Focusing on Chiari

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The South Side’s 19 health centers offer medical homes to patients in neighborhoods surrounding the University of Chicago Medical Center. Working together, the medical center and these clinics will make for a healthier South Side.

Illustration by Nora Morales
James Kinney didn’t have a primary care doctor when he checked into the emergency room in excruciating pain last summer. The uninsured electrician didn’t have anywhere else to turn.

But by the time he left the hospital, he’d set up a follow-up appointment at a health clinic in his neighborhood on 115th Street. Now, almost a year later, the 65-year-old man visits that clinic for check-ups every three months. The clinic charges him based on his income, and the regular check-ups prevent any little medical concerns from growing into big problems.

“It’s been great,” Kinney said. “Very convenient.”

The University of Chicago Medical Center would like a few thousand of Kinney’s neighbors to follow his example. That’s why the university is building partnerships with local health centers and clinics: both to improve patients’ health and to relieve stress on the emergency room.

This year alone, there will be some 60,000 patient visits to the medical center’s adult emergency room, and roughly a quarter of them—15,000 visits—will be by people who use the ER as their only form of medical attention. These are people who have no primary care physician or “medical home.”

“It’s cultural,” said Michelle Obama, vice president for community and external affairs at the medical center, herself a South Side native who, following the lead of her parents and grandparents, grew up unaccustomed to regular physical check-ups. “If you don’t believe you can afford to go to the doctor, you don’t go.”

That’s a problem for lots of reasons. For one, basic medical care can prevent patients’ problems from erupting into emergencies.
For another, because the medical center is a research facility with internationally ranked physicians and scientists, it costs more for the same treatment than does a typical community hospital. And because the medical center is located among some of the poorest Chicago neighborhoods, it sees more uninsured patients and Medicaid patients—the very people who have the most trouble paying—than any other private hospital in the state.

With the recent Cook County budget cuts closing half of the county’s 26 health clinics, basic medical care will be even more challenging for Chicago’s poorest.

If many of the patients coming into the medical center’s ER had received primary care elsewhere they could have avoided a trip to the hospital. In fact, preventable hospitalization costs for diseases such as asthma and diabetes are three times higher in this community than in the rest of the state, Obama said.

Obama said the medical center takes partial blame for overshadowing the smaller clinics with marketing. “For decades we had been an institution operating in isolation,” she said. “We didn’t know these other physicians; we didn’t know their names.”

So medical center leadership, concerned physicians such as Chief of Emergency Medicine Jim Walter, MD, and the community affairs office have begun building those relationships. In 2004, they started “knocking on doors” of community health centers and clinics to establish partnerships.

That year, the number of people who used the ER at least three times per year (called “frequent users”) had jumped by 26 percent.

A year later, the medical center received a two-year Healthy Communities Access Program (HCAP) federal grant—one of 230 grants nationwide totaling $430 million. With it, the medical center officially implemented the South Side Health Collaborative in February 2005.

The transformation is proving to be more a subtle shift than a raucous revolution. At its heart are “patient advocates.” For the past two years, a small group of these medical center employees, funded by the HCAP grant, have matched medically homeless patients with primary care physicians. The advocates listen to patients’ needs and concerns, show them maps of the community clinics and schedule appointments.

“It’s cultural. If you don’t believe you can afford to go to the doctor, you don’t go.”

—Michelle Obama, Vice President for Community and External Affairs

Sir Williams, one of the advocates, sees from 20 to 30 patients during his 10-hour shifts in the emergency room. “It’s cool if I see you in the ER today and then don’t ever see you again,” he said. After all, most people don’t want to spend hours in a congested waiting room and then another hour or two in a curtained room waiting to see a doctor they’ve never met.

“This isn’t a unique problem,” Obama said. “You’ve got Medicaid and Medicare that work somewhat, but many people are falling through the cracks.”

More than 1,000 community-based Federally Qualified Health Centers, established specifically to help those in poverty, exist in the United States. They serve 11 million patients, nearly half of whom are uninsured. So far, the collaborative has connected more than 1,500 patients with primary care medical homes that the patients didn’t know existed before.
Building relationships quickly

On a typical day in the emergency room, patients’ stories may sound remarkably similar. Charletta Frazier, 26, says she has checked into an emergency room three times in the past year. Sharon Rowlett, 37, who currently has no insurance, has made “three or four” trips in the same amount of time. And 66-year-old John Sanders, whose wife came up from Texas to help him, feels too sick to talk.

They’re all in the ER for different reasons, but each lacks one crucial thing: a doctor who might have prevented the daylong trips to the hospital. This is where the patient advocates—Williams and four others who occupy the ER virtually 24/7—come in.

Advocate Brenda Daniels waited until a physician had resolved Frazier’s emergency before talking with her about follow-up care. Their conversation was casual and quick.

“You have a very pretty name,” Daniels said to break the ice. And within seven minutes, they set up Frazier with other medical services.

Daniels handed Frazier a brochure with a map of South Side health centers inside. The SSHC offers 19 community sites via 10 partners where patients can establish medical homes. “Generally people like to pick places near their homes so it’s not a big stretch,” she said.

Studying the map, Frazier pointed to one center located on 75th Street and Jeffrey Avenue. Daniels checked the large blue binder in her lap that contains many of the health centers’ appointment schedules.

“Dr. Bearden is in the office from 2 to 5 p.m. on Tuesdays and Thursdays,” she said, still focused on the schedule. “He’s got a 4 and a 4:30 this Thursday, Dec. 7.”

She looked up to see Frazier nodding. When Frazier inquired about OB/GYN services, Daniels told her that Bearden would refer her to a specialist.

“Essentially the patient advocates are marketing for other health centers,” said Mishra, director of SSHC operations and the person to whom the advocates report. “They speak on behalf of the doctors.”

It’s not quite sales work, but the advocates’ job is to change people’s views of the medical world. “That’s the hardest part, the education piece,” Williams said. “People are so set in their ways.”

Many of these patients—had they received primary care elsewhere—could have avoided a hospital stay altogether.

Patient advocate Wanda Trice (top) notes a patient’s answers to a series of health care questions, among them: Are there reasons you don’t have a regular doctor? At left: Physicians in Chicago’s constantly overcrowded ER check patient waiting lists and call inpatient floors in search of an available bed. Top photo by Dan Dry, left photo by Eric Herzog

96% are African American
93% live in the 12 zip codes that surround the medical center
72% are 20 to 50 years old
68% have completed high school
63% are female
42% rely on Medicaid
31% are employed full time;
30% are unemployed
15% have asthma
15% have high blood pressure
10% have anxiety or depression
8% abuse drugs and/or alcohol

This proves true for patient Rowlett. But when advocate Wanda Trice met with her, Trice explained that because she is uninsured, the Chicago Family Health Center would charge her based on a sliding scale. Rowlett nodded, and appeared slightly relieved. “I never went [to a physician] because I have no insurance. They’d just give you the run-around from this person to that person,” she said of her attempts to schedule appointments.

However, even when a patient has insurance, the current state of U.S. health care often resembles a mess of not one, but many tangled webs. For that reason, the South Side Health Collaborative seeks both to clean the mess and to change a culture.
Advocates and the ER

58 times.
That's how many visits one homeless man made to the emergency room last year, Williams recalls.

Sometimes “they come in just for warmth,” Williams said, “or for a boxed lunch.”

To that man, the ER serves a much different purpose than to a lawyer on the North Shore or, for that matter, to Williams, who, even after an internship at the medical center, didn’t know exactly how to use the ER. “Say you have back pain for three months and suddenly decide to go to the emergency room. In the ER they’re going to ask, ‘Why is this an emergency now and not three months ago?’”

Within his eight months of advocate work, Williams has learned those particulars. He knows that when the ER is packed, with patients in the rooms and patients in the lobby waiting for rooms, that doesn’t necessarily mean he’ll be busy. When the beds in the main hospital are full, the ER overflows because patients have nowhere else to go. When this happens, Williams and the other advocates make their way through the patients waiting for hospital beds. However, they can’t see anyone in the waiting room due to privacy regulations.

Each advocate comes from a different background and training. Daniels, for example, was the ER’s lead coordinator and then left for a few years before she applied as an advocate. Trice—the longest-serving advocate, hired at SSHC’s inception at the medical center—comes from a social services background. She applied for the position partly because she lives nearby. Williams came from volunteerism and plans to eventually move into law.

Each day, he checks the computer list of patients to see who doesn’t have a medical home. When a name comes up flagged, Williams grabs his papers and blue appointment binder and heads to one of the curtained rooms.

“What we feel is most important is that all of our patients have someone to follow up with,” he said before pulling the curtain aside.

From the bed, a young woman looked up, slightly alarmed. Williams introduced himself and explained his role. People can get confused, he said; they sometimes mistake him for a physician and start telling him their health problems. Up front, he told the young woman what he was there to do. “Let me get this information from you, and then we’ll pick a place together,” he said.

When he asked her if she had a primary-care physician, just as the paperwork asked her when she checked in, she reiterated the “no.” Although 48 percent of patients who check into the ER answer no to the survey question, half of them really do have a primary-care physician. The language confuses them, Mishra said, adding that people’s perceptions differ among the terms “primary-care doctor, medical home and general physician.”

With Williams’ help, the young woman was no longer one of the confused. She gave Williams her address and immediately he spouted off health centers close to her home. Like learning the ins and outs of health insurance plans, “It’s something you just pick up over time.” Williams said.

The woman looked down at the map. No. 13 on South Michigan Avenue was the Illinois Eye Institute; an asterisk next to its name signified on-site financial counselors. “That’s really close. That’s walking distance from my house,” she said, visibly encouraged by the newfound medical option.

SSHCC PRIMARY CARE PROVIDER ACCOMPLISHMENTS

The six-month post-visit chart review of the first 320 patients who had their first appointment with an SSHC provider shows that these patients are establishing a primary care medical home.

Of patients referred to the two senior centers, 71% have had a Mini Mental Status Examination and 33% have been given the pneumococcal vaccine.

Screening and prevention tests are being conducted. The most frequent is a cholesterol determination test for 53% of patients.

Patients are returning to SSHC primary care providers for ongoing care; 38% of patients have been seen two or more times.
Just as Daniels did for Frazier, Williams consulted the appointment binder and rattled off several 3 p.m. appointments in the coming weeks and a 9:30 a.m. Saturday appointment. The woman opted for the latter because, she said, “I won't have anyone to pick up my kids otherwise.”

As Williams wrote his name and contact information on the back of the woman’s brochure, he listed what she needed to bring with her to the appointment, including $15 to $20. The health centers aren’t free for patients, but many charge on a sliding scale based on income.

“What we feel is most important is that all of our patients have someone to follow up with.”

—Patient Advocate Sir Williams

With that, Williams headed back to his seat at one of the two main ER stations. His conversation with the woman lasted barely 10 minutes, but it was one that could end up saving the woman—and Chicago’s ER—thousands of dollars.

“I’ve always wanted to do something to help people,” Williams said. Ultimately, he’d like to attend law school and has been considering health law ever since becoming an advocate. “I really feel that health care is the basis for everything. This is a good way for me to be in on the ground floor, to talk to the people.”

### Leadership and the future

Exactly how much time and money this will save the medical center and the people of the South Side—and how much it will improve the general health of local patients—is impossible to pinpoint. The estimated figures alone were enough to enable Obama to convince the medical center to continue funding the advocates even after HCAP ran its two-year course.

Through follow-up phone calls, focus groups and kept appointments at the 19 involved sites, the medical center—via its patient advocates—has made “several thousand linkages,” Obama said.

The medical center’s relationships with its neighbors have blossomed in those two years. “We’re learning from one another,” Mishra said. Without those partnerships, it would be more difficult for the medical center to approach community health centers and try to help one another.

In focus groups, Mishra said responses from patients who have tried the health centers were very good overall, but that “not all were glowing.” Some patients cited long waits at the FQHCs or concerns about cleanliness.

“We’re going to focus on those challenges,” Mishra said. “Now we can open that first conversation, say, ‘Hey, maybe we can help you out with that carpeting,’ because it helps the perception. It allows both partners in the collaboration to push back on each other.”

Walter said that the ER staff is especially passionate about the collaborative because “we think it’s exactly what our patients need. We are very proud that our collaborative has served as a national model for how the ER and community providers can work together on behalf of patients.”

However, the effort seems essential at this point. “We had been able to survive as an island,” Obama said, “but now the world is seeping in, and our salvation will be the success of our partners.”