

Community Asthma Coalition

Action Learning, Action Research, Participatory Research

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Thank You

- Dr. Caress Dean helped with the initial evaluation design of this project.
- Dr. Sameer Vohra & Dr. Jeanne Koehler are my partners in this work.
- Kim Luz and Megan Williams at HSHS St. John's Hospital have contributed data and dollars to this project.



By the end of this session...

- Who needs to be educated about Social Determinants of Health, and how should we do that?
- Why do medical providers need to build community coalitions in response to clinical conditions?
- What frame can you use to think about population-level solutions?

What do you want to know?

- Creating Momentum
- Broadening Scope
- Coalition Building Process
- Who we are educating?

Quick Overview

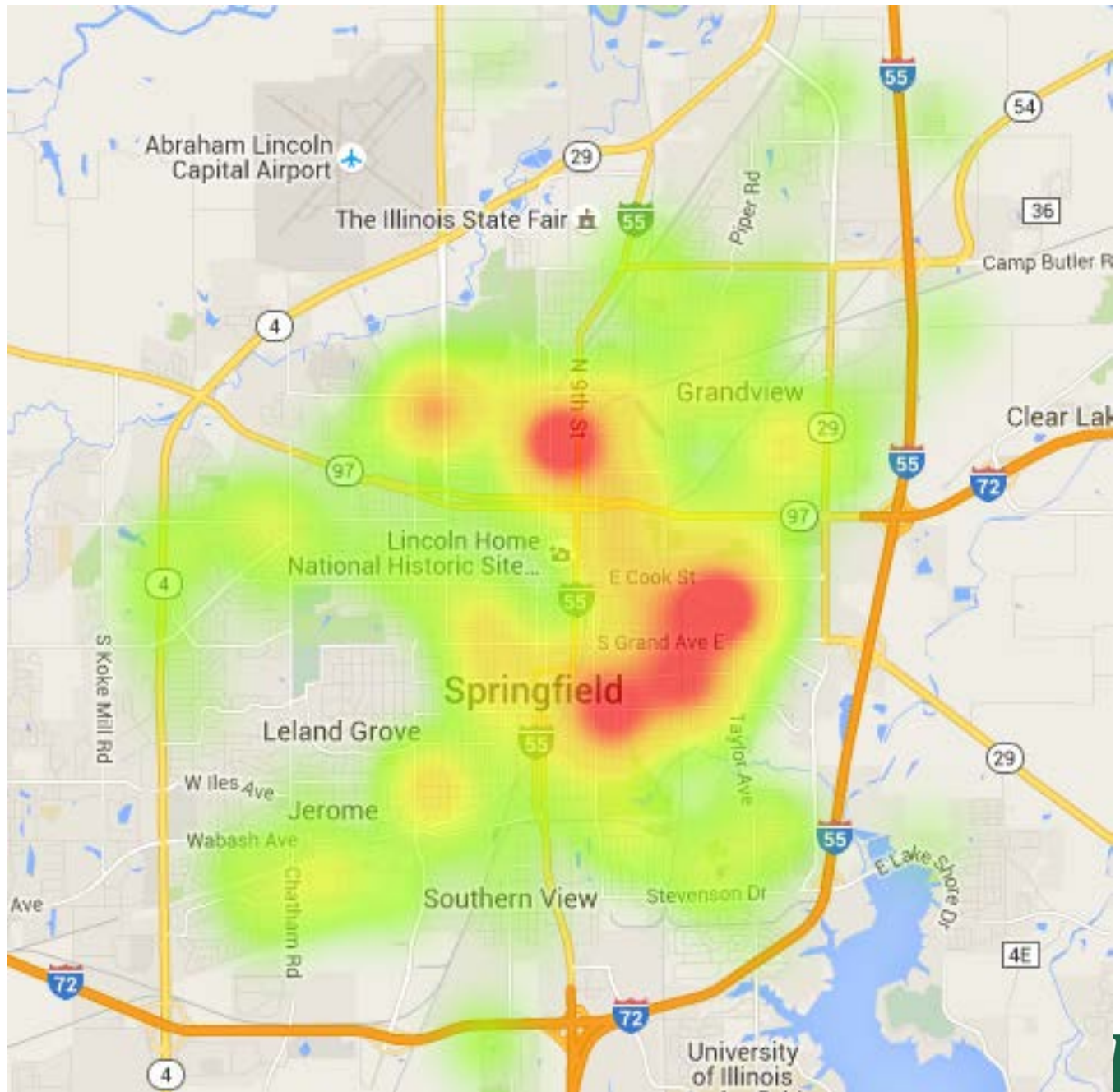
- Armed with a Community Health Needs Assessment (CHNA) identifying asthma disparities as a community priority, and information from our legal partners about housing conditions, we met with the state health department, and received a small grant which enabled us to fund a pilot study around asthma triggers.
- We leveraged our title as the “Sangamon County Asthma Champions” to start building a coalition of healthcare workers, our newly minted Medical-Legal Partnership, the state and local public health departments, and the local children’s hospital, and the school nurses, to tackle the wide range of socio-economic factors leading to poor asthma control in children in certain zip codes.





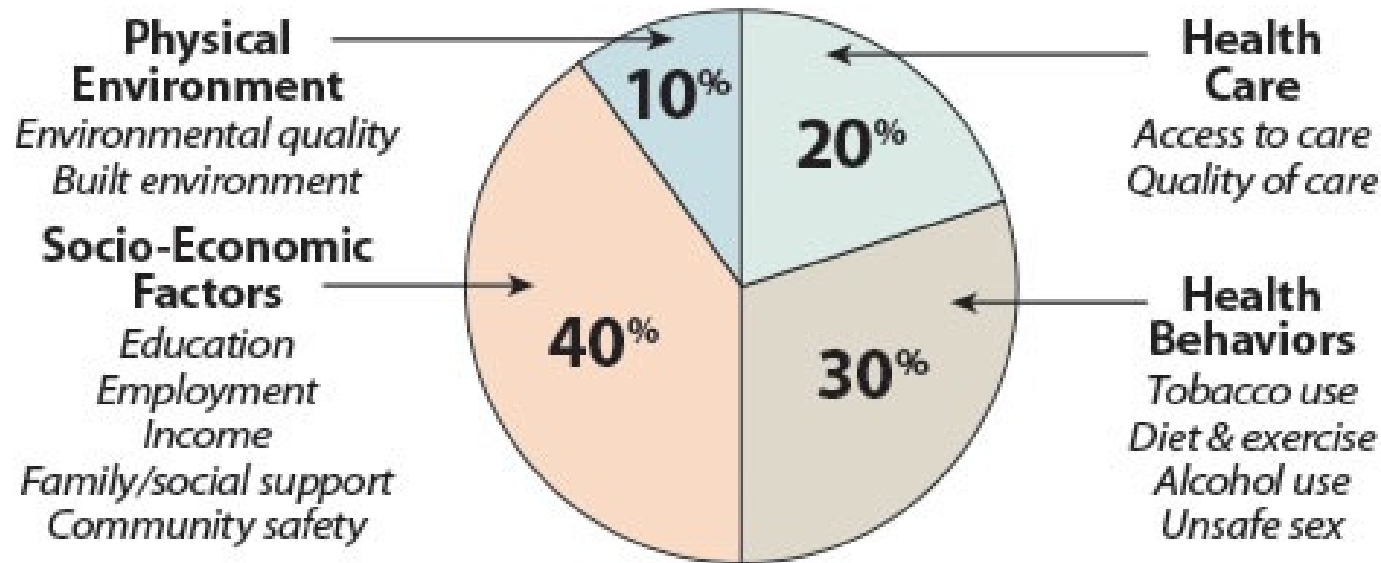
Hospital Sisters
HEALTH SYSTEM

SJS Pediatric Asthma Heat Map Super Users – Springfield



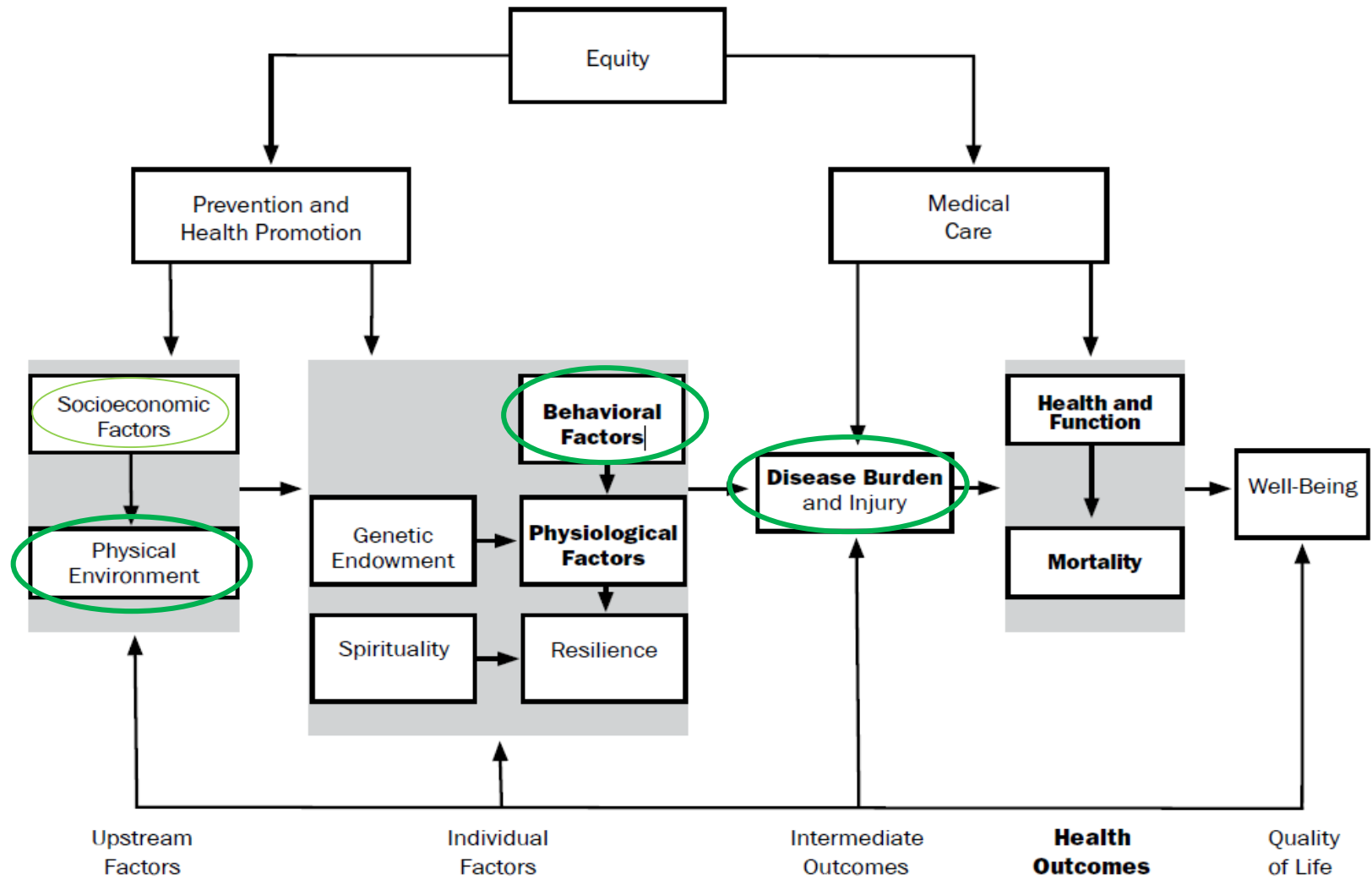
Social Determinants of Health

Population Health



Source: Authors' analysis and adaption from the University of Wisconsin Population Health Institute's *County Health Rankings* model ©2010, <http://www.countyhealthrankings.org/about-project/background>







Figure 1. A Model of Population Health



Note: Measures of population health in the Triple Aim measurement menu in Table 1 appear in bold text in Figure 1
 Stiefel M, Nolan KA. Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on www.IHI.org)



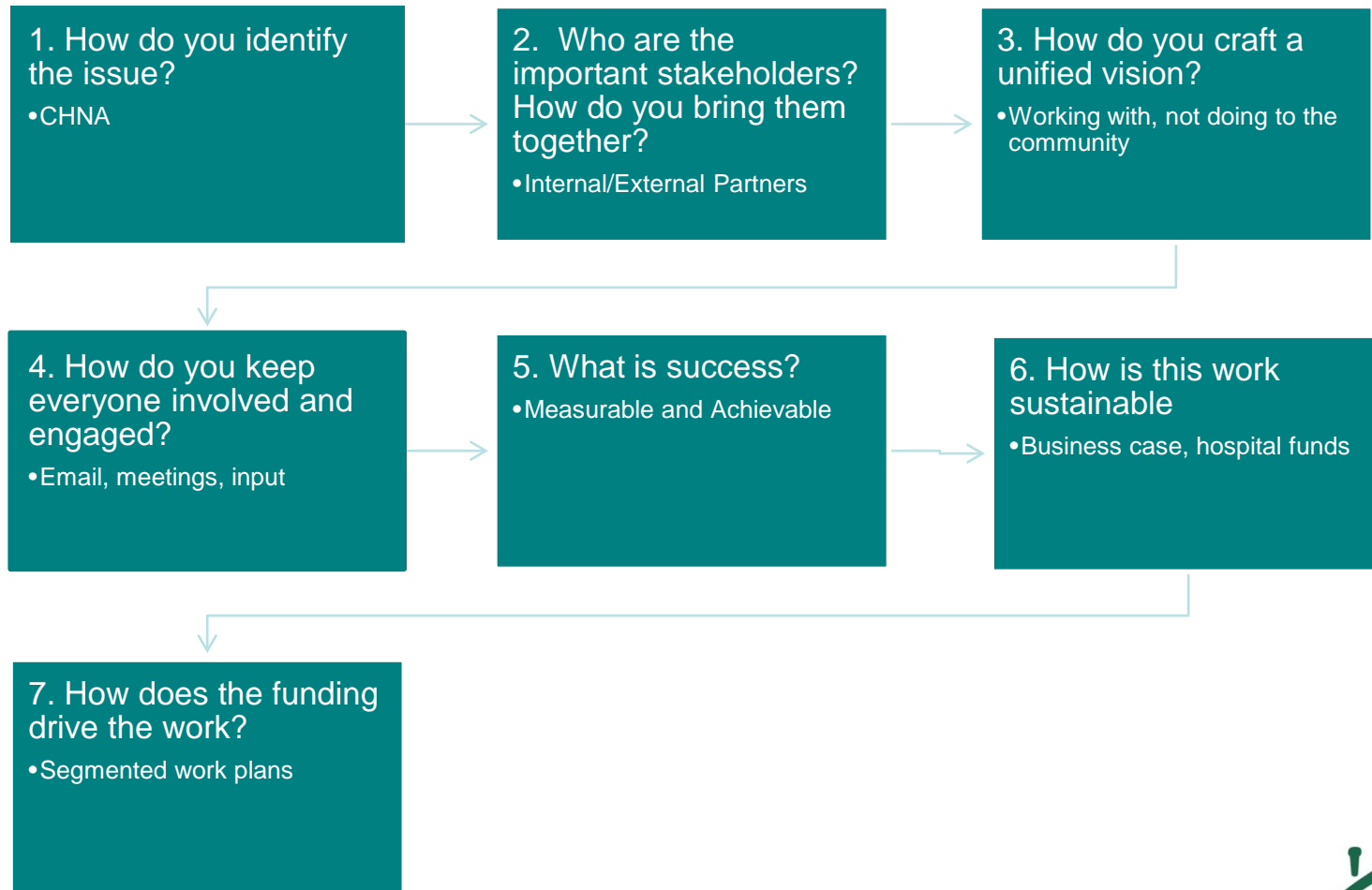
Table 1. Menu of Triple Aim Outcome Measures

Dimension of the IHI Triple Aim	Outcome Measures
Population Health   	Health Outcomes: <ul style="list-style-type: none"> • Mortality: Years of potential life lost; life expectancy; standardized mortality ratio • Health and Functional Status: Single-question assessment (e.g., from CDC HRQOL-4) or multi-domain assessment (e.g., VR-12, PROMIS Global-10) • Healthy Life Expectancy (HLE): Combines life expectancy and health status into a single measure, reflecting remaining years of life in good health
	Disease Burden: Incidence (yearly rate of onset, average age of onset) and/or prevalence of major chronic conditions
	Behavioral and Physiological Factors: <ul style="list-style-type: none"> • Behavioral factors include smoking, alcohol consumption, physical activity, and diet • Physiological factors include blood pressure, body mass index (BMI), cholesterol, and blood glucose (Possible measure: A composite health risk assessment [HRA] score)
Experience of Care 	Standard questions from patient surveys , for example: <ul style="list-style-type: none"> • Global questions from Consumer Assessment of Healthcare Providers and Systems (CAHPS) or How's Your Health surveys • Likelihood to recommend
	Set of measures based on key dimensions (e.g., Institute of Medicine's six aims for improvement: safe, effective, timely, efficient, equitable, and patient-centered)
Per Capita Cost  	Total cost per member of the population per month
	Hospital and emergency department (ED) utilization rate and/or cost

Why Community Coalitions?

- Working with and not doing to the community
- Different interpretations of problems and solutions
- Sustainability

How Can I Think Through This?



SIU School of Medicine Mission

Assist the people of central and southern Illinois in meeting their health care needs through

- Education,
- Patient Care,
- Research, and
- Service to the Community.



Who do we need to educate?

- **Providers** need to learn about social determinants so they recognize the upstream opportunities for improving the Triple Aim and model tackling the social determinants of health to **students**.
- **Communities** need to know that providers are listening and ready to partner with them.
- **Payors** need to learn the business case for population health solutions.

What are we teaching?

- Medical treatment information?
- Social Determinants of Health?
- How to tackle Social Determinants?
- Population Health?
- Business case for Population Health?

Population Science & Policy

Pilot
Innovative
Approaches

Evaluate
Interventions

Change
Policies for
Sustained
Improvements

Disseminate
Results

What's the goal?

Moving beyond contrived problem-based learning in medical school to real world problem solving with learners at many levels from different professions within the school and community.

Questions?

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