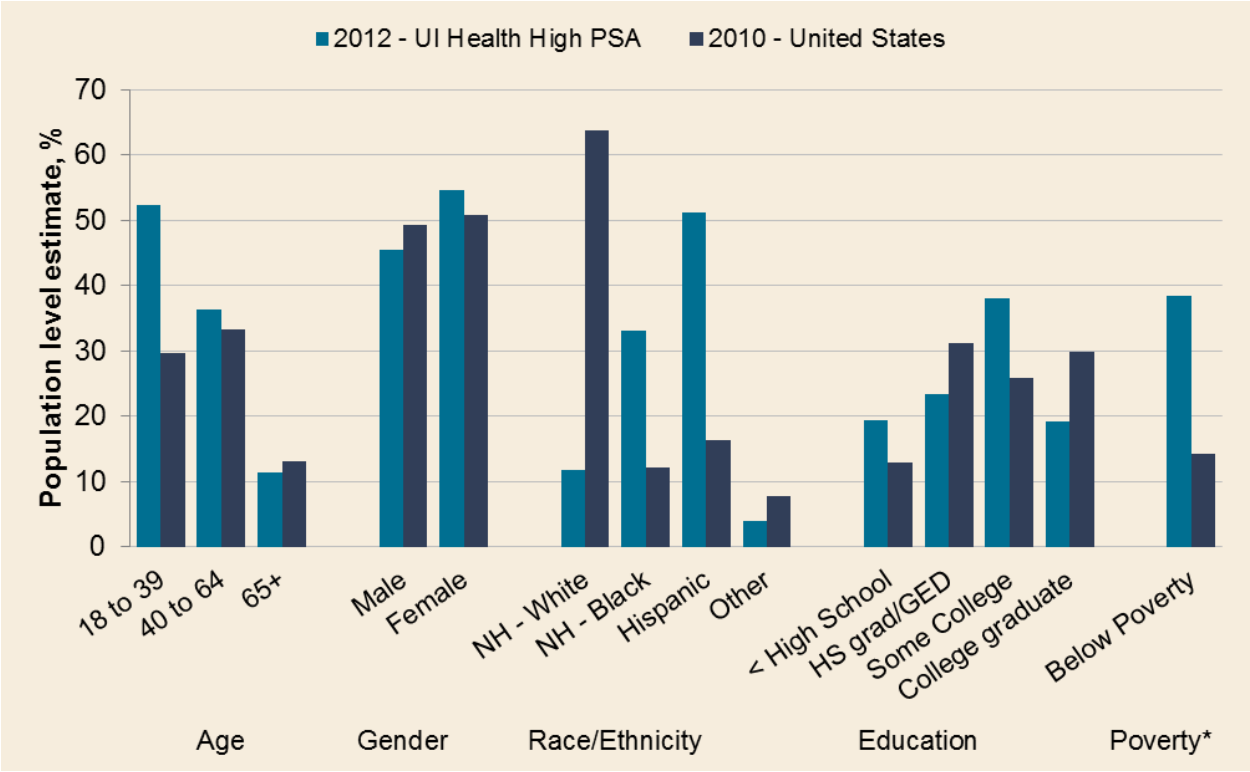
	University of Illinois Hospital and Health Sciences System
	University of Illinois Hospital
	Outpatient Care Center
	Family Medicine Center
	Mile Square Service Site

Demographics of the Community

From the 2010 US Census Data, the population in UI Health's high PSA is estimated to be 516,572. It is comprised primarily of Hispanics (51%), followed by non-Hispanic African Americans (33%) and non-Hispanic Caucasians (12%) (Figure 2). Compared to the United States, UI Health's high Primary Service Area appears to be younger, non-Caucasian, living below poverty and not completing education, both at the high school and college levels.

- Among respondents 18-64 years old, 37% reported having private insurance, while about 32% reported having public insurance (Medicaid and Medicare) coverage, and 31% reported being uninsured.

Figure 2. Demographics of UI Health high PSA

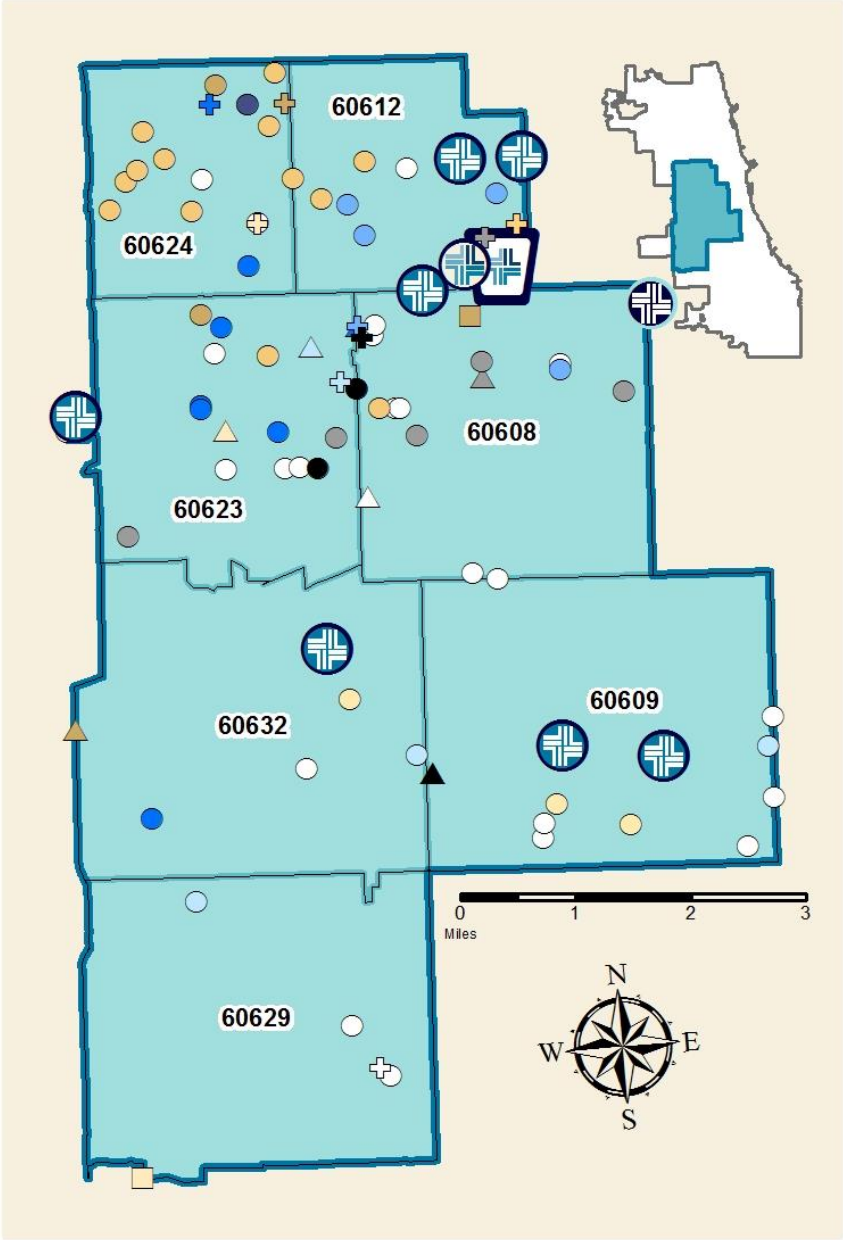


diseaseSources: 2012 PRC-UI Health Community Health Survey. Professional Research Consultants Inc.
2010 US Census Data
Notes: *Poverty was based on administrative poverty thresholds determined by the US Department of Health and Human Services.

EXISTING FACILITIES AND RESOURCES

UI Health recognizes that there are many existing health care resources within the community that are available to respond to the needs of its residents. Figure 3 illustrates resources specific to UI Health as well as all other major health facilities and resources in our high PSA.

Figure 3. Health Facilities and Resources in UI Health High PSA



UNIVERSITY OF ILLINOIS
Hospital & Health Sciences System
Changing medicine. For good.

	University of Illinois Hospital and Health Sciences System		Hospitals / Emergency Rooms / Medical Centers
	University of Illinois Hospital		Holy Cross Hospital
	Outpatient Care Center		John H. Stroger, Jr Hospital
	Family Medicine Center		Mt. Sinai Hospital & Medical Center
	Mile Square Service Site		RML Specialty Hospital
	Federally Qualified Health Centers		Rush University Medical Center
	Access Community Health Network (multiple locations)		Sacred Heart Hospital
	Alivio Medical Center (multiple locations)		Saint Anthony Hospital
	Centro de Salud Esperanza (multiple locations)		Schwab Rehabilitation Hospital
	Chicago Family Health Center		Hartgrove Hospital
	Circle Family Health Care Network (multiple locations)		**Nursing Homes / Adult Care**
	Erie Family Health Center (multiple locations)		California Gardens Nursing & Rehabilitation Center
	Friend Family Health Center (multiple locations)		El Valor Residence
	Heartland Health Outreach (multiple locations)		International Nursing and Rehabilitation Center
	Lawndale Christian Health Center (multiple locations)		Park House Nursing and Rehabilitation Center
	PCC Community Wellness Center		The Renaissance at Midway
	Hospice Care		Sacred Heart Home
	Odyssey Hospice		Schwab Rehabilitation Center
	Vitas Innovative Hospice Care		

HOW UI-CAN DATA WERE OBTAINED

Background

This assessment was conducted by **Professional Research Consultants, Inc. (PRC).** PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting **community health needs assessments (CHNAs)** such as this in hundreds of communities across the United States since 1994. This CHNA is a follow-up to a similar study conducted in 2009 and is a systematic data-driven approach to determining the health status, behaviors and needs of residents in the PSA of the UI Health System. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness. From this needs assessment, communities within our PSA may identify issues of greatest concern and therefore decide to allocate resources to those areas, thereby making the greatest possible impact on community health status.

UI-CAN Survey Methodology

This assessment utilizes data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data), which allow for comparison to benchmark data at the state and national levels. Qualitative data includes primary research gathered through a series of Key Informant Focus Groups.

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys. Questions used in this survey are able to address gaps in data relative to health promotion and disease prevention objectives and other recognized health issues within UI Health's PSA.

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 primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities. A random sample of 351 individuals, age 18 and older, in the UI Health System high PSA were selected to participate in this survey. Once the interviews were completed, responses were weighted in proportion to the actual population distribution based on the 2010 US Census, so as to appropriately represent the high PSA as a whole. All administration of the surveys, data collection and data analysis was conducted by PRC. 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 UI Health's high PSA with a high degree of confidence.

Public Health, Vital Statistics, and Other Data

A variety of secondary data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the UI Health System high PSA were obtained from the following sources:

- Center for Disease Control & Prevention
- National Center for Health Statistics
- US Census Bureau
- US Department of Health and Human Services
- Administrative data from UI Health

Benchmarks are included wherever possible and include statewide data from the CDC BRFSS, nationwide data from the 2011 PRC National Survey, as well as Healthy People 2020. This survey was also conducted through the Metro Chicago area as part of a broader study facilitated by the **Metropolitan Chicago Healthcare Council (MCHC).** Therefore, comparisons were also made at the regional level.

Community Stakeholders Input

As part of the community health assessment, four focus groups were held: one on June 19, 2012, with key informants from South Chicago, another on June 21, 2012, comprised of key informants from throughout Cook County, and two on June 22, 2012, with key informants from North Chicago Downtown/West Chicago area (Table 1). 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 a representative of public health, such as a physician, social worker, or other health professional, as well as several individuals who work with low-income, minority, or other medically underserved populations, and those who work with persons with chronic disease conditions.

Table 1. Organizations participating in key informant interviews and the populations they serve

Cook County Thursday, June 21st, Noon to 2:00 PM	Populations Served		
Organization	Medically Underserved	Low-Income Residents	Minority Populations
Addiction Services, Professionals Program			X
United Way of Metropolitan Chicago	X	X	X
Campaign for Better Health Care	X	X	X
Rush Oak Park Hospital	X	X	X
Rush University	X	X	X
Chicagoland Chamber of Commerce			
Rush University Medical Center	X	X	X
School of Public Health, University of Illinois at Chicago	X	X	X
March of Dimes, Illinois Chapter	X	X	X
Rush University	X	X	X
Cook County Department of Public Health, Oak Forest Hospital Campus	X	X	X
Access to Care	X	X	X

North Chicago Friday, June 22nd, 7:00 to 9:00 AM	Populations Served		
Organization	Medically Underserved	Low-Income Residents	Minority Populations
North Park University	X	X	X
Heartland Health Outreach	X	X	X
Heartland International Health Center	X	X	X
Thorek Memorial Hospital		X	X
Community Alternatives Unlimited	X	X	

Table 1 cont'd. Organizations participating in key informant interviews and the populations they serve

Downtown/West Chicago Friday, June 22nd, Noon to 2:00 PM	Populations Served		
Organization	Medically Underserved	Low-Income Residents	Minority Populations
Sinai Community Institute	X	X	X
Horizon Hospice and Palliative Care	X	X	X
Westside Ministers Coalition	X	X	X
Preventive Medicine, Rush University Medical Center	X	X	X

South Chicago Wednesday, June 20th, Noon to 2:00 PM	Populations Served		
Organization	Medically Underserved	Low-Income Residents	Minority Populations
La Rabida Children's Hospital	X	X	X
Centers for New Horizon	X	X	X
KLEO Center	X	X	X
South East Chicago Commission	X	X	X

At the conclusion of each key informant focus group, participants were asked to write down what they individually perceive as the top five health priorities for the community, based on the discussion as well as their own experiences and perceptions. Their responses were collected, categorized and tallied to produce the following priorities:

- Access
- Education/prevention
- Obesity, including nutrition
- Mental health
- Oral health

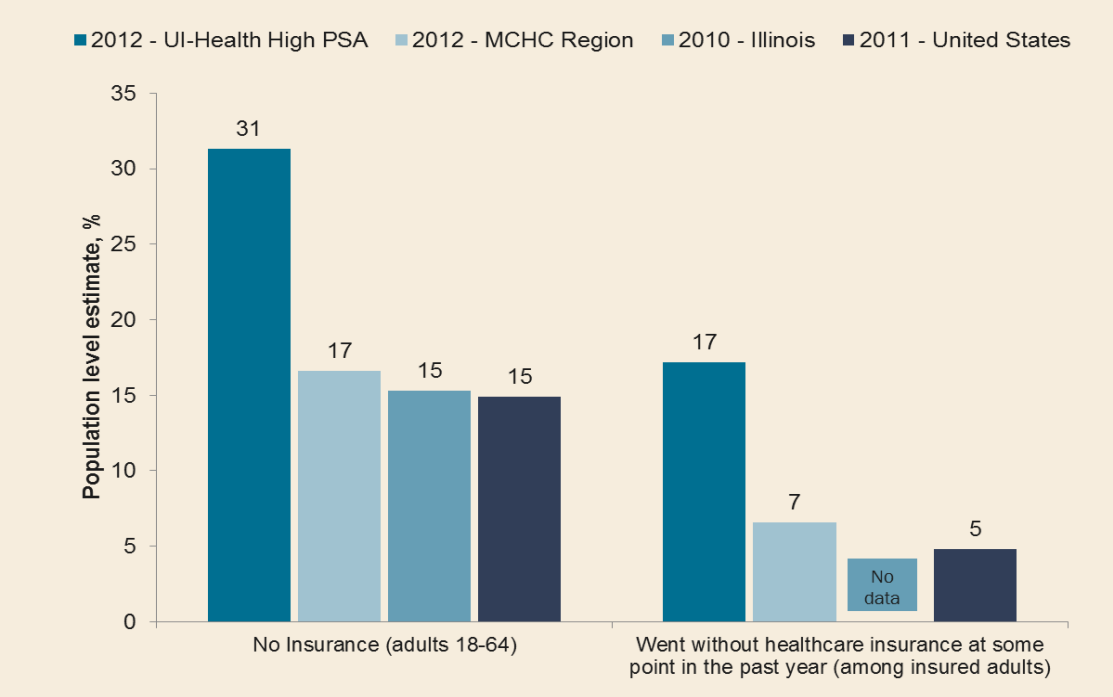
Summary of Quantitative and Qualitative data

A summary of the findings from the PRC survey and the key informant interviews are described below.

1. Access to care

- Figure 4. shows that the proportion of those uninsured is about double compared to the benchmarks
- Among insured adults, 17% reported going without insurance at some point within the past year of the survey.

Figure 4. Lack of insurance coverage among adults 18-64 years old



One key informant described another potential problem causing lack of insurance coverage: the working poor. This includes both those whose employers do not offer insurance, and those who may qualify for employer insurance but elect not to enroll because the costs are too high.

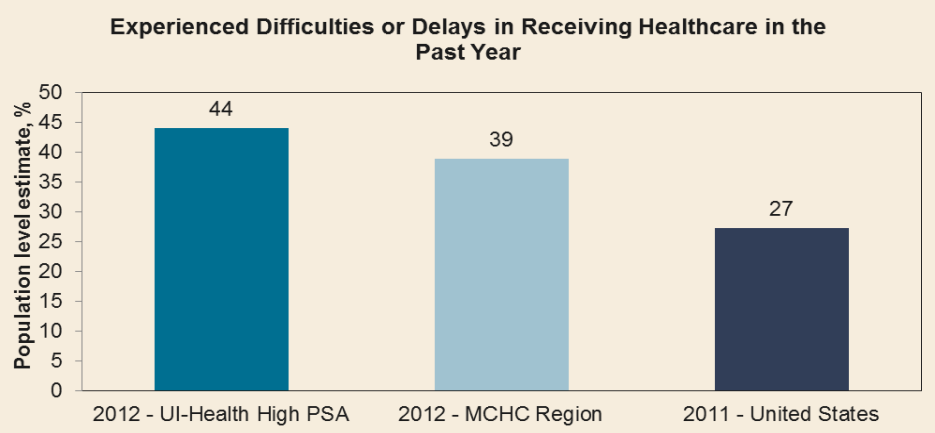
"You have the people with lots of resources, insurance, then you have folks that don't have or they have public aid. But then you have those in the middle, the working poor, so I want to just bring that up, the difficulty with those populations whereas they have employment and maybe their place of employment even offers health insurance but they cannot afford to take that" – Key informant (Cook County).

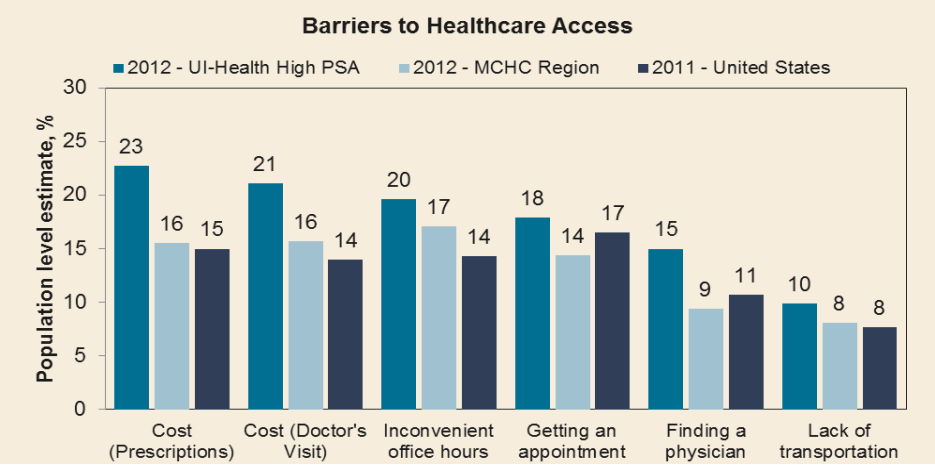
In addition to the large number of uninsured respondents in our high PSA, about 4 in 10 (44%) of the respondents reported experiencing some type of difficulty or delay in

receiving healthcare in the past year. Figure 5 illustrates barriers to healthcare access, with the most common barriers being:

- Cost (both for prescriptions and for doctor's visit)
- Inconvenient office hours.

Figure 5. Access to healthcare





The cost of healthcare and prescription medications can overwhelm families, even those with insurance. Many of the participants worry about the new Medicaid rules that require that patients with more than 4 prescriptions per month must get prior approval. Two key informants from the Downtown/West Chicago focus group discuss their concerns:

"If the doctor give the best treatment in the world and sends his patient home, and he sends them home to somebody who doesn't have enough money to buy the prescription, we are back to square one." Key informant-1 (Downtown/West Chicago)

"And it's going to be even harder to afford, now that they made the cut in Medicaid. I think I just read that they're going to pay for four medications. But it's like, 'Well good luck with that with chronic disease.'" - Key informant-2 (Downtown/West Chicago)

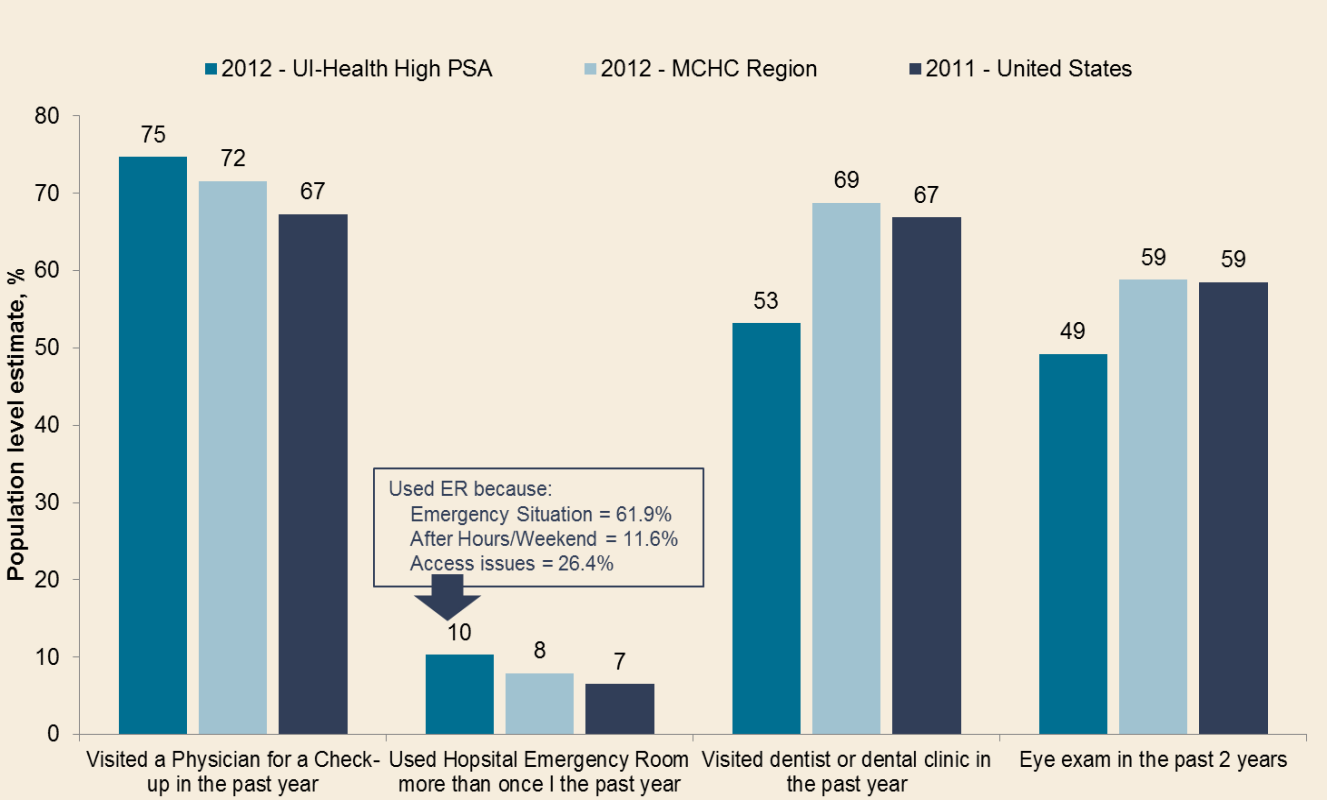
Inconvenient office hours are an additional barrier to healthcare access for respondents within UI Health's high PSA. Some respondents discussed the difficulty in taking an entire day off of work to visit a clinic because clinics close before their shifts end. These barriers can lead to decreased utilization of clinics and increased use of the emergency department (Figure 6).

Access to dental and eye care are also significant problems.

- Only 53% of respondents reported visiting a dental clinic in the past year
- Less than half of the respondents reported having an eye exam in the past 2 years

The burden from healthcare costs coupled with the lack of convenient clinic hours can lead to fragmented care for individuals in our community, which in turn can lead to increased prevalence of chronic conditions.

Figure 6. Utilization of UI Health Services



2. Follow-up Care

Improving health outcomes, particularly hospital readmissions, are of great concern not only in our health system, but also nationwide. Chronic conditions currently identified by the Centers for Medicaid and Medicare Services (CMS) as conditions with high rates of

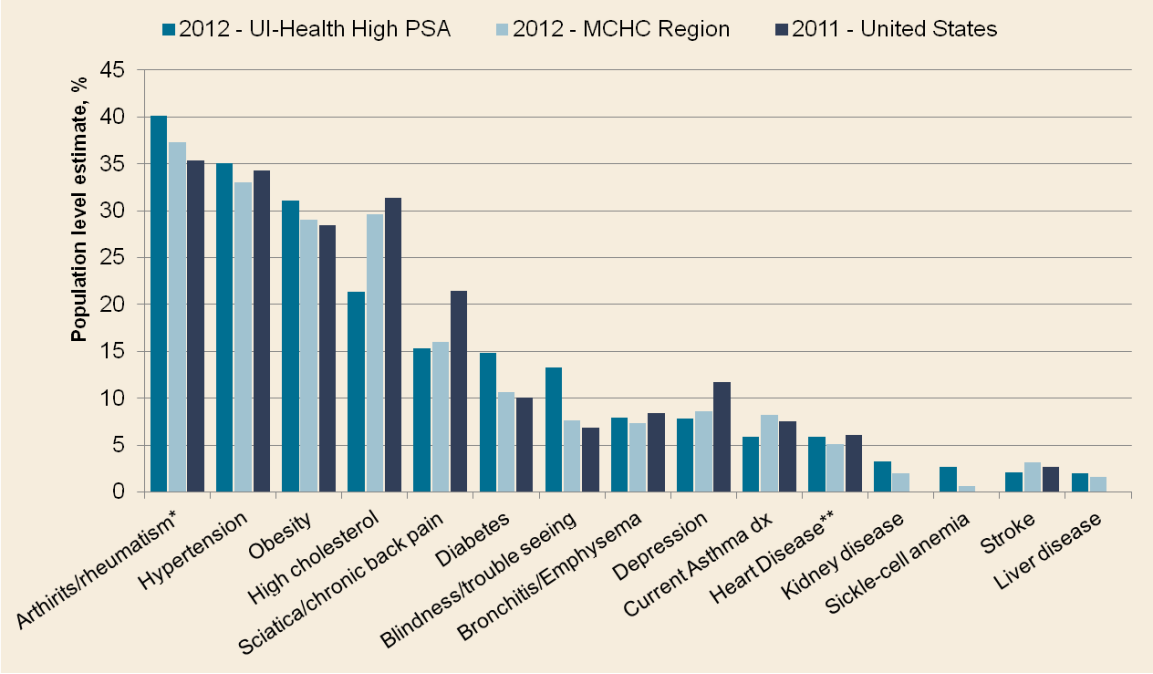
readmissions are heart failure, pneumonia and myocardial infarction. CMS is likely to add chronic obstructive pulmonary disease (COPD) and vascular procedures. These conditions, along with sickle cell, constitute populations at high risk of readmissions following discharge home from UI Hospital.

3. Chronic Conditions

Based on the data from the 2012 PRC CHNA survey, the three most prevalent conditions – arthritis/rheumatism (for adults over 50), hypertension, and obesity – are higher compared to benchmark data (Figure 7). Prevalence of diabetes and blindness/trouble seeing are also higher compared to benchmark data

- Arthritis/rheumatism = 40%
- Hypertension = 35%
- Obesity = 31%
- Diabetes 15%
- Blindness/trouble seeing = 13%

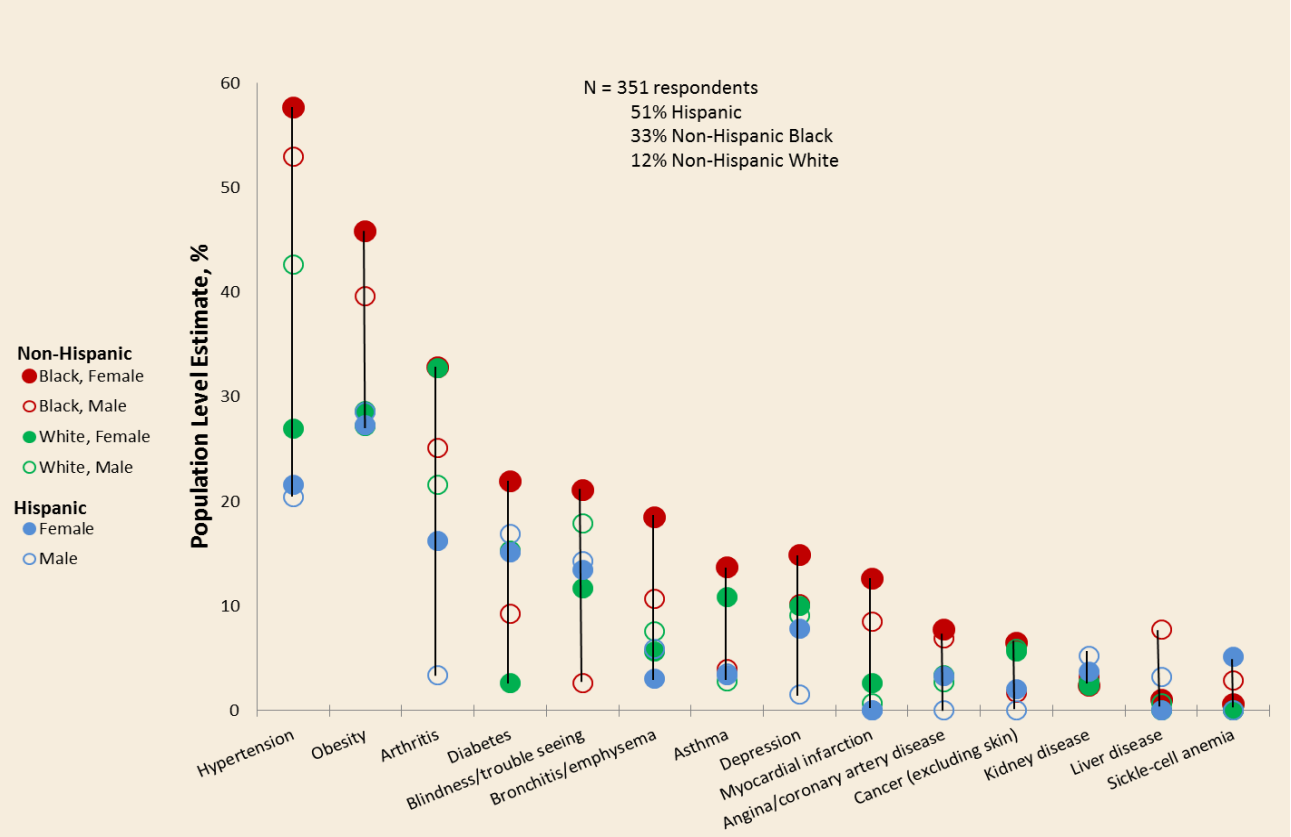
Figure 7. Prevalence of health conditions



Notes: *Arthritis/rheumatism for adults 50+ years old
**Heart disease = Diagnosis of angina, heart attack or coronary artery

There also appears to be racial/ethnic disparities for these chronic conditions, as illustrated in Figure 8. The same five conditions listed above as having prevalence higher compared to benchmark data also appear to have the greatest disparity.

Figure 8. Health disparities within UI Health's high PSA



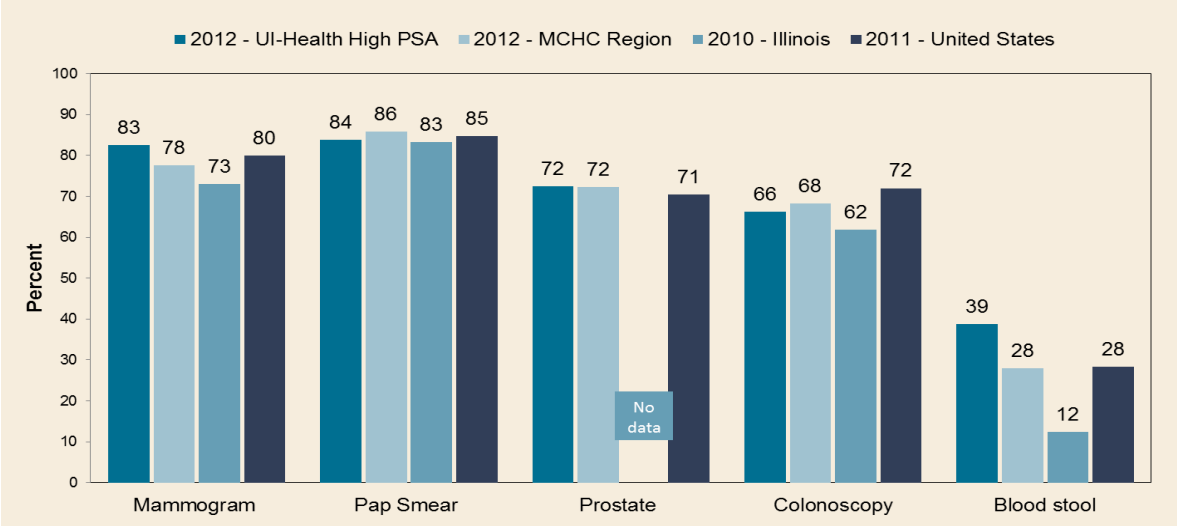
4. Cancer Screening

The following results are age-adjusted cancer death rates per 100,000 people for the city of Chicago from 2006-2008.

- Lung cancer = 51.6
- Prostate cancer = 34.6
- Female breast cancer = 26.9
- Colorectal cancer = 21.8

These age-adjusted death rates for lung cancer, prostate cancer, female breast cancer and colorectal cancer are higher compared to benchmarks. Screening methods are vital in early detection which can help in preventing deaths associated with cancer. Figure 9 shows the proportion of community residents utilizing screening services.

Figure 9. Cancer screening in UI Health's high PSA



Notes: Mammogram = past 2 years; women 50-74
Prostate = past 2 years; men 50+
Blood stool = past 2 years; adults 50+
Pap smears = past 3 years; all women
Colonoscopy = EVER; adults 50+

- 17% of women 50-74 years old have not been screened for breast cancer
- 16% of women have not had a pap smear in the past 3 years
- 28% of men over 50 have not been screened for prostate cancer
- 34% of adults over 50 have never had a colonoscopy

Information Gaps

While this assessment is quite comprehensive, 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 (e.g. the 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 (e.g. pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups) might not be identifiable or might not be represented in numbers sufficient for independent analysis. 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 a great number of medical conditions that are not specifically addressed. Additionally, telephone based surveys also have limitations, which include severe restriction on the length of the survey, increased likelihood of incomplete

responses (i.e. participants hanging up mid survey), and exclusion of certain populations (i.e. those without a phone).

Because of these gaps, we are developing an ambitious, innovative community health needs assessment that will focus on the people in our backyard. Expected to launch in the second half of 2013, **University of Illinois Survey on Neighborhood Health (UNISON Health)** will involve in-person interviews with a random sample of people who live in the Chicago neighborhoods that surround us. Our survey team will be asking questions about health behaviors, healthcare access and use, prevalence of health conditions, and quality of life. The study is being developed by the Survey Research Lab, the University of Illinois at Chicago's own nationally-recognized survey research team. The content will complement initiatives such as Healthy Chicago and Healthy People 2020, creating opportunities for joint efforts with city, state, and national partners.

UNISON Health was designed specifically to understand the health and health needs of people living in 24 community areas served by UI Health. Information from UNISON Health could also be used for evaluation or planning purposes at the level of wards, legislative districts, or other geographic units. We are eager to collaborate with public officials and community leaders to ensure that this is a shared resource that can help all of us better understand health and health needs.

UNISON Health will allow us to leverage the strengths that only UI Health can claim: high level expertise in the full range of the health sciences in Chicago, including medicine, nursing, dentistry, pharmacy, applied health, public health, and social work; an array of top-notch multidisciplinary institutes and centers with roots across the Chicago area; and a common deep and long-standing institutional commitment to our diverse communities.

We can use UNISON Health to target our efforts in ways that will truly improve health care for those who need it most. UNISON Health will help us to identify populations that may benefit most from existing clinical programs or new programs that need to be built. It can guide innovative student coursework and training about how best to work with community partners to eradicate health disparities. And it can help us strengthen and build community partnerships designed to address the needs of people our health system serves.

UNISON Health is a signature program of the University of Illinois Hospital & Health Sciences System, and the first of its kind in the country. It represents our determination to succeed in our mission to eradicate health care disparities, deliver personalized medicine, and provide high-value health for the people we serve.

Vulnerable Populations

The 2012 PRC CHNA survey yielded a wealth of information about the health status, behaviors and need for respondents within our high PSA. A distinct advantage of the primary quantitative (survey) research is the ability to stratify 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, and racial/ethnic minority groups.

HEALTH NEEDS OF THE COMMUNITY

Areas of Opportunity for Community Health Improvement

The following "health priorities" represent recommended areas of intervention, based on the information gathered through UI-CAN and the guidelines set forth in *Healthy People 2020.* From these data, opportunities for health improvement exist in UI Health's high PSA with regard to the following health areas

Areas of opportunity identified though this assessment	

Access to health care services (including medical, mental, vision and oral health)	• Lack of healthcare coverage
	  ○ Insurance instability
	  ○ Medicare supplement insurance
	  ○ Medicaid reimbursement rates
	• Difficulties accessing healthcare services
	  ○ Barriers to healthcare access (cost, hours, availability, transportation)
	  ○ Childcare
	  ○ Cultural competence
	• Specific source of care
	• Prescription misuse
	• ER utilization
	• Dental check-ups
	• Eye exams

Arthritis, osteoporosis, and chronic back conditions	• Prevalence of arthritis/rheumatism (Age50+)
Cancer screening for early detection/prevention of deaths	• Cancer deaths (Including prostrate, breast, lung, and colorectal)

Chronic conditions and factors	• Prevalence of heart-related conditions
	  ○ Hypertension
	  ○ Heart failure
	  ○ Stroke
	• Prevalence of diabetes
	• Prevalence of sickle cell
	• ER utilization due to asthma
	• Obesity prevalence (adults and children)
	• Chronic depression

Chronic kidney disease	• Kidney disease deaths
Family planning	• Teen births • Births to unwed mothers
HIV	• HIV/AIDS deaths
Injury and violence prevention	• Neighborhood safety • Violent crime • Domestic violence • Firearm-related deaths • Homicides
Follow-up care	• High readmission rates Conditions currently identified by CMS ○ Heart failure ○ Pneumonia ○ Myocardial infarction Conditions likely to be added by CMS ○ Chronic obstructive pulmonary disease ○ Vascular procedures Conditions that contribute to health disparities and high readmissions ○ Sickle cell
Maternal, infant and child health	• Prenatal care • Low birth weight • Infant mortality
Nutrition, physical activity and weight	• Fruit/vegetable consumption ○ Access to affordable produce ○ Nutrition education • Physical activity levels ○ Access to safe, affordable exercise facilities • Children's screen time
Sexually transmitted infections	• Incidence of STI's ○ Gonorrhea ○ Primary/secondary Syphilis ○ Chlamydia
Substance abuse	• Cirrhosis/liver disease • Illicit drug use
Tobacco use	• Tobacco use • Exposure to environmental tobacco smoke

Development of UI-CAN

UI Health brought together its leadership team to review the identified needs and determine the best path forward, including what data would be necessary to inform programs to reduce health disparities. Led by Dr. Jerry Krishnan, associate vice president for population health sciences, and Dr. Nicole Kazee, director of health policy and programs, this effort incorporated input from the following groups:

- UIC Survey Research Lab
- Office of Community Engagement and Neighborhood Health Partnerships
- UIC faculty and content experts across the health sciences colleges
- UI Health Science deans
- Internal Community Health Advisory Council (ICHAC)
- Partner's Council for Community Health
- Healthy City Collaborative
- Chicago Department of Public Health
- U.S. Centers for Disease Control and Prevention

Our process focused on incorporating feedback from groups that represent the community and the varied internal stakeholders, and the long term objective of obtaining the appropriate data that will best meet our needs. We will continue to work with these partners and others as we roll out the larger UNISON Health program.

Prioritization Process

After reviewing the results from the 2012 PRC survey, the following criteria were used to determine the health needs to be prioritized for action in FY2014-FY2016:

- **Magnitude**. Overall prevalence of chronic diseases and conditions, while 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 resources available.
- **Consequences of inaction.** The risk of not addressing the problem at the earliest opportunity.
- **Alignment with UI Health System Mission.** How well does the health need align with the health system's mission to eliminate health disparities.

UI Health leadership deliberated on the areas of opportunity identified though the PRC survey and after numerous meetings ranking each health need, based on the criteria above, the areas of opportunity were prioritized into two categories, high (immediate) and future needs.

Identified high priority health needs of the community

Based on the prioritization process above, UI Health leadership identified the following areas as the focus of effort for FY2014-FY2016:

1. Access to medical, mental, vision and oral health services
2. Follow-up care
3. Chronic conditions and factors
    a. Heart-related conditions (hypertension, heart failure and stroke)
    b. Diabetes
    c. Asthma
    d. Sickle cell
    e. Obesity
    f. Depression
4. Cancer screening
    a. Lung, breast, colorectal and prostate

Future priorities

In acknowledging the wide range of priority health issues that emerged from UI-CAN, UI Health determined that it could only focus on those which it deemed most pressing, most under-addressed, and most within its ability to influence. Below we list some additional priorities that our health system will examine in collaboration with providers and patients to identify the path forward. In some cases, there are already programs in place at UI Health and we will need to determine how such programs could be enhanced in collaboration with our internal and external partners. In other cases, we will need to develop new programs and identify resources to develop and sustain them. The following health needs will form the basis of future work and/or targets for collaboration with other providers in our PSA.

- Arthritis, Osteoporosis, & Chronic Back Conditions
- Chronic Kidney Disease
- Family Planning
- HIV
- Injury & Violence Prevention
- Maternal, Infant, & Child Health
- Sexually Transmitted Diseases
- Substance Abuse
- Tobacco Use

IMPLEMENTATION STRATEGIES AND ACTION PLANS

The following tables outline UI Health's plans to address those priority health issues chosen for action in the FY2014-FY2016 period.

Results from the PRC survey and the key informant interviews showed that 44% of respondents had difficulties in receiving healthcare in the past year. The most reported barriers were cost (prescription and doctor's visit) and inconvenient office hours. Also, other healthcare services, particularly dental and vision, are underutilized. Therefore, UI Health plans to address the need for greater access to healthcare services by making services more accessible to residents of our high PSA.

Access to health care services (including medical, mental, vision, and oral health)	
Goal	To increase utilization of our health system by making services more accessible
Outcome measures	Proportion of community residents reporting clinic usage in the previous year
Timeframe	FY 2014 – FY 2016

Strategies & Objectives	**Strategy #1**: Increase infrastructure and expand capacity
	• Open an urgent care facility through Mile Square in FY 2014
	• Expand clinic hours
	  ○ Add Saturday and evening hours at Mile Square locations
	  ○ Add evening hours to multiple clinics in the Outpatient Care Center (Pediatrics, Family Medicine, Physical Therapy, etc)
	  ○ Increase hours of operation for the Sickle Cell Acute Care Center
	• Provide transportation for sickle cell patients in crisis through Medex
	• Add dental clinic in the new Mile Square building

	• Increase the number of postgraduate pediatric dentistry and prosthodontic residents to expand the capacity of those clinics
	
	Strategy # 2: Link patients with comprehensive services through better integrated care
	• Develop potential care coordination models for agreements with the state Medicaid agency and other payers
	• Apply for external funding to support innovative models of coordinated care (e.g., through the Center for Medicare and Medicaid Innovation)
	• Provide optometrist for diabetic patients with vision problems in Mile Square Clinics
	• Physician outreach
	  ○ Transition adolescents with sickle cell from other institutions lacking an adult program to our adult clinic through targeted outreach calls to pediatricians
	  ○ Refer hypertensive patients visiting the ED to Primary Care Providers (PCPs) at Mile Square if patient currently has no PCP
	• Provide specialty care for some chronic conditions (asthma, sickle cell) in Mile Square locations.
	
	Strategy #3: Increase marketing to improve community knowledge about services and locations of UI Health
	• Create radio, newspaper, billboards advertisements aimed at the public
	• Implement a targeted campaign to local optometrists to increase referrals for ophthalmology specialty care
	• Conduct site visits to local emergency rooms to educate them about our specialty programs, should they need to transfer patients

Limited access to high quality care and socioeconomic resources among some patient populations contribute to hospital readmissions. UI Health developed and received funding for an innovative strategy that involves health system level interventions as well as interventions to improve patient's ability to self-manage after discharge home. The **PAtient Navigator to rEduce Readmissions program (PArTNER)** was funded as a 3-year program by the Patient Centered Outcomes Research Institute. UI Health is also developing and implementing additional care coordination programs to enhance quality of care and reduce ER visits and hospitalizations.

Follow-up care	
Goal	Develop an integrated care coordination/patient navigation strategy to improve health and health outcomes
Outcome measures	Readmission rates of target conditions from previous year
Timeframe	FY 2014 – FY 2016

Strategies & Objectives	**Strategy #1**: Provide patient navigators to guide patients through the healthcare system
	• PAtient Navigator to rEduce Readmissions grant (PArTNER)
	  ○ This project will develop and test a program that combines proactive lay patient advocates from the community in which the patient lives (community health worker, CHW) together with a peer-led telephone information line to increase self-management skills and social support in patients being discharged from our hospital.
	• Hire two additional patient navigators in oncology to help guide cancer patients
	• Use in-person navigators at Mile Square clinics
	
	Strategy # 2: Increase care coordination to ensure patients receive appropriate care
	• Implement the Emergency Interdisciplinary Care (EPIC) Coordination for Frequent ER Visitors initiative
	  ○ Using an interdisciplinary care model, this program creates and activates individualized health management programs to transition frequent ER visitors to a medical home
	  ○ Goals of the program are to enhance quality of care, improve outcomes, and lower Illinois Medicaid costs by reducing ER visit and hospitalizations
	• Create a patient-centered medical home for kidney disease
	  ○ Provides coordinated care to patients with end-stage renal disease
	• Develop potential care coordination models for agreements with the state Medicaid agency and other payers
	• Apply for external funding to support innovative models of coordinated care (e.g., through the Center for Medicare and Medicaid Innovation)

The prevalence of certain chronic conditions (hypertension, diabetes, obesity) is high among residents of our high PSA when compared to benchmarks. There also appear to

be gender and racial disparities across all chronic conditions. Because the mission of UI Health is to reduce racial and ethnic disparities, we plan to address this health need by identifying resources and increasing awareness and education to help prevent the onset of chronic conditions or to help manage and reduce the burden of chronic conditions among members of our community.

Chronic conditions and factors	
Goal	Provide resources and education and increase awareness to help prevent the onset of chronic conditions or to help manage and reduce the burden of chronic conditions
Outcome measures	Percentage of Mile Square patients with asthma, diabetes, and hypertension who meet HRSA indicators for quality of care
Timeframe	FY 2014 – FY 2016

Strategies & Objectives	**Strategy #1**: Expand specialty care at FQHCs
	• Increase physician site visits
	  ○ Allergists and pulmonologists will visit Mile Square locations to provide treatment to patients and education to PCPs about treatment guidelines
	  ▪ Potential to model for other chronic diseases
	• Increase telemedicine
	  ○ Hematologists from the University will use telemedicine to discuss sickle cell disease and treatments with patients, PCPs, and nurses at Mile Square locations.
	
	Strategy # 2: Increase focus on patient centered care to provide personalized treatments for chronic conditions
	• Chicago Home AsthMa Pediatric (CHAMP) pilot program: Reduce frequency of ED visits related to pediatric asthma exacerbations through at-home visits with a community health worker
	• PArTNER grant: Provide patient navigator to reduce 30-day readmissions for target conditions
	• EPIC initiative: Use personalized interdisciplinary care coordination to reduce ER visits and hospitalizations
	
	Strategy # 3: Increase education and awareness about chronic conditions through community outreach and screening services
	• Staff from FQHCs to attend community events and health fairs and provide education and screening for hypertension
	• Stroke Center will visit various churches in the Hispanic and

	African American community to provide blood pressure and diabetes screening along with individualized risk factor screening • Bariatrics will provide patient education to the public (available web-based) regarding nutrition and weight loss • Diabetes Wellness Program will provide diabetes and nutrition education classes in English and Spanish • Department of Psychiatry will participate in National Depression Screening Day every October • Drive awareness of sickle cell through call-to-action advertising in the African American community ○ TV, radio, billboard, online/mobile tools, etc. **Strategy #4:** Create new service lines to expand and improve treatment of chronic conditions • Heart Failure • Thoracic

The age-adjusted death rate for lung cancer, prostate cancer, female breast cancer and colorectal cancer for Chicago are higher compared to benchmarks. Therefore in order to address this health need, UI Health plans to increase awareness and utilization of screening programs in order to detect the onset of cancer early in the hopes of preventing cancer deaths.

Cancer screening	
Goal	Increase awareness and utilization of screening programs within the health system
Outcome measures	Proportion of community residents screened by targeted cancer programs from the previous year
Timeframe	FY 2014 – FY 2016
Strategies & Objectives	**Strategy #1**: Create a lung cancer screening program • Provide low-dose CT screening for patients at high risk for lung cancer at a reduced cost **Strategy #2:** Become an accredited Breast Cancer Center • Comprehensive and integrated breast cancer program beginning with the mammogram **Strategy #3:** Leverage existing resources to promote screening for colorectal and prostate cancer

NEXT STEPS

Over the next three years, UI Health will continue to evaluate the needs in the community and our progress in addressing them.

A key next step will be the launch of UNISON Health, scheduled for later this year. This will provide a more detailed examination about health behaviors, healthcare access and use, prevalence of health conditions (with a focus on chronic conditions), and quality of life, as well as key biometric data that will allow us to deepen our understanding of actual health status. In some cases, this uses the same benchmarks as the PRC survey, which will allow us to measure progress in the time since the PRC study was conducted.

The development of this study has involved representatives from key stakeholders across the university, in the community, and in public health departments. We will continue to work with all of these units to ensure that our survey is conducted appropriately and, more importantly, that we use the information we learn in ways that will truly benefit our community.

THE UNIVERSITY OF ILLINOIS HOSPITAL & HEALTH SCIENCES SYSTEM

Mission

The mission of the University of Illinois Hospital & Health Sciences System is to leverage its unique combination of clinical care, health sciences education and biomedical research in providing high-quality, cost-effective healthcare for the people of the state of Illinois and delivering personalized health in pursuit of the elimination of racial and ethnic health disparities.

Patient Care

The University of Illinois Hospital & Health Sciences System includes a 495-bed tertiary hospital, an outpatient facility, and 19 neighborhood clinics serving communities throughout the near west, south and southwest sides of Chicago. UI Hospital remains among the nation's leaders in patient care developments that are changing medicine for the better, and making positive and lasting differences in health science and in people's lives.

Education

For more on education, visit the College of Medicine

Research

The University of Illinois Hospital & Health Sciences System is one of the very few institutions in the country (and the only one in the State of Illinois) with research faculty across all of our health sciences colleges. Our research spans the full spectrum of biomedical investigation, from understanding the molecular basis of disease to improving the health of populations.

Community Commitment

The University of Illinois Hospital & Health Sciences System is committed to improving the quality of life of people living in Chicago as well as the state of Illinois. Through Community Outreach programs, we strive to make the many resources of our hospital and health sciences system accessible to the communities we serve, resulting in a lasting and positive impact on health and wellness today and tomorrow.

Contact Us

Vice President for Health Affairs Administration
914 South Wood Street (M/C 973), Chicago, IL 60612
Web: http://hospital.uillinois.edu/CHNA
Email: uican@uic.edu

University of Illinois
Hospital & Health Sciences System
Changing medicine. For good.