Welcome
Housekeeping

Q&A Session

- We will answer questions you have during the session at the end of the presentation
- Use the Q&A function to post your questions
- We’ll answer as many questions as we have time for
- For those we don’t have time to answer, we will post answers on our website

Stay Connected

- Visit our webpage and, at the bottom, register for HTC updates
- HFS.illinois.gov/Transformation
Our Vision for the Future

**WE IMPROVE LIVES**
- We address social and structural determinants of health.
- We empower customers to maximize their health and well being.
- We provide consistent, responsive service to our colleagues and customers.
- So equity is the foundation of everything we do.

**WE ACHIEVE THIS BY**
- Valuing our staff as our greatest asset.
- Always improving.
- Inspiring public confidence.
Healthcare Transformation (noun)

‘health-care trans-for-ma-tion’

a person-centered, integrated, equitable, and thorough or dramatic change in the delivery of healthcare at a community level
Healthcare Transformation Legislation Passed in January and Incorporated Feedback from Many Stakeholders

We Heard You. Collectively, you have said that you want:

- Outcome-based solutions to reduce healthcare disparities with measurable impact
- Prioritization of Safety Net Hospitals
- Prioritization of Critical Access Hospitals and distressed areas statewide

Thank You For Your Comments, Suggestions and Constructive Feedback

- Hospitals (Academic, Critical Access, Large, and Safety Nets)
- Customers
- Federally Qualified Health Centers
- Labor (SEIU)
- Legislators (MWG, Black, Latino, Women’s Caucus Members, GOP, and More)
- Managed Care Organizations
- Philanthropic Organizations
- Providers
- Civic Institutions
- And More…
We also incorporated feedback community members and customers who want a shift from transactional to more integrated, relationship-based care.

<table>
<thead>
<tr>
<th>From Transactional</th>
<th>To Relationship-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Logistics / Administrative</strong></td>
<td>I expect to be able to schedule a timely appointment, close to home, when I have a health care need.</td>
</tr>
<tr>
<td>I often need to wait months before I am able to get an appointment and appointments aren’t always close to where I live.</td>
<td></td>
</tr>
<tr>
<td><strong>Point-of-Service Experience</strong></td>
<td>I expect my time to be valued and for my appointment to be on time.</td>
</tr>
<tr>
<td>Due to providers running behind schedule, I often need to wait to be seen.</td>
<td></td>
</tr>
<tr>
<td><strong>Patient-Provider Relationship</strong></td>
<td>I expect my doctor to take the time to understand and invest in my whole [bio-psycho-social] person.</td>
</tr>
<tr>
<td>When a provider spends a short amount of time with me and just hands me with a prescription, I feel like a number.</td>
<td></td>
</tr>
<tr>
<td><strong>Decision Making</strong></td>
<td>I expect to take an active, respected role in making decisions about my body and health.</td>
</tr>
<tr>
<td>My doctor tells me what to do based on what he/she thinks is best for me.</td>
<td></td>
</tr>
<tr>
<td><strong>Care Plan</strong></td>
<td>I expect care recommendations that fit my insurance, finances and life circumstances.</td>
</tr>
<tr>
<td>My provider gives me a prescription that’s not covered by insurance or recommends physical activity when it isn’t safe in my neighborhood to exercise outside (and a fitness membership is expensive).</td>
<td></td>
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</tbody>
</table>
WHY TRANSFORMATION?
THE CURRENT LACK OF

- Access to care (due to logistic, economic, cultural, and healthcare literacy barriers)
- Stability in the critical healthcare delivery system
- Coordinated, cross-agency focus on Social Determinants of Health

LEADS TO

- Inconvenient, inconsistent, expense-ridden care that's often not culturally competent
- Care that does not focus on Chronic Disease management
- Care that doesn’t fit people’s lives

RESULTING IN

- Poor Health Outcomes
In some of the most socially-vulnerable areas of Illinois, we see high rates of Medicaid-enrollee hospitalizations for outpatient-treatable conditions.

**Top Most Frequent and Resource Intensive Hospitalization Diagnoses**

With resource intensiveness defined as the rate of re-admission for the disease block.

<table>
<thead>
<tr>
<th>SO. CHICAGO</th>
<th>SOUTH COOK</th>
<th>WEST CHICAGO</th>
<th>WEST COOK</th>
<th>EAST ST. LOUIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood affective disorders (bipolar, depression)</td>
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</tr>
<tr>
<td>Schizophrenia, schizotypal disorders</td>
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<td>Schizophrenia, schizotypal disorders</td>
<td>Psychoactive substance use disorders (alcohol, opioids)</td>
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<td>Schizophrenia, schizotypal disorders</td>
</tr>
<tr>
<td>Hypertensive diseases</td>
<td>Hypertensive diseases</td>
<td>Hypertensive diseases</td>
<td>Other bacterial diseases (sepsis)</td>
<td>Hypertensive diseases</td>
</tr>
<tr>
<td>Chronic lower respiratory diseases (asthma, COPD)</td>
<td>Chronic lower respiratory diseases (asthma, COPD)</td>
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<td>Hypertensive diseases</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>Diabetes mellitus</td>
<td>Diabetes mellitus</td>
<td>Diabetes mellitus</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>Cerebrovascular diseases</td>
<td>Cerebrovascular diseases</td>
<td>Cerebrovascular diseases</td>
<td>Cerebrovascular diseases</td>
<td>Hemolytic anemia</td>
</tr>
<tr>
<td>Hemolytic anemias</td>
<td>Hemolytic anemias</td>
<td>Hemolytic anemias</td>
<td>Hemolytic anemias</td>
<td>Noninfective enteritis and colitis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Chronic lower respiratory diseases (asthma, COPD)</td>
</tr>
</tbody>
</table>

**Treatable Conditions / Preventable Hospitalizations:**

- **Mental Illnesses (especially, bipolar and depression)**
- **Substance Use Disorders (especially, alcohol and opioid)**
- **Ambulatory Care Sensitive Conditions (especially, hypertension, asthma, COPD and diabetes)**
And we see low rates of engagement in outpatient care pre- and post-hospitalization.

Proportion of Prior and Subsequent Outpatient Care among Patients who Received Hospital-Level Care for Ambulatory Care Sensitive Conditions

NOTE: Included in this analysis are the highest frequency mental and behavioral disorders: schizophrenia, mood affective disorders (bipolar and depression), anxiety disorders, developmental disorders and behavioral/emotional disorders with onset in childhood or adolescence.

EXAMPLE:

HTC Informational Session March 12, 2021
Residents in these communities face multiple social-determinant-of-health barriers to staying healthy and getting care.

<table>
<thead>
<tr>
<th>Knowledge &amp; Information</th>
<th>Economic</th>
<th>Healthcare Service</th>
<th>Socio-Cultural</th>
<th>Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Lack of factual and trustworthy health information</td>
<td>- Lack of time for self-care (i.e., exercise, preparing healthy food, preventative care, etc.)</td>
<td>- Lack of preventive screening or programming in the community</td>
<td>- Culturally ingrained food and cooking habits</td>
<td>- Lack of resources (i.e., food, recreation, transportation, walking infrastructure, etc.)</td>
</tr>
<tr>
<td>- Lack of knowledge of signs and symptoms of prevalent health conditions</td>
<td>- Inability to afford healthy food</td>
<td>- Previous negative healthcare experience</td>
<td>- Healthcare system mistrust</td>
<td>- Poor air quality due to local polluters</td>
</tr>
<tr>
<td>- Lack of knowledge of what is covered or not covered in insurance plan</td>
<td>- Unemployment, economic instability</td>
<td>- Fear of going to healthcare facilities due to COVID-19</td>
<td>- Hesitancy to seek care until emergency (due to historic mistrust, cultural issues, immigration status, fear, stigma, or previous bad experience)</td>
<td>- Presence of unhealthy foods</td>
</tr>
<tr>
<td>- Fear of getting healthcare as a result of the lack of knowledge of information (i.e., fear due to costs involved, bad diagnoses, etc.)</td>
<td>- Housing instability</td>
<td>- Poor quality of local healthcare facilities (self-reported)</td>
<td>- Concealing health issues from family &amp; friends</td>
<td>- Prevalence of drugs and alcohol in communities</td>
</tr>
<tr>
<td>- Lack of awareness of where to seek care that fits one’s needs</td>
<td>- Lack of insurance or under-insured</td>
<td>- Long wait times at the point of care</td>
<td>- Insufficient transportation options</td>
<td>- Exposure to ongoing crime, street violence, domestic abuse, neglect and discrimination</td>
</tr>
<tr>
<td>- Difficulty understanding technical medical terms and physician instructions</td>
<td>- Inability to afford out-of-pocket care costs (for example, co-pays)</td>
<td>- Service quality disparities</td>
<td>- Lack of resources (i.e., food, recreation, transportation, walking infrastructure, etc.)</td>
<td>- Lack of knowledge of local resources to help manage condition</td>
</tr>
<tr>
<td>- Difficulty applying physician instructions to personal circumstances</td>
<td>- Inability to afford treatment (e.g., medication, equipment, supplies, etc.)</td>
<td>- &quot;Transactional&quot; experiences with providers (e.g., short acronym, bias towards medication, etc.)</td>
<td>- Social isolation (lacking a support system)</td>
<td>- Stress on social support system (i.e., emotional, physical, economic)</td>
</tr>
<tr>
<td>- Lack of knowledge of where to seek care that fits one’s needs</td>
<td></td>
<td>- Lack of trained, culturally competent providers</td>
<td></td>
<td>- Prevalence of drugs and alcohol in communities</td>
</tr>
</tbody>
</table>

**EXAMPLE:**

- Residents in these communities face multiple social-determinant-of-health barriers to staying healthy and getting care.
When people decide to seek care, they make an implicit cost-benefit analysis, trading off time, money and trouble against the value they expect to gain from care.

The barriers voiced by community residents in socially-vulnerable areas tip the balance toward the costs of seeking care and away from the value of getting healthcare.
Clinical care accounts for no more than 20% of a person's health and individual health behaviors, no more than 30%\(^1\).

A full 50% of health can be attributed to **social determinants of health**, the broad term that includes social, economic, and environmental factors.

**Health needs cannot be addressed by healthcare systems alone.**

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With the Healthcare Transformation Collaboratives project, HFS is seeking to fund partnerships that address both healthcare needs and social determinants of health.

HFS is seeking partnerships that re-imagine the way healthcare is provided in communities by linking healthcare systems more tightly with community resources that address social determinants of health in order to meet the needs of residents more holistically and reduce inequities in healthcare delivery.
Healthcare Transformation Collaboratives (HTC) Overview
Reorient Healthcare Delivery in Illinois around People and Communities

And do so through...

• Meaningful engagement with community residents on transformation projects
• Multi-disciplinary collaboration across healthcare systems, community organizations, community residents and other community-based entities

In order to create new ways to deliver healthcare that...

• Fit people’s lives
• Solve complex healthcare access issues in holistic ways
• Improve health outcomes and reduce health inequities
• Address both healthcare needs and social determinants of health needs
• Are financially sustainable and racially equitable
Allocate The Entire $150 Million With At Least A Minimum As Follows:

- **$30 Million**
  - Safety Net Hospital Partnerships to Address Health Disparities
  - Particularly partnerships with community safety-net hospitals
  - Plus: $40 Million in Capital
  - $65 Million CARES

- **$20 Million**
  - Safety Net + Larger Hospital Partnerships to Increase Specialty Care

- **$30 Million**
  - Hospital + Other Provider Partnerships in Distressed Areas to Address Health Disparities
  - Lead By CAHs, SNs or other hospitals in distressed communities

- **$15 Million**
  - Critical Access Hospital Partnerships
  - Anchored By CAHs or with CAHs as significant partners

- **$15 Million**
  - Cross-Provider Care Partnerships
  - Lead By Minority Providers, Vendors, or NFPs
  - To fill unmet needs with a special emphasis on cultural competency and/or social determinants of health

- **$5 Million**
  - Workforce Development & Diversity Inclusion Collaborations
  - Must be in alignment with overarching innovation proposal strategy
  - Enhance Preventative and Specialty Care Access
  - Loan Repayment
  - Recruitment and Scholarships or similar ideas to enhance availability in distressed communities

HTC Informational Session March 12, 2021
Example Collaboration Partners

Hospitals
School Based Health Centers
Maternal Child Health Providers
Senior Care Providers
Food Suppliers
Other Healthcare Providers

POTENTIAL PARTNERS

Substance Use Treatment Providers
Transportation
Community/Fitness Centers
Housing Assistance
Health Education Experts
Primary and Preventative Care Specialists

All collaborations must include a registered Illinois Medicaid Provider that is eligible to bill for Medicaid services.
HFS believes the $150 million as an annual transformation pool is a start to a realignment of resources. Leveraging state resources to attract other investments including federal, state and private dollars.

We recommend coordinating transformational projects with other sources of funding to spur broad investment in community projects that have a coordinated comprehensive approach.

**State Collaboration**
- One-time state capital funds would be available in early years.
- Coordination with CDB, DCEO, DHS, IDPH other state agencies to magnify the effort on a community by community basis.

**Business Community**
- At the appropriate time, engage the larger business community to and encourage/ incentivize investment in the collaborative projects.
- The state’s investment should invite private investment.

**Philanthropic**
- Similar to the business community, non-profits and philanthropic efforts must be included to spur collaborative system investment.
- This strengthens sustainability in the system.
The Vision For Sustainability of Successful Partnerships/Collaborations

- Each project, once fully implemented, must be sustainable with funding streams beyond transformation dollars, including claims or alternative payment models in future years.
- Improved outcomes with evidence that the innovations support other funding sources.
- Payment models within the normal mechanisms in place that allow HFS/MCOs to pay for services will apply.
Example Project
Linking healthcare and food access

Collaborators come together to ensure access to healthy foods in a community by:

- Establishing new retail food stores and farmers’ markets in the community
- Integrating food insecurity screening into standard physician workflow

Collaborators:
- Physicians and other healthcare system representatives
- Food growers, distributors and retailers
- Local entrepreneurs
- Food access activists and community residents
- Economic development entities
- Philanthropic organizations
- Local government / lawmakers
Example Project
Linking healthcare and housing

Collaborators come together to increase housing stability in the community by:

• Building/renovating multi-unit dwellings to provide affordable, safe rental properties
• Retrofitting homes to be safe and healthy
• Integrating housing screening into standard physician workflows
• Establishing a process for patients to be linked to resources for affordable housing options and home retrofits

Collaborators:
> Physicians and other healthcare system representatives
> Community and economic development entities
> Community housing activists and residents
> Philanthropic organizations
> Local government / lawmakers
Example Project
Peer counselors workforce trained to provide behavioral healthcare

Collaborators come together to expand access to mental healthcare and substance abuse recovery by:

• Training/certifying community residents in recovery from mental and substance use disorders to become peer counselors
• Providing for supervision of peer counselors by psychologists and other specialists

Collaborators:
> Hospitals
> Residential/outpatient rehabilitation facilities
> Behavioral healthcare providers
> Mental health activists and community residents
> Faith organizations
> Workforce development specialists
> Philanthropic organizations
Healthcare Transformation Collaboratives:
Application Requirements
Collaborations must take a “community-first” approach to proposed projects

Community input is a key proposal requirement. HFS will prioritize innovation partnerships that meaningfully engage community members to address their needs and the barriers they face to maintaining health and accessing healthcare.

To truly transform health, citizens need to be involved in transformation in a meaningful way. The more people and communities are engaged in collaboration efforts, the more impact they will have.
Projects must improve health outcomes and reduce disparities

HFS is seeking projects that improve health outcomes and reduce disparities by addressing challenges related to:

- Access to care
- Social determinants of health
- And/or care integration and coordination
Projects must be driven by data

The focus of transformation efforts must be supported by data

Data for select areas available at HFS.illinois.gov/Transformation:

HFS contracted with UIC to conduct data analysis of Medicaid claims and community input sessions in the following areas of Illinois:

- Chicago-South Side
- Chicago-West Side
- East St. Louis Metropolitan Area
- South Cook County
- West Cook County

For efforts outside these areas:

- More areas are being targeted for data analysis.
- HFS will be providing a data set that applicants and consulting partners can use.
- The data set will not be available for the April application due date but will be made available well in advance of the fall funding cycle for applicants.

1Claims data was analyzed in West Cook County but community input sessions were not conducted in this area.
Projects must align with and use HFS Quality Pillars and Metrics

Projects must align with one or more of HFS’ Quality Pillars…

- Maternal and Child Health
- Adult Behavioral Health
- Child Behavioral Health
- Equity
- Improving Community Placement

**and track metrics to show impact on outcomes and equity**

- Applicants must propose metrics that the program will be accountable for improving
- For a given quality pillar, one or more metrics from the HFS Quality Strategy document that aligns with that pillar must be tracked
- Once metrics are agreed upon in the funding agreement, HFS will establish a baseline metrics for the community, a method for tracking process and improvement targets
At a minimum, proposals must...

- Bolster or retain jobs in the community
- Be financially sustainable within 5 years
- Incorporate racial equity in the project
- Demonstrate appropriate minority business participation in projects
SUMMARY OF REQUIREMENTS

· Meaningfully engage community members to address health and healthcare access challenges

· Improve health outcomes and reduce disparities by addressing access, social determinants of health and/or care integration and coordination

· Provide data that supports the need for the project

· Establish metrics to show impact on health outcomes and equity

· Show a path to sustainability

· Bolster or retain jobs in the community

· Incorporate racial equity in the project

· Demonstrate minority participation in the project
Healthcare Transformation Collaboratives: Logistics
Key Dates: Spring 2021 Funding Cycle

March
- 3/8: Spring application for funding available
- 3/12 Informational webinar
- 3/15 Questions about application due to HFS

April
- 4/9 Spring applications due

May

June
- Awards announced no later than June 30th
Healthcare Transformation Collaboratives

Reorienting our system in Illinois around people and communities: This is the goal of Healthcare Transformation Collaboratives.

There are four major components to the Transformation plan:

- Focus on community needs, for all levels of healthcare, with an emphasis on addressing social and structural determinants of health.
- Improve health and wellness for individuals and communities.
- Tailor solutions to meet the unique needs of individual communities.
- Invest in projects, large and small, that improve outcomes, decrease disparities, and are sustainable over time.

Stay informed by signing up below for alerts

"... ensuring equitable healthcare access and delivery is more important than ever, especially in Black and Brown communities, and for Illinois residents who are uninsured or underinsured."* Governor J.B. Pritzker

Application and Tools

- HFS Healthcare Transformation Collaboratives Application (pdf)
- Application Budget Form (xls)
- Application Overview/Provider Notice
- Healthcare Transformation Collaboratives: Executive Summary (pdf)
- Comprehensive Medical Programs Quality Strategy (pdf)
- Frequently Asked Questions (FAQs) (pdf)

FY2021 application is available now on HFS.illinois.gov/Transformation as a downloadable PDF (supporting materials can be found here as well)

- Questions about the application should be submitted via email to HFS.Transformation@Illinois.gov

- Completed applications should be submitted via email to HFS.Transformation@Illinois.gov
Not ready now? No problem.

There will be future funding cycles along with opportunities for applicants to get consulting support to prepare proposals.

Future Funding Cycles:
- Fall 2021 (application due date forthcoming)
- Future funding cycles will be announced later this year

Consulting support:
- Application for consulting support will be announced soon
- For Fall 2021 applicants, consulting support will be available starting in June
Consulting support will be available for funding application for Fall 2021 and beyond.

Requests for consulting support will require a separate application (application to launch soon).

Example types of consulting support to be provided:
- Support for creating a governance structure for collaborations
- Assistance with developing a Clinically Integrated Network
- Data analytics
- Healthcare IT infrastructure
- Community engagement
- Evaluation of physical plant improvement for capital funding
- Racial equity
STAY CONNECTED

Register for HTC updates at
HFS.illinois.gov/Transformation

Email Questions No Later Than Monday, March 15, 2021 to:
HFS.Transformation@illinois.gov
Q&A