

## Healthcare Transformation Collaboratives Cover Sheet

- 1. Collaboration Name:** Cook County Health & Hospitals System DBA Cook County Health
- 2. Name of Lead Entity:** Cook County Health
- 3. List All Collaboration Members:** Cook County Health, CCH CountyCare, South Suburban College, Access Community Healthcare Network, Malcom X College, Cook County Health Foundation
- 4. Proposed Coverage Area:** Cook County
- 5. Area of Focus:** South Side Chicago and South Suburban Cook County
- 6. Total Budget Requested:** \$80,860,546

## 0. Start Here - Eligibility Screen

### Eligibility Screen

Note that applications cannot qualify for funding which:

1. fail to include multiple external entities within their collaborative (i.e. entities not within the same organization); or, 2. fail to include one Medicaid-eligible biller.

Does your collaboration include multiple, external, entities?

Yes

No

Can any of the entities in your collaboration bill Medicaid?

Yes

No

### 1. Participating Entities

1. What is the name of the lead entity of your collaborative?

Cook County Health & Hospitals System DBA Cook County Health

2. Please provide primary contact information, secondary contact information, and the Tax ID # of each entity in your collaborative. Please list the lead entity in the top row.

Entity Name	Tax ID # (xx-xxxxxx)	Primary Contact	Position	Email	Office Phone	Mobile Phone	Secondary Contact	Secondary Contact Position	Secondary Contact Email
Cook County Health		Israel Rocha	Chief Executive Officer				Andrea Gibson	Chief Strategy Officer	
CCH County Care		Aaron Galeener	Interim Chief Executive Officer				Andrea McGlynn	Director of Clinical Services	
South Suburban College		Lynette Stokes	President				Patrick Rush	Executive Director of PR & Resource Development	
Access Community Healthcare Network		Donna Thompson	Chief Executive Officer				Ann Lundy	Chief Operating Officer	
Malcom X College		Elizabeth Gmitter	Executive Director-College Initiatives and Projects				David A. Sanders	President	
Cook County Health Foundation		Cherry Justice	Executive Director				Juandalynn Johnson	Grant Program Manager	

3. Please confirm that you have entered the required information for each entity in the table above, including secondary contact information and Tax ID #.

I confirm

4. Please upload the most recent IRS Form 990 (including Schedule H, if applicable) for all participants in the collaboration. (Note: These 990s will all have to be compiled into a single PDF file.)

IRS 990\_Combined

### Participating Entities

1. Are there any primary or preventative care providers in your collaborative?

Yes

No

1A. Please enter the names of entities that provide primary or preventative care in your collaborative.  
Cook County Health

2. Are there any specialty care providers in your collaborative?

Yes  
No

2A. Please enter the names of entities that provide specialty care in your collaborative.  
Cook County Health

3. Are there any hospital services providers in your collaborative?

Yes  
No

3A. Please enter the name of the first entity that provides hospital services in your collaborative.  
Cook County Health

3B. Which MCO networks does this hospital participate in?

YouthCare  
Blue Cross Blue Shield Community Health Plan  
CountyCare Health Plan (Cook County only)  
IlliniCare Health  
Meridian Health Plan (Former Youth in Care Only)  
Molina Healthcare

3C. Are there any other hospital providers in your collaborative?

Yes  
No

4. Are there any mental health providers in your collaborative?

Yes  
No

4A. Please enter the names of entities that provide mental health services in your collaborative.  
Cook County Health

5. Are there any substance use disorder services providers in your collaborative?

Yes  
No

5A. Please enter the names of entities that provide substance abuse disorder services in your collaborative.

Cook County Health

6. Are there any social determinants of health services providers in your collaborative?

Yes  
No

6A. Please enter the names of entities that provide social determinants of health services in your collaborative.

Cook County Health

7. Are there any safety net or critical access hospitals in your collaborative?

Yes  
No

7A. Please list the names of the safety net and/or critical access hospitals in your collaborative.  
Cook County Health, Access Community Health Network) ACHN

8. Are there any entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that that are majorly controlled and managed by minorities?

Yes

No

8A. Please list the names of the entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that that are majorly controlled and managed by minorities.

Access Community Health Network) ACHN

9. Please list the Medicaid-eligible billers (firms that can bill Medicaid for services) in your collaborative, and the Medicaid ID for each.

Cook County Health, Stroger Hospital

Cook County Health Provident Hospital

Access Community Health Network) ACHN

10. Below are high-level descriptions of project types that appeared in the Transformation funding statute. Check any that apply to your project; if none apply, please provide a brief description of what kind of entities comprise your collaboration. (This question is informational only and will not affect your eligibility).

Safety Net Hospital Partnerships to Address Health Disparities

Safety Net plus Larger Hospital Partnerships to Increase Specialty Care

Hospital plus Other Provider Partnerships in Distressed Areas to Address Health Disparities (led By Critical Area Hospitals, Safety Net Hospitals or other hospitals in distressed communities)

Critical Access Hospital Partnerships (anchored by Critical Area Hospitals, or with Critical Area Hospitals as significant partners)

Cross-Provider Care Partnerships Led By Minority Providers, Vendors, or Not-For-Profit Organizations

Workforce Development and Diversity Inclusion Collaborations

Other

1.10A Participating Entities CCH Medicaid-eligible billers

## 2. Project Description

### Brief Project Description

1. Provide an official name for your collaboration. NOTE: Please ensure that this name matches the name given in the "Application Name" field in the Project Information form at the beginning of the application.

Southside Micro-Hospital Access Transformation

2. Provide a one to two sentence summary of your collaboration's overall goals.

Address the deficit of hospital beds and urgent care in the South side of Chicago and improving access to care.

### Detailed Project Description

There are shortages of primary care physicians in many communities within South Cook County coupled with a hospital bed ratio of 522 beds per person and/or 2 beds per 1000, below the national 2021 average of 2.5 (according to Becker's Healthcare). With recent service reductions at Mercy Hospital and the closure of Metro South not only has access to primary and specialty care been further reduced, but the bed to patient ratio has fallen further below the national average within this geographical area. To address this, CCH is proposing establishing two micro-hospitals/urgent care facilities in conjunction with CountyCare and collaborating with Malcom X, South Suburban College and Access Community Health Network (ACHN). The CCH-led collaboration is situated in a market that continues to experience service gaps. Both micro hospitals will have certified trauma informed Social Workers to provide a higher level of care coordination taking into account how trauma affects people's lives, their service needs and service usage. The collaboration provides CCH the opportunity to expand the footprint in communities where we have populations in need of hospital access without having to build full scale hospitals.

This collaboration between CCH, CountyCare, ACHN, South Suburban College and City Colleges will benefit all entities through the effective and efficient allocation of resources. While ACHN continues to provide their communities with patient-centered medical homes, collaboration with CCH will allow improved access to inpatient services, urgent care, and in turn connecting more residents to the medical home model. In addition, when it is determined any patient receiving primary medical services at a ACHN clinic requires a specialty referral, the patient will receive expedited scheduling services at a CCH micro hospital, therefore minimizing wait time for treatment. ACHN will help facilitate to improve the effectiveness, efficiency, timeliness, and quality of care; patient access to care; adherence to evidence-based guidelines; care coordination and care management; and patient experiences with care. These improvements, in turn, will lead to better health outcomes and management of chronic conditions. In addition, the collaboration with ACHN will be a demonstration project could expand to other FQHCs. By Improving access and patient outcomes the collaboration expects shared savings in care provision benefiting both the managed care organization (CountyCare) and ACHN.

CCH strives to improve the quality of care for Cook County residents which in turn will reduce the cost of care by methods such as reductions in ER admissions and treating patients before they become episodic. CCH will manage the health of patients in medically underserved communities in a primary care setting (such as those patients with asthma, diabetes, and congestive heart failure), and channel the highest acuity patients to an inpatient care setting. ACHN will act as a navigation center (Hub and spoke model) facilitating connectivity and communication with CCH. In addition, to improving access and patient outcomes the collaboration expects shared savings in care provision benefiting both the managed care organization (CountyCare) and ACHN.

The micro-hospital model reaches into communities where patients live and provides access to urgent care, ambulatory procedures, full scale dental clinic, diagnostic testing and a small inpatient unit. This proposal will eliminate health disparities and inequalities to provide improved health equity, wellness, and quality of life for residents of South Cook County. While we do plan to address health disparities in the traditional sense through direct patient care addressing morbidities identified by ACHN and CountyCare such as hypertension, renal diseases, Behavioral Health and overall cardiovascular health we will include some of the socioeconomic disparities of the community which affect the overall health through the design and development of a health equity clinical program for select healthcare career programs for

students residing in the service area we are targeting to build two micro hospitals. Malcom X and South Suburban Colleges will expand healthcare educational opportunities to residents in the areas where the micro hospitals will be located and providing a multidisciplinary educational approach on the current health issues and disparities in our underserved community. Through this expansion of career educational programs, we anticipate building a connection to the community, supply economic development, lay the foundation for community collaborations, and increase employment opportunities.

Both Malcom X and South Suburban College will build a pipeline for students to gain valuable clinical work experience for selected programs such as Medical Assistants, Community Health Workers (CHW), Certified Recovery Support Specialist (CRSS) and Nurses setting up a linear path to possible employment at one of the CCH micro hospitals. Additionally, South Suburban College offers career programs in Coding Specialists, Echocardiographers, and MRI and radiologic technicians. We are excited with the opportunity of employing Navigators, CHWs and CRSSs as these three roles are the link between ACHN, CCH and the community. CHWs usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve and provide preventive and promotional care to the community. CRSSs which require certification will target those suffering from mental health illness or co-occurring mental illness and substance use recovery support.

To help lessen the financial burden students face, students enrolled in the healthcare career programs at Malcom X College would receive a stipend of \$1000 during their clinical training to support the cost of required certifications. Ensuring we are in compliance with CCH employment rules, CCH will review options to connect this stipend to a commitment to working for CCH for a period of time after the training period. During the first two years we intend to have ten students assigned at each micro hospital at \$40,000. We are evaluating the possibility of beginning internships at an existing CCH facility in the third year of the HTC which would provide the first graduating class an opportunity for employment at one of the micro hospitals upon the facilities opening in year four.

CCH is one of the largest public health care systems in the nation, serving the residents of the second most populous county in the United States. CCH provides health care through our hospitals, regional outpatient centers, community-based centers located throughout Cook County and manage the largest Medicaid managed care plan in Cook County. CCH's mission is to deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public; and advocate for policies, which promote and protect the physical, mental, and social well-being of the people of Cook County. This proposal to establish micro hospitals is in line with our intrinsic mission.

The service area is on the south side of Chicago and Cook County including the following zip codes.

**60609 60628 60643** 60411 60429 60453 60462 60471 60480  
**60615 60629 60649** 60415 60430 60455 60463 60472 60482  
**60616 60631 60652** 60419 60438 60456 60464 60473 60487  
**60617 60632 60653** 60422 60439 60457 60465 60475 60501  
**60619 60633 60655** 60425 60443 60458 60466 60476 60803  
**60620 60636** 60406 60426 60445 60459 60467 60477 60805  
**60621 60638** 60409 60428 60452 60461 60469 60478 60827

*Data analyses in this application used data from zip codes in bold print.*

Capital improvements include \$25 million in buildout and real-estate expenses for each micro hospital. In terms of new intervention and the collaboration, CCH would focus on leveraging CountyCare to support access for their members to these sites and partnership with ACHN. The budget includes funding for supporting startup operational expenses. The expectation would be to become self-sustaining based on the expected payor mix and reimbursement rates.

## 2.1 Project Description

### **3. Governance Structure Structure and Processes**

1. Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated and priorities set?

CCH will leverage the internal governance structure in place with CountyCare and Cook County Health in the form of the board of directors and have ACHN and recipients of transformation funding.

#### **Accountability**

2. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally, and with extensive participation from each participating entity? What methods will be used to enforce policy and procedure adherence? A project manager at CCH will be hired to oversee all activities of the project. This position will be tasked with managing all partner organizations to ensure that activities are accomplished. Monthly check-ins with each partner organization will be established, at least in the beginning, to ensure fidelity of the proposal as well as uniform implementation. If challenges arise, the project manager will be altered as soon as possible and the partner organization or the consortium as a whole will be convened to troubleshoot.

In addition, this project will be engaged with Cook County Health System Corporate Compliance Program, which will ensure integrity of the project. Cook County Health System Corporate Compliance Program incorporates two (2) distinct Compliance Programs: encompassing CCH as a provider of health care services in addition to CountyCare Medicaid Health Plan with executive oversight of both programs by a Chief Compliance & Privacy Officer. In looking at the breadth of Compliance at CCH, system-level services occur within both CCH hospitals (John H. Stroger, Jr. Hospital of Cook County and Provident Hospital of Cook County), multiple outpatient clinics, correctional medicine at the Cook County Jail and Juvenile Temporary Detention Center, and the Cook County Department of Public Health. It also includes providers, clinicians and others that provide direct care to patients, in addition to workforce members not directly involved in patient care. In an indirect way, Corporate Compliance also encompasses all of CCH's "business associates" – parties who have contracted with CCH and have access to our patients' and members' protected health information in varying capacities. Although the CountyCare Medicaid Health Plan's Compliance Program is addressed through a separate annual report, both programs are organized to function at the overarching organizational level and are designed to promote a culture of compliance within CCH as a whole. Corporate Compliance has outlined and enforced the expectation that all workforce members are responsible for prevention, detection, and reporting of instances that may not comport with state, federal, or local law, or CCH policy.

#### **New Legal Entity**

3. Will a new umbrella legal entity be created as a result of your collaboration?

Yes

No

#### **Payments and Administration of Funds**

4. How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's

intended purpose? If the plan is to use a fiscal intermediary, please specify.

Cook County Health is a member hospital (and Medicaid provider) designated to receive HFS directed payments on behalf of the Collaborative. Directed payments received will be directed to the BEP fiscal agent to distribute the funds according to the Plan's specifications.

Given that CCH is a large institution, mechanisms have been established to coordinate grant administration with the Finance Department for fiscal activity, Purchasing Department for resource and service procurement, Legal Services for contract negotiations and Human Resources to timely hire for designated grant positions. The chart attached shows how the administration and the fiscal management of the proposed project will be integrated into the current administration.



#### 4. Racial Equity High-Level Narrative

A fundamental focus of healthcare transformation is racial equity. Please provide a high level description of how the design of your proposal incorporates racial equity. (Greater detail will be requested in the questions below.)

Reducing racial and ethnic health disparities is a fundamental part of CCH's mission. The Collaborative will address the health needs of the community, in addition we will be creating educational opportunities within the community for those interested in a career in healthcare placing students on a path to employment at the micro hospitals.

#### Racial Equity Impact Assessment Questions

1. Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?

Hispanic or Latino: 24.8%

Black: 50.1%

White: 20.5%

Two or More Races: 0.9%

American Indian: 0.2%

Asian: 3.2%

Some Other Race: 0.2%

2. Have stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities — been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged?

Many partner organizations have individuals with lived experience working with them and have engaged in the development of this proposal. This proposal is a reflection of the needs of the communities CCH and organizations serve; therefore, it is imperative that the diversity of the communities is represented. As the project moves forward, feedback from patients will be used to inform the rapid-cycle improvement strategy process and will shape the implementation and continued work.

3. Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

African Americans, Hispanic or Latino and Asian are the three groups most disadvantaged. While each of these share similar experiences to disparities and inequalities to healthcare, the Hispanic or Latino and Asian population experience issues with cultural and linguistic competence; these two groups often live in fear of deportation which further complicates the disparities in healthcare. For many Chicagoans, race, income, and insurance affect access to care across many conditions and contribute to excess deaths, particularly in predominantly Black and Brown neighborhoods. Because of systemic racism in Chicago and Cook County, people of minority status have often been marginalized and not been able to access the care they deserve. This has translated to some hospitals seeing patients with more complex needs, often patients of color.

Examining inpatient hospitalization rates among CCH patients, almost 48% of cases at Stroger Hospital identified as Black, compared to 17% at similar, large complex care medical centers, and 22% at America's Essential Hospitals. Likewise, almost 26% identified as Hispanic at Stroger compared to 7.6% at large hospitals and 20% at America's Essential Hospitals. When it comes to chronic disease, black and brown rates at Stroger are significantly higher than comparable hospitals and national averages (heart failure: 62% vs 25% vs 62% for Blacks, 26% vs 8% vs 16% for Hispanics; type II diabetes: 41% vs 21% vs 26% for Blacks, 43% vs 10% vs 20% for Hispanics; stroke: 55% vs 18% vs 25% for Blacks, 30% vs 6% vs 12% for Hispanics). Detailed graphical information is included in the attached PowerPoint presentation titled 4 Racial Equity \_CountyCare Health Equity Analytics

4. What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

Historic racism of Chicago and Cook County have significantly contributed to this disparity. Redlining, block busting and physical location of medical care have significantly contributed to racial disparities. A pamphlet published in 1954 outlines the systemic racism of Chicago Hospitals with regard to births and deaths as well as routine medical care. The text speaks to the racist policies created by hospitals to restrict black admissions by limiting the number of beds designated for Black patients. Overall life expectancy among Blacks is decreasing, and the gap between the life expectancy of Blacks and non-Blacks are widening.

Historic and current racism in Chicago's institutional and social structures have created the current state of striking inequities in chronic disease mortality, the homicide and infant mortality rates, and the numbers of deaths due to HIV and opioid overdose. This gap is being driven by 5 main causes of death: 1. Chronic Diseases (e.g., heart disease, cancer and diabetes), 2. Homicide, 3. Infant mortality, 4. HIV, flu and other infections and 5. Opioid overdose.

5. What does the proposal seek to accomplish? Will it reduce disparities or discrimination?

The proposal will address the lack of healthcare in the MUAs of South Cook County. Through proper onboarding and retraining current staff on healthcare inequities coupled with providing more healthcare services, better care management (care coordination) and patient education we expect to see an improvement (lower rate) of disparities. We propose strengthening programs for residents in which part of their training would be in our Ambulatory Community Health Network (ACHN) community clinics. Previous research has identified a correlation between residents training as safety-net providers for the uninsured and other vulnerable populations are significantly more likely to practice in medically underserved areas. Additionally, medical students who train with underserved populations are believed to have learned social responsibility and better understand the social determinants of health, making them more likely to serve in these areas.

6. What are negative or unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized?

The success of this program will rely on CCH working with the communities to determine their needs, work with the communities and provide the services that meet those needs. In addition, the community will need to welcome and want to break the current patterns contributing to inequity. As with any social service intervention, there could be unintentional consequences. Safeguards will be put in place to ensure when adverse issues arise, they will be identified and resolved in a timely manner. Such safeguards would include monthly meetings with stakeholders, quality performance measures, and qualitative interviews with staff and patients.

7. Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

CCH has been innovative in addressing various health disparities through a multi-disciplinary approach. CCH has identified disparities that have disproportionality affected the people of Cook County- opioid use disorder (OUD) and food insecurity. CCH addresses both of these areas through a multi-faceted lens. CCH currently provides identification, screening, and linkage to recovery support services for patients with SUD in a variety of settings, as many of CCH's patients have screened positive for OUD (over 1,000/month). CCH has addressed social inequities of OUD through the Cook County minimum wage ordinance and addressing stigma of substance use disorders (SUD); addressed institutional inequities through adult probation policies at the Cook County Jail; and addressed living conditions by expanding access to medication assisted treatment (MAT); and has addressed risk behaviors by implementing individual provision of MAT and access to naloxone. For food insecurity, CCH addressed social inequities by opposing SNAP changes; institutional inequities by implementing a Good Food Purchasing Program; living conditions by implementing screening and referral of patients to Fresh Trucks; and risk behaviors by instituting individual health education seminars. We are open to feedback to improve the approach further and will engage in routine evaluation.

8. Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement?

Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

This proposal seeks to expand services by hiring additional staff to work in the micro hospitals to provide care to residents of Southern Cook County which includes a subset of uninsured patients- some of the system's most vulnerable and costly patients. In addition, this proposal aims to enhance the current CMIS platform which tracks patients within Cook County Health.

This data will be continuously monitored by the data manager and will be shared at monthly and quarterly meetings with partnering organizations. This data will serve as a check point to see if patient care is most efficient and effective at reducing social disparities and adverse medical outcomes.

9. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How

will the level, diversity and quality of ongoing stakeholder engagement be assessed?

Benchmarks for this proposal are patient dependent as this is a patient-centered proposal however larger, public health outcomes and trends will be monitored. Trends of points of care and needs will be assessed.

An example of this is if someone is in need of housing but did not engage with a housing partner. Qualitative interviews with patients will be used to see what gaps still exist in this model and how the consortium as a whole can rectify. Along with the collection of performance measures (see later in the proposal) the qualitative interviews and/or focus groups with providers and patients will inform the implementation and continued work of the project- ultimately feeding the rapid-cycle improvement strategy.

## 5. Community Input

### Service Area of the Proposed Intervention

1. Identify your service area in general terms (e.g., "West Chicago", "East St. Louis Metro Area", "Southeastern Illinois").

The service area for our focus is the South Side of Chicago and portions of South Suburban Cook County. The borders roughly extend from 18th Street south to 138th Street and west to Harlem Ave. (43).

**2. Please select all Illinois counties that are in your service area. (NOTE: Selecting a county does not mean that your intervention must service the entire county.)**

Select counties:

Cook

3. Please list all zip codes in your service area, separated by commas.

60608, 60608, 60616, 60632, 60609, 60615, 60615, 60629, 60636, 60621, 60637, 60637, 60456, 60805, 60620, 60619, 60619, 60643, 60628, 60633

### Community Input

1. Describe the process you have followed to seek input from your community and what community needs it highlighted.

We continue to analyze existing data to understand the communities, their potential needs and realistic solutions we can implement before engaging the community. The strength of this Collaborative includes the ability to connect people to resources and opportunities and strengthen partnerships with ACHN, Malcom X and South Suburban College across the targeted service area. The Collaborative has and will continue to employ various community engagement strategies to establish the needs of the communities it is serving. These strategies will be carefully conducted, so they are meaningful and inclusive, as outlined in each of the following planning phases:

- Phase I: HFS Healthcare Transformation Conceptualization
- Phase II: Application Comment Period Responsiveness
- Phase III: Community Advisory Committee
- Phase IV: Program Development
- Phase V: Advocacy and Outreach

### Input from Elected Officials

1. Did your collaborative consult elected officials as you developed your proposal?

Yes

No

## 6. Data Support

1. Describe the data used to design your proposal and the methodology of collection.

We extracted 2020 data from the webpages from Illinois Department of Public Health Annual Hospital Questionnaire.

- General Hospital Information
- Hospital Utilization – Beds, Admissions and Inpatient Days by Category of Service; Patient Characteristics
- Patients by Payment Source – Number of Inpatients and Outpatients by Primary Source of Payment
- Procedure Rooms, Equipment Numbers and Utilization by Type, Emergency and Trauma Services, Laboratory Studies
- Surgeries – Operating Rooms and Inpatient and Outpatient Surgeries by Type
- Deliveries, Organ Transplants, Open Heart Surgery and Cardiac Catheterization
- Revenue – Hospital Inpatient and Outpatient Revenue by Payment Source and Cost of Charity Care
- Capital Expenditures

Criteria to determine hospital bed ratios.

- Zip codes identified by proximity to South Cook County
- Hospitals, acute care beds from 2020 IDPH Annual Survey
- Population by zip from census

## 7. Health Equity and Outcomes

1. Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes.

CCH also administers CountyCare, a Medicaid managed care plan for Cook County residents, which serves nearly one in every 10 Cook County residents with Medicaid. Patients seen at CCH's sites are economically disadvantaged minorities, many who are not traditionally connected to a regular healthcare provider. Currently, 47% of patients are uninsured, and 38% are insured through Medicaid. 50% of patients are African American, 37% White, 33.5% Hispanic, 2% American Indians/Alaskan Natives, 4% Asian, 0.5% multiple, 0.08% Native Hawaiian/Pacific Islander, and 7% Other ethnic or racial minorities. About 30% of CCH patients speak a language other than English at home. The average breakdown of the patient population is as follows: 6.60% < 0-20 years, 8.51% 21-30 years, 11.16% 31-40 years, 16.56% 41-50 years, 25.45%, 51-60 years, and 31.46% 60+ years. In Cook County, the median household income is \$59,426, and 16% of individuals live below the poverty line.

Access Health workforce Increasing the number of minorities practicing health professions  
Improving geographical distribution of professionals Better distribution of specialties Quality  
Design of health services Improving integration of public health and clinical medicine Increasing patient  
education and outreach Clinical skills Improving clinician communication skills Improving skills of cultural  
humility, and working in cultural contexts Ensuring that health care services are provided in a culturally  
and linguistically sensitive manner

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

The Collaborative will improve outcomes and reduced disparities through the innovative, transformative and aligned model of micro hospital care that is inclusive of all major stakeholders: residents, social service agencies, behavioral health and primary care providers, specialists, hospitals and payers.

- It addresses the realization that the health care system creates dependency for some and alienates others rather than empowering individuals and their families to self-monitor and proactively manage their health.
- It recognizes that there is a unique and too often overlooked role for Social Workers and Navigators.
- It recognizes that it often takes warm handoffs rather than simply referrals to help patients navigate the health care system.
- It creates employment opportunities for residents of the community being served to enhance economic recovery.

3. Why will the activities you propose lead to the impact you intend to have?

We believe that the Collaborative's approach to integrated care coordination will, by design, positively impact racial equity because the patients we are targeting are those most likely to experience inequities due to their race/ethnicity.

## 8. Access to Care

1. Name the specific obstacles or barriers to healthcare access you are targeting in your service area. Describe the causes of these obstacles that your project specifically seeks to address and explain why you have chosen to address these causes.

Some challenges identified are the lack of health literacy or social capital to navigate the complex and fragmented social service system which leads to lack of access of care, limited coordination between service providers and the lack of timeliness in service delivery. Social determinates of health create barriers to self-care and compliance with treatment plans. We plan to address the following issues through the Collaborative.

- Insufficient network of providers
- Lack of emergency room services
- Lack of diagnostic testing
- Lack of ambulatory surgery centers
- Lack of nutritious food
- Assistance with appointments and referrals
- Transportation
- Financial assistance for medical services

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

The micro hospitals will address the lack of care (availability of providers, ED services, diagnostics, and procedural services) in South Cook County. Transportation and financial assistance are services currently offered through CountyCare and would expand to the micro-hospital coverage area.

3. Why will the activities you propose lead to the impact you intend to have?

Our proposal is designed to systematically identify gaps and address the barriers to equitable care through known improvement methodologies and data science.

## 9. Social Determinants of Health

1. Name the specific social determinants of health you are targeting in your service area. Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes.

Inadequate health insurance coverage is one of the largest barriers to health care access, and the unequal distribution of coverage contributes to disparities in health. Out-of-pocket medical care costs may lead individuals to delay or forgo needed care (such as doctor visits, dental care, and medications), and medical debt is common. Vulnerable populations are particularly at risk for insufficient health insurance coverage; people with lower incomes are often uninsured, and minorities account for over half of the uninsured population. Social Risk Factors (SRF) have a major impact on people's health, well-being, and quality of life.

Examples of SRF include:

- Racism, discrimination, and violence
- Easier access to care
- Health education
- Access to nutritious foods
- Language and literacy skills

It is imperative, if we want to reduce health inequity, that we begin to place a heavier emphasis on social determinants of health and the impact that they have on patient experiences and health outcomes.

Expanding access to health services is an important step toward reducing health disparities. Factors like economic, social, cultural, and geographic barriers to health care must also be considered, as well as new strategies to increase the efficiency of health care delivery which can be achieved through micro-hospitals.

Disparities in access to primary health care exist, and those patients face barriers that decrease access to services and increase the risk of poor health outcomes. Obstacles include the inability to take time off work to attend appointments, geographic and transportation-related barriers, and a shortage of primary care providers, as well as a mismatch of providers who reflect and better understand the assets and challenges of the communities they serve. These barriers may intersect to further reduce access to primary care. Residents of Cook County without care may experience reduced access to primary care due to limited provider office hours and availability. Many primary care providers do not offer services during typical off work hours, posing barriers to workers without sick leave benefits.

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

- Promote the consistency and equity of care through the use of evidence-based guidelines.
- Ensure an adequate supply of services to minority patients.
- Better recruiting efforts to hire bi-lingual staff.
- Support the use of community health workers.
- Implement multidisciplinary treatment and preventive care teams.
- Implement patient education programs to increase patients' knowledge of how-to best access care and participate in treatment decisions.
- Integrate cross-cultural education into the training of all current and future health professionals.

3. Why will the activities you propose lead to the impact you intend to have?

Our proposal identifies the gaps and address barriers to equitable care, primarily the difficulty of residents having access to care.



## 10. Care Integration and Coordination

1. Describe how your proposal improves the integration, efficiency, and coordination of care across provider types and levels of care.

Partnering with ACHN in the community ensures patients will have a continuum of care when their medical needs extend beyond the scope of what a primary physician can provide. When patients are referred to a CCH micro hospital, they will receive a higher level of care not requiring admittance to a full facility hospital, in addition, we will connect the patient with CountyCare's care coordinators to arrange for care coordination post discharge if required or requested by the patient.

2. Do you plan to hire community health workers or care coordinators as part of your intervention?

Yes

No

2A. Please submit care coordination caseload numbers and cost per caseload (stratified by risk, if applicable).

Care coordination teams are organized around a primary care provider (physician, advanced practice nurse, physician assistant) in addition to nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. Often through the care coordinators they will build these teams by linking themselves and their patients to providers and services in their communities.

All members of the care team play a role in coordination of care. Teams deliver comprehensive, first-contact care and address the needs of patients and families through a broad range of services delivered by multidisciplinary professionals. In the team-based care model, all care team members contribute to the health of the patients.

CCH, the lead agency for the HTC is closely integrated with CountyCare Health Plan and ACHN serving the target area. As such our goal is to leverage the well-established Medicaid MCO care coordination model, in particular CountyCare's robust provider-based care coordination model since CountyCare is the largest MCO in the Cook County and these service areas. This HTC provides another opportunity to "connect the dots" between providers and MCO's and ensure that MCO care coordination is deployed at the point of care at real-time at critical episodes of care in this case, onsite at the micro-hospitals. The MCO care coordination model utilizes Care Coordinators to:

- Provide episodic, provide problem-solving services to all members experiencing a change in condition
- Integrate all services for members in Home and Community Based (Waiver) Services
- Offers the Complex Care Management Program to any members stratified to high and moderate risk, pregnant members and any other member interested in enrolling in the program.

For CountyCare members, the program falls under the ultimate oversight of CCH, the lead agency. For microhospital patients enrolled in other Medicaid MCOs, the care team will utilize the same processes to collaborate with the MCO's Care Coordination/Care Management programs. The CountyCare Care Coordination program will support the micro-hospitals with the new and emerging State-led Care Coordination programs such as Pathways for children with high behavioral health needs. Above all this HTC seeks not to duplicate or complicate the already dense care coordination landscape but to plug into, maximize and leverage well-established resources.

### Specific Services

All members

- Initial completion of health risk screen/assessment within 60 days of enrollment.
- Ongoing monitoring for changes in condition for referral to complex care management via surveillance data, screening, and assessment, change in condition and member provider referral.
- Problem solving support, care gap closures, and other contracted care coordination services as requested and as need identified through contact or referral.
- 

High and moderate risk members & (M)LTSS members

- Assessment and care plan within 90 days of stratification to high or moderate risk
- Care plan review every 30 days (high risk) or 90 days (moderate risk).

- Member contact with care coordinator every 90 days; face-to-face every six months.
- Increased contact and service plan requirements for (M)LTSS members, varies by program.

3. Are there any managed care organizations in your collaborative?

Yes

No

3A. Please list the names of the managed care organizations in your collaborative.

CountyCare

## 11. Minority Participation

**1. Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise Program (BEP) and/or not-for-profit entities majorly controlled and managed by minorities that will be used on the project as subcontractors or equity partners.**

List entities here:

None

2. Please describe the respective role of each of the entities listed above, and specify whether they will have a role only during the implementation of your proposal or if they will have a role in the ongoing operation of your transformed delivery system.

Access Community Health Network services address the health of the underserved communities through preventive care, chronic disease management, and support services. To address patients' comprehensive health needs, ACHN physicians, nurse practitioners, and other providers are teamed with outreach staff, case managers, social workers and substance abuse counselors to advance a continuum of care.

Additional BEP's will be contracted by the Collaborative to provide the following functions:

- Architectural Design
- Construction builds and management
- Real estate brokers

## 12. Jobs

### Existing Employees

1. For collaborating providers, please provide data on the number of existing employees delineated by job category, including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these job levels.

New staff will be hired for both micro hospitals.

### New Employment Opportunities

2. Please estimate the number of new employees that will be hired over the duration of your proposal.

148

3. Describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve.

Recruitment efforts will be focused on hiring staff for the micro hospitals from the service areas. Having diverse staff enables us to understand and meet the needs of people with diverse perspectives and creates an atmosphere that supports positive relationships within the community we will serve.

4. Please describe any planned activities for workforce development in the project.

Funding has been allotted for the Collaborative members to ensure the implementation of best practices and the effective, culturally responsive provision of services. Collaboration with Malcom X and South Suburban College which provides educational opportunities and economic development within the community ensures a full circle of social determinants of health are addressed in this collaboration.

### 13. Quality Metrics

1. Tell us how your proposal aligns with the pillars and the overall vision for improvement in the Department's Quality Strategy.

The collaboration is focused on improving the health equity of the targeted service area by focusing on the overall arching theme of improving population health. This will be carried out through improving access to care, offering services currently not available in the community, and providing educational and employment opportunities.

### 2. Does your proposal align with any of the following Pillars of Improvement?

2A. Maternal and Child Health?

Yes

No

2B. Adult Behavioral Health?

Yes

No

Adult Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

Improve behavioral health services and supports for adults by:

- Improving integration of physical and behavioral health
- Improving transitions of care from inpatient to community-based services
- Improving care coordination and access to care for individuals with alcohol and/or substance use disorders

2C. Child Behavioral Health?

Yes

No

2D. Equity?

Yes

No

2E. Community-Based Services and Supports?

Yes

No

3. Will you be using any metrics not found in the quality strategy?

Yes

No

#### **14. Milestones**

For all activities described in your proposal, please provide a calendar of milestones to show progress (e.g., when IT will be purchased, when IT will be operative, when construction projects will begin and end, when people will be hired, etc.) The timeline should be in months from award.

Please see attached

## 15. Budget

### 1. Annual Budgets across the Proposal

#### 2. Number of Individuals Served

Please project the number of individuals that will be served in each year of funding.

Year 1 Individuals Served

0

Year 2 Individuals Served

50000

Year 3 Individuals Served

100000

Year 4 Individuals Served

150000

Year 5 Individuals Served

200000

Year 6 Individuals Served

200000

#### 3. Alternative Payment Methodologies

Outline any alternative payment methodologies that your proposal might utilize for receiving reimbursement for services from MCOs.

None

## **16. Sustainability**

Provide your narrative here:

The micro hospital model will enable CCH to provide care access points for a wider range of illnesses and injuries priced below a full-service hospital emergency center or inpatient facility. We will leverage our current business model generating funds through CountyCare and receiving payments as a Medicaid disproportionate share (DSH) hospital.