



# HEALTHCARE TRANSFORMATION PROPOSAL

November 2020

# 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.



## This is possible because...

<b>...WE VALUE OUR STAFF AS OUR GREATEST ASSET.</b> We do this by:	<b>...WE ARE ALWAYS IMPROVING.</b> We do this by:	<b>...WE INSPIRE PUBLIC CONFIDENCE.</b> We do this by:
<ul style="list-style-type: none"> <li>▶ Fully staffing a diverse workforce whose skills and experiences strengthen HFS.</li> <li>▶ Ensuring all staff and systems work together.</li> <li>▶ Maintaining a positive workplace where strong teams contribute, grow and stay.</li> <li>▶ Providing exceptional training programs that develop and support all employees.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Having specific and measurable goals and using analytics to improve outcomes.</li> <li>▶ Using technology and interagency collaboration to maximize efficiency and impact.</li> <li>▶ Learning from successes and failures.</li> </ul>	<ul style="list-style-type: none"> <li>▶ Using research and analytics to drive policy and shape legislative initiatives.</li> <li>▶ Clearly communicating the impacts of our work.</li> <li>▶ Being responsible stewards of public resources.</li> <li>▶ Staying focused on our goals.</li> </ul>



## RECENT INVESTMENTS IN THE HEALTHCARE ECOSYSTEM

- Distributed first round of CARES payments of \$150 million; \$60 million of which is directed specifically to Medicaid providers in disproportionately affected areas.
- Unprecedented response during first months of pandemic to ensure access through eligibility maintenance and new access points, such as telehealth. MCO partners have distributed food and worked on multiple SDoH projects and done rate add-ons for behavioral health. \$75 million in stability payments to hospitals.
- Led negotiation and implementation of \$250 million new funding through the FY21 hospital assessment, with \$85 million directed towards Safety-Net hospitals.
- Significant funding for enhanced rates, including \$150 million towards physician rate increases, minimum wage increases in several areas, and increases for behavioral health (mental health and SUD).
- Developed system to accept and screen all Medicaid provider claims and forward to the MCOs to provide more transparency into billing and denial issues.
- Updated Managed Care Resolution Portal to ensure fair resolution of disputes involving MCOs and providers in an electronic and secure format.
- Leveraging enhanced federal funding to connect health care providers and MCOs in a unified, state-wide Healthcare Data Exchange System (HL7 format).
- Rolling out 5-pillared Quality Strategy to invest in priorities such as equity and behavioral health.
- Invested \$66.2 million with minority and women owned businesses through MCOs - representing a 37% increase in expenditures with diverse businesses over FY19.

## 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



## A WORK IN PROGRESS

What we've done to get to  
where we are now...

- Lots of listening – to individual hospitals and other providers, to legislators and stakeholders, to presentations of specific transformation ideas from providers, MCOs, Safety Nets, FQHCs, SEIU, IPHI, and more
- Worked with Medicaid Work Group and additional legislators to identify key components of a process
  - Real, sustainable, equitable, customer-focused change
  - Outcome-based solutions to reduce healthcare disparities
  - Transformation funds not going toward the status quo
- Toured several Safety-Net Hospitals
- Heard from advocates, industry consultants, foundations and volunteers about change needed
- **Commissioned an academic community needs & data study (UIC)**



# WHY TRANSFORMATION?



**THE STATUS QUO IS  
NOT BRINGING THE  
RESULTS PEOPLE  
WANT OR DESERVE**

*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*

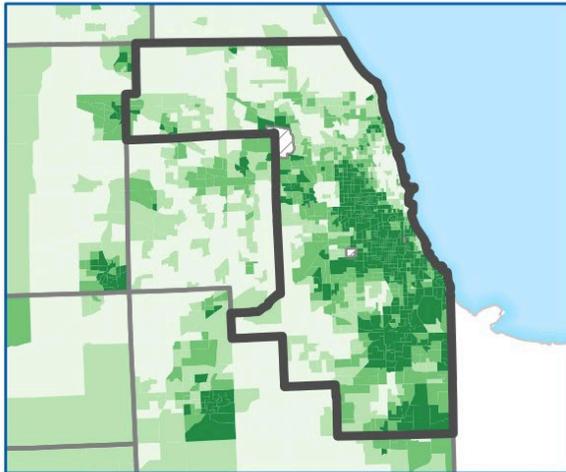
- Inconvenient, inconsistent, expense-ridden care that's often not culturally competent
- Care that does not focus on Chronic Disease management
- Care that doesn't fit people's lives



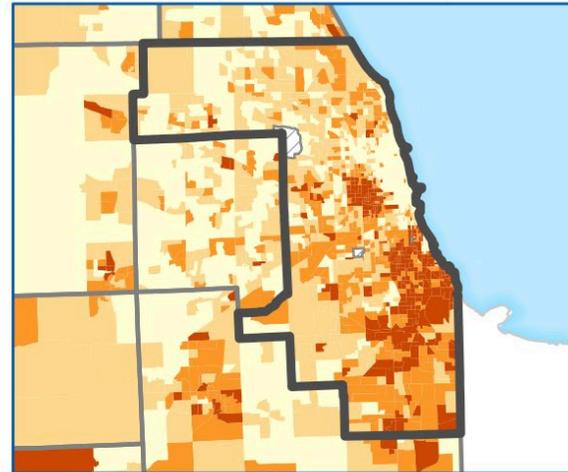
*RESULTING IN*

- **Poor Health Outcomes**

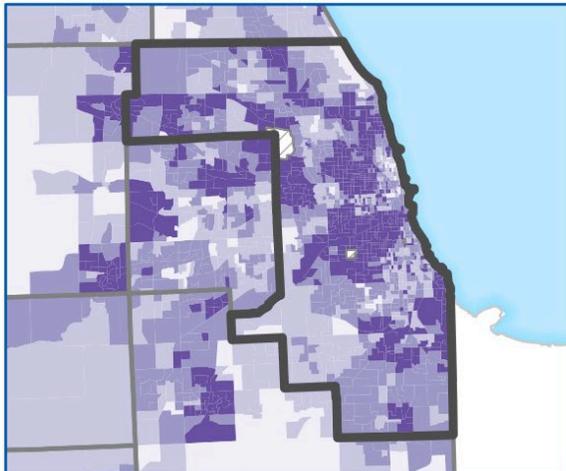
### Socioeconomic Status



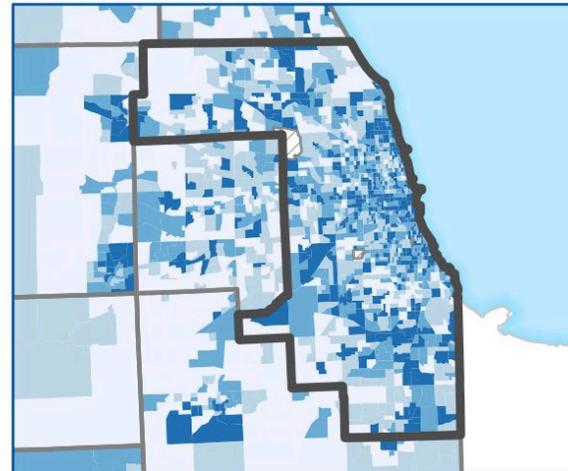
### Household Composition/Disability



### Race/Ethnicity/Language



### Housing/Transportation



## SOCIAL INEQUITIES AMPLIFY THE PROBLEM

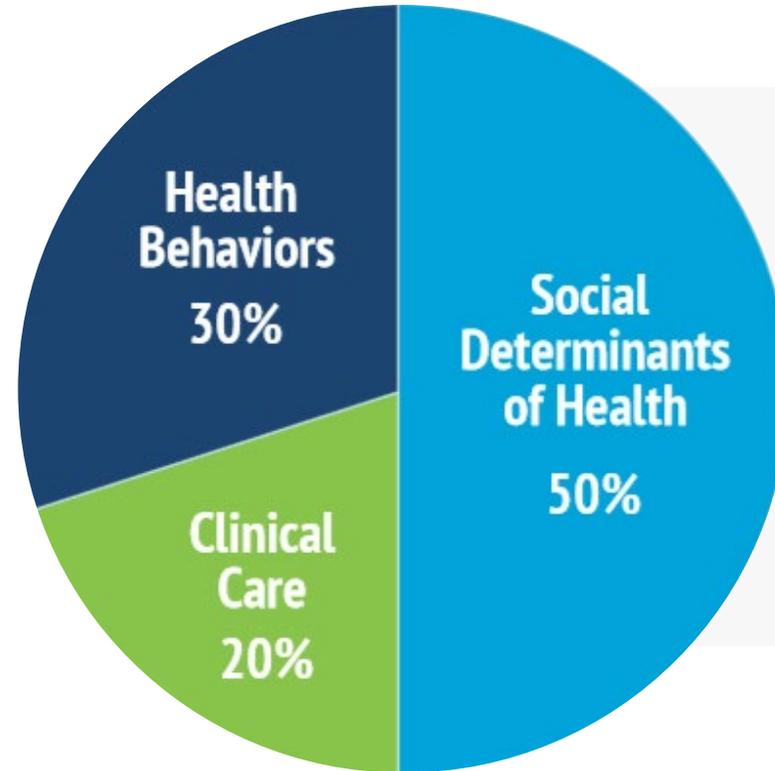
- Disparities exist in every county in Illinois.
- Communities are impacted in different ways whether its economic, race, language, housing, transportation or disability.
- Each community has different needs to work toward equity.

# Social determinants influence 50% of a community's health outcomes

Clinical care accounts for no more than 20 percent of a community's health and individual health behaviors, no more than 30%<sup>1</sup>.

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

This is often summed up as: *a person's health is more a matter of one's zip code than their genetic code.*



- Economic stability
- Education
- Housing
- Transportation
- Food security
- Social support networks
- Environmental quality

<sup>1</sup>Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. American Journal of Preventive Medicine 50(2):129-135. <https://doi.org/10.1016/j.amepre.2015.08.024>



# Meet the UIC Team

## UIC SCHOOL OF PUBLIC HEALTH (SPH)



**Jibril Alim**  
Research Asst.,  
Epidemiology &  
Biostatistics



**Sanjib Basu**  
Data Lead;  
Professor,  
Epidemiology &  
Biostatistics



**Joel Flax-Hatch**  
Research Asst.,  
GIS



**Vincent Freeman**  
Epi Lead; Assoc.  
Professor,  
Epidemiology &  
Biostatistics



**Yan Gao**  
Research Asst.,  
Epidemiology &  
Biostatistics



**Wayne Giles**  
Dean, UIC School  
of Public Health



**Ronald Hershow**  
Assoc. Professor,  
Epidemiology &  
Biostatistics



**Heng Wang**  
Clinical Asst.  
Professor,  
Epidemiology &  
Biostatistics

## UIC INSTITUTE FOR HEALTHCARE DELIVERY DESIGN (IHDD)



**Kshitij Gotiwale**  
Communication  
Designer



**Ann Kauth**  
Project Lead,  
Design  
Researcher



**Jerry Krishnan**  
Asst. Vice  
Chancellor,  
Population Health  
Sciences



**Hugh Musick**  
Project Oversight



**Jenni Schneiderman**  
Community Input  
Lead; Design  
Strategist



**Tracy Weems**  
Business Operations  
and Project  
Management Asst.

## COLLABORATORY FOR HEALTH JUSTICE



**Jeni Hebert-Beime**  
Interim Assoc. Dean  
for Community  
Engagement

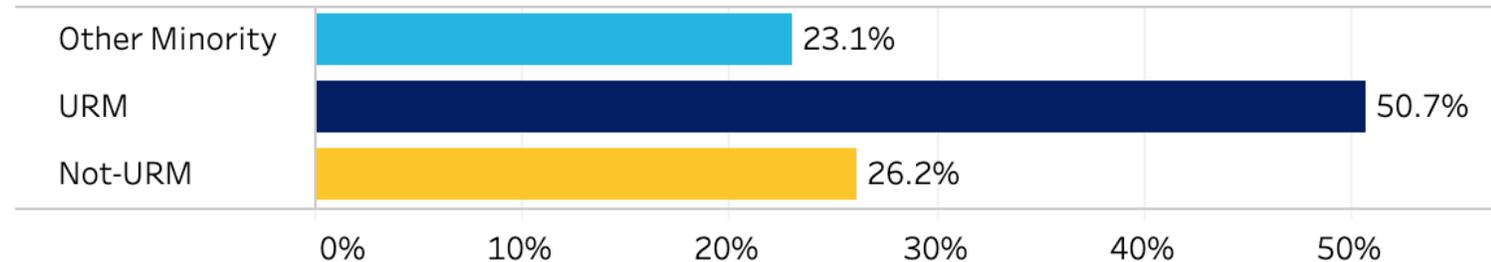


**Alexis Grant**  
Community  
Engagement Fellow



- One of the nation's most diverse public research universities
- Federally-designated as a Minority-Serving Institution (MSI), Hispanic-Serving Institution (HS) and Asian American and Native American Pacific Islander-Serving Institution (AANAPISI)
- 2018 Higher Education Excellence in Diversity (HEED) Award Recipient
- 29.7% of faculty and staff are under-represented minorities (URM)
- UIC's commitment to diversity, community engagement and equity attracts both students and faculty to the school

### 2019 Student Enrollment by Under-Represented Minority (URM) Status





## SCHOOL OF PUBLIC HEALTH



Committed to:

- **Community** as the basic unit of analysis for public health, enabling communities to address their own problems, sharing skills, lowering barriers to action, and acting as a catalyst for progress.
- **Justice** whereby everyone is given access to the resources necessary to live a humane life and to fulfill their full potential.
- **Diversity**, celebrating unique contributions to the fabric of our community
- **Respect**, for the members of this community and for those whom our efforts are intended to serve
- **Equity**, in health and social justice
- **Engagement**, with the communities we serve

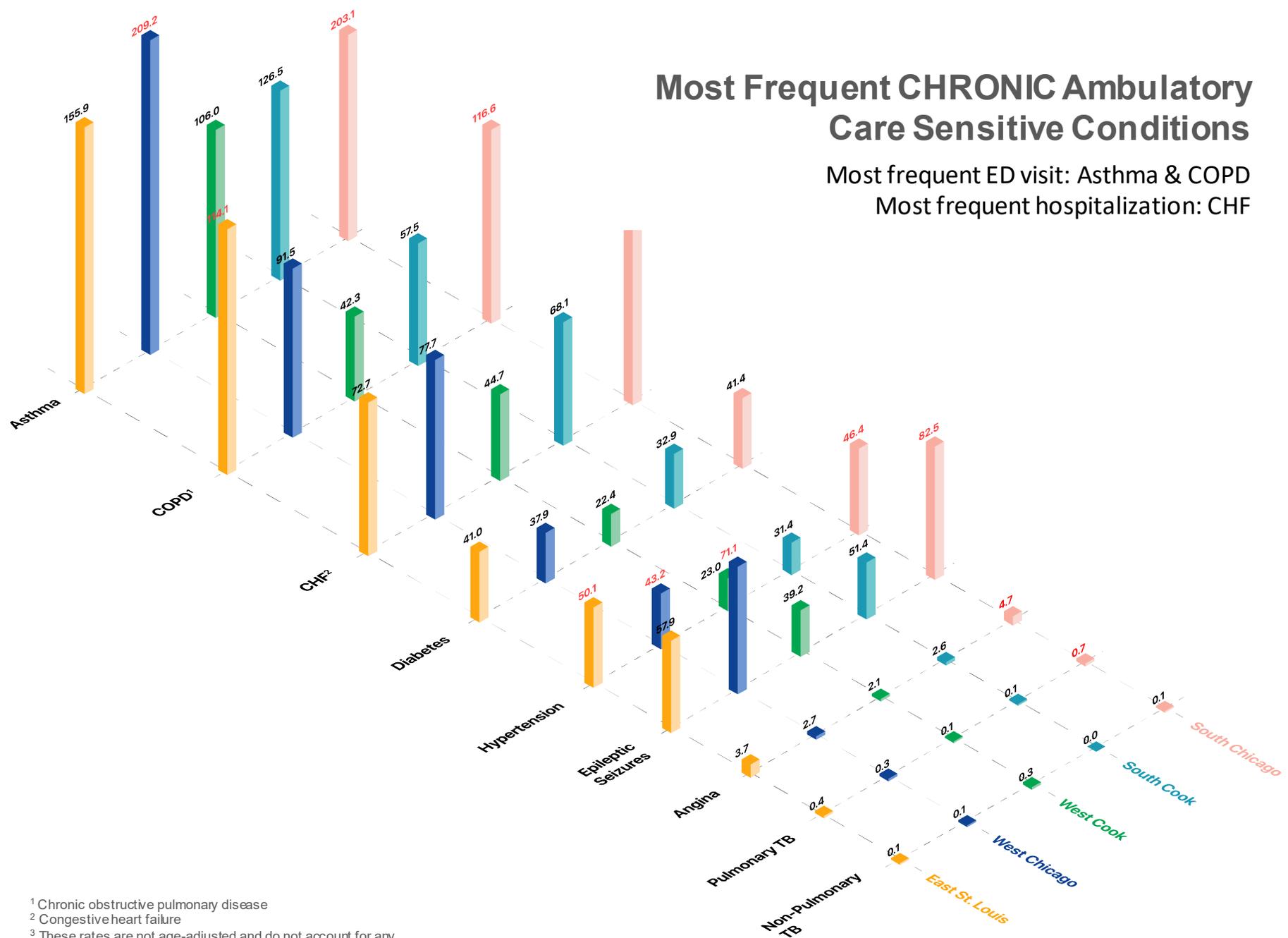


## FOR EXAMPLE:

Communities with high rates of social vulnerability have high rates of hospital-level care for uncontrolled chronic diseases

Most frequent **CHRONIC** Ambulatory Care Sensitive Conditions (ACSCs) associated with hospitalizations and ED visits<sup>3</sup>

Crude rates per 10,000 Medicaid enrollees by catchment area, Medicaid Utilization Data FY2018



<sup>1</sup> Chronic obstructive pulmonary disease

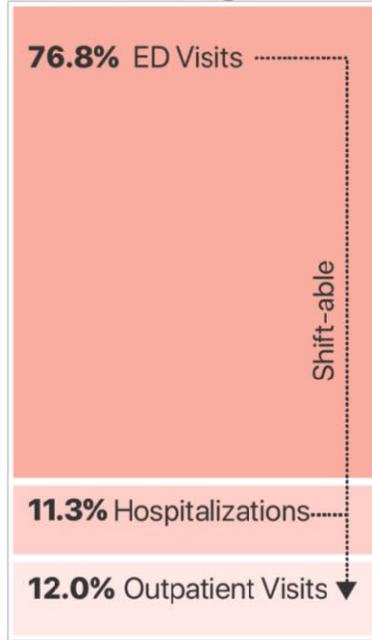
<sup>2</sup> Congestive heart failure

<sup>3</sup> These rates are not age-adjusted and do not account for any differences in the age distribution of the Medicaid recipient population between catchment areas.

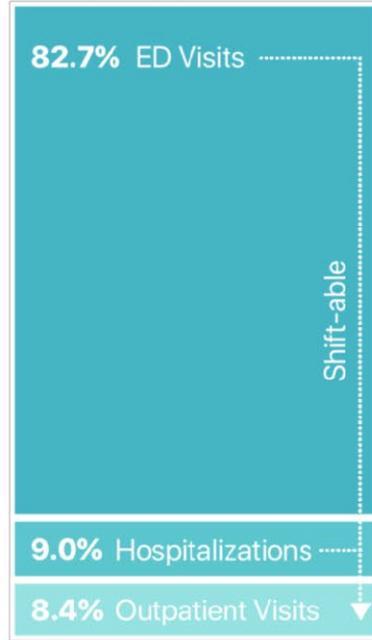


# These uncontrolled chronic diseases come at a high cost to the system...

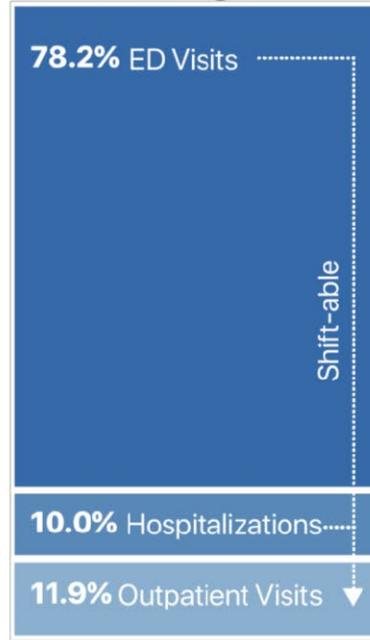
## South Chicago



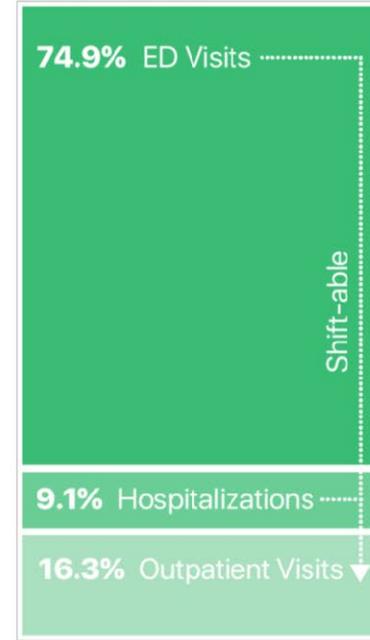
## South Cook



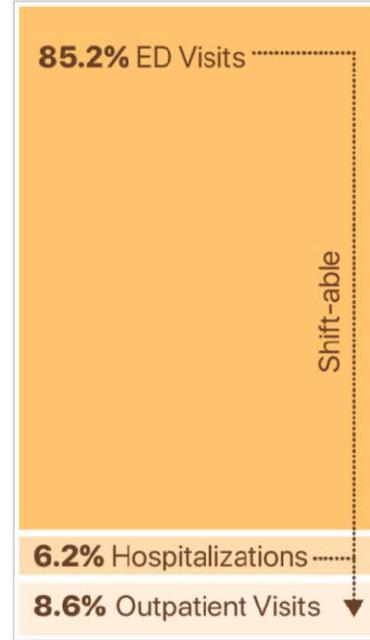
## West Chicago



## West Cook



## East St. Louis



### Top ACSC ED Visits

- Severe ENT Infection
- Asthma
- COPD

- Severe ENT Infection
- Asthma
- Bronchitis

- Severe ENT Infection
- Asthma
- COPD

- Severe ENT Infection
- Asthma
- Cellulitis

- Severe ENT Infection
- Dental Conditions**
- Cellulitis

### Top ACSC Hospitalizations

- CHF
- COPD
- Asthma
- Bacterial Pneumonia
- Diabetes

- CHF
- Diabetes**
- COPD
- Bacterial Pneumonia
- Asthma

- CHF
- COPD
- Asthma
- Bacterial Pneumonia
- Diabetes

- CHF
- Bacterial Pneumonia
- Asthma
- COPD
- Cellulitis

- CHF
- COPD
- Bacterial Pneumonia
- Diabetes
- Cellulitis

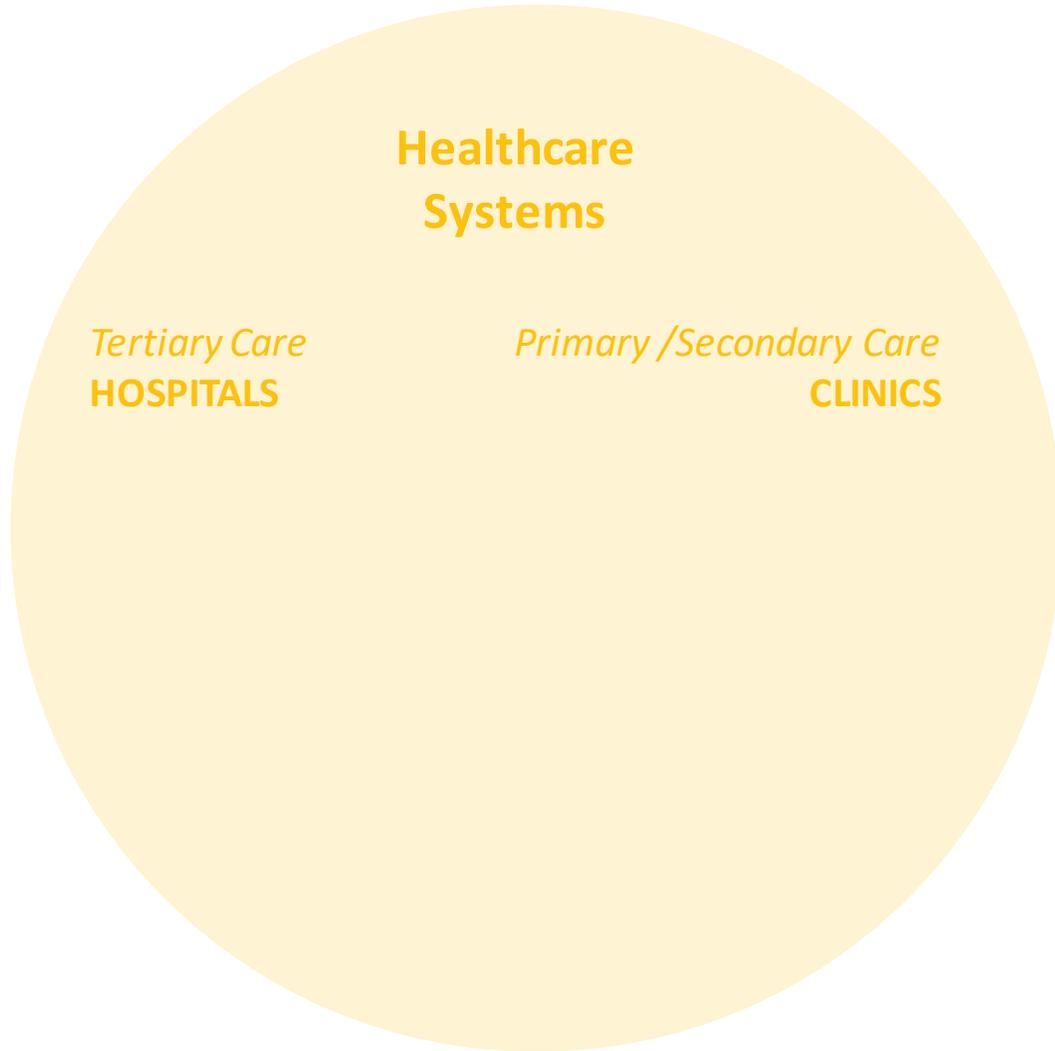


And at a high cost  
to individuals and  
families...

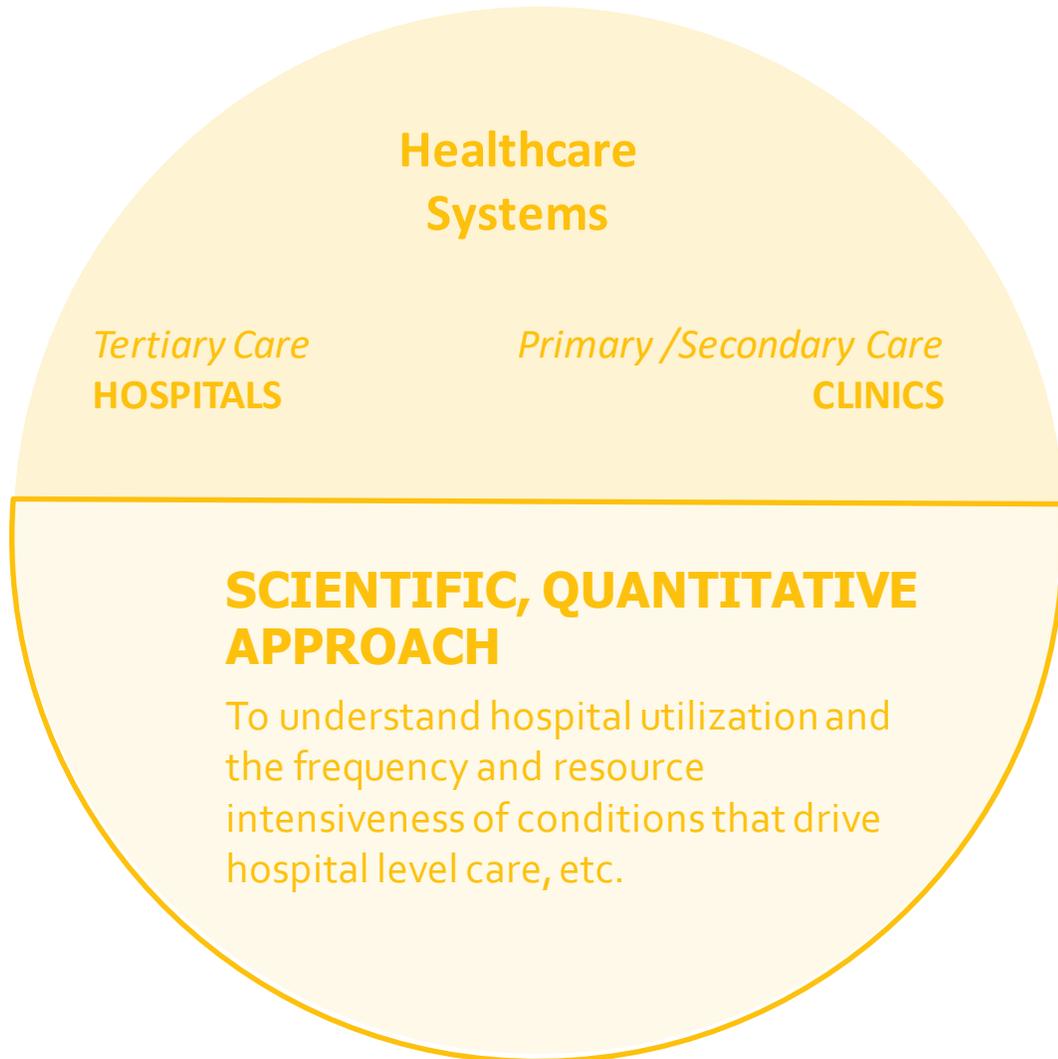
*“We found my uncle in a diabetic coma because he could not afford his medication. His everyday life, now, is someone trying to take care of him because he cannot take care of himself. His manhood was taken away because he couldn’t afford his insulin and because he couldn’t afford to eat properly.”*

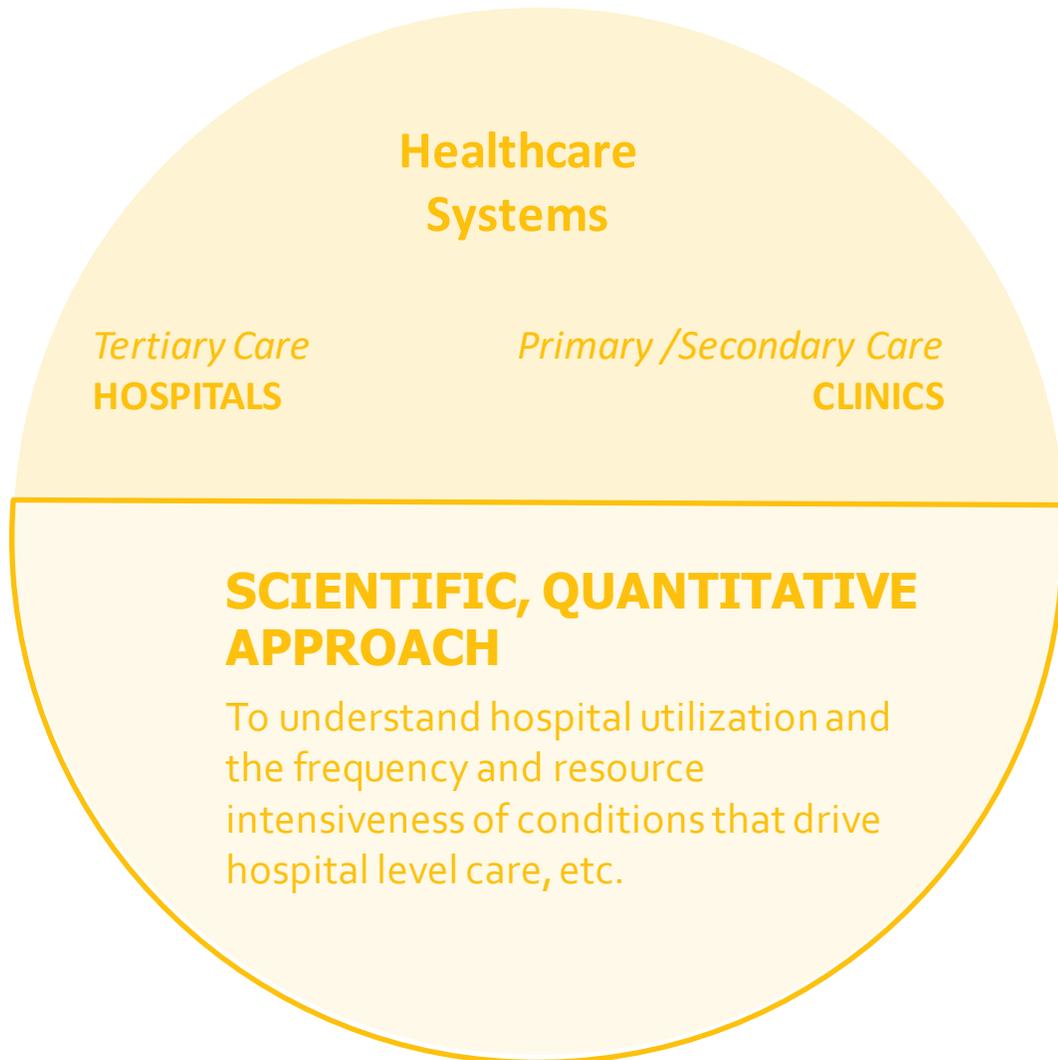
**- Female, 26-35 years old, Markham, IL**

# Yet current care delivery models treats the healthcare system and the community as two distinct, self-contained domains



# Accounting for social determinants of health calls for a comprehensive approach to understanding healthcare needs





- **Started with 5 of the most distressed areas in Illinois:**
  - South Chicago
  - West Chicago
  - South Cook
  - West Cook
  - East St. Louis Metro area
- **Identified the most frequent and resource intensive conditions that drive hospitalization**
- **Identified demographic/geographic populations most closely associated with hospital-level care for key conditions**



# Top Most Frequent and Resource Intensive Hospitalizations Diagnoses

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

## SO. CHICAGO

Mood affective disorders (bipolar, depression)

Schizophrenia, schizotypal disorders

Psychoactive substance use disorders (alcohol, opioids)

Hypertensive diseases

Chronic lower respiratory diseases (asthma, COPD)

Diabetes mellitus

Cerebrovascular diseases

Complications of surgical/ medical care

Hemolytic anemias

Other forms of heart disease Diseases of liver

## SOUTH COOK

Mood affective disorders (bipolar, depression)

Schizophrenia, schizotypal disorders

Psychoactive substance use disorders (alcohol, opioids)

Hypertensive diseases

Chronic lower respiratory diseases (asthma, COPD)

Diabetes mellitus

Cerebrovascular diseases

Complications of surgical/ medical care

Hemolytic anemias

Diseases of liver

## WEST CHICAGO

Mood affective disorders (bipolar, depression)

Schizophrenia, schizotypal disorders

Psychoactive substance use disorders (alcohol, opioids)

Chronic lower respiratory diseases (asthma, COPD)

Hypertensive diseases

Diabetes mellitus

Cerebrovascular diseases

Complications of surgical/ medical care

Hemolytic anemias

Diseases of liver

## WEST COOK

Mood affective disorders (bipolar, depression)

Schizophrenia, schizotypal disorders

Other bacterial diseases (sepsis)

Psychoactive substance use disorders (alcohol, opioids)

Chronic lower respiratory diseases (asthma, COPD)

Hypertensive diseases

Diabetes mellitus

Cerebrovascular diseases

Complications of surgical/ medical care

Diseases of liver

## EAST ST. LOUIS

Mood affective disorders (bipolar, depression)

Psychoactive substance use disorders (alcohol, opioids)

Schizophrenia, schizotypal disorders

Hypertensive diseases

Diabetes mellitus

Hemolytic anemias

Child/adolescent behavioral & emotional disorders

Noninfective enteritis and colitis

Chronic lower respiratory diseases (asthma, COPD)

Other bacterial diseases (sepsis)

**Mental Illnesses** (especially, bipolar and depression and schizophrenia)

**Substance Use Disorders** (especially, alcohol and opioid)

**Ambulatory Care Sensitive Conditions** (especially, hypertension, asthma, COPD and diabetes)



# Middle-age to senior men are most closely associated with top conditions

## Depressive Disorders

- **Middle ages (45-64)**
- **Men**
- **West Chicago is particularly burdened** by hospitalizations for depressive disorders

## Bipolar Disorders

- No one particular age group is associated with this condition
- **Men**
- **West Chicago is particularly burdened** by hospitalizations for depressive disorders

## Alcohol Use Disorders

- No one particular age group is associated with this condition
- **Men**
- No one area is particularly burdened with this condition (all areas have high rates)

## Opioid Use Disorders

- **Middle ages (45-64)**
- **Men**
- **West Chicago is particularly burdened** by hospitalizations for depressive disorders

## Asthma

- **Middle ages and seniors (45+)**
- **Men**
- **West Chicago is particularly burdened** by hospitalizations for chronic ACSCs such as Asthma

## COPD

- **Middle ages and seniors (45+)**
- **Men**
- **West Chicago is particularly burdened** by hospitalizations for chronic ACSCs such as COPD

## Hypertension

- **Middle ages and seniors (40+)**
- **Men**
- No one area is particularly burdened with this condition (all areas have high rates)

## Diabetes Mellitus

- **Middle ages and seniors (40+)**
- **Men**
- **West Chicago & East St. Louis Metro Area are particularly burdened** by hospitalizations for diabetes

- **Partnered with community organizations to conduct community input sessions**
  - Community organizations recruited residents (using a convenience sample)
  - Community organizations conducted the conversations
  - Collaborated with community organizations to interpret the findings
  
- **Used a human-centered design approach**
  - Use of open-ended, exploratory conversations to understand people’s experiences of health & healthcare
  - Conducted a cluster analysis of conversations to find consistent patterns
  - Identified key patterns related to needs and barriers to health and healthcare
  - Used these patterns to guide solution development\*



\* In HCD, after guiding principles are identified, prototype solutions are crafted based on those principles, tested and modified as needed until a solution is finalized.



# Community Input Partners and Stats

## Session logistics

- Small group discussion
- 1.5 hour sessions
- Held via WebEx phone call

## Community Partners



**South Cook:**  
Southland Ministerial Health Network



**West Chicago\*:**  
Chicago Hispanic Health Coalition



**South Chicago:**  
Teamwork Englewood

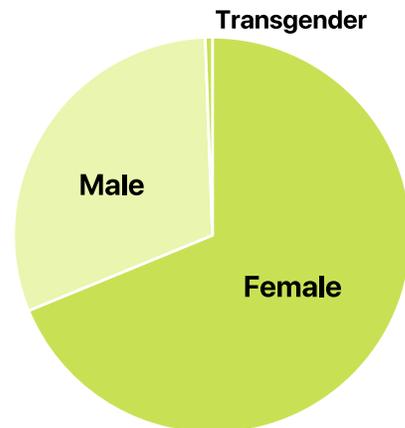
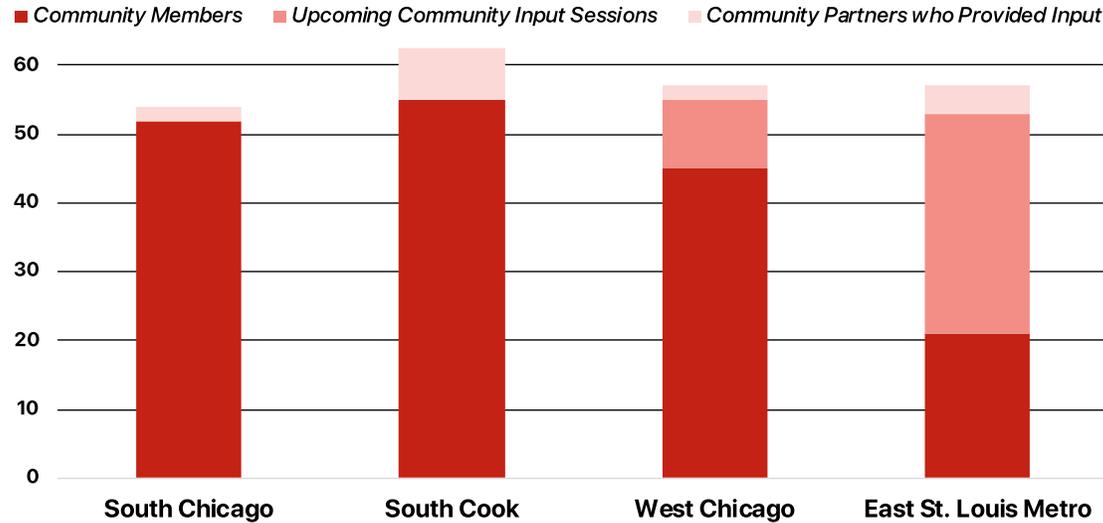


**East St. Louis Metro Area:**  
University of Illinois Extension Service (St. Clair Co.) and the Madison County Housing Authority (Madison Co.)

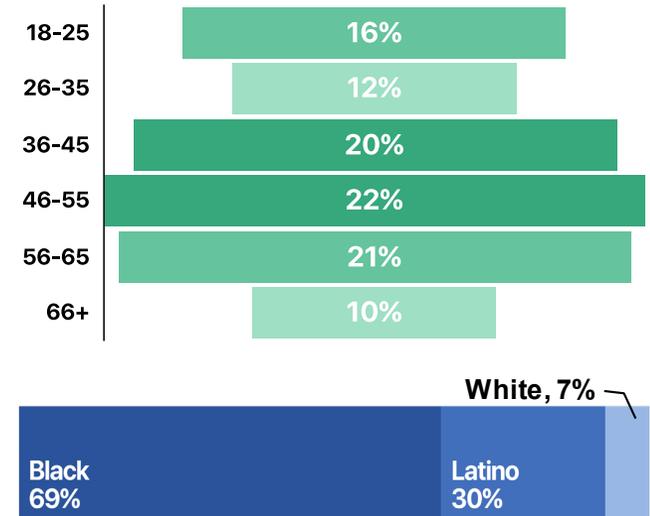


\* We are utilizing relationships that Teamwork Englewood has in West Chicago to do additional community input there

## Participants



## Age & Race



## Insurance Status

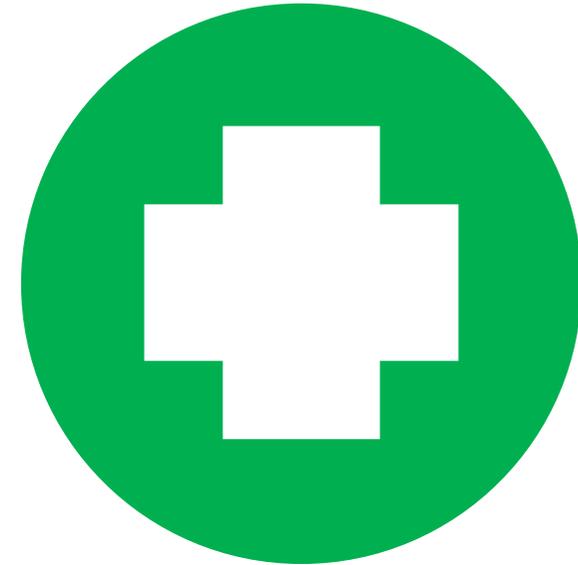
Insured - Private (Employer)	+++++ 27%
Insured - Private (Self)	++ 2%
Insured - Medicaid	+++++ 35%
Insured - Medicare	+++++ 13%
Uninsured	+++++ 23%

## WHY A HUMAN-CENTERED DESIGN APPROACH?

Human-centered design is used to build experiences that “fit” people:



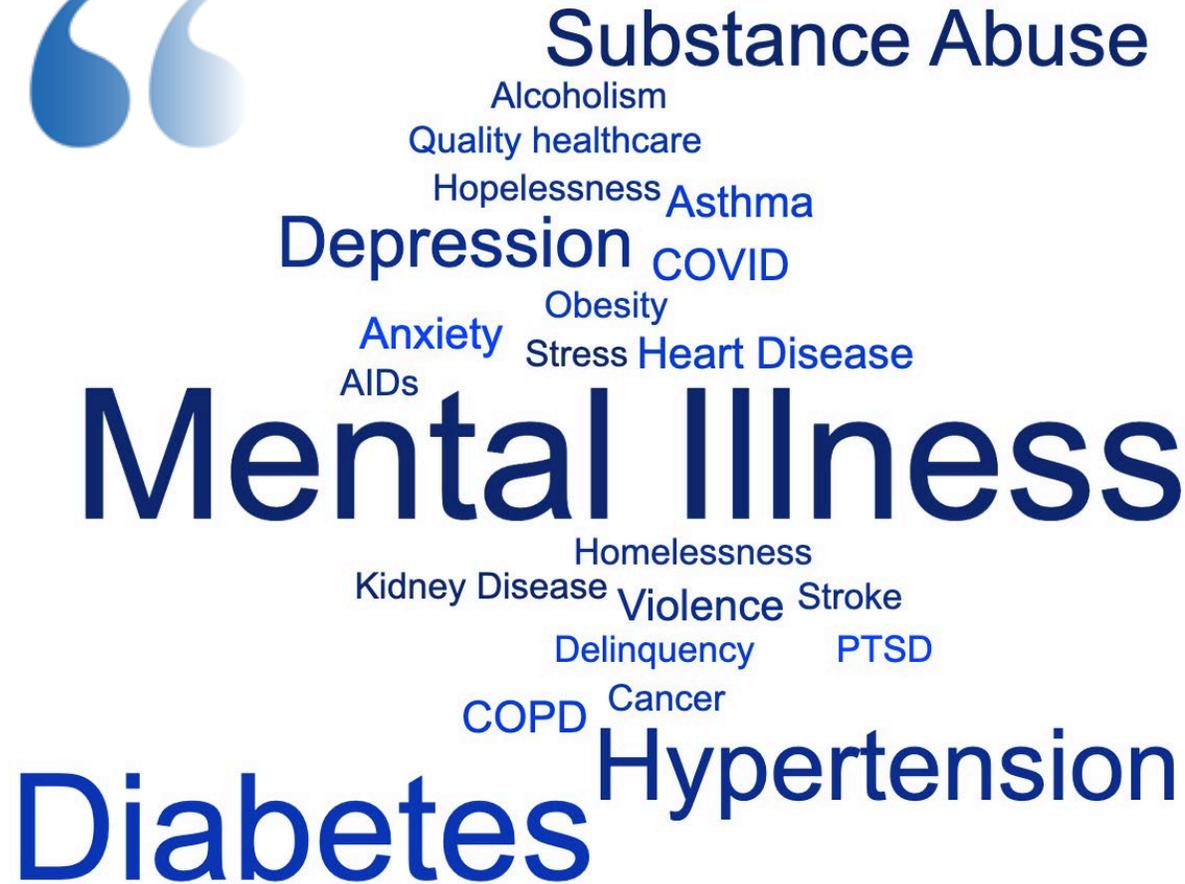
We've come to expect a good user experience here, one that can be tailored to our needs



Why should healthcare be any different?

## We want healthcare to work for people.

Top health concerns for community residents:



## COMMUNITY MEMBERS' TOP CONCERNS ECHO DATA FINDINGS

**We also heard stories about historic, cultural, economic and logistical barriers to healthcare as well as disconnections between the care people expect and need and the care they experience.**



**Barb\*, age 56**  
**Chicago, West Side**  
**Public Insurance: Medicaid**

*\*Name changed*

*Photo source: Photo by [Nickolas Nikolic](#) on [Unsplash](#)*

## Currently disabled, former bookkeeper

- Abuse survivor
- Wife, sister, mother, grandmother
- Living with with bipolar disorder

*“My psych doctor went into adolescent psychiatry so I was transferred to another psych doctor. **I was just handed over to her. She didn’t really read my background or get to know me.** I saw a new medication for bipolar on TV and I was interested in trying it because it said you don’t gain weight with it. I mentioned it to her...and her attitude was like, ‘you’re gonna take what I tell you to take.’ I didn’t like that.... I want to be included in conversations about what I take and what goes into my body.”*



**Rodney, age 29**  
**East St. Louis Metro Area**  
**Private Insurance**

*\*Name changed*  
*Photo source: UI Health Flicker*

## Short Haul Trucker

- Divorced, single dad to 2 young boys (partial custody)
- Struggles balancing work with caring for boys
- Concerned about his sedentary lifestyle and eating habits
- Living with type 2 diabetes

*“A couple of years ago, I wanted to go out for the Police Academy and I wanted to get into better shape. **My doctor told me to just eat a well-balanced diet. When I asked her about what that is, she told me to Google it. So I paid \$30 copay for that.** I do struggle to find information about just a well-balanced diet for regular people. A lot of the stuff I see is for people who are super-athletes and what they should eat. I just want to know what to eat that’s healthy for a regular person.”*

**Let's hear LaKeya's story....**

# LaKeya's Journey: Back then....

Lacked knowledge about diabetes prevention

Didn't know the signs and symptoms of diabetes

Lives in a USDA low income / low food access area

Lives in an area where the social and economic fabric has deteriorated

Previous doctors only prescribed medication

Lacked knowledge and support for best eating / exercise practices

# LaKeya's Journey: And now....

Has a collaborative relationship with a new doctor who is treating her diabetes holistically

Getting support and education from her provider around nutrition and physical activity

Has social support from her family and a Facebook group to change ingrained eating habits and adopt new physical activity habits

Passing down her new lifestyle habits to her daughter to prevent diabetes in the next generation of her family

# Imagine how much healthier our communities could be with:

**Broader community awareness of, and support for, healthy eating and physical activity habits**

**Access to affordable, healthy food**

**Year-round access to safe places for physical activity**

**More socially and economically stable communities**

**Broader awareness of diabetes signs and symptoms**

**Widespread screening and testing for diabetes**

**Trusted, accessible providers who collaborate with patients to treat diabetes and other chronic conditions holistically**

**Integrated nutrition and physical activity support**

# Community members, especially those with chronic conditions, clearly expressed wanting holistic, relationship-based, continuous care

## From transactional

“I got transferred to a another psych doctor for my bipolar. I was just handed over to her. She didn’t really read up on my background or get to know me.”



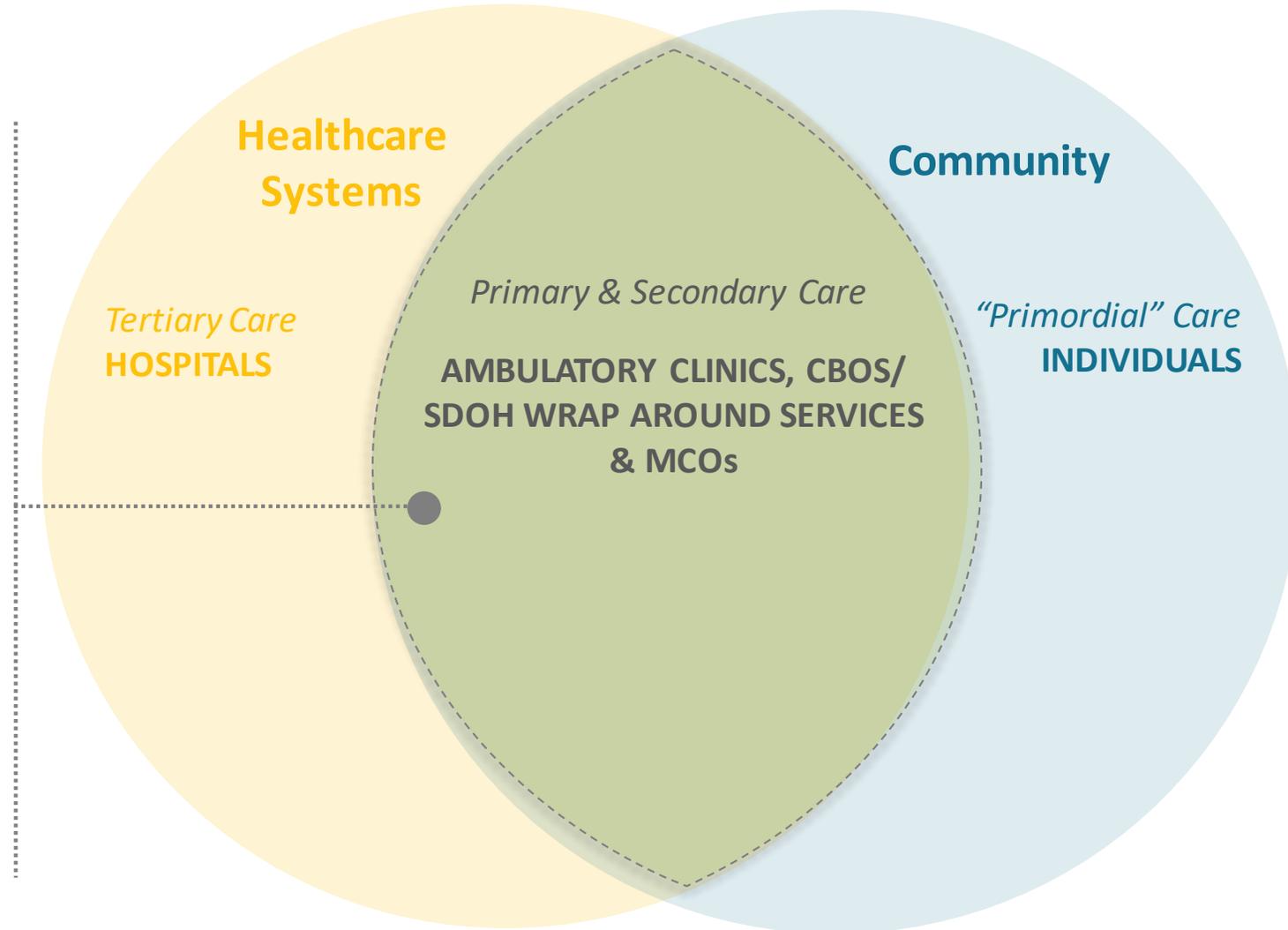
## To relationship-based

- **Depression**
- **Bipolar**
- **Substance use disorder**
- **Hypertension**
- **Diabetes**
- **Asthma/COPD**
- **+ Comorbidities**

**Health Homes and Care Coordination** are examples relational, continuous care.

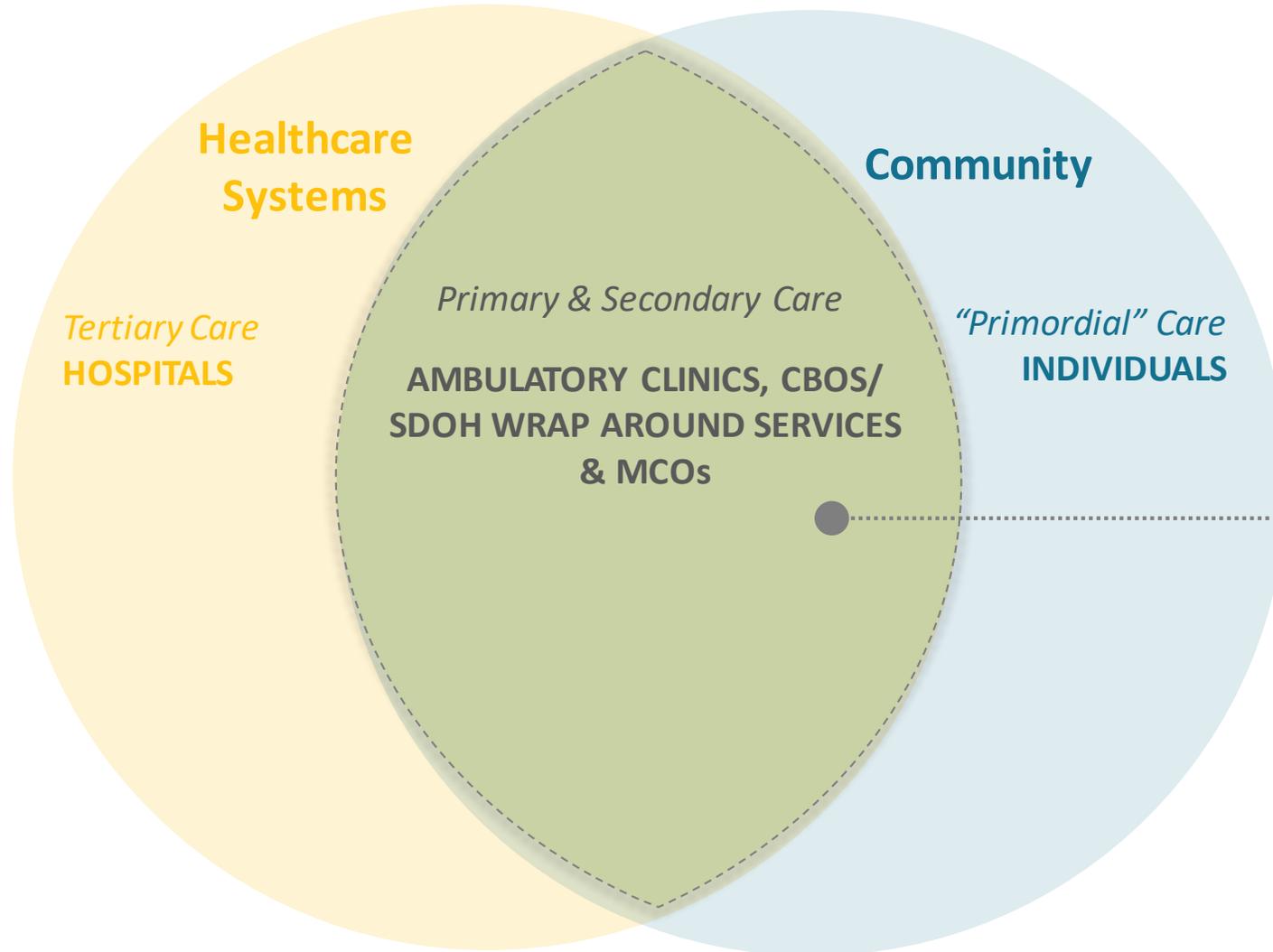
## Use MCO quality incentives to:

- Invest in clinic-community linkages (CCL) that address health and SDOH
- Promote continuous, relationship-based care for chronic conditions (integrated, coordinated care)
- Building capacity for CCL and integrated coordinated care
- Engage people in care
- Continuously reduce or eliminate barriers to care





# We do this by linking healthcare and community resources together to meet the needs of individuals in a more coordinated, holistic way



And, building these linkages will help restore **trust** in the healthcare system and increase engagement in health as a result



# EXAMPLE PROJECT: CHW Support of Low-Income Patients Across Primary Care Facilities

**Intervention site:** Philadelphia, PA

**Target population:** Patients\* who resided in a high-poverty zip code, uninsured or publicly insured, diagnosed with 2+ chronic diseases

**Dates:** January 2015 to March 2016

## CHALLENGE

- Half of the US population lives with a chronic disease.
- The burdens of chronic disease are even greater among **people with lower income, who often have multiple chronic conditions and face social challenges associated with worse outcomes.**

## INTERVENTION

**Use of community health workers (CHWs), trusted laypeople from the local community hired and trained by health care organizations, to support patients using the Individualized Management for Patient-Centered Targets (IMPACT - a standardized intervention in which CHWs provide tailored social support, navigation, and advocacy to help low-income patients achieve health goals)**

## RESULTS

Use of a standardized CHW intervention to address socioeconomic and behavioral factors can:

- improve quality of care
- reduce hospitalization

Kangovi S, Mitra N, Norton L, et al. Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities: A Randomized Clinical Trial. JAMA Intern Med. 2018;178(12):1635–1643. doi:10.1001/jamainternmed.2018.4630

\*Patients were recruited from a Veterans Affairs (VA) medical center, a federally qualified health center, and an academic family practice clinic.

# EXAMPLE PROJECT: The Community Agency–Delivered Care Transitions Intervention

**Intervention sites:** Two EDs\* in Northern Florida

**Target population:** Seniors with limited health literacy insured by Medicare

**Dates:** July 2103 to August 2014

## CHALLENGE

- **Older, chronically ill patients with limited health literacy are often under-engaged in managing their health and turn to the emergency department (ED) for healthcare needs.**
- Interventions to increase patient engagement can increase the use of preventive care, reduce hospital-based care and improve outcomes.

## INTERVENTION

- The ED-to-home intervention was modeled on the Care Transitions Intervention<sup>SM</sup> (CTI), an evidence-based program to increase patient engagement and reduce 30-day readmissions and healthcare costs in hospitalized patients.
- Trained **coaches from community area agencies on aging administered the intervention.**
- **Coaches helped ED-discharged patients schedule follow-up doctor visits, recognize disease worsening, reconcile medications; and communicate with providers.**

## RESULTS

The coaching intervention significantly **reduced declines in patient engagement** observed after usual post-ED care.

Schumacher JR, Lutz BJ, Hall AG, et al. Feasibility of an ED-to-Home Intervention to Engage Patients: A Mixed-Methods Investigation. *West J Emerg Med.* 2017;18(4):743-751. doi:10.5811/westjem.2017.2.32570

\*Site 1 ED (90,000 visits/year) is a tertiary referral center serving a community of 250,000 and a White (62%) and African-American (28%) population with various payers (40% public, 36% private).

\*Site 2 ED (89,000 visits/year) is a tertiary referral center serving a metropolitan area of one million and African-American (59%), White (33%), publicly insured (44%) and uninsured (24%) patients.



# EXAMPLE PROJECT:

## The Community Paramedic–Delivered Care Transitions Intervention

**Intervention sites:** EDs in Dane County, WI (Madison metro area) and Monroe County, NY (Rochester metro area)

**Target population:** Seniors discharging from the ED

**Dates:** January 2016 to Present

### CHALLENGE

- The ED is a crucial source of care for older adults living in the US
- **ED-to-home transition is frequently associated with adverse events** (e.g., readmission, mortality).
- The **ED discharge process often fails to ensure that people leaving the ED understand essential next steps** (e.g., managing meds, obtaining follow-up care, and identifying symptoms that require immediate medical attention).
- **Few interventions have demonstrated a consistent and statistically significant benefit**; those that do are difficult to implement in the time-pressured ED.

### INTERVENTION

- A slightly **modified Care Transitions Intervention (CTI)**, an evidence-based, hospital-to-home transitions program, to the ED-to-home context, to improve this transition for older adults
- 4-week program with enrollment in the ED at discharge, one in-person home visit, and up to 3 telephone support calls
- **Used paramedics to serve as coaches to deliver the CTI** (due to wide availability, advanced training, and community respect for these providers)

### RESULTS

- **CTI has been shown to reduce hospital readmissions and costs**
- **Initial findings show that ED-to-home CTI delivered via paramedics is feasible**

Shah, Manish N; Hollander, Matthew M; Jones, Courtney MC; Caprio, Thomas V; Conwell, Yeates; Cushman, Jeremy T; DuGoff, Eva H; Kind, Amy J.H; Lohmeier, Michael; Mi, Ranran; Coleman, Eric A. **Improving the ED-to-Home Transition: The Community Paramedic-Delivered Care Transitions Intervention-Preliminary Findings.** Journal of the American Geriatrics Society (JAGS), 2018-11, Vol.66 (11), p.2213-2220

**To change the status quo, we need to reorient the entire system around people and communities.**



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Making this change requires

# COLLABORATIVE COMMUNITY INVESTMENT



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## A Competitive RFP/Q Includes:

- An application process
- Scoring by the Department
- Lack of incentive for collaboration
- Not as focused on desired outcomes

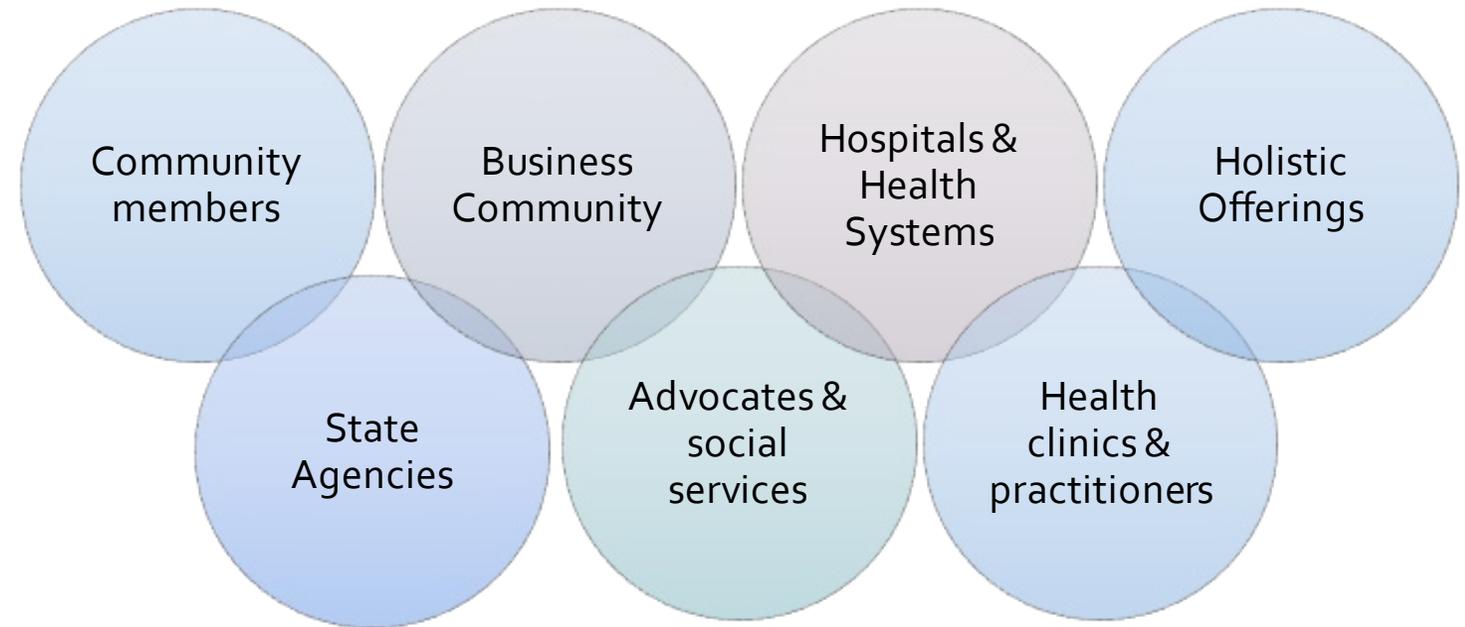


## Collaborative, Big Table Process

- Community-wide, whole system approach
- Proposals prioritized based on community input
- Broad multidisciplinary, community-based collaboration
- Focused on innovation and collaboration to radically change outcomes

# WHAT DOES COLLABORATION LOOK LIKE?

By collaborating, we encourage diverse perspectives to join together to create sustainable, person-centered, integrated, equitable change, *change that re-imagines healthcare delivery* at a the community level.



**We envision a process that integrates stakeholders across the care and community spectrum (from preventative care, primary care and specialty care to social service, community organizations and other community institutions) that will....**

Stimulate investment in communities with the most need by addressing gaps identified by community stakeholders

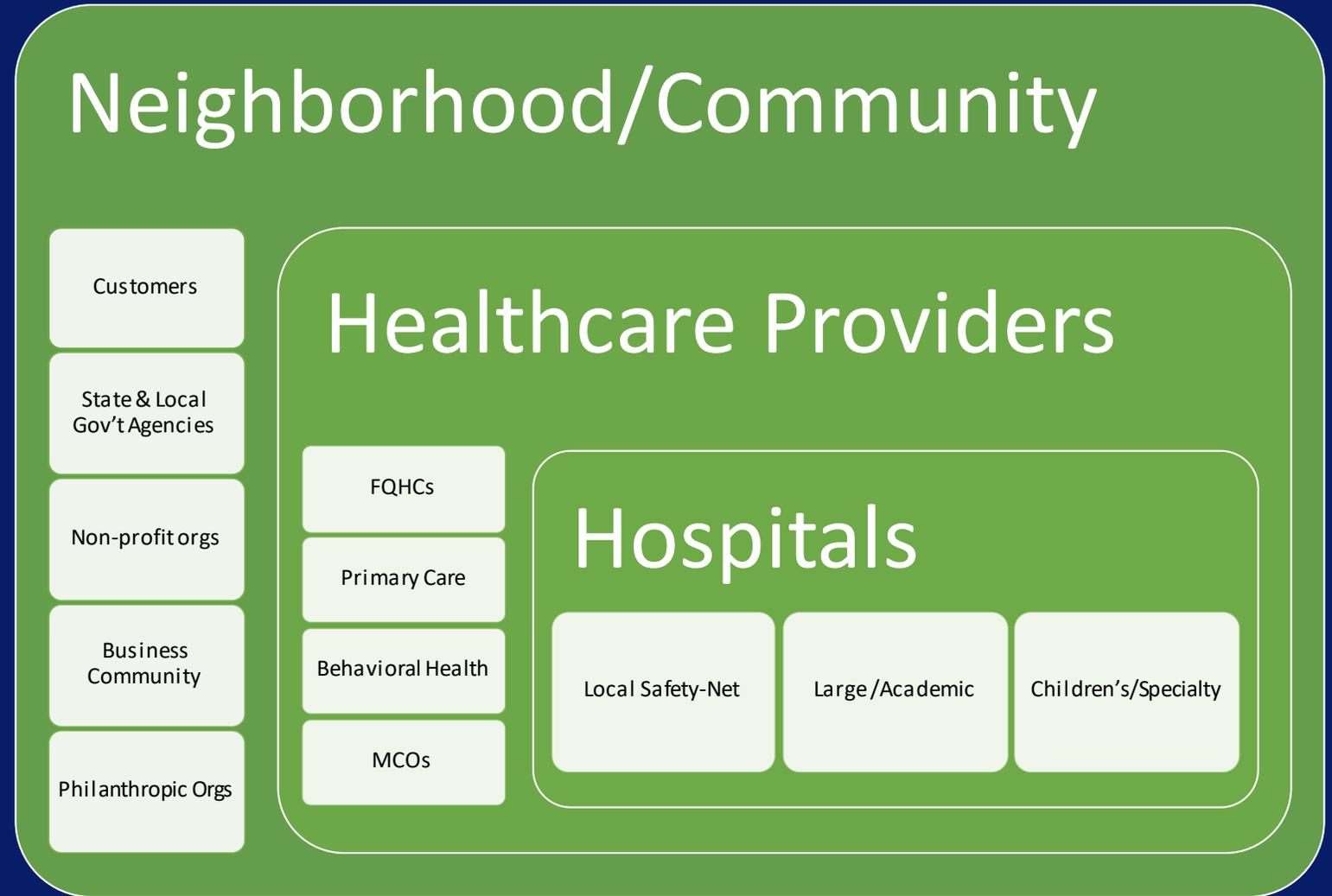
Set a path for systemic change throughout the state over multiple years and stimulate competition inclusive of mental, behavioral, and dental health

Assure that state dollars can be magnified by other investments from the business and philanthropic communities informed by community input

**COLLABORATION IS KEY**



# TYPES OF PARTICIPANTS FOR EACH COMMUNITY PROJECT





# PROPOSED FUNDING MIX

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.

# PROJECT GOALS OR CRITERIA



## Improve Care in Target Communities

- ✓ Drive collaboration amongst multiple stakeholders in the community to address both healthcare and social determinants of health
- ✓ Ensure that healthcare and SDOH services are linked to improve outcomes
- ✓ Emphasize preventative, primary and specialty care
- ✓ Emphasize integrated, team-based care for chronic health conditions
- ✓ Address both physical and behavioral health including substance use disorders



## Address Economic Factors

- ✓ No reduction in access to services
- ✓ Same or increased jobs
- ✓ Designed to be sustainable via utilization-based payments



## Data - and Community-Driven

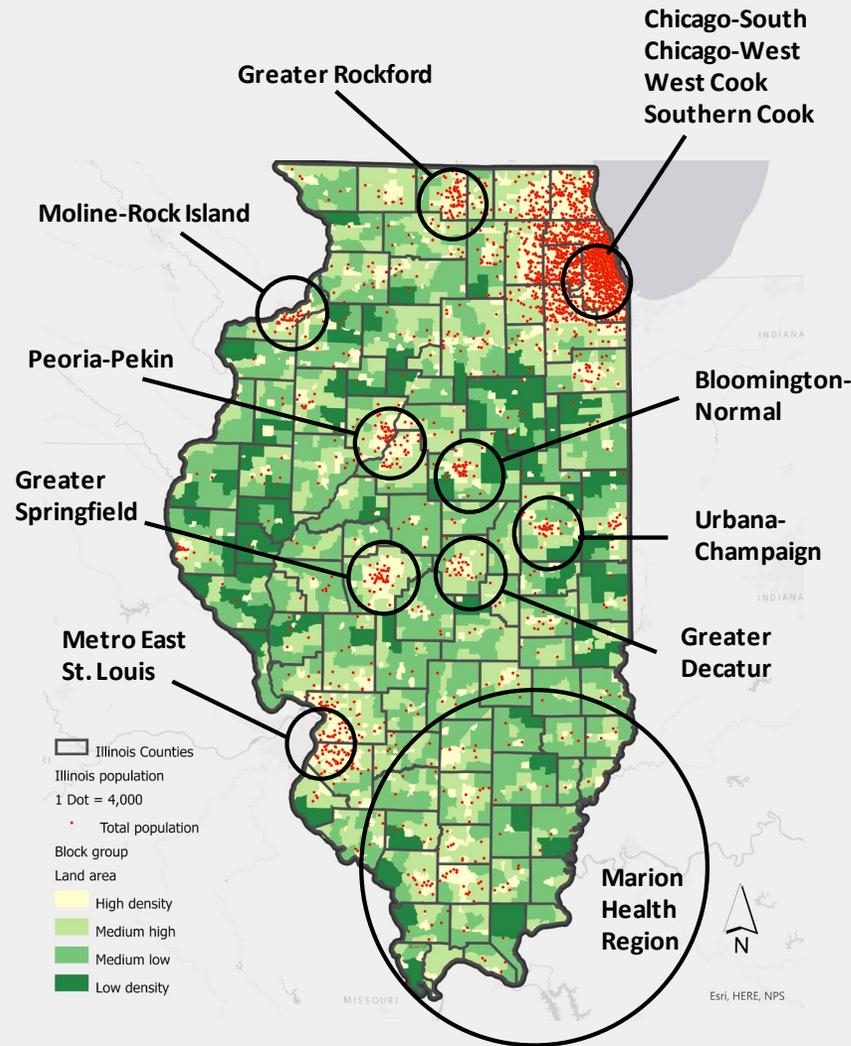
- ✓ Base on community needs and input
- ✓ Equitable / reduce disparities
- ✓ Use data to design and promote integration of care
- ✓ Have identified goals, measurable metrics and verifiable project milestones



# START WITH AREAS MOST SUSCEPTIBLE TO HEALTH DISPARITIES

## Potential Communities:

Most vulnerable areas based on the U.S. Centers for Disease Control and Prevention's Social Vulnerability Index (SVI) for Illinois and areas disproportionately impacted by COVID-19 (see underlined zip codes/counties).



Areas	CDC Social Vulnerability Index Percentile <sup>1</sup>	Most Vulnerable Zip Codes or Counties
<b>Chicago-South Catchment</b>	87.6	<u>60621</u> , <u>60636</u>
<b>Chicago-West Catchment</b>	83.5	<u>60623</u> , <u>60624</u>
Marion Health Region <sup>2</sup>	75.2	<u>Jefferson</u> , <u>Marion</u> , <u>Saline</u>
Greater Decatur MSA	63.9	<u>62522</u> , <u>62523</u>
<b>West Cook Catchment</b>	58.0	<u>60153</u> , <u>60804</u>
<b>Southern Cook Catchment</b>	56.6	<u>60472</u> , <u>60827</u>
Urbana-Champaign MSA	53.5	<u>61801</u> , <u>61820</u>
Bloomington-Normal MSA	50.9	<u>61701</u> , <u>61761</u>
Greater Rockford MSA	50.6	<u>61101</u> , <u>61104</u>
Springfield MSA	45.9	<u>62701</u> , <u>62703</u>
Moline-Rock Island MSA	45.4	<u>61201</u> , <u>61443</u>
<b>Metro East St. Louis Catchment<sup>3</sup></b>	42.1	<u>62204</u> , <u>62207</u>
Peoria-Pekin MSA	38.3	<u>61603</u> , <u>61605</u>

NOTES & Abbr.: **Regions in bold** were analyzed for this report. Underlined zip codes are areas disproportionately affected by Covid-19 (DIAs). CDC = U.S. Centers for Disease Control and Prevention; MSA = Metropolitan statistical area

<sup>1</sup>Population-weighted average of the state-standardized SVI percentile ranks for component zip codes (or counties), 1 to 100

<sup>2</sup>Counties: Clay, Crawford, Effingham, *Fayette*, Franklin, Gallatin, Hamilton, *Jackson*, *Jasper*, *Jefferson*, Lawrence, *Marion*, *Perry*, *Saline*, *Wabash*, *Wayne*, *White*, *Williamson* + Southern7 (Alexander, Hardin, *Johnson*, *Massac*, *Pope*, *Pulaski*, and *Union*). *Italicized counties* include DIA-designated zip codes.

<sup>3</sup>Includes St. Clair, Monroe, Clinton, Madison, and Jersey counties



# FY21: Fund Pilots to Jump Start Collaboration and Innovation

## INNOVATION PILOT TYPES:



Safety Net Hospital Partnership Pilots



Critical Access / Other Distressed Area Partnership Pilots



Cross-Provider Care Partnership Pilots

- ✓ 12-18 month planning grants/ pilots
- ✓ Must include a CBO + one unrelated specialty or behavioral health partner
- ✓ Goal of pilot must be re-imagining the way communities are served
- ✓ Health equity must be a primary focus and measured
- ✓ HFS to assist with planning and racial equity analyses
- ✓ Successful pilots to create pipeline for future funding



# Fund Diverse Workforce Development



**\$5-10**  
Million

## Culturally competent, diverse workforce development:

- ✓ Loan repayment for immediate term
- ✓ Recruitment and Scholarships for future
- ✓ Preventative and specialty care
- ✓ Ongoing annually



## **FUTURE YEARS: Invest in Successful Projects from Pilot Phase**



### **Advance Pilots to Larger Transformation Projects**

**Create a funding schedule for communities and/or criteria in rule**

- ✓ **Clear benchmarks and milestones to meet goals, including service enhancement and disparity reduction**
- ✓ **Prioritize projects**
  - that include safety nets and/or are in distressed communities
  - couldn't otherwise happen without state
  - that bring in additional funding
- ✓ **4-8 communities funded per year**
- ✓ **Max of \$30M per year per project per year (Min of \$1M per year)**
- ✓ **Tie in Capital Process**
- ✓ **Each project must phase to complete sustainability over four years**
- ✓ **Fund additional pilots / planning grants to create ongoing pipeline**

# PROPOSED PROCESS



## Define in Law or Rule

- ✓ Checklists / Criteria that every project has to plan to meet
- ✓ Minimum / Maximum awards / Minimum BEP-like criteria
- ✓ UIC data released to design projects



## Outline of Projects to HFS

- ✓ Transparent Process – Publish all Requests
- ✓ First Awards as quickly as possible after approval



## HFS Immediately Begins Procurement / Hiring

- ✓ Team Dedicated to Transformation
- ✓ Work to Bring in Other Resources



## Ongoing Learning and Improving Outcomes

- ✓ Learning Collaboratives
- ✓ Ongoing Measurement and Reporting
- ✓ Have identified goals, measurable metrics and verifiable project milestones

Draft legislation for framework,  
criteria, process, spending

Procure consultants to inform  
collaborating communities

Get funding into communities to  
start re-imagining future

Keep learning from pilots

Criteria for future years / projects

Ongoing evaluation collaboratives

## SUMMARY



# DISCUSSION



# APPENDIX



# INDICES USED TO RANK COMMUNITIES

## Concentrated Disadvantage

- Concentrated disadvantage is a life course indicator used to measure community well-being.
- It provides a geographically based, community-level snapshot of concentrated poverty and economic segregation, and how the interaction of economic and social factors affects health outcomes throughout a lifespan.
- It is calculated as the percentage of households located in census tracts using five census variables: percentage below poverty line, receiving public assistance, female-headed households, unemployed, younger than 18.
- Concentrated disadvantage indicators are measured on different scales, such as counts, percentages or U.S. dollars. The raw values of each indicator are standardized using the common approach of z-score transformation to combine indicators measured on different scales into one index.

## Child Opportunity Index

- The Child Opportunity Index (COI) measures and maps the quality of resources and conditions that matter for children to develop in a healthy way in the neighborhoods where they live for the 100 largest US metropolitan areas.
- It focuses on a number of neighborhood factors expected to affect healthy child development such as proximity to early childhood education centers and retail healthy food.
- The rationale for using a composite index such as the Child Opportunity Index is that multiple factors have combined influence on a person's wellbeing.
- Some factors such as, poverty and lack of healthy food choices have detrimental effects, while others like access to health care and high-quality early childhood education confer advantage.
- The Child Opportunity Index accounts for the contributions of both positive and negative factors.