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# Illinois – Working to Make Health Primary

***Home Centered Care Improving Health Outcomes, Reducing Costs and Hospital Admissions for the Aging Population***

- People 65 years or older are the fastest growing age group in the United States, and the highest utilizers of costly hospital and nursing home services. Without a change in approach, the demand and costs for long-term services and support will increase as our society ages.
- Dr. Thomas Cornwell realized the benefits of utilizing house call programs to service this complex and costly patient population. In 1997, he founded a community hospital-sponsored house call program to provide quality, affordable care in the comfort of elderly patients' own homes.
- Lab tests, EKGs, X-rays, ultrasounds, IVs and other forms of modern medical technology offered at a hospital are used in the patient's home, helping to reduce hospital readmission and health care costs.
- Providing care in the home also ensures the patient-physician connection continues after hospital discharge, further reducing costs.
- Dr. Cornwell's supporting hospital, Northwestern Medicine Central DuPage Hospital, is one of only three hospitals in Illinois (of 127 Illinois Hospitals) that has never received a readmission penalty.
- Building off the success of his house call practice, Dr. Cornwell founded the Home Centered Care Institute in 2012, which is a collaborative, not-for-profit organization dedicated to the national expansion of house call practices and the integration of community resources.

***Health Plans Investing in Value-Based Care Models***

- Blue Cross Blue Shield of Illinois (BCBSIL) has been implementing local, value-based care models for over two decades and has continually refined and improved the model every year.
- Today, the BCBSIL program works with 75 medical groups and covers more than 700,000 members under a program that rewards quality of care over volume of care.
- In 2015, BCBSIL launched four new coordinated care groups in its continued effort to lower medical costs while improving health outcomes. With the addition of these new groups, BCBSIL now has nine Accountable Care Organizations (ACOs) in Illinois serving more than 450,000 patients.

***Student Partnerships in Chicago's South Side Improve Community Health, Transform Future Primary Care Workforce***

- Youth on Chicago's South Side face critical public health issues, including obesity, violence and sexual health. As director of the University of Chicago Medicine's Summer Service Partnership (SSP), Dr. Kohar Jones partners medical students on teams with local youth to promote community health and address health disparities.
- University of Chicago students from the Pritzker School of Medicine, Social Services Administration and pre-health college students work with high school students from the South Side on a tiered mentoring summer service-learning program. SSP empowers youth to address the social determinants of health through a community health service project, through which they learn critical skills in teamwork and community engagement.
- From addressing obesity through bilingual nutrition classes at a local middle school to creating a YouTube video where teens teach teens about safe sex, SSP mobilizes youth to be a voice for health in their communities, while transforming the training of our future primary care workforce.

***Family Medicine and the City of Chicago Fight to Curb Tobacco* Use**

- In 2011, the City of Chicago launched its "Healthy Chicago" initiative. Dr. Carolyn Lopez and the other eight members of the Chicago Board of Health were challenged with tackling the city's public health agenda—including curbing adult and youth tobacco and e-cigarette use.
- At the time, the city's smoking rate among high school students was above 13 percent—with 80 percent of adult smokers starting at age 18 or younger.
- By focusing on innovative approaches and working alongside the family medicine community to counter tobacco industry opposition, the city was able to decrease the smoking rate among high school students by 20 percent in two years.
- Today, smoking rates among adults and youths are at an all-time low, resulting in notable savings for the state—thanks, in large part, to efforts like those supported by the Chicago Board of Health, Dr. Lopez and the family medicine community.

***Improving End of Care Life in Illinois and the Nation***

- During the past decade, the hospice industry has experienced substantial growth in the number of hospice programs and patients served.
- Dr. Javette Orgain has been a leader in the hospice movement through her former and current work with VITAS Healthcare, formally Vitas Innovative Hospice Care.
- Interdisciplinary hospice teams have helped to preserve the quality of life for those who no longer respond effectively to treatment and have a life expectancy of six months or less. These teams have helped reduce health care costs by enabling patients to be cared for primarily at home in a supportive environment or in an inpatient hospice unit whenever possible.

- At the end of life, greater continuity with primary care is generally associated with reducing avoidable hospitalizations,[1] less emergency department use,[2] and increased out-of-hospital deaths for patients with a terminal illness.[3]

***Integrating Mental Health into Primary Care to Transform Youth Mental Health Services***

- Children's mental health issues are common but often under-recognized and undertreated. Services are often fragmented and providers are often unaware of the wide range of community resources and how to link successfully to them.
- The stigma and lack of community-based mental health promotion often mean that children do not get the help they need, resulting in a greater incidence of mental illness.
- Dr. Janet Albers and family physicians at the Southern Illinois University (SIU) School of Medicine are integrating mental health with primary care in the medical home to transform the way mental health care is provided to youth.
- SIU Family Medicine has focused on community outreach to public schools. This includes SIU's Care-A-Van in Carbondale, a school and rural health center on wheels that provides teen-friendly medical and behavioral/ mental health services to students at partnering schools in the region.
- In addition, the Meaningful Opportunities for Success and Achievement through Service Integration for Children (MOSAIC) project in Springfield and the SIU Peds Care program in Quincy both provide screening and intervention for social, emotional and behavioral health issues for children in the medical home, as well as partnerships with schools and neighborhood settings.
- As a result of integrated mental health in primary care, school attendance has improved, patient engagement in care has increased and there are fewer appointment no-shows.
- An integrated team led by family physicians and including advanced practice professionals, behaviorists and psychiatrists within the medical home makes care seamless for children and families. Early screening of mental health is promoted, and children's stigma towards mental health is reduced.

***Teaching the Value of Primary Care and Serving the Underserved***

- Nearly 50 million people lack access to primary care because of physician shortages in their communities. This shortage is projected to reach 91,500 by 2020.
- To maintain the status quo, Illinois will require an additional 1,063 primary care physicians by 2030, a 12 percent increase of the state's current (as of 2010) 8,832 practicing primary care providers (PCPs).
- Training physicians for the opportunities and challenges in caring for medically underserved communities in an outpatient setting is a priority for Dr. Deborah Edberg and her team at a

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[1] Cheng SH, Chen CC, Hou YF. A longitudinal examination of continuity of care and avoidable hospitalization: evidence from a universal coverage health care system. Arch Intern Med. 2010;170(18):1671–1677. doi: 10.1001/archinternmed.2010.340.

[2] Burge F, Lawson B, Johnston G. Family physician continuity of care and emergency department use in end-of-life cancer care. Medical Care. 2003;41(8):992–1001. doi: 10.1097/00005650-200308000-00012.

[3] Burge F, Lawson B, Johnston G, Cummings I. Primary care continuity and location of death for those with cancer. J Palliat Med. 2003;6(6):911–918. doi: 10.1089/109662103322654794.

Teaching Health Center (THC) residency program, which is funded by the Health Resources and Services Administration (HRSA) and housed at Erie Family Health Center in Chicago.

- In addition to participating in traditional hospital and specialty rotations, the THC residents spend most of their time providing comprehensive primary care to more than 7,000 patients in Humboldt Park – a low-income, predominately Hispanic community on Chicago's west side. The THC also expanded Erie's capability to provide services each year by nearly 3,000 patients and created 28 jobs in the community.
- THC-trained physicians are three times more likely to work in a community health center or other safety-net primary care settings after completing the program. Nearly all of last year's graduates from the THC program have chosen to remain in safety-net primary care, addressing critical provider shortages in these communities.
- The THC program trains young doctors to be future community health center leaders, advocates, and researchers and continues to be a highly competitive residency that attracts the best caliber candidates to primary care.

***Team-based Practice Environments Prepare Future Health Professionals, Improve Patient Health Outcomes***

- Loyola University Chicago is transforming the way it trains future health care professionals by integrating them into team-oriented practice environments to improve population outcomes, especially in underserved communities.
- The Loyola I-CARE-PATH program, funded by the Health Resources and Services Administration (HRSA), provides comprehensive care to patients while helping educate nursing, medical, dietary and social work students to work as a coordinated care team through the Interprofessional Education and Collaborative Practice (IPECP) model.
- For example, as a registered dietician at Loyola University Chicago's Marcella Niehoff School of Nursing, Mary D'Anza helps care teams provide nutritional guidance to patients, many of which have multiple conditions.
- Care teams that are part of Loyola's I-CARE-PATH program have improved health outcomes, increased access to medications and services, and improved patients' lifestyle behaviors.

**Diabetes Complications Reduced Through Prevention and Community Collaboration**

- NorthShore University HealthSystem and the Lake County Health Department/Community Health Center recognized that many of the complications that local diabetes patients suffered could have been prevented.
- The organizations joined forces to create "Be Well-Lake County," a fully comprehensive diabetes management program that provides more than 1,000 medically underserved patients with disease management, subspecialty care, assistance with medication and testing supplies, on-site Hemoglobin A1C testing, an exercise training component, and a community garden.
- As a result of the program, overall diabetes complications were reduced; more than half of the participants lost weight while others saw decreased Hemoglobin A1C levels.

***Family Doctor Makes House Calls in Chicago's South Side to Address Health Disparities***

- Chicago's South Side is home to some of the city's most underserved and dangerous neighborhoods, where many residents lack access to basic primary care services. In addition, many young adults from these under-resourced neighborhoods struggle to complete advanced degrees like medical school.
- Dr. Fred Richardson, a family physician and native of Englewood, returned to Chicago's South Side after medical school to become a solo practitioner, serving the same neighborhoods he grew up in. Dr. Richardson has been making house calls for seniors and the disabled in the south side neighborhoods since 1990. He also mentors and teaches minority students who are struggling with medical school, many of which have been on probation or dismissed.
- Dr. Richardson's work over the past two decades has improved access to care for underserved communities, as well as helped dozens of minority students stay in medical school to finish their studies.

***Stakeholder Collaboration Empowering Employees to Self-Manage their Chronic Diseases***

- Effective chronic disease management prevents other health complications, reduces associated hospitalizations and costs, and is crucial to overall health.
- Recognizing that both employers and their employees could benefit from chronic disease management, the Midwest Business Group on Health and the Illinois Pharmacists Association (IPhA) partnered to create a chronic disease management program that uses a value-based benefits model to improve quality of care and reduce overall health care costs.
- The program, called "Taking Control of Your Health," asks employers to waive co-payments for medications and supplies for chronic conditions. In return, employees voluntarily participate in regular visits with specially trained local pharmacists, who provide regular screenings and coaching and coordinate care with patients' primary care physicians.
- Through incentives and collaboration, the program motivates patients to self-manage their conditions, resulting in a reduction in preventable hospitalizations, healthier workers and a decrease in overall health care costs.