Strategic Planning: Board Progress Report + Discussion

September 18, 2009
Agenda

- Process Overview and Progress Update
- Current State:
  - Market Characteristics
  - CCHHS Overview
- Financial Planning Update
- Interview/Focus Group Feedback
- Town Hall Meeting Input (Preliminary)
- Discussion: Core Themes + Design Principles
- Next Steps
Agenda

- Process Overview and Progress Update
  - Current State:
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Process Overview

Phase 1 – Kick-off & Retreat:
- Set the Stage for the Planning Process

Phase 2 – Discovery:
- Evaluate Current Position and Opportunities

Phase 3 – Strategic Direction:
- Develop a Shared Vision and Strategic Direction

Phase 4 – Financial Plan:
- Develop a 3-year Financial Plan

Phase 5 – Action Plan:
- Specify Action Plan and Accountabilities
Process Outcomes—CCHHS Direction, Focus, and Action

Direction – CCHHS
Preferred Future State

To become...

ICS Consulting, Inc.
Major Steps

Phase 2 — Discovery:
Evaluate Current Position & Opportunities

- External Market Analysis
- CCHHS Profile & Analysis
- Site Visits
- Financial Data Bases
- Interviews & Focus Groups
- Patient Interviews
- Town Hall Meetings
Agenda

- Process Overview and Progress Update

- Current State:
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  - CCHHS Overview

- Financial Planning Update

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- Town Hall Meeting Input (Preliminary)

- Discussion: Core Themes + Design Principles

- Next Steps
Nationally, health system pressures are making it increasingly difficult for safety-net providers to maintain their mission.

Key National Trends

- **Increasing Uninsured**
- **Increasing Uncompensated Care**
- **Decreasing Physicians Providing Charity Care**

Impact on Public Hospitals

- Increased demand for services
- Decreased access to specialty care, notably mental health, surgical care, dental, and vision care most difficult to obtain
- Increase in the amount of uncompensated care provided
- Competition with non-safety-net providers

Source: Health Affairs, August 12, 2008
Cook County is estimated to have the third largest uninsured population in the U.S., although the percentage of uninsured is lower than many other counties.

### Uninsured by County, Top 10, 2005

<table>
<thead>
<tr>
<th>County</th>
<th>Age 0-64</th>
<th></th>
<th>Age 19-64</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number Uninsured</td>
<td>Percent Uninsured</td>
<td>Margin of Error</td>
<td>Number Uninsured</td>
</tr>
<tr>
<td>Los Angeles County, California</td>
<td>2,047,332</td>
<td>23.4%</td>
<td>0.9</td>
<td>1,744,275</td>
</tr>
<tr>
<td>Harris County, Texas</td>
<td>1,140,803</td>
<td>32.0%</td>
<td>1.5</td>
<td>885,108</td>
</tr>
<tr>
<td><strong>Cook County, Illinois</strong></td>
<td><strong>784,930</strong></td>
<td><strong>16.9%</strong></td>
<td><strong>1.0</strong></td>
<td><strong>653,691</strong></td>
</tr>
<tr>
<td>Maricopa County, Arizona</td>
<td>702,940</td>
<td>21.3%</td>
<td>1.1</td>
<td>546,301</td>
</tr>
<tr>
<td>Dallas County, Texas</td>
<td>616,973</td>
<td>29.1%</td>
<td>1.7</td>
<td>461,060</td>
</tr>
<tr>
<td>Miami-Dade County, Florida</td>
<td>599,047</td>
<td>29.0%</td>
<td>1.0</td>
<td>493,390</td>
</tr>
<tr>
<td>Orange County, California</td>
<td>566,296</td>
<td>21.5%</td>
<td>1.4</td>
<td>454,764</td>
</tr>
<tr>
<td>San Diego County, California</td>
<td>541,560</td>
<td>21.6%</td>
<td>1.5</td>
<td>415,409</td>
</tr>
<tr>
<td>Riverside County, California</td>
<td>472,455</td>
<td>26.8%</td>
<td>1.8</td>
<td>364,528</td>
</tr>
<tr>
<td>San Bernardino County, California</td>
<td>414,035</td>
<td>23.2%</td>
<td>1.0</td>
<td>322,638</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, Small Area Health Insurance Estimates/County and State by Demographic and Income Characteristics/2005
Inpatient demand clearly exceeds existing service levels

Expected IP Discharges for Uninsured

<table>
<thead>
<tr>
<th>Cook County Use Rate*</th>
<th>Est. Uninsured Pop.</th>
<th>Expected Dischgs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>92.1 discharges/1000 population</td>
<td>× 785,000</td>
<td>= 72,281</td>
</tr>
</tbody>
</table>

* Reflects discharges per 1000 population for ages 0-64
Sources: CompData, U.S. Census Bureau

ICS Consulting, Inc.
The vulnerable population is highest in the city of Chicago

### Health Insurance Coverage, Age 19-64, 2005

<table>
<thead>
<tr>
<th></th>
<th>Private Insurance</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>Illinois</td>
<td>75.2%</td>
<td>74.7%</td>
<td>7.5%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Chicago</td>
<td>63.3%</td>
<td>62.6%</td>
<td>11.5%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Suburban Chicago</td>
<td>82.9%</td>
<td>81.0%</td>
<td>3.1%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Downstate</td>
<td>72.7%</td>
<td>74.1%</td>
<td>10.7%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

**Segmenting the uninsured: a much higher percent of men, Latinos, and those aged 19-25**

<table>
<thead>
<tr>
<th>Demographic Category</th>
<th>% Uninsured Women Within Each Category</th>
<th>% Uninsured Men Within Each Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>16.9%</td>
<td>20.3%</td>
</tr>
<tr>
<td><strong>By Geographic Area</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicago</td>
<td>24.3%</td>
<td>29.6%</td>
</tr>
<tr>
<td>Suburban Chicago</td>
<td>13.0%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Downstate</td>
<td>15.9%</td>
<td>19.3%</td>
</tr>
<tr>
<td><strong>By Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 19 to 24 years</td>
<td>26.5%</td>
<td>34.9%</td>
</tr>
<tr>
<td>Age 25 to 49 years</td>
<td>16.6%</td>
<td>20.9%</td>
</tr>
<tr>
<td>Age 50 to 64 years</td>
<td>13.3%</td>
<td>11.8%</td>
</tr>
<tr>
<td><strong>By Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>12.0%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Latina/o</td>
<td>33.1%</td>
<td>40.0%</td>
</tr>
<tr>
<td>African American</td>
<td>25.9%</td>
<td>31.4%</td>
</tr>
<tr>
<td><strong>By Employment Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed full time year round</td>
<td>10.6%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Employed less than full time year round</td>
<td>18.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Not employed</td>
<td>23.2%</td>
<td>31.5%</td>
</tr>
<tr>
<td><strong>By Income Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income &lt; 100% of poverty</td>
<td>39.4%</td>
<td>54.8%</td>
</tr>
<tr>
<td>Income &lt; 200% of poverty</td>
<td>34.6%</td>
<td>46.3%</td>
</tr>
<tr>
<td>Income &lt; 300% of poverty</td>
<td>28.6%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Income &lt; 400% of poverty</td>
<td>24.3%</td>
<td>31.7%</td>
</tr>
<tr>
<td>Income &gt; 400% of poverty</td>
<td>7.5%</td>
<td>8.3%</td>
</tr>
</tbody>
</table>


Notes: In 2005, 100% of poverty was approximately $10,000 for an individual and $20,000 for a family of four.

*Insured/uninsured do not sum to totals due to more detailed adjustments by age, race, employment status and income level.*
The disease burden is greater in minority populations, particularly in the African-American community.

### 10 Leading Causes of Death by Race/Ethnicity for 2005 in Chicago

<table>
<thead>
<tr>
<th>Causes of Death</th>
<th>All Races</th>
<th>Hispanic</th>
<th>Mexican</th>
<th>Puerto Rican</th>
<th>Asian</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>265.4</td>
<td>132</td>
<td>152.7</td>
<td>202.5</td>
<td>141.5</td>
<td>365.7</td>
<td>275.2</td>
</tr>
<tr>
<td>Cancer</td>
<td>204.6</td>
<td>109.5</td>
<td>121.6</td>
<td>175.1</td>
<td>132.7</td>
<td>304.4</td>
<td>193.6</td>
</tr>
<tr>
<td>Stroke</td>
<td>49.5</td>
<td>22.7</td>
<td>32.8</td>
<td>RS</td>
<td>27.2</td>
<td>75.5</td>
<td>45.3</td>
</tr>
<tr>
<td>Chronic Lwr Resp Dis</td>
<td>33.2</td>
<td>RS</td>
<td>RS</td>
<td>RS</td>
<td>RS</td>
<td>40.9</td>
<td>38.9</td>
</tr>
<tr>
<td>Diabetes</td>
<td>29</td>
<td>31.6</td>
<td>36.3</td>
<td>60.6</td>
<td>25.6</td>
<td>41.9</td>
<td>22.9</td>
</tr>
<tr>
<td>Nephritis</td>
<td>22.5</td>
<td>RS</td>
<td>18.1</td>
<td>RS</td>
<td>RS</td>
<td>39.2</td>
<td>16.4</td>
</tr>
<tr>
<td>Alzheimer’s Disease</td>
<td>RS</td>
<td>RS</td>
<td>RS</td>
<td>RS</td>
<td>RS</td>
<td>RS</td>
<td>17.6</td>
</tr>
<tr>
<td>Homicide</td>
<td>16.4</td>
<td>9.6</td>
<td>9.6</td>
<td>RS</td>
<td>RS</td>
<td>36.2</td>
<td>RS</td>
</tr>
<tr>
<td>Septicemia</td>
<td>25.5</td>
<td>20</td>
<td>21.4</td>
<td>50.1</td>
<td>RS</td>
<td>44.2</td>
<td>19.3</td>
</tr>
<tr>
<td>Influenza &amp; Pneumonia</td>
<td>23</td>
<td>14.4</td>
<td>RS</td>
<td>RS</td>
<td>RS</td>
<td>29</td>
<td>24.6</td>
</tr>
<tr>
<td>Accidents</td>
<td>33.9</td>
<td>26.1</td>
<td>25.9</td>
<td>40.8</td>
<td>RS</td>
<td>49.6</td>
<td>30.6</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>RS</td>
<td>16.9</td>
<td>15.6</td>
<td>36.5</td>
<td>RS</td>
<td>RS</td>
<td>RS</td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>RS</td>
<td>4.3</td>
<td>3.7</td>
<td>RS</td>
<td>RS</td>
<td>RS</td>
<td>RS</td>
</tr>
</tbody>
</table>

*RS = Rate Suppressed because the number of deaths < 21*

Source: CDPH
Health indicators in the South region of the County demonstrate the disparities

Maternal and Child Health Indicator

Infant Mortality Rate Trends
By Region 2000-2005

SOURCE: CDPH

ICS Consulting, Inc.
There are a very large number of community health centers; however the southern parts of Chicago and the County still appear to be underserved

Community Health Center Locations, Cook County

Total Sites = 125


ICS Consulting, Inc.
In fact, the areas of greatest health need have fewer accessible community health options

Community Areas with Lowest Health Ranking

WEST
Austin (#25)
North Lawndale (#29)

SOUTH
Douglas (#35)
Englewood (#67)
West Englewood (#68)
Greater Grand Crossing (#69)
Woodlawn (#42)
South Shore (#43)
Auburn Gresham (#71)
Washington Heights (#73)
Roseland (#49)
West Pullman (#53)

Source: CDPH
Current State Profile

- Who We Serve
- What We Do
- How We Do
CCHHS offers a large network of hospitals and health centers to the residents of Cook County

Cook County Health and Hospitals System

△ Hospitals
1. J.H. Stroger, Jr. Hospital/Core Center
2. Provident Hospital
3. Oak Forest Hospital

✚ Ambulatory and Community Health Network
1. Austin Health Center
2. Cicero Health Center
3. Englewood Health Center
4. Cottage Grove Health Center
5. Dr. Jorge Prieto Health Center
6. Fantus Health Center
7. Sengstacke [Provident] Health Center
8. John Stroger Specialty Care Center
9. Logan Square Health Center
11. Near South Health Clinic
12. Oak Forest Specialty Health Center
13. Robbins Health Center
14. Vista Health Center
15. Woodlawn Health Center
16. Woody Winston Health Center

● Cermak Health Services
ICS Consulting, Inc.
CCHHS facilities are well-placed to serve the poorer areas of the county but there are most certainly some gaps.

CCHHS Locations and Median Household Income by ZIP Code

- Hospitals
- Ambulatory and Community Health Network
- Cermak Health Services

<table>
<thead>
<tr>
<th>Median HH Income (2007)</th>
<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100,000 to $500,000</td>
<td>Green</td>
</tr>
<tr>
<td>$75,000 to $99,999</td>
<td>Yellow</td>
</tr>
<tr>
<td>$50,000 to $74,999</td>
<td>Orange</td>
</tr>
<tr>
<td>$25,000 to $49,999</td>
<td>Red</td>
</tr>
<tr>
<td>$0 to $24,999</td>
<td>White</td>
</tr>
</tbody>
</table>

Source: CCHHS

ICS Consulting, Inc.
As expected, CCHHS draws inpatients primarily from the poorer areas of the county.

Inpatient Origin by ZIP Code, 2008

- Hospitals
- Ambulatory and Community Health Network
- Cermak Health Services

CCHHS Inpatients*, 2008

* Excludes ZIP codes with less than 10 inpatients

Source: CCHHS

ICS Consulting, Inc.
Outpatients, however, come from a much broader service area.
CCHHS has a huge OP business on a comparatively modest inpatient platform, particularly at Provident and Oak Forest Hospitals

### CCHHS Utilization Statistics and Cost, 2008

<table>
<thead>
<tr>
<th>Patient Activity</th>
<th>Stroger</th>
<th>Provident</th>
<th>Oak Forest</th>
<th>Distrib. Clinics</th>
<th>CORE *</th>
<th>Cermak</th>
<th>CCDPH/ TB</th>
<th>Central Admin</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACHN Visits</td>
<td>394,629</td>
<td>26,726</td>
<td>18,951</td>
<td>132,002</td>
<td>31,280</td>
<td>**</td>
<td>***</td>
<td></td>
<td>603,588</td>
</tr>
<tr>
<td>Admissions</td>
<td>23,248</td>
<td>5,191</td>
<td>2,799</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>31,238</td>
</tr>
<tr>
<td>Patient Days</td>
<td>116,097</td>
<td>20,815</td>
<td>23,787</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>160,699</td>
</tr>
<tr>
<td>ALOS</td>
<td>5.0</td>
<td>4.0</td>
<td>8.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5.1</td>
</tr>
<tr>
<td>ER Visits</td>
<td>128,599</td>
<td>40,370</td>
<td>28,768</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>197,737</td>
</tr>
<tr>
<td>Case Mix Index</td>
<td>1.114</td>
<td>0.964</td>
<td>0.985</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budget Est. ('000s)</td>
<td>$660,559</td>
<td>$127,515</td>
<td>$126,854</td>
<td>$14,031</td>
<td>$26,619</td>
<td>$56,293</td>
<td>$23,929</td>
<td>$42,024</td>
<td>1,077,824</td>
</tr>
<tr>
<td>Percent</td>
<td>61.3%</td>
<td>11.8%</td>
<td>11.8%</td>
<td>1.3%</td>
<td>2.5%</td>
<td>5.2%</td>
<td>2.2%</td>
<td>3.9%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Mike Koetting analysis using FY08 Financial Work Papers

Notes:
* Includes only County-funded visits; provides another 30,000 visits with other funding
** Provides health services for Cook County Jail detainees, about 10,000 at one time, 100,000 over the course of a year
*** Maintains several clinics—including very heavily used dental clinics and STD clinics
CCHHS spent approximately $4,000 per unique patient served

Estimated CCHHS Cost per Unique Patient, 2008

$997,602,000
Est. CCHHS Cost*  ÷  245,976 unique patients served

Cost = $4,056 per unique patient

By Comparison:

2008 CCHHS Cost: $4,056
2006 Medicaid per Enrollee Cost: $4,129
2008 Est. Commercial HMO Premium**: $3,600

* Excludes costs for Cermak and CCDPH/TB locations
** Commercial HMO Premium estimated at $300 PMPM using historic Illinois data and 2008 National data

Source: Mike Koetting analysis using FY08 Financial Work Papers

ICS Consulting, Inc.
While healthcare needs in the County have grown, CCHHS inpatient activity has declined over the last five years, primarily due to budget cuts.

Source: CCHHS
CCHHS outpatient activity has also declined over the last several years, due to budget cuts.
CCHHS has long waits for both primary care and specialty care clinics

Appointment Availability to Primary Care and Specialty Clinics

OP Visits by Type, 2008

- Screening: 63,667 (9%)
- Specialty: 244,898 (43%)
- Primary: 273,743 (48%)

Source: ACHN reports

Primary Care

Adult Specialties #1

Source: Navigant Report, 2009

ICS Consulting, Inc.
CCHHS serves primarily an African-American population, more so on the inpatient side.

Inpatients by Race, 2008

- White: 12%
- Hispanic: 18%
- Black: 58%
- Other: 9%
- Aslan: 3%

Outpatients* by Race, 2008

- White: 11%
- Hispanic: 26%
- Black: 51%
- Other: 9%
- Aslan: 3%

* Excludes ER
Source: CCHHS

ICS Consulting, Inc.
CCHHS has a unique distribution of patients by sex and age, reflecting the insurance status of patients.

CCHHS Patients by Sex, 2008

- Male: IP = 53%, OP = 44%
- Female: IP = 47%, OP = 56%

Inpatients by Age, 2008

- 0-19: 18%
- 20-35: 15%
- 36-64: 36%
- 65+: 31%
- 65+: 14%

* Excludes ER
Source: CCHHS: CompData

ICS Consulting, Inc.
CCHHS provides a disproportionate share of the self-pay/charity care in the County

Payer Mix Comparison
Discharges, 2008

Note: Excludes normal newborns
Source: CompData; National Association of Public Hospitals

ICS Consulting, Inc.
CCHHS has a considerably different service mix relative to Cook County discharges overall.

IP Service Mix Comparison, 2008

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Cook Cty</th>
<th>CCHHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>28.7%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Cardiac Services</td>
<td>13.2%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Oncology</td>
<td>3.9%</td>
<td>8.8%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>5.9%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>11.9%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>4.6%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Psych/Subst. Abuse</td>
<td>10.8%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>4.7%</td>
<td>3.0%</td>
</tr>
<tr>
<td>ENT</td>
<td>1.5%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Gynecology</td>
<td>1.6%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Vascular Services</td>
<td>2.1%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>1.5%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Trauma</td>
<td>1.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>1.8%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Spine</td>
<td>1.7%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0.6%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>0.7%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Neonatology</td>
<td>3.4%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Other</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Note: IP numbers exclude normal newborns; CCHHS data appears to be underreported by about 8%
Source: CompData
Both Provident and Oak Forest have a service mix that is driven by ER activity. OF has a longer ALOS driven by the Rehab service and also General Medicine

### IP Service Mix Comparison by Hospital, 2008

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Stroger</th>
<th>Provident</th>
<th>Oak Forest</th>
<th>Total CCHHS</th>
<th>Cook County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dischgs</td>
<td>Percent</td>
<td>Days</td>
<td>Dischgs</td>
<td>Percent</td>
</tr>
<tr>
<td>General Medicine</td>
<td>6,990</td>
<td>34%</td>
<td>25,857</td>
<td>2,017</td>
<td>40%</td>
</tr>
<tr>
<td>Cardiac Services</td>
<td>2,488</td>
<td>12%</td>
<td>9,060</td>
<td>1,403</td>
<td>28%</td>
</tr>
<tr>
<td>Oncology</td>
<td>2,273</td>
<td>11%</td>
<td>10,005</td>
<td>148</td>
<td>3%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>1,634</td>
<td>8%</td>
<td>15,463</td>
<td>147</td>
<td>3%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>1,320</td>
<td>6%</td>
<td>5,120</td>
<td>428</td>
<td>9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>1,014</td>
<td>5%</td>
<td>3,654</td>
<td>204</td>
<td>4%</td>
</tr>
<tr>
<td>Psych/Sub.Abuse</td>
<td>630</td>
<td>3%</td>
<td>2,146</td>
<td>214</td>
<td>4%</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>779</td>
<td>4%</td>
<td>5,044</td>
<td>30</td>
<td>1%</td>
</tr>
<tr>
<td>ENT</td>
<td>749</td>
<td>4%</td>
<td>2,245</td>
<td>37</td>
<td>1%</td>
</tr>
<tr>
<td>Gynecology</td>
<td>604</td>
<td>3%</td>
<td>2,579</td>
<td>110</td>
<td>2%</td>
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<tr>
<td>Vascular Services</td>
<td>576</td>
<td>3%</td>
<td>3,260</td>
<td>53</td>
<td>1%</td>
</tr>
<tr>
<td>Urology</td>
<td>391</td>
<td>2%</td>
<td>1,436</td>
<td>48</td>
<td>1%</td>
</tr>
<tr>
<td>Trauma</td>
<td>366</td>
<td>2%</td>
<td>1,797</td>
<td>7</td>
<td>0%</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>0%</td>
<td>0%</td>
<td>30</td>
<td>341</td>
<td>12%</td>
</tr>
<tr>
<td>Spine</td>
<td>305</td>
<td>1%</td>
<td>1,524</td>
<td>10</td>
<td>0%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>225</td>
<td>1%</td>
<td>2,182</td>
<td>9</td>
<td>0%</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>226</td>
<td>1%</td>
<td>1,778</td>
<td>8</td>
<td>0%</td>
</tr>
<tr>
<td>Neonatology</td>
<td>116</td>
<td>1%</td>
<td>2,237</td>
<td>106</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>80</td>
<td>0%</td>
<td>236</td>
<td>4</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20,806</td>
<td>100%</td>
<td>95,623</td>
<td>4,988</td>
<td>100%</td>
</tr>
<tr>
<td><strong>ALOS</strong></td>
<td>4.60</td>
<td></td>
<td>4.12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: IP numbers exclude normal newborns; CCHHS data appears to be underreported by about 8%
Source: CompData
CCHHS’ IP business is driven by a few core service lines

CCHHS IP Activity by Service Line, 2008

Source: CompData
The market, however, has a different distribution

Cook County Discharges by Service Line, 2008

Source: CompData
CCHHS’ “market share” is strong in few core areas but notably weak in high volume and high Medicaid services such as Obstetrics and Neonatology.

CCHHS Market Share by Service Line, 2008

Overall: 4.3%

Source: CompData
Patients with insurance—particularly Hispanic patients—often prefer other hospitals

CCHHS Market Share by Payer, Inpatient Discharges, 2008

- Self Pay/Charity: 35.2% (48,142)
- Medicaid: 4.1% (156,932)
- Private Ins: 1.0% (207,566)
- Medicare: 1.3% (248,123)
- Total Cook County: 660,763

CCHHS Medicaid Market Share, 2008

- Black: 5.7%
- Hispanic: 1.9%
- White: 2.4%
- Asian: 1.9%
- Other: 4.7%

Note: Excludes normal newborns
Source: CompData

ICS Consulting, Inc.
Hispanic patients with choice prefer other hospitals for care

### Inpatient Hospital Discharges by Payer, Hispanic Population, 2008

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Medicaid</th>
<th>Self Pay/Charity</th>
<th>Private Inc</th>
<th>Medicare</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mount Sinai Hospital</td>
<td>3,421</td>
<td>1,185</td>
<td>1,578</td>
<td>462</td>
<td>6,646</td>
</tr>
<tr>
<td>Saint Mary Of Nazareth Hospital Center</td>
<td>2,663</td>
<td>234</td>
<td>1,476</td>
<td>2,204</td>
<td>6,577</td>
</tr>
<tr>
<td>Advocate Illinois Masonic Medical Center</td>
<td>2,849</td>
<td>406</td>
<td>2,167</td>
<td>1,020</td>
<td>6,442</td>
</tr>
<tr>
<td>MacNeal Hospital</td>
<td>1,431</td>
<td>304</td>
<td>2,937</td>
<td>818</td>
<td>5,490</td>
</tr>
<tr>
<td>Norwegian-American Hospital</td>
<td>2,228</td>
<td>1,388</td>
<td>605</td>
<td>873</td>
<td>5,094</td>
</tr>
<tr>
<td>University Of Illinois Medical Center</td>
<td>1,919</td>
<td>204</td>
<td>1,215</td>
<td>915</td>
<td>4,253</td>
</tr>
<tr>
<td>Saint Anthony Hospital - Chicago</td>
<td>2,812</td>
<td>124</td>
<td>628</td>
<td>684</td>
<td>4,248</td>
</tr>
<tr>
<td>CCHHS</td>
<td>735</td>
<td>3,050</td>
<td>159</td>
<td>191</td>
<td>4,135</td>
</tr>
<tr>
<td>Northwestern Memorial Hospital</td>
<td>1,626</td>
<td>102</td>
<td>1,380</td>
<td>710</td>
<td>3,916</td>
</tr>
<tr>
<td>Rush University Medical Center</td>
<td>1,179</td>
<td>145</td>
<td>1,192</td>
<td>864</td>
<td>3,380</td>
</tr>
<tr>
<td>Advocate Christ Hospital &amp; Medical Center</td>
<td>995</td>
<td>186</td>
<td>1,392</td>
<td>565</td>
<td>3,138</td>
</tr>
<tr>
<td>Children's Memorial Hospital</td>
<td>2,011</td>
<td>9</td>
<td>488</td>
<td>3</td>
<td>2,511</td>
</tr>
<tr>
<td>Loyola University Medical Center</td>
<td>1,000</td>
<td>198</td>
<td>867</td>
<td>404</td>
<td>2,469</td>
</tr>
<tr>
<td>Swedish Covenant Hospital</td>
<td>1,020</td>
<td>207</td>
<td>517</td>
<td>571</td>
<td>2,315</td>
</tr>
<tr>
<td>Northwest Community Hospital - Arlington</td>
<td>1,230</td>
<td>114</td>
<td>569</td>
<td>204</td>
<td>2,117</td>
</tr>
<tr>
<td>Other Hospitals</td>
<td>11,234</td>
<td>1,925</td>
<td>8,763</td>
<td>7,143</td>
<td>29,065</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>38,252</strong></td>
<td><strong>9,871</strong></td>
<td><strong>25,933</strong></td>
<td><strong>17,640</strong></td>
<td><strong>91,696</strong></td>
</tr>
</tbody>
</table>

Note: Excludes normal newborns
Source: CompData
In light of the challenges, the response by safety net providers has been two-fold.

Key Trends

- **Increasing Uninsured**
  - Millions
- **Increasing Uncompensated Care**
  - Billions
- **Decreasing Physicians Providing Charity Care**
  - Percent

Public Hospitals’ Response

- **Defensive actions** – limiting indigent care exposure
  - Restricting non-emergent patients
  - Developing referral agreements
  - Enforcing financial policies

- **Offensive actions** – attracting better payer mix
  - Marketing to insured patients
  - Leveraging competitive advantages
  - Upgrading facilities
  - Expanding into new services
  - Changing “safety-net” image

Source: Health Affairs, August 12, 2008
Agenda

- Process Overview and Progress Update
- Current State:
  - Market Characteristics
  - CCHHS Overview
- Financial Planning Update
- Interview/Focus Group Feedback
- Town Hall Meeting Input (Preliminary)
- Discussion: Core Themes + Design Principles
- Next Steps
## Financial Planning Update: Draft Baseline Cash Forecast

<table>
<thead>
<tr>
<th>Annual, in 000's</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FY08</td>
</tr>
<tr>
<td>Operating revenue</td>
<td></td>
</tr>
<tr>
<td>Patient Service Revenue</td>
<td>$279,006</td>
</tr>
<tr>
<td>FMAP</td>
<td>-</td>
</tr>
<tr>
<td>Inter-Governmental Transfers (IGT)</td>
<td>127,270</td>
</tr>
<tr>
<td>NetDSH</td>
<td>-</td>
</tr>
<tr>
<td>Net Total Patient Service Revenue</td>
<td>406,276</td>
</tr>
<tr>
<td>Other revenue</td>
<td>6,184</td>
</tr>
<tr>
<td>Total operating revenue</td>
<td>412,460</td>
</tr>
<tr>
<td>Operating expenses</td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>492,243</td>
</tr>
<tr>
<td>Employee benefits (Excludes Pension Expense)</td>
<td>88,111</td>
</tr>
<tr>
<td>Pension Expense</td>
<td>90,443</td>
</tr>
<tr>
<td>Supplies</td>
<td>137,570</td>
</tr>
<tr>
<td>Purchased services, rental and other</td>
<td>117,155</td>
</tr>
<tr>
<td>Depreciation</td>
<td>47,478</td>
</tr>
<tr>
<td>Utilities</td>
<td>17,647</td>
</tr>
<tr>
<td>Services contributed by other County offices</td>
<td>6,393</td>
</tr>
<tr>
<td>Total operating expenses</td>
<td>997,040</td>
</tr>
<tr>
<td>Operating Loss</td>
<td>(584,580)</td>
</tr>
<tr>
<td>Adjustments for cash basis</td>
<td></td>
</tr>
<tr>
<td>Pension</td>
<td>90,443</td>
</tr>
<tr>
<td>Malpractice</td>
<td>60,000</td>
</tr>
<tr>
<td>Depreciation</td>
<td>47,478</td>
</tr>
<tr>
<td>Employee benefits</td>
<td>88,111</td>
</tr>
<tr>
<td>Capital investment</td>
<td>-</td>
</tr>
<tr>
<td>Dept of Health</td>
<td>(13,679)</td>
</tr>
<tr>
<td>Net Subsidy Requirement, Baseline</td>
<td>(312,227)</td>
</tr>
</tbody>
</table>
Financial Planning Update (in process)

- Model baseline cash source and use for all 8 operating entities on a quarterly basis through 2012. (Status: working model complete.)

- For each entity, model strategic initiatives (Status, in process, model construction framed out):
  - Productivity, rely on work product of Navigant
  - Supply chain, rely on work product of Navigant
  - Revenue cycle, rely on work product of Med Assets
  - Strategic planning, result of financial analysis and scenario modeling

- Combine baseline forecast with planned strategic initiatives to create cash planning model.
  - Key financial milestones and metrics
    - Modeled by entity
    - Modeled on a quarterly basis
  - Allows for tracking and management of key initiatives.
Agenda

- Process Overview and Progress Update
- Current State:
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- Financial Planning Update
- Interview/Focus Group Feedback
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To date, interviews/focus group sessions have been conducted with senior executive/clinical leadership throughout CCHHS:

**COOs and Senior Management Teams:**
- Ambulatory Community Health Network
- Cermak
- CORE
- Department of Public Health
- Oak Forest Hospital
- Provident Hospital
- Stroger Hospital

**Service Line Focus Groups:**
- Cancer
- Communicable Diseases/HIV
- Emergency/Trauma/Critical Care/Inpatient Svcs.
- Primary Care/Ambulatory Specialty Care/Chronic Care
- Surgical Services
- Women & Children

**Clinical Leadership:**
- Chief Medical Officers
- Chairs and Service Chiefs

**Other Focus Groups:**
- Combined Medical Leadership: CCHHS/Provident/U of C
- Employee Union representatives
- Executive Committee of Medical Staff
- Supervisory staff from multiple ACHN clinics
- Various management levels (Stroger)
Interviews/Focus Groups (External)

To date, interviews/focus group sessions have been conducted with official representatives from the following organizations:

- ACCESS Community Health Network (scheduled)
- AIDS Foundation
- American Cancer Society
- Chicago Coalition for the Homeless
- Chicago Community Trust
- Chicago Department of Public Health
- Chicago Metropolitan Agency for Planning
- Cook County Board Commissioners (some sessions pending)
- Emergency Mobilization Network/Health & Medicine Policy Research Group
- Family Christian Health Center (Harvey)
- Health and Disability Advocates
- Illinois Department of Human Services/Mental Health Division
- Illinois Department of Human Services/Substance Abuse Division
- Illinois Department of Public Health
- Illinois Health Care Coalition
- Illinois Hospital Association
- Illinois Primary Healthcare Association
- Metropolitan Chicago Healthcare Council
- National Immigrant Justice Center
- South Suburban Council on Alcoholism and Substance Abuse
- Unions; AFSCME, SEIU, NNOC/CAN, and others
- Southside Health Collaborative

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Other Input: Patients, Town Hall Meetings

- **Patients:**
  - Approximately fifty (50) interviews with Stroger ambulatory patients have been conducted.

- **Town Hall Meetings (held or scheduled to date):**
  - South Suburbs - South Suburban Community College/South Holland (July 27)
  - Near South - Urban League (August 3)
  - West/Central - Malcolm X (August 6)
  - Northwest County - Oakton Community College/Des Plaines (August 13)
  - Northeast - Truman College/Uptown (August 21)
  - West - Math &Science Academy/Forest Park (August 24)
  - Latino/Hispanic Session (September 9)

*Note:* Town Hall meetings were coordinated with various neighborhood groups to ensure that their views were represented at these sessions. These groups include: West Side Health Authority, Grand Crossing, Heartland Alliance, Maternal and Infant Health Coalition, Access Health, and Midwest Latino Health Research Center.
**Interview Feedback ROADMAP**

- **ACCESS**
  - Are patients able (and willing) to access the System?

- **SERVICES**
  - Are appropriate services available to meet patient needs?

- **PROCESSES**
  - Are resources and systems in place to ensure good outcomes?

- **INFRASTRUCTURE**
  - Does the delivery platform (facilities, equipment, information technology) support high-quality services?

- **ORGANIZATION**
  - Do systems, processes, measures, and accountabilities lead to solid operational performance?
Interview Findings

**Strengths**

- CCHHS widely recognized as available resource for vulnerable population ("The safety net of safety nets")
- Caregivers seen as competent, caring and compassionate

**Concerns**

- Multiple access barriers to the System overall:
  - Limited entry points
  - Availability of caregivers
  - Geographic barriers
  - Parking and way-finding barriers
  - Wait times
  - Etc.
- Primary care access limited, with cutbacks further restricting the availability and accessibility of services; long wait lists and extended "appointment-to-seen" times
- Lack of primary care leads to overutilization of specialists
Health clinics not strategically located, especially given geographic distribution of vulnerable population clusters, Latino population

Stroger and Oak Forest hospitals not ideally-located relative to vulnerable population centers

An overarching problem is getting access to specialty care; availability and geographic access

Some private sector hospitals less inclined to accommodate uninsured patients

Reputation, perceived image an access barrier to many
Interview Findings

**Strengths**

- Strong, dedicated core of physicians and other caregivers
- Recognized capabilities in certain areas, e.g.:
  - Trauma
  - Burn Care
  - AIDS/HIV
  - Rehab
- Actual care provided considered typically good-to-excellent (access being main issue)
- Resident training programs/GME affiliations

**Concerns**

- Few clinical areas broadly seen as true centers of excellence
- Current service emphasis on acute intervention versus prevention, patient education
- Perceived need to emphasize more neighborhood screening, early detection (e.g., mammograms)
- Overall, lack of coordinated disease-specific focus, chronic disease management (e.g., diabetes)

ICS Consulting, Inc.
### Interview Findings

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lack of primary care follow-up for ED patients</td>
</tr>
<tr>
<td></td>
<td>Limited access to specialty care</td>
</tr>
<tr>
<td></td>
<td>Declining OB, pediatrics volumes (impact of Medicaid, SCHIP)</td>
</tr>
<tr>
<td></td>
<td>Deliveries at Stroger and Provident (especially) below optimal levels for efficiency, quality; concerns re: malpractice insurance costs (Many pre-natal patients opt for delivery at hospitals outside the System.)</td>
</tr>
</tbody>
</table>
Interview Findings

**Strengths**

- Lack of dental, oral hygiene services
- Lack of long-term care in System (with closure at Oak Forest)
- Minimal services geared to the needs of the geriatric population
- Need for closer coordination/interface with mental health services
- Teaching and research a real strength, but not always tied to healthcare priorities; need clear vision/direction

**Concerns**

- Some concerns expressed re: number, mix, and cost/benefit impact of residents
Interview Findings

**Strengths**

- Current emphasis on System-wide clinical planning and overall direction seen as positive
- Current process improvement efforts also viewed positively
- IRIS referral management system given high marks

**Concerns**

- Fragmentation of care, with little “system” interface/integration between the various components and sites of care
- Lack of comprehensive case management and patient tracking systems; not a patient-centered delivery model
- Lack of patient record integration
- Lack of post-discharge follow-up
- Services fragmented along departmental lines; lack of integrated service line approach, lack of dedicated nursing teams, etc.

ICS Consulting, Inc.
Interview Findings

**Strengths**

- Limited use of clinical pathways, tools for patient care quality and safety
- Emphasis on process vs. outcomes

**Concerns**

- “Send it to the ER” culture (Stroger ED overloaded with patients in holding at any given time; reflects lack of care coordination, lack of available specialists, need for improved functionality of urgent care; contributes to unnecessary admissions)
- Perceived need to focus more on primary care case management approach; both from quality as well as reimbursement perspectives
Interview Findings

**Strengths**

- Perception that many clinics operate well below optimum volumes

**Concerns**

- Need for safety net for no-show patients
- Need to focus on patient experience, quality outcomes; targets and measures
- Lack of comprehensive approach to patient discharge planning & coordination (potential to reduce ALOS)
- Inconsistent billing procedures & practices; many services simply not billed (especially professional fees); contributes to weak information base
Interview Findings

**Strengths**

- Stroger Hospital relatively new, attractive facility, proximate to major medical schools, transportation
- Provident and Oak Forest hospitals; facilities with untapped potential

**Concerns**

- Fantus Clinic facilities woefully inadequate in terms of capacity, functionality, security, cleanliness, and aesthetics; not in compliance with codes; at end of useful life
- Number/location of ambulatory care clinics seen as inadequate
- Lack of adequate, up-to-date medical equipment (e.g., imaging) a problem for all campuses
Interview Findings

**Strengths**

- Provident and Oak Forest hospitals lack defined focus and direction; facilities being used for activities they weren’t built to accommodate

**Concerns**

- Space/equipment has not kept pace with changing usage patterns (e.g., need for upgraded imaging, ancillary services at all facilities)

- Lack of dedicated clinic space, equipment for major service lines

- Physical access barriers to handicapped and elderly at Stroger and other sites
Interview Findings

**Strengths**

- Overarching question posed: Does CCHHS need three inpatient facilities? (Reportedly, public perception is that Oak Forest is already closed!)

**Concerns**

- Need robust, state-of-art information technology platform to support both care delivery and operations
- Need systems/technologies to support and integrate System across delivery sites (e.g., PACS)
Interview Findings

**Strengths**

- Commitment to Mission
- Competent, dedicated core group of caregivers
- Management team being rapidly built up
- Move to Group Purchasing Organization (GPO) strongly praised
- System Board strongly supported and seen as providing positive (and essential) leadership

**Concerns**

- “Scars” from ‘07 cutbacks still deeply felt in organization; gaps in coverage, as well as need to rebuild trust
- Need for concerted, proactive medical staff recruitment, professional development, and retention process
- Shortage of RN’s a problem throughout System
- Lack of dedicated caregiver staff for most disciplines (cross-training is standard practice)
Interview Findings

**Strengths**

- Many basic management functions (e.g., purchasing, HR, management reporting) not seen as up to par with industry standards

**Concerns**

- Hiring processes “dysfunctional;” a major barrier to talented applicants
- Historic reputation of System as prone to patronage hiring
- Need physician productivity targets, measures, and accountability
- Departmental supervisors viewed as mixed quality; some quite strong, others lacking
Interview Findings

**Strengths**

- Instances of poor alignment of job requirements and skill sets

**Concerns**

- Conscientious work ethic not reinforced/rewarded
- Need financial management systems specific to System needs
- Lack of service marketing, branding
- Need for more aggressive public relations initiatives: “We need to tell our story.”
- Management processes seen as historically “top-down” with minimal communication; hope is that new management team will encourage more collaborative approach with open communication
Interview Findings

**Strengths**

- High management turnover in recent years has contributed to lack of consistency, continuity of policy, direction

**Concerns**

- Concerns re: viability/future role of System Board; continuance of Board considered “absolutely critical”

- Significant concerns re: potential impact of proposed tax roll-back
Agenda

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- Discussion: Core Themes + Design Principles
- Next Steps
**PROCESS OVERVIEW**

- Seven Town Hall meetings have been conducted to date:

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<thead>
<tr>
<th>Date</th>
<th>Location</th>
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<tbody>
<tr>
<td>July 27</td>
<td>South Suburban College (South Holland)</td>
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<td>August 3</td>
<td>Chicago Urban League (Chicago)</td>
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<td>August 6</td>
<td>Malcolm X College (Chicago)</td>
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<td>August 13</td>
<td>Oakton Community College (Des Plaines)</td>
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<td>August 21</td>
<td>Truman College (Chicago)</td>
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<td>August 24</td>
<td>Math and Science Academy (Forest Park)</td>
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<td>September 9</td>
<td>Hispanic Town Hall (Westside Tech Institute)</td>
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</table>

- Follow-up meetings with each group to review preliminary strategic initiatives will be scheduled in October.
PROCESS OVERVIEW

In addition to public commentary, questionnaires were handed out to Town Hall participants to elicit their input regarding Cook County Health and Hospitals System’s:

– Program and Service Strengths
– County Healthcare Needs
– Issues and Challenges
– Opportunities and Priorities

The questionnaire has also been posted on-line, with survey results still pending.

The questionnaire has been made available to patients at Stroger, Oak Forest, and Provident hospitals.
PROFILE OF PARTICIPANTS

- Interested Residents
  - Expressed concerns regarding access, service cut-backs and unmet service needs
  - Shared frustrations with the System’s history of lack of leadership/management continuity and inattention to System and community needs
  - Strong sentiment expressed by Hispanic Community that CCHHS isn’t Hispanic-friendly

- Patient/Former Patient (self or family member) of County Health System
  - Reasons for using county were primarily financial, followed by location/access
  - Primary services used by respondents were Stroger Hospital outpatient clinic, ER and inpatient services.
  - In rating System services (quality of care, user-friendliness, staff service, wait times, facilities and locations) values fell in the satisfactory range, with the exception of wait-times which were rated poor.
Patient CCHHS Selection Decisions (based on current questionnaire results)

Why CCHHS

Services Used

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Rating of CCHHS Services (based on current questionnaire results)

Rating of CCHHS Services

- Quality of Care
- User-friendliness
- Service (staff)
- Wait Times
- Facilities
- Locations

Key:
- Poor
- Unsatisfactory
- Satisfactory
- Very Good
- Excellent

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PROFILE OF PARTICIPANTS (cont’d)

- Non-patients (self or family) of County Health System indicated that the leading factors that would lead them to use CCHHS in the future were less wait time, and quality of care.

- Employee of County Health System or Other County Department
  - Frustration expressed regarding recent and anticipated lay-offs, and hiring processes
  - Concern regarding perceived shortage of clinical and support staff
  - Participants indicated support for current System strategic planning efforts

- Advocacy Groups and Other Stakeholders
  - Expressed concerns regarding growing needs in communities
  - Shared strong interest in partnership with the System
For non-patients, factors that could lead individuals to use County in the future. (based on current questionnaire results)
CURRENT STRENGTHS
- What are the current program and service strengths of the System?

NEEDS
- What are the County’s unmet healthcare needs?

CHALLENGES
- What are the key issues and challenges that the System now faces?

PRIORITIES
- What are the System’s major opportunities? Priorities?
CCHHS PERCEIVED PROGRAM AND SERVICE STRENGTHS

- There was overwhelming praise for the Mission, especially the commitment to provide health services to vulnerable individuals/groups.

- Strong support was expressed for the clinical staff and level of clinical care:
  - Majority of respondents indicated that they would recommend CCHHS to family member or friend.
  - Dedicated and quality physicians, nurses and technicians.
  - Excellence in education, research and technology.

- Specific clinical programs and services identified as strengths included:
  - Trauma Center at Stroger Hospital
  - Local Community Clinics
  - Free/low cost prescriptions
  - Burn Unit
  - CORE Center
  - Neonatal
COUNTY HEALTH CARE NEEDS

- The leading single biggest health care need identified was health prevention and wellness. This was followed by improved access to primary and specialty screening/services.

- If CCHHS was able to expand a service or start a new service the lead priorities identified by respondents were:
  - Neighborhood Health Centers
  - Prevention and Early Detection Service

- If CCHHS was forced to reduce services, the leading services identified as most important to maintain was neighborhood centers.
Healthcare Needs (based on current questionnaire results)

Single Biggest Health Care Need That CCHHS Should Focus on in the County

- Prevention
- Screening
- Access when health problems arise
- Access to primary care
- Access to specialty care
- Expand/improve trauma care

ICS Consulting, Inc.
Service Priorities (based on current questionnaire results)

Possible New Services or Expanded Services

- Neighborhood Health Centers
- School Health Centers
- Fantus
- Prevention and Early Detection
- Specialty Outpatient
- Programs for Children
- Birth Facilities
- Geriatrics
- Services at Oak Forest
- Services at Provident
- Specialized Inpatient at Stroger

ICS Consulting, Inc.
Service Priorities (based on current questionnaire results)

Most Important Services to Be Maintained at Current Levels

- Neighborhood health centers
- School health centers
- Fantus Clinic
- Prevention and early detection
- Specialty outpatient care
- Programs for Children
- Birth Facilities
- Oak Forest Hospital
- Provident Hospital
- Specialized Services at Stroger
- Free/low cost prescriptions
- Low patient cost sharing

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COUNTY HEALTH CARE NEEDS (cont’d)

- Other clinical areas identified as significant needs included:
  - Dental Services
  - Mental Health Services
  - Diabetes
  - Infectious Diseases

- Population groups identified at high risk included:
  - Older Adults (ages 50-65)
  - Cook County Jail and Juvenile Detention Center residents who are being released back into community.
  - Pregnant Women and Infants
  - Students (ages 18-25)
  - Undocumented residents
PERCEIVED ISSUES AND CHALLENGES

- Leadership, management and administrative processes
  - Inefficiencies and incompetence
  - Lack of financial accountability
  - Too much political involvement and influence
  - Board not representative of communities served

- Access
  - Language and cultural barriers
  - Long waits in ER and during admissions process
  - Long waits for follow-up and screening appointments
  - Difficulties getting to appointments due to transportation and parking
  - Difficulties getting prescriptions (need to come back)
PERCEIVED ISSUES AND CHALLENGES (cont’d)

- Communication, coordination of care and follow-up
  - Difficulties for patient and family to get information
  - Lack of coordination of care and follow-up
  - Long waits for follow-up services

- Lack of adequate clinical and support staff—expressed needs for additional:
  - Nurses
  - Physicians
  - Support staff to help direct patients to appropriate services and manage communications
  - Translation services
PERCEIVED OPPORTUNITIES AND PRIORITIES

- Clinical Services
  - Increase *neighborhood clinics* and expand *prevention* services
  - Dental Services
  - Mental Health
  - Pharmacy
  - Maternal and Neonatal
  - Select Specialty Services
  - Infectious Disease screening and follow-up (including Cermak)
  - Rehab/LTC
PERCEIVED OPPORTUNITIES AND PRIORITIES

- Operations
  - **Increase operational efficiencies** and financial/revenue accountability
  - **Electronic medical records**
  - **Streamline patient processing**, including triage/direction at point of access to appropriate services, coordination of care, follow-up and communication.
  - **Reduce wait times** for all services
  - **Improve customer service and communication**
  - Review and **improve access** (e.g., parking and travel)
PERCEIVED OPPORTUNITIES AND PRIORITIES (cont’d)

Organization

- Provide more **bilingual/bicultural staff**
- Work jointly with other advocate groups, providers and safety networks in region to more efficiently and effectively **meet the needs of growing un-insured and under-insured patients**
- **Evaluate “make-buy” options** for services based on County clinical capacity and needs (e.g., Let FQHC’s provide neighborhood services)
- Be a leader in local, state, and national efforts to **advocate for policies and funding** for healthcare services
- Consider **board representation to reflect communities served** (more diversity, neighborhood representatives)
- **Define clear message of services provided and communicate** that message throughout communities
Agenda

- Process Overview and Progress Update
- Current State:
  - Market Characteristics
  - CCHHS Overview
- Financial Planning Update
- Interview/Focus Group Feedback
- Town Hall Meeting Input (Preliminary)
- Discussion: Core Themes + Design Principles
- Next Steps
Shared Perceptions of a Desired Future State for CCHHS: What the System Should “Look Like” in 2012 and Beyond:

- Needs-focused; addresses health issues of residents
- Strategically-distributed geographic access points
- Resource/care coordination with collar counties
- Primary care availability/accessibility (through System resources and/or partnerships)
- Strong specialty care service base
- Highly visible and recognized clinical centers of excellence
- Services meet volume thresholds for quality of care, efficiency
**Shared Perceptions of a Desired Future State (cont’d):**

- Patient-centered
- Systemized patient care management; care pathways, tracking, and follow-up
- Strong focus on screening, early detection, chronic disease management (e.g., diabetes)
- Sub-regional hubs (“medical home” structures) to support the above
- Robust health information technology, including interface of patient care referral/tracking systems with other entities
**Shared Perceptions of a Desired Future State (cont’d):**

- New (possibly relocated) facilities for services currently housed in Fantus Clinic
- Provident Hospital redeveloped for expanded outpatient role (e.g., specialty care, ambulatory surgery)
- Determine best use for Oak Forest facilities: Expand rehab (perhaps in partnership with VA)? Reestablish long-term care? Expand outpatient facilities?
- Defined relationships with community provider partners: hospitals, medical schools, FQHC’s, other
**Shared Perceptions of a Desired Future State (cont’d):**

- Progressive, streamlined approaches to medical staff/employee recruitment and retention
- Culture of staff selection, training, and development consistent with ethic of service excellence
- State-of-the-art management functions and processes
- System branding, marketing, and public relations supports a positive image
- System Board is made permanent and has level of authority/autonomy consistent with challenges the Board is asked to address
- System meets high standards for accountability and stewardship
- A truly integrated System: “a System that functions as a system”
Major Strategic Issues (for discussion)

Some Key Questions:

- What is the System all about?
  - Primary care or specialty/tertiary care as primary role?
  - Role of other modalities (e.g., rehabilitation, long-term care)?
  - Geographic distribution of access, care points?
  - Role interface with other providers: community hospitals, public health agencies, FQHC’s?
  - Balance between direct provision of care and efforts to coordinate with partner providers of care?
  - Coordination with collar counties?
Other key questions:

- Clinical emphasis: centers of excellence?
- Medical education and research: role and direction?
- Future role of Provident, Oak Forest facilities and campuses?
- Future of Fantus and related services?
- Development priorities and sequencing?
Agenda

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Next Steps

Phase III—Strategic Direction:
Establish Vision & Goals

- Delineate System design principles
- Board/Steering Group Retreat
- Formulate Vision and Goals
- Identify Major Strategic Initiatives
### Tasks & Timelines

#### CCHHS Strategic Planning Tasks/Timeline

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<thead>
<tr>
<th>TASK/MEETINGS</th>
<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
<th>NOV</th>
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<td><strong>Phase I - Organization/Kick/Off</strong> (completed)</td>
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<td><strong>Phase II - Discovery</strong></td>
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<td>Complete market analysis</td>
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<td>Complete clinical and ops. profile assmt.</td>
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<td>Complete individual/group interviews</td>
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<td>Conduct external interviews</td>
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<td>Town Hall Meetings--Round 1</td>
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<td><strong>Phase III - Formulation</strong></td>
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<td>Summarize/synthesize Ph. II findings</td>
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<td>Board Progress Report</td>
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<td>Develop draft framework: vision, goals</td>
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<td>Identify major strategic initiatives</td>
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<td>Dedicated Board Meeting</td>
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<td><strong>Phase IV - Financial Plan</strong></td>
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<td>Develop &quot;momentum&quot; financial model</td>
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<td>Model financial impact of strategies</td>
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<td>Complete forecast/model roll-up</td>
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<td><strong>Phase V - Action Plan</strong></td>
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<td>Link strategic initiatives to action steps</td>
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<td>Establish timetables</td>
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<td>Link to measures and accountabilities</td>
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<td>Board Retreat</td>
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<td>Presentations, review, revisions</td>
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<td>Town Hall Meetings--Round 2</td>
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<td>Finalization and approvals</td>
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