



Sometimes, it takes a community to spread good health

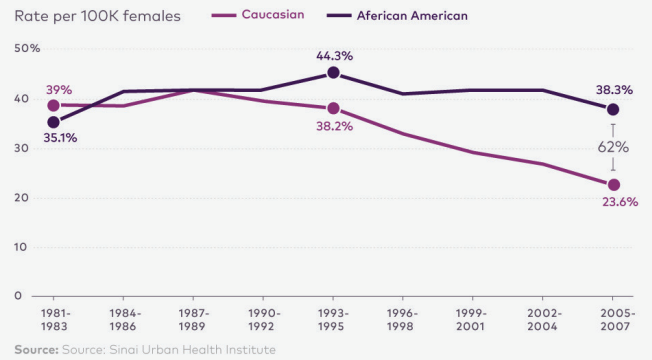
By Alan Channing | June 28, 2016

In healthcare, consumers have more skin in the game than ever. They face higher costs; they want more value. They need to be engaged in their own care, taking steps to keep healthy and out of the hospital.

But patients aren't always equipped to do this on their own.

For example, there is a rich literature about racial disparities in healthcare: How people of color are underdiagnosed and therefore undertreated. When I was CEO of Sinai Health System in Chicago, the Sinai Urban Health Institute did a big study on mortality rates of breast cancer — starting in Chicago, then extending to other major cities — and stratified the data ethnically. We discovered that over a 20-year period, African-American women in 41 of the largest U.S. cities were dying at a rate four times as high as that of Caucasian women.

Age-adjusted female breast cancer mortality, African American and Caucasian, Chicago 1981-2007



There was no good clinical evidence to explain this discrepancy, but we wanted to address the problem. When we dug into the data, we learned that access to screenings, quality of screenings, and follow-up appointments made up the biggest difference in the mortality rate delta.

So we developed a new “community health navigator” position within the health system, supported by the Avon Foundation. Our navigators were educated on best practices for accessing the system, and on the importance of mammography screenings and follow up.

We sent them out to meet with people in the various neighborhoods and host community conversations. The anecdotes that came back were telling. We heard that most patients who were not getting screened had seen friends or family die from breast cancer. They had come to believe that preventative screenings were causing cancer. So our first job was education.

Our second task was assuring that people had adequate access to quality mammography for screening purposes. We published the American College of Surgeons quality measures and invited the other mammography providers in the community to publicly report their results. The concept of outcome transparency had not yet caught on when we raised this question.

It took work to shift patients' perception of mammographies and get them engaged in the health system. The navigators literally took people by hand to educate them and get them the care they needed.

The outcome was dramatic: A 100 percent increase in mammography completion rates, an increase in follow-up physician office visits from 60 percent to 73 percent, and the establishment of a Chicago-wide Breast Cancer Task Force that continues to seek out, educate, and provide access to mammography and follow-up care.

Today, the Chicago Breast Cancer Task Force hosts a quality consortium that includes 54 healthcare provider organizations. They participate in a voluntary quality improvement program that has received federal designation as a Patient Safety Organization, and is the first in the country to be solely focused on breast health.

This is the downstream impact of early intervention – and of altering the social determinants of health. It's a process of pairing neighbors with neighbors, removing barriers to access, and ensuring transparent quality.

“Skin in the game” isn't only an economic mechanism, after all. In the accountable care era, it also means being aware of the systemic barriers to screening and care.

Moving forward, this will be a crucial strategy for managing risk-based reimbursements. When we all do well, everybody wins.

Alan Channing is a consultant and the former CEO of Sinai Health System in Chicago.



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