



# IMPACT 2023

## STRATEGIC PLAN



COOK COUNTY  
HEALTH

DRAFT

# Table of Contents

2	<b>About Cook County Health</b>
3	<b>Letter from the CEO</b>
5	<b>Healthcare Landscape</b>
6	<b>Mission &amp; Vision</b>
7	<b>Focus Area 1: Deliver High Quality Care</b>
14	<b>Focus Area 2: Grow to Serve and Compete</b>
18	<b>Focus Area 3: Foster Fiscal Stewardship</b>
23	<b>Focus Area 4: Leverage and Invest in Assets</b>
28	<b>Focus Area 5: Impact Social Determinant and Advocate for Patients</b>

---

33	<b>Appendices</b>
34	Glossary
38	Organization Structure
39	Demographics, Utilization and Membership Data
45	Community Town Hall Summary
46	Employee Town Hall Summary
47	Employee Survey
51	Timeline
52	Presentation List
53	Enabling Ordinance

Note to the reader: **IMPACT 2023** provides strategic concepts and initiatives to guide CCH through the next three years recognizing that the System is operating in an extremely dynamic local, state and federal environment that may result in adjustments and reprioritizations to ensure success for the organization. The organization of the plan should not be seen as a prioritization of initiatives and objectives; rather, it is intended to describe how CCH will adapt and respond to the new health care landscape.

Once adopted, progress toward attainment of the objectives in **IMPACT 2023** will be monitored by the CCH Board of Directors. Tactics, measurements and milestones will be incorporated into the budget approval process over the next three years.

Please see the glossary for definitions of select health care terms used in this report. Underlined terms are hyperlinked in the electronic PDF.

For more information, please visit [www.cookcountyhealth.org](http://www.cookcountyhealth.org).

# About Cook County Health

**Cook County Health (CCH or System) is one of the largest public health systems in the United States, providing a range of health services regardless of a patient's ability to pay. Through the health system and the health plan, CCH serves more than 500,000 unique individuals annually. The System operates:**

- John H. Stroger, Jr. Hospital of Cook County, a 450-bed tertiary, acute care hospital in the Illinois Medical District;
- Provident Hospital of Cook County, 79-bed community acute care hospital on the South Side;
- More than a dozen community health centers, which offer primary and specialty care, along with diagnostic services;
- The Ruth M. Rothstein CORE Center, a comprehensive care center for patients with HIV and other infectious diseases. The CORE Center is the largest provider of HIV care in the Midwest and one of the largest in the nation;
- Cook County Department of Public Health, a state and nationally certified public health department serving suburban Cook County;
- Correctional Health Services, which provides health care services to the detainees at the Cook County Jail and residents of the Juvenile Temporary Detention Center every year; and
- CountyCare, the largest Medicaid managed care plan in Cook County.

The System's hospitals and ambulatory network, including its Primary Care Medical Home model, are Joint Commission accredited. Stroger Hospital also holds certifications in stroke, burn, perinatal and oncology care.

The Cook County Department of Public Health (CCDPH) serves 2.5 million residents in 124 municipalities and serves the public health needs of its jurisdiction through effective and efficient disease prevention and health promotion programs. CCDPH's approach to protecting and promoting health brings residents, partners and resources together to address issues facing the communities it serves. The department is responsible for the prevention of the spread of nearly 70 reportable communicable diseases and the enforcement of Cook County and Illinois public health laws, rules and regulations.

In fall 2012, leveraging the Affordable Care Act (ACA), CCH launched CountyCare as a demonstration project through a U.S. Centers for Medicare and Medicaid Services (CMS) 1115 Waiver granted to the state of Illinois to early-enroll newly eligible low-income Cook County adults into a Medicaid managed care program. Many of CountyCare's 300,000+ members are long-standing CCH patients who previously received care, in keeping with CCH's mission to care for all regardless of their ability to pay.

CountyCare is (a Managed Care Organization) operated by CCH. Through CCH, CountyCare receives a capitated per-member per-month payment and pays for services rendered to members within the network. CountyCare's provider network includes all CCH facilities, every Federally Qualified Health Center in Cook County, community mental health centers and drug treatment centers, 4,000 primary care providers, 16,000 specialists and more than 50 hospitals.

CountyCare also covers approved home- and community-based services, vision and dental services, and allows members to fill prescriptions at local pharmacies or use CCH pharmacy services, including a mail-order system.

## Letter from the CEO



In 2016, Cook County Health (CCH) embarked on a three-year strategic plan amidst the most dramatic changes the health care industry had seen in decades. The Affordable Care Act (ACA) was the single most transformative social policy change health care has seen since the introduction of Medicare and Medicaid in the 1960s. With the ACA came continued evolution of managed care, new reimbursement models and most importantly coverage for millions of Americans. CCH faced an uncertain future if it did not respond boldly to these new circumstances. Our 180-year legacy of caring for the most vulnerable was challenged by a groundbreaking policy that would extend coverage to many of our previously uninsured patients yet leave others behind. There would still be a need for a public safety net system to care for the 150,000 individuals who would remain uninsured in Cook County, but would there be the resources to pay for their needs at a time when we were trying to stand on our own financial feet? These newly covered “legacy” CCH patients could now choose to go elsewhere and take the accompanying reimbursements with them or we could develop a plan that would allow us to compete for patients and families we have long served. To succeed would require multiple strategies to address access and capacity, finances, equipment, staffing and quality. Failure was not an option. As always, our patients were relying on us.

Now almost 10 years after the signing of the ACA, CCH is proudly carrying out its mission with a renewed sense of commitment and confidence in a far more complex local and national environment. We have accomplished a great deal since the ACA was adopted by Congress, but without question two things stand out: the willingness of the System, our board and the County board to adapt in a rapidly changing environment

and the creation of CountyCare, our Medicaid health plan. When I rejoined the System in 2013 and was subsequently named CEO in 2014, strategic transformation was well underway. CountyCare was growing and Illinois was moving rapidly toward mandated managed care for Medicaid enrollees. And while the plan was working, other external realities were crying for attention. Gun violence, a growing epidemic of opioid-related fatalities, food insecurity, threats to the ACA and other forms of inequity were increasingly challenging the communities we have long served. 2016 was a good time for us to convene and plan the best we could for the next several years of our ongoing transformation.

IMPACT 2020, our 2017-2019 strategic plan, provided the roadmap we needed to focus on our future while remaining true to our historical mission. To shift Cook County Health from a provider of sick care to a provider of health care. To focus on quality and safety, every patient, every encounter. To reconsider our system’s role in the larger health care market. To integrate our component parts and partner with others. To grow. To serve. To compete. To advocate. To leverage. To invest. With the strong direction and support of our board, we developed a plan that does not sit on a shelf but rather has served as a guide when our board has contemplated strategic initiatives designed to protect our mission and better meet the needs of our patients and communities. We anticipated the need to be nimble, understanding that significant changes at the local, state and national levels of government and in health care could require significant shifts in strategy or at least temporary distractions.

In the end, IMPACT 2020 prioritized critical initiatives like improving quality and safety, modernizing our facilities and

investing in our employees. The most tangible result of IMPACT 2020 was the opening of the new Professional Building on our central campus. With the steadfast commitment of Cook County Board President Preckwinkle and the support of the Cook County Board of Commissioners, we replaced the circa 1959 Fantus Clinic with a beautiful, modern facility our patients and staff deserve. This building is a testament both physically and symbolically of our commitment to the patients we serve. Following the opening of the Professional Building in Fall 2018, we opened a new health center in Arlington Heights in January 2019, and by the end of 2019 we will open new facilities in North Riverside and Blue Island.

We built the largest Medicaid health plan in the county despite competing with national brands. We celebrated the 20th Anniversary of the CORE Center and the 50th Anniversary of our Trauma Unit. We raised the bar in correctional health and now serve as a national model for the delivery of high quality care to the detained. We earned the highly coveted Health Information Management Systems Society Level 7 designation for the full integration of our electronic medical record, an honor that few other systems in the nation have achieved. We continued to welcome Navy medical personnel into our renowned trauma unit to exchange knowledge and skills with our heroes in combat. We attacked the opioid epidemic from multiple angles and continue to address food and housing insecurity in meaningful ways. We fought (and will continue to fight) at every level of government to protect the Affordable Care Act and expand access to populations it has left behind. We have leveraged the strengths and expertise of our public health department to drive strategic decisions that will guide our population health strategies for years to come. And importantly, we did all of this (and more) while remaining responsible stewards of local tax dollars.

IMPACT 2023 requires us to reflect on the past three years with the future in mind. What's next? What drives us to provide the highest quality, most culturally competent care to every patient, every day with a commitment that fosters an environment committed to zero harm? What must we do to thrive in an environment where reimbursements will be driven by outcomes regardless of how sick the patient was when they presented to us or the complexity of their social structures? What is our competitive edge against local and national systems who enjoy greater brand recognition and far greater resources? What programs and services do we offer that will set us apart? How do we advocate for universal access to affordable, high quality health care for all? How do we

partner with others to best utilize limited resources and make a measurable impact on the communities we serve? Where are the gaps in services for the communities that rely on us? What will happen if the ACA is repealed, in part or in whole? How will inevitable hospital closures impact our communities and how should CCH respond? How do we supply the increasing demand for charity care with limited resources? How do we recruit physicians, nurses and others who reflect the patients we serve? How do we evolve as both a provider-of-choice and an employer-of-choice? Can we serve as a catalyst for the type of large-scale changes that are needed to decrease adverse childhood events, improve maternal outcomes, improve health equity and change the trajectory of chronic diseases like hypertension and diabetes?

These are hard questions without the environmental, socio-economic and political considerations that exist in our county, state and nation today. IMPACT 2023 provides some of the answers and recommendations for the future while recognizing that unanticipated changes in the environment will require us to pivot. The coming years will no doubt continue to challenge us, but there are few organizations that have survived the test of time with the same core mission as we have.

I am honored to serve as the Chief Executive Officer of this important community asset, but this is a group effort. It is a shared commitment to our 180-year-old mission that has allowed us to be so successful over this last decade. The support of President Toni Preckwinkle and the Cook County Board of Commissioners coupled with the vision and commitment of our independent Board of Directors, has allowed us to accomplish much to be proud of. I want to thank our staff for their compassion, their commitment and their resilience on this journey to transform Cook County Health into a patient-centered organization that is recognized as the community asset it is. But most importantly, I want to thank our patients and our health plan members for placing their continued trust in us.

We hope that the ambitious plans we have laid out in IMPACT 2023 demonstrate our continued commitment to the communities and patients we serve and appropriately honor the legacy of this noble organization.

Sincerely,

**John Jay Shannon, MD**  
**Chief Executive Officer**

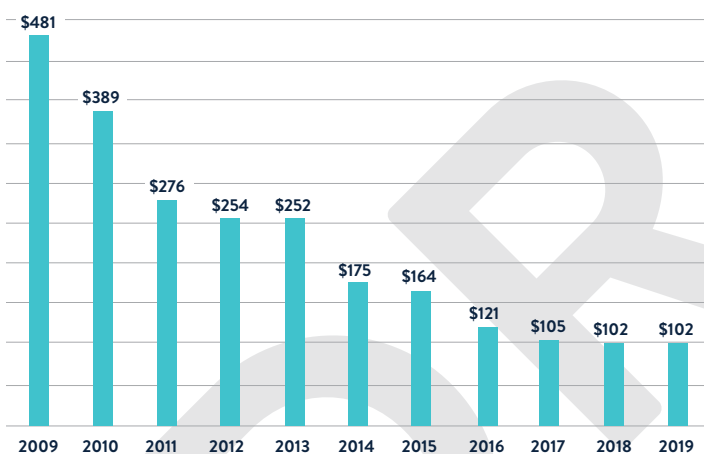
# Healthcare Landscape

## NAVIGATING EXTERNAL REALITIES

Cook County Health holds a unique position in the local, state and national health care landscape. As such, the decisions, policies and actions of public officials, private health systems, insurance carriers and others must be carefully monitored and used to inform strategies that will enable CCH to stay true to its 180-year-old mission to care for all County residents regardless of income, insurance or immigration status.

The Affordable Care Act allowed CCH to implement strategies designed to ensure its financial stability in a local environment where fewer tax dollars have been available.

### County Health Fund Allocation to CCH Operating Expenses



Efforts and attempts to erode tenets of the ACA at the state and federal level have had an impact on CCH resulting in an increased demand for health care by the uninsured. CCH's 2017-2019 Strategic Plan, IMPACT 2020, contemplated the need to remain nimble in a highly dynamic environment.

As CCH completes its 2020-2022 strategic plan, continued attention and responsiveness to external realities will be required. The following are just a few of the local, state and federal considerations that CCH will monitor and adapt to over the course of the next several years.

## RISING UNINSURED NUMBERS

In 2016, the number of uninsured individuals in Cook County (9%), the state of Illinois (7%) and the country (10%) were at a historic low; a direct result of the Affordable Care Act. Despite this, CCH has continued to provide more than 50% of all the charity care in Cook County. In fact, CCH's proportion of charity care since the enactment of the ACA has risen despite decreases experienced by other health care systems. In the years following the ACA, state and federal actions resulted in fewer people with coverage, which placed additional demands on CCH for charity care.

**In 2016, 35% of CCH patients were uninsured, a historic low. In 2018, due to actions at the state and federal level, that number increased to 43%.**

## CHANGING LANDSCAPE

IMPACT 2020 recognized that the local health care landscape would face continued consolidations and even some hospital closures. As health systems consolidate and expand operations in areas with attractive payor mixes, traditional safety net institutions will be stressed trying to fill in the gaps. Additional safety net closures are probable, placing increased expectations and demands on CCH. Furthermore, consolidations, market entrances and exits in the managed care space, as well as changes in Medicaid policy at the state and federal level, will pose unique challenges or opportunities to CCH as both a provider of care and a provider-led health plan.

Over the course of IMPACT 2023, additional changes at the local, state and federal level are fully expected. Policy changes that impact immigration, chip away at the Affordable Care Act or even shift the country toward a single payor system will have enormous impacts on CCH. The ability to leverage positive changes, pivot where necessary and limit risk will be key to the future of CCH.

## Mission



To deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public; and advocate for policies that promote and protect the physical, mental and social well-being of the people of Cook County.

## Vision



In support of its public health mission, Cook County Health will be recognized locally, regionally and nationally – and by patients and employees – as a progressively evolving model for an accessible, integrated, patient-centered and fiscally-responsible health care system focused on assuring high quality care and improving the health of the residents of Cook County.



FOCUS AREA 1

# Deliver High Quality Care

DRAFT



# Deliver High Quality Care

There is nothing more fundamental in health care than the delivery of safe, high quality care for every patient at every encounter. Over the past three years, intense focus has been placed on implementing evidence-based, highly reliable systems to ensure that all patients are provided the same opportunity to heal regardless of the complexities of their individual needs. Accreditation by The Joint Commission (TJC) signifies compliance with standards of care established by the U.S. Centers for Medicaid and Medicare Services (CMS). In the past three years, Stroger and Provident hospitals as well as CCH's ambulatory network and Primary Care Medical Homes have been reaccredited by TJC. In a highly competitive environment, accreditation must be viewed as the minimum standard. At CCH, efforts to improve quality and ensure patient safety are about raising the bar.

Since the adoption of IMPACT 2020, more than 90% of CCH employees – from physicians to food service workers – have been trained in “high reliability” practices designed to ensure that all employees understand how attention to detail, clear communication, and a questioning attitude assure safe care of the patient. High reliability training empowers staff at all levels in the organization to ask questions and raise concerns where patient and employee safety may be compromised. Daily safety huddles are now the organizational norm throughout CCH, providing a scheduled opportunity for multidisciplinary groups to discuss any matter that may impact patient safety whether on a specific unit, at a clinic or in correctional health.

Quality initiatives come in all shapes and sizes. They include large-scale systematic efforts as well as individualized plans designed to address the needs of our most complex patients through the vast expansion of care coordination activities over the past three years.

The needs of a 45-year-old diabetic with heart disease are vastly different from those of a 30-year-old pregnant woman with a substance use disorder. One may have a strong family network that can assist them post-discharge while the other may not have stable housing or access to healthy foods.

Care management provides patients and health plan members with a “back-stop” by ensuring that they have access to the medical and social services needed to improve their health.

Care managers are often nurses or social workers who are supported by a cadre of professionals from case managers to community health workers. The addition of more than 200 care managers and community health workers in the past three years has enabled CCH to offer care management services to over 8,000 individuals at any given time. Care management also addresses cultural, legal and linguistic barriers that might otherwise impede the progress of a patient and links patients with social services that may improve outcomes such as food support or housing.

Significant progress has been made in providing care coordination services at CCH to assist with opioid discharges and other behavioral health needs. And while today, our care coordinators have a full panel of patients, the full value of care coordination will be realized in the coming years as CCH fully integrates the model across the System connecting all relevant areas from correctional health to public health, from the emergency department to inpatient and outpatient settings.

Expert staff and modern facilities are at the core of providing high quality care.

Specific investments in nursing in the coming years will move CCH closer to Magnet® Status. A shared governance model is being implemented that will give frontline nurses the opportunity to share in decision making that impacts patient care practices and the work environment. Leadership development programs will provide critical training to enable nurses to advance their career at CCH and a nurse residency program will expose new nurses to CCH earlier in their career-seeking process.

In 2018, CCH finished construction on its first new building since Stroger Hospital opened in 2002. The 282,000 square foot professional building at the corner of Polk Street and Damen Avenue did far more than provide a modern space to match the care CCH has long provided. It delivered on the promise to provide high quality care with dignity and respect and is critical to the System's growth strategy. It allowed CCH to create interdisciplinary teams around complex conditions like cancer. It also enabled the decommissioning of the Fantus Clinic and the construction of a new parking lot designed to provide expanded parking for patients.

Significant investments have been made in existing facilities over the past several years including the renovation of the fourth floor of Stroger Hospital to create a Women’s and Children’s Center offering inpatient and outpatient services in a multi-disciplinary model. Strengthening maternal/child health services throughout the System with linkages to additional support services will be imperative as CCH seeks to improve maternal/child health outcomes in the coming years.

New facilities throughout Cook County will provide much needed comprehensive services closer to our patients, including dental and behavioral health, and will include important linkages to programs like the Women, Infant and Children’s Supplemental Nutrition Program (WIC). IMPACT 2023 continues to advance an ambitious capital improvement strategy in new buildings and new equipment.

Health care is dependent on technology. At CCH, this is best demonstrated by the 1.4 million computer transactions occurring every day that are dependent on a complex integration of more than 300 computer applications across the System.

CCH’s journey to providing the highest level of technology available began in 2002 when the first electronic medical record (EMR) was implemented. Since that time, CCH has literally moved from paper medical records to a fully integrated electronic system across the inpatient, outpatient and correctional health arenas. An individual who accesses services at Cook County Jail may see a CCH primary care physician months after discharge. That patient will have a digital file that the care team can immediately access, saving time and money while preventing unnecessary and duplicative testing.

CCH’s commitment to meeting technology advances and demands was recognized in 2018 by the Health Information Management Systems Society (HIMSS) as a Stage 7 organization – an honor bestowed on health systems reflecting the highest standards in the implementation, integration and execution of the electronic medical record. Less than 10% of health systems in the United States have earned this distinction.

As technology continues to advance, health care Information Technology (IT) must keep pace at all levels from online scheduling of appointments to revenue cycle to security to artificial intelligence and everything in between. Evaluating, understanding and executing IT strategies to ultimately improve health outcomes is a constant process that requires both human and financial resources.

CCH has also made investments in technology to improve the patient experience. The health system introduced eConsult

in 2016 which allows a primary care physician the ability to electronically submit questions or images to a CCH specialist who reviews and responds to the request in less than 48 hours. Nearly half the time, the use of eConsult avoids an unnecessary office or emergency room visit for the patient, thus ensuring the System has capacity for those who most need it.

Regardless of these investments, CCH’s ability to compete in the health care environment will depend almost entirely on its ability to deliver an excellent patient experience as reflected by our patients and benchmarked by external rating organizations. IMPACT 2020 set out a number of strategies to improve the patient experience including increasing the number of bilingual staff, reducing wait times, providing cultural competency and customer service training and launching its own transportation fleet. These are imperative in a modern health system and IMPACT 2023 recognizes a number of new opportunities for further improvement including additional efforts to improve cultural competency.

There is perhaps no clinical service that embodies the mission of CCH better than Correctional Health. It is where one can witness firsthand the intersection of multiple inequities in our society. Caring for the detained populations at the Cook County Jail and the Juvenile Temporary Detention Center is a complex yet incredibly rewarding endeavor. The past few years have brought the opioid and mental health epidemics to the front door of these facilities. CCH has responded with innovative programs to care for detainees while in the jail and provides warm hand-offs to community partners for individuals at discharge. Since initiating Medicaid applications at the jail in 2013, more than 20,000 detainees have been enrolled, providing them with continued access to critical community-based services upon release. In 2018, CCH realized its goal to markedly improve the care and services provided to detainees. Achieving this goal led to the dissolution of a 10-year old U.S. Department of Justice consent decree. In 2018, CCH began providing mental health services at the Juvenile Temporary Detention Center (JTDC) as part of its commitment to provide comprehensive and integrated behavioral health services across the organization. Today, the efforts and commitment of the correctional health team stand as a national model for the delivery of care to the justice-involved.

Delivering high quality care requires a multi-disciplinary approach and organizational commitment that extends beyond the life of any one strategic plan. It is the core of what every health system sets out to do and CCH is no different.

## DELIVER HIGH QUALITY CARE

### IMPACT 2020 ACCOMPLISHMENTS:

- The Joint Commission (TJC) accreditation for Stroger, Provident and Ambulatory Health Centers; TJC Primary Care Medical Home certification
- Implemented training in safety culture and high reliability throughout the organization
- Established a Women's and Children's center in Stroger Hospital
- Behavioral health integrated into primary care health centers
- Increased patients assigned to a Primary Care Medical Home (PCMH) each year
- Added CLAS cultural competence item to patient satisfaction surveys
- Established care coordination program to provide health risk and social determinant screening and connection to community-based support services
- Opened new outpatient health centers on the Central Campus (Professional Building) and in Arlington Heights
- Substantial progress on replacement health centers for Oak Forest, Cicero, Logan Square and Provident
- Achieved substantial compliance with US Department of Justice at Cook County Jail
- Correctional Health implemented Naloxone distribution at the jail
- Assumed responsibility for mental health services at the Juvenile Temporary Detention Center
- Attained National Commission on Correctional Health Care Certification for the Juvenile Detention Center
- Implemented connectivity HUB to facilitate orders/results between system and community-based providers, compatible with varied electronic medical record systems
- Supported the creation of Community Triage Centers for individuals with urgent behavioral health needs in Roseland and West Garfield Park
- Obtained Health Information and Management Systems Society (HIMSS) Level 7 designation
- Increased "Willingness to Recommend" from first quarter 2017 to first quarter 2019 by 9%

# Focus Area 1: Deliver High Quality Care

OBJECTIVE	HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
<p><b>1.1</b> Continuously improve clinical operations, practices and procedures across CCH to enhance quality, reliability, safety and efficiency.</p>	<p><b>1.1 A</b> Develop specific strategies and implementation plans related to the quality pillars (patient experience, readmissions, safe processes of care, clinical documentation, ambulatory pay for performance and mortality).</p> <p><b>1.1 B</b> Establish maternal/child health services at the community centers as key providers of maternal/child services. Assess and pilot additional strategies to support the continuum of maternal health services throughout the System.</p> <p><b>1.1 C</b> Enhance and reinforce organizational practices that improve a culture of safety and result in safe patient outcomes.</p> <p><b>1.1 D</b> Improve the health status of patients by implementing the tenets of the medical home at CCH outpatient centers and practices that provide value.</p> <p><b>1.1 E</b> Improve inpatient and ambulatory patient care by adopting strategies that move towards nursing Magnet® certification.</p> <p><b>1.1 F</b> Assure reliable supply chain to provide timely and safe clinical practice.</p> <p><b>1.1 G</b> Deploy appropriate emerging technology to improve portability and functionality.</p> <p><b>1.1 H</b> Leverage IT in the clinical environment by using artificial intelligence and predictive analytics to improve patient care. Review the electronic medical record and determine if there are any untapped management tools to activate.</p> <p><b>1.1 I</b> Implement data governance model to improve data integrity and provide meaningful and timely reports to measure service performance against external benchmarks. Increase independent user access to data dashboards to improve knowledge, decision making and patient care.</p> <p><b>1.1 J</b> Optimize health system integration and care transitions to benefit patients and the health system using an approach that is consistent with evidence-based practices.</p> <p><b>1.1 K</b> Modernize information technology infrastructure to improve the patient experience.</p> <p><b>1.1 L</b> Assess contribution of Race, Ethnicity, and Language (REaL) factors to adverse events and develop mitigation strategies. Assess the contribution of disparities to health outcomes and adverse events. Determine if a patient's cultural or racial factors contribute to adverse outcomes and evaluate the causes of these outcomes. Focus quality efforts in areas that are directly impacted by disparities.</p>	<p>Achieve targets established by the High Reliability Organization (HRO) Committees. Exceed average/median external rating.</p> <p>Implement new maternal health navigator program at every Health Center that provides prenatal care. Increase 3% year-over-year prenatal visits; deliveries; newborn visits from a FY18 baseline of 6,205 prenatal visits; 987 deliveries; and 1,087 newborn visits.</p> <p>10% reduction in harm index over next three years.</p> <p>Achieve benchmarks for HEDIS and Pay for Performance.</p> <p>Achieve nursing-sensitive safety outcomes and process metrics (NDNQI Metrics) to allow consistent and meaningful progress towards Magnet®.</p> <p>Streamline procurement process to reduce time to enter into contracts.</p> <p>Achieve HIMSS for Infrastructure certification; Implement Voice Over Internet Protocol (VOIP) system-wide.</p> <p>Finalize a plan on using artificial intelligence and predictive analytics by the 2nd quarter of 2020 that includes areas of focus and relevant metrics. Complete assessment of the Cerner Electronic Medical Record platform for additional management tools.</p> <p>Establish definitions and requirements for data input and provide routine reporting and real-time dashboards available for managers and for quality/performance oversight activities. Ability to produce ad hoc reports and generate data within established timelines. Increase number of dashboard users. Increase number of standard Cerner reports useful to local managers.</p> <p>Improved discharge planning that includes engaging the Patient Support Center. Reduce length of stay and improved utilization of appropriately reimburseable admission status.</p> <p>Implement free guest Wi-Fi across CCH where practical; strengthen cybersecurity; Refresh network infrastructure enabling faster network speeds, high availability, and next generation technologies; Fully optimize existing technology such as Tele-Tracking, TIGR to enhance patient care. Implement systems to ensure external providers can easily refer patients to CCH and receive results following new and follow up appointments.</p> <p>100% of intake staff are trained on how to accurately input race, ethnicity and language (REaL) data by 2022. Begin to validate and stratify outcomes data by REaL.</p>

OBJECTIVE	HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
<p><b>1.1</b> Continuously improve clinical operations, practices and procedures across CCH to enhance quality, reliability, safety and efficiency.</p> <p><b>1.2</b> Develop systems that meet or exceed expectations and enhance the patient experience.</p> <p><b>1.3</b> Improve the availability of and access to health care, especially preventive care, for Cook County residents.</p>	<p><b>1.1 M</b> Deploy applications that enhance services and facilitate exchange of clinical and public health data.</p> <p><b>1.1 N</b> Launch culturally-tailored health promotion programming and interventions. Shape our health centers to be culturally and linguistically sensitive.</p> <p><b>1.2 A</b> Implement best practices to enhance patient experience using data from patient satisfaction surveys. Use improvement strategies and support leadership strategies at the unit, department and site levels.</p> <p><b>1.2 B</b> Develop comprehensive cultural competency strategy.</p> <p><b>1.2 C</b> Launch initiatives focused on customer service, patient conveniences (e.g. Quiet Campaign).</p> <p><b>1.3 A</b> Enhance strategic partnerships with community providers.</p> <p><b>1.3 B</b> Develop a roadmap of service needs by conducting a geographic analysis of providers, income, disease prevalence, etc., throughout the County to determine gaps in health services and recommend a service delivery plan.</p> <p><b>1.3 C</b> Complete a master facilities plan and make investments to make CCH more competitive.</p> <p><b>1.3 D</b> Develop a comprehensive patient education strategy (e.g. diabetes prevention training, prenatal education, blood pressure self testing).</p> <p><b>1.3 E</b> Take advantage of state and federal initiatives to innovate care delivery services and programs, beneficial to patients and members.</p> <p><b>1.3 F</b> Mature behavioral health portfolio.</p> <p><b>1.3 G</b> Implement operational improvements to tap into unused capacity and create more access.</p>	<p>Analyses of clinical conditions informed by public health data sets to integrate into clinical practice strategies.</p> <p>Implement new health promotion program within community health centers by December 2020.</p> <p>Continue to produce an annual patient experience plan informed by survey results. Improve patient ratings year-over-year.</p> <p>Train 100% of employees in cultural competency. Facilitate hiring of additional bi-lingual employees by increasing the number of bilingual job descriptions to 50, 75, 100 for 2020, 2021 and 2022 respectively, from a current baseline of 20.</p> <p>Increase “willingness to recommend” to 60th percentile by 2022, up from the current 51st percentile.</p> <p>CCH patient population meets HEDIS Medicaid target for an agreed upon set of metrics.</p> <p>Finalize comprehensive review of health care services (in 2020) in the County by provider type and population that can be updated, but would also include model/formula to explore and evaluate various expansion and/or partnership opportunities. Develop a multi-year strategy to grow CCH specialty services to meet community needs in a financially viable manner. Establish effective strategies that meet community needs and bring value to CCH.</p> <p>Complete master facilities plan. Open new health facilities at Hanson Park, North Riverside, Blue Island, Harrison Square and the new Provident facility. Identify additional locations for health center expansions or replacements.</p> <p>Establish inter-professional Patient Education committee for the System and establish metrics first quarter of 2020. 100% of diabetic patients are offered diabetic education, and 30% of diabetic patients receive diabetes management education by 2022. 100% of prenatal patients are offered prenatal education, and 30% complete entire prenatal education curriculum by 2022.</p> <p>Implement Integrated Health Homes if approved by the state.</p> <p>Full integration of behavioral health into primary care. Enhance Medication Assisted Treatment (MAT) infrastructure with workflow/pathway creation of level 1, 2, and 3 Behavioral Health services. Secure grant funding for opioid treatment and engage law enforcement partners in the development of deflection to treatment programs.</p> <p>Set target of “third next available” appointments to less than 14 days for new specialty referrals. Target increase in eConsult use by 10%. Increase in-care list by 25% from FY2019 baseline. Pilot use of in-home monitoring for selected patient population (e.g. diabetes and hypertension).</p>

OBJECTIVE	HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
<p><b>1.4</b> Ensure a continuum of services to meet evolving needs to ensure continuity of care and meet patient needs at all stages of their lives.</p> <p><b>1.5</b> Integrate services with correctional health to improve health outcomes by ensuring continuation of care when individuals are released from correctional or detention facilities and reside in Cook County.</p>	<p><b>1.4 A</b> Conduct analysis of services and identify gaps in the continuum of care to build valuable strategies for special populations (e.g. elderly, disabled, etc.).</p> <p><b>1.5 A</b> Improve transitions of care to the community through enhanced discharge planning.</p>	<p>Complete analysis and implementation plans on service gaps with recommendations on services to be provided by CCH or through partner organizations. Develop recommendations including on long-term care (including nursing home care), embedded care coordinators and senior care services in outpatient centers, home-based connections, telehealth, community-based care in lieu of institutionalization for elderly and special needs populations.</p> <p>Increase discharge planning such as the Naloxone Program and other warm hand-offs in the community by 20%. Expand transitions into community-based services through partnerships with CCH care management and PCMH providers, including linkages to housing, community based mental health providers. Establish community care coordination for justice-involved youth.</p>

DRAFT



**FOCUS AREA 2**

# **Grow to Serve and Compete**

**DRAFT**

# Grow to Serve and Compete

The implementation of the Affordable Care Act and mandatory managed care in Illinois' Medicaid program were the catalyst for CCH to build a comprehensive strategy shifting from the provision of sick care to the provision of health care. Reimbursements were no longer based on the number of individuals seen in a clinic or the procedures performed. Capitation and value-based reimbursement models incentivized providers to keep their patients healthy and out of expensive inpatient settings.

As a provider of complex specialty care operating in a managed care environment, CCH has developed a growth strategy to increase the number of patients it serves in a primary care capacity and to increase services to those referred by external primary care providers. To accomplish this, CCH is in the midst of a multi-year capital program to renovate, relocate or rebuild its community health centers using a model that allows for the expansion of primary care and the integration of more specialty care in the community. Services such as dental and behavioral health will be standard in new facilities to address glaring health inequities in access to these critical services. Furthermore, prioritizing important relationships with Federally Qualified Health Centers will require additional specialty care responsiveness from the System.

On the inpatient side, CCH is planning to build a new, modern facility on the Provident campus that will consolidate inpatient and outpatient services to provide exceptional care and attract new patients. Provident Hospital typically cares for an older population. A new facility focused on specific service lines provides CCH with an opportunity to grow both inpatient and outpatient volumes and offer state-of-the-art diagnostic services, relieving patients of travel to Stroger for common

diagnostics or routine treatments. In 2019, Provident Hospital reopened its Intensive Care Unit and plans to reopen its busy emergency room to ambulance runs.

IMPACT 2020 also contemplated a growth strategy for the System's health plan. As the result of effective acquisition and marketing strategies and the addition of a member reward program, today CountyCare stands as the largest Medicaid managed care plan in Cook County with more than 300,000 members or 30% of the market share. Maintaining market share in an environment where continued contraction among managed care plans is likely will require increased focus on member services, benefits and marketing. Critical to CCH's success will be the ability to serve more CountyCare members at CCH health centers and hospitals and with various telehealth strategies. IMPACT 2023 lays out a series of strategies to provide a greater proportion of services to CountyCare members while keeping CCH doctors and facilities as network providers in the other Medicaid managed care plans operating in Cook County. CCH must also effectively assist members with redetermination and advocate for systematic improvements in processing eligibility and redetermination applications at the state level.

More than 14,000 CCH patients or health plan members are aging into Medicare every year. These are patients who have established relationships with providers but in the absence of a specific strategy around aging patients, many historically left CCH when they transitioned into Medicare coverage. In the coming year, CCH will execute an innovative strategy that will provide these patients with coverage options that will enable coordinated care management, improve transitions of care, promote timely follow-up and build engagement.

## GROW TO SERVE AND COMPETE

### IMPACT 2020 ACCOMPLISHMENTS:

- Acquired former Family Health Network and Aetna Better Health members, doubling the CountyCare membership we serve to over 300,000
- CCH is on pace to increase unique primary care patients seen at CCH by 10%, to at least 96,669 by the end of FY2019
- CountyCare domestic spend increased from \$187 million in FY2016 to \$200 million in FY2018
- The health plan achieved NCQA accreditation in 2017



## Focus Area 2: Grow to Serve and Compete

OBJECTIVE	HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
<p><b>2.1</b> Establish CCH as a provider of choice.</p>	<p><b>2.1 A</b> Grow services lines that are needed by the community and deploy them geographically, in a patient-centered way to ensure CCH is providing the “right care at the right time and right place.”</p> <p><b>2.1 B</b> Maximize use of services and overall utilization.</p> <p><b>2.1 C</b> Improve Stroger and Provident Hospital Emergency Department throughput.</p> <p><b>2.1 D</b> Market CCH services and strengthen the CCH brand.</p> <p><b>2.1 E</b> Explore opportunities for CCH to be a provider for County employees as well as other employers.</p> <p><b>2.1 F</b> Minimize external referrals for care.</p> <p><b>2.1 G</b> Establish additional specific programs at Provident to maximize meeting the community needs.</p> <p><b>2.1 H</b> Maximize value of CCH resources (people, technology) to provide greater access to benefit patients.</p>	<p>Primary Care: Volume of primary care patients increase by 3% year-over-year from a baseline of 92,143 primary care patients in FY2018.</p> <p>Specialty Care: Stroger Campus to provide for key specialties minimum 4 days/week, evening and Saturday hours. Provident Campus to provide full array of specialties minimum 3 days/week and evening hours. Provide selected specialties for new and expanded outpatient locations. Review all community locations to determine increased deployment of specialists for greater access to specialists.</p> <p>Overall: Achieve 80% facility capacity utilization. Achieve 80% of primary care providers at productivity of 10 patients per session by 2022.; Provident: Reinstigate ambulance runs; Average Daily Census increase from 12 by 1.3% each year. ER Growth by 1.3% in FY 2020, 1% increase in FY 2021, 1% increase in FY 2022.</p> <p>Create an operational efficiency dashboard to include: Average time from ED arrival to ED departure for admitted ED patients; Average time from admit decision to ED departure time for admitted patients; Average arrival to ED departure for discharged ED patients; Physician discharge orders before 9:00 am; ED Left Without Being Seen (LWBS) to 2% by 2022.</p> <p>Position CCH providers/leadership as thought leaders on quality and population health management. Complete rebranding process. Conduct market research. Develop consumer and non-consumer facing strategies to raise awareness of specialty care. Develop sponsorship strategy. Develop strategies to maintain CountyCare market share.</p> <p>Collaborate with Cook County Risk Management Department to explore feasibility, timing, and tactics to make CCH services a health service alternative.</p> <p>Internal referrals increase; eConsults increase (including by CCH providers); third next available is less than 14 days for new and follow up.</p> <p>Create Centers of Excellence for women’s health (gynecology, cardiology, breast, endocrine), lifestyle center (dietary, fitness, chronic disease management), orthopedic center (podiatry, joints, hand), and men’s health programs (urology, cardiology, endocrine).</p> <p>Create an operating room dashboard to include: first case start times (target 80%), growth targets (10% per year), case cancellations rates (less than 5%), block utilization (95%) and operating room hours (80% utilization). Utilization of operating rooms at Provident and Stroger (80% of all operating room capacity). Implement telemedicine/tele psychiatry.</p>

OBJECTIVE	HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
<p><b>2.2</b> Retain and grow CountyCare market share.</p> <p><b>2.3</b> Grow market share in non-traditional CCH populations.</p>	<p><b>2.2 A</b> Explore options in acquiring additional members through changes in the marketplace.</p> <p><b>2.2 B</b> Continue to implement a strong member retention and growth strategy to retain market share. Advocate for state policy changes that result in a simpler redetermination process.</p> <p><b>2.2 C</b> Enhance incentive programs and member benefits for improved health outcomes and member retention.</p> <p><b>2.3 A</b> Execute Medicare Advantage strategy that includes Chronic Conditions Special Needs Plan (C-SNP) persons with HIV; Institutional Special Needs Plan (I-SNP); Institutional Equivalent Special Needs Plan (IE-SNP); Medicare-Medicaid Alignment Initiative (MMAI).</p> <p><b>2.3 B</b> Migrate to managed care capability including accepting risk.</p>	<p>Gain auto-assignment for eligible justice-involved individuals in Cook County.</p> <p>Achieve plan redetermination at least 20% greater than the State.</p> <p>Offer a value-added benefit package that ties to quality outcomes, increases member engagement, and improves member retention.</p> <p>Approval by CMS with Model of Care and Network for all three lines of business.</p> <p>Develop competencies in-house to evaluate and negotiate risk arrangements, and ensure CCH has the ability to accept managed care patients who are part of risk arrangements.</p>

DRAFT



**FOCUS AREA 3**

# **Foster Fiscal Stewardship**

# Foster Fiscal Stewardship

As a public institution competing with private health systems, CCH has to carefully balance every strategy to succeed. Through the improvements in operations and several dimensions of the revenue cycle, CCH is proud that it has reduced its reliance on local taxpayers to fund its operations. In fact, today the only operating revenue CCH receives from local taxpayers funds the Cook County Department of Public Health and Correctional Health Services wherein CCH provides services that do not have reimbursement. The remaining 97% is generated by the health system.

CCH's local tax support is one of the lowest in the nation when compared with other large public health systems. Yet without the financial resources to invest in infrastructure, technology and employees, CCH will be at a competitive disadvantage, making it even more critical for CCH to collect every dollar possible to protect the mission of the organization.

This has been at the center of CCH's financial strategy over the past several years. Prior to the enactment of the Affordable Care Act, CCH had served mostly uninsured individuals and those in fee-for-service Medicaid. Medicaid reimbursement was based on the number of individuals cared for in the inpatient or outpatient setting. Most of our uninsured patients qualified for charity care, which in 2017 exceeded \$296M and represented 53% of all the charity care provided by hospitals in Cook County. Without patient fees and other revenues that assist in covering the uninsured, CCH's ability to carry out its mission is seriously threatened.

The simplicity of that historical payor mix did not require the sophisticated systems that private hospitals had built

and matured over decades of caring for a mainly insured population. In 2013, CCH had one main payor and by 2018 had more than 20, each with its own processes. Significant investment in infrastructure, technology, staff and training was required to succeed in an environment that now includes multiple Medicaid and Medicare managed care organizations. From 2013 to 2017, the number of bills generated and the charges associated with them increased by 50%, a testament to how far the organization has come in developing a modern revenue cycle system. The collection of billions of dollars in earned patient service revenue is what has allowed CCH to reduce its reliance on local taxpayers over the past 10 years.

Further illustrating CCH's success since the adoption of IMPACT 2020, CCH has assumed a significant portion of the current pension liability for its 6,700 employees and beginning in 2019, has assumed all debt service on new capital projects. CCH is working closely with Cook County government on strategies that will allow it to assume a greater proportion of its current pension obligations.

CCH has successfully secured more than \$23 million in grant funding since 2016 and the continued maturity of the Cook County Health Foundation promises additional non-tax revenue to support CCH initiatives.

Controlling expenses through the utilization of acuity and clinical activity based staffing models, maximizing automation and tracking out-of-network expenses, coupled with advocating for the continuation of important programs like the Affordable Care Act and the 340B Drug Discount program will ensure CCH's continued financial success.

## FOSTER FISCAL STEWARDSHIP

### IMPACT 2020 ACCOMPLISHMENTS:

- Achieved 97% self-funding for operations, minimizing the local taxpayer burden
- Increased CountyCare member volume to over 300,000
- Began funding a portion of the current annual pension payments
- Increased Medicaid and Medicare Managed Care revenue from 2016 to 2018 by 8.2%
- Self-funding capital equipment and improvements from the operating budget
- Secured \$77 million in financial support for Graduate Medical Education
- Secured \$23 million in grant funds between 2016 and July, 2019
- Implemented the Countywide ERP system at CCH
- Improvements implemented in provider documentation
- Executed marketing and branding strategy
- Reduced “bad debt allowance” by 22% or \$69 million from 2017 to 2018 by improving the quality and collectability of payments owed

# Focus Area 3: Foster Fiscal Stewardship

OBJECTIVE	HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
<p><b>3.1</b> Optimize CCH revenue.</p>	<p><b>3.1 A</b> Maximize reimbursements from payors by continuing to improve operations, including revenue cycle improvements.</p> <p><b>3.1 B</b> Maximize extramural grant sources in alignment CCH initiatives, including primary care, maternal/child health, workforce development, behavioral health, HIV, social determinants of health and capital improvements; capture 10% indirect cost. Continue to build out the grants administrative infrastructure and increase the funds managed by CCH.</p> <p><b>3.1 C</b> Continually improve documentation through ongoing provider feedback and provider education to support timely, complete and accurate billing.</p> <p><b>3.1 D</b> Maximize auto-assignment for CountyCare.</p> <p><b>3.1 E</b> Increase CountyCare membership in the Integrated Care Program (ICP) by assisting members with disabilities attain Social Security Income/Social Security Disability Income (SSI/SSDI).</p> <p><b>3.1 F</b> Identification of Skilled Nursing Facility and Home Health Partners for CountyCare members.</p> <p><b>3.1 G</b> Advocate for local government financial support of unfunded mandates such as correctional health and public health services.</p> <p><b>3.1 H</b> Optimize information technology infrastructure to improve revenue capture.</p>	<p>Increase MCO revenue by 10% each year from FY2019 baseline. Achieve 60% Pay for Performance (P4p) targets and benchmarks; Increase provider empanelment for MCOs to 80% of Medical Group Management Association (MGMA) or the FQHC benchmark. Reduce claims denials for managed care organizations by 80% from current levels and reduce accounts receivable. Improve authorization process for inpatient/observation care by Inpatient Care Coordination team for CountyCare members.</p> <p>Increase extramural support by \$5M annually, including capital. Increased alignment and coordination of extramural activities to improve impact.</p> <p>Write and implement a three-year plan to improve documentation.</p> <p>Improve health plan quality and operational performance to assure maintaining and improving auto-assignments.</p> <p>Have RFP and procurement complete by 10/1/19 and vendor selection and engagement by FY2020. CountyCare will report on SSI/SSDI enrollment in Q2 2020.</p> <p>CountyCare SNF quality program requiring HFS approval has been submitted and is being reviewed by the State.</p> <p>Public and Correctional Health expenses continue to be covered by local taxpayer support.</p> <p>Successful implementation of patient accounting system, online bill payment, online financial counseling.</p>
<p><b>3.2</b> Control costs and maximize efficiencies.</p>	<p><b>3.2 A</b> CountyCare to continue implementation of Medical Cost Action Plan that all CountyCare departments anticipate in to reduce costs through a combination of operational efficiencies and recontracting.</p> <p><b>3.2 B</b> Increasing full-time employees, reducing agency and overtime costs.</p> <p><b>3.2 C</b> Maximize lab automation.</p> <p><b>3.2 D</b> Utilize data (volume, unit costs) to ensure staffing is in-line with appropriate best practices.</p>	<p>Achieve \$30 million in savings to CountyCare plan, while preserving excellence in clinical services and plan operations.</p> <p>Streamline and automate processes that reduce time to hire and expedite other human resource processes. Reduction in vacancies to 10% of workforce.</p> <p>Achieve 95% error free rate.</p> <p>Establish annual targets based on industry benchmarks for overall staffing, including overtime and agency staffing that align with volumes and clinical complexity.</p>

OBJECTIVE	HIGHLIGHTED STRATEGIES	EXPECTED OUTCOME
<p><b>3.1</b> Optimize CCH revenue.</p> <p><b>3.3</b> Pharmaceutical Management.</p>	<p><b>3.2 E</b> Evaluate training programs to determine optimal size and CCH strategic and fiscal value.</p> <p><b>3.2 F</b> Conduct event review and overall analysis for all litigation and implement and communicate lessons learned to mitigate financial risks through employee training.</p> <p><b>3.2 G</b> Reduce facility expenses.</p> <p><b>3.2 H</b> Transition high volume network providers to value-based contracts for CountyCare.</p> <p><b>3.2 I</b> Improve competition for CCH contracted work by increasing transparency of what we plan to procure each year.</p> <p><b>3.3 A</b> Optimize pharmacy economics.</p>	<p>Assessment of 2 physician training programs with recommendations to leadership about strategic and financial attributes to inform organizational planning.</p> <p>With Risk Management, identify litigation trends and implement strategic interventions where appropriate to minimize risk. Continue trainings for staff across the organization on topics like litigation, informed consent, following event reporting and evaluation protocols in order to preserve privileges in litigation matters.</p> <p>Complete close out of health system operations at the Oak Forest property and fully transferred Oak Forest maintenance to the County. Establish internal construction team to reduce facility rehab costs. Move all remaining employees out of the Polk Administration building to allow the County to proceed with building decommissioning, Integrate CORE facility maintenance into CCH portfolio. Review the structure of the building and maintenance division and leverage these resources across all of CCH locations.</p> <p>Execute at least one significant contract with a network provider that transfers risk while preserving excellence in member services in 2020.</p> <p>Establish Annual Buying Plan and increase MBE/WBE contract participation.</p> <p>Revenue optimize: Identify contractual opportunities to increase pharmacy reimbursement for current formulary products. Insource specialty pharmaceuticals creating opportunity to generate revenue.</p> <p>Minimize Expenses: Maximize use of programs available that will reduce medication expense (such as 340B program) or that will allow eligible patients to obtain required medications through external programs (such as insurance Medication Assistance Programs). Reduce practice variation, especially around chronic disease management, to ensure prescriptions are evidence-based, decreasing variation of drug uses among expense classes.</p>

FOCUS AREA 4



# Leverage and Invest in Assets

DRAFT



# Leverage and Invest in Assets

Employees are the heart of any organization and the primary determinant of its success. With more than 6,000 employees working in a 24-7 operation spread across one of the nation's largest counties, CCH must be intentional in leveraging and investing in a workforce that is committed to the historical mission of the organization, while applying modern business practices that will achieve success in a competitive environment and establish CCH as an employer of choice.

Leveraging the workforce starts with a genuine interest in understanding the workforce. To that end, CCH conducted an employee engagement survey in 2018 to understand everything from what motivates them to what frustrates them; from how they view the organization to how they envision their future. More than 3,000 employees completed the survey.

The results of the survey have been used to develop strategies to better engage employees at both the department and system level. Departments will report out on their strategies at monthly leadership meetings, sharing ideas, successes and challenges across the organization. Additionally, a multi-disciplinary employee engagement committee is working on a number of system-wide strategies including formal 'employee of the month' and service anniversary programs.

Fundamental to staffing an efficient, modern and complex health care system is the ability to recruit and retain top talent and to prioritize workforce training and development, offer a competitive compensation structure and provide an environment that allows professionals the opportunity to work at the top of their license. Today's health care systems, including CCH, are leveraging the skills and talents of new roles like care coordinators and community health care workers to complement the work of others and, meet the needs of patients in the most culturally sensitive and convenient manner possible.

CCH is fortunate that its employees are deeply committed to the mission but has been challenged in providing education, career development and other investments that are customary in private health systems. Timely recruitment is an important consideration as the health care workforce remains competitive yet CCH faces a number of requirements that increase the time it takes to hire; competitors can hire a health care worker in a fraction of the time. From compliance with the employment plan and requirements from the Collective Bargaining

Agreements, CCH must work with its labor partners to identify and implement tactics that respect these requirements but that allow CCH to operate in a competitive environment where employees can be recruited and on-boarded quickly and where compensation is aligned with role complexity, market realities, and performance.

CCH has recently introduced a catalogue with dozens of training opportunities for leaders and employees and looks forward to expanding educational opportunities across the organization regardless of position or grade. These opportunities must focus on operational and individual skill-building as well as large-scale organizational imperatives from retaining insured populations to improving maternal-child health outcomes.

The implementation of the county-wide performance management system will provide additional opportunities for employees and their managers to discuss professional development as well as individual goals and objectives on a routine basis. CCH seeks to work with its labor and county partners to identify growth opportunities that recognize employment longevity as well as specific union seniority.

CCH will continue to tackle serious public health concerns from lead poisoning and violence to sexually transmitted infections using evidence-based approaches, community outreach and even traditional marketing strategies to ensure that the communities impacted have a deep understanding of the issues and access to a portfolio of services designed to prevent and/or mitigate injury and disease. These efforts will require CCH to collaborate with other organizations including the Chicago Department of Public Health to maximize resources and impact.

CCH has historically been an insular organization focused on sick care. In recent years, efforts have been made to broaden the understanding and promotion of the health system and health plan throughout the county. CCH's Community Affairs team participates in approximately 400 events annually. Additionally, CCH staff across multiple areas chair or sit on the boards and committees of dozens of community-based organizations in an effort to raise awareness of the programs and services and identify opportunities to link patients or individuals to

additional services. IMPACT 2023 contemplates a multi-disciplinary Community Affairs plan that includes health and educational programming at CCH sites based on community needs, participation in additional outreach events and increased collaboration between CCH's community health centers and the communities they serve. IMPACT 2023 will also see the completion the of implementation of Community Advisory Councils (CACs) at all its centers. The CACs are designed to ensure that CCH has a deep understanding of the communities with the goal of providing additional programs and services tailored to the needs of the individual communities.

Perhaps CCH's best kept secret is the research it has long conducted to discover or improve treatments, identify linkages between health and social determinants and offer clinical trials to its patients. In recent years, CCH has worked to leverage the expertise of its clinical and social research teams beyond

these traditional avenues. Establishing CCH physicians and operational leaders as experts in areas beyond the traditional care setting has broadened awareness of the important research that CCH has conducted. Taking this to the next level, in 2019, CCH began a series of Research & Innovation Summits. The Summits provide an opportunity to organize and elevate CCH's research, clinical and advocacy efforts into a half-day learning and sharing session for interested stakeholders. The Summits have proven invaluable to foster collaboration and further potential funding opportunities.

CCH aspires to create a Center for Health Equity and Innovation which will enable it to house several component parts of the organization, creating an intentional and collaborative strategy around health equity and advocating for innovative approaches to addressing existing and emerging population health challenges.

## LEVERAGE AND INVEST IN ASSETS

### IMPACT 2020 ACCOMPLISHMENTS:

- Achieved substantial compliance on the employment plan
- Added extended hours at health centers
- Completed the employee engagement survey and established a structure for implementation of the results
- Implemented online annual performance evaluations
- Implemented Clinical Learning Environment (CLER) Pathways to Excellence
- Conducted analyses of CountyCare claims data on homelessness and opioids
- Maximized the efficiency of care plans for patients with chronic disease by implementing HealtheIntent
- Initiated collaboration between Care Coordination and CCDPH's Adverse Pregnancy Outcomes Reporting System (APORS) to improve outcomes
- Established clinical effort agreements for each provider and department
- Hosted innovation summits on opioids and homelessness

# Focus Area 4: Leverage and Invest in Assets

OBJECTIVE	HIGHLIGHTED STRATEGIES	EXPECTED OUTCOMES
<p><b>4.1</b> Recruit, hire and retain the best employees, who are committed to the CCH mission.</p> <p><b>4.2</b> Strengthen the CCH Workforce.</p>	<p><b>4.1 A</b> Finalize implementation of online performance evaluations.</p> <p><b>4.1 B</b> Develop an industry-based class and compensation strategy to recruit, hire and retain the best employees to support the continued transformation of the organization.</p> <p><b>4.1 C</b> Analyze and develop solutions for employee transportation needs.</p> <p><b>4.2 A</b> Enhance workforce training opportunities.</p> <p><b>4.2 B</b> Conduct an analysis of organizational leadership by span of control, bench strength and develop an approach to succession planning.</p> <p><b>4.2 C</b> Review of competency-based, “top of license” model of care across the System.</p> <p><b>4.2 D</b> Develop strategies that foster flexibility and career development for unionized employees.</p> <p><b>4.2 E</b> Pursue partnerships with nursing schools to foster and grow recruitment of excellent and culturally-competent nurses to CCH.</p> <p><b>4.2 F</b> Improve the continuous learning environment of CCH and conduct an ongoing review of the effectiveness of academic affiliations.</p>	<p>Performance evaluations done online for all personnel.</p> <p>Create performance-based pay plan for non-union employees.</p> <p>Complete analysis of actionable recommendations, considerate of other local employers.</p> <p>Develop curriculum for CCH employee to develop/enhance skill sets. Training catalogue created detailing all training available across CCH.</p> <p>Complete analysis of actionable recommendations, considerate of other local employers.</p> <p>Update Advanced Practice Provider job descriptions to have more defined requirements and clinical activity expectations. Implement plan to optimize roles of Community Health Workers and Psychologists.</p> <p>Establish career ladders within specialized technical positions. Increase online and interactive training courses to enhance supervisory skills. Develop opportunities for entry level positions to train for more technical positions (e.g. Building Service Worker to Medical Assistant).</p> <p>Establish one partnership and complete a cost/benefit analysis of a nursing residency program. Relevant metrics to gauge success are: nursing turnover rate by tenure, number of new hires by colleges and number of schools of nursing partnerships.</p> <p>Identify benefits resulting to both CCH and University of Illinois with a finalized agreement with University of Illinois School of Public Health. Assess master affiliation agreements in alignment with clinical priorities.</p>
<p><b>4.3</b> Leverage CCH workforce.</p>	<p><b>4.3 A</b> Develop and execute employee engagement action plans based on learnings from the employee engagement survey. Enhance collaboration with labor to further employee engagement.</p> <p><b>4.3 B</b> Strengthen inter-departmental communications and collaboration better-coordinated services and improved patient outcomes.</p> <p><b>4.3 C</b> Support an environment of continuous process improvement by increasing managers’ competencies using process improvement and project management tools.</p> <p><b>4.3 D</b> Support board development and leverage CCH Board of Directors as resources.</p>	<p>Establish employee recognition/awards program.</p> <p>Improve patient outcomes and Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) scores related to teamwork. Decrease in number of patient grievances and increase in employee satisfaction.</p> <p>Standardize process improvement approach to projects. Identify professional membership(s) to support ongoing process improvement. Train all managers on process improvement.</p> <p>Create an annual calendar that anticipates strategic presentations to the Board. Board to complete an annual self-assessment process regarding best governance practices and incorporates opportunities identified into changes in board practices.</p>

OBJECTIVE	HIGHLIGHTED STRATEGIES	EXPECTED OUTCOMES
<p><b>4.4</b> Utilize industry benchmarking and tools to improve quality, cost, utilization and patient outcomes.</p>	<p><b>4.4 A</b> Establish staffing productivity model to optimize efficiency and effectiveness for key areas (e.g. nursing, environmental services). Develop a predictive staffing model/variable workload staffing model.</p> <p><b>4.4 B</b> Develop the ability to analyze specific initiatives to determine mission alignment and attainment of outcomes.</p> <p><b>4.4 C</b> Evaluate outcome data and utilization patterns to determine the efficacy of various system strategies (e.g. care coordination).</p> <p><b>4.4 D</b> Update Clinical, Administrative, Research and Teaching (CART) process to review and standardize expectations and that actuals are aligned with these expectations. Distribute dashboards to benchmark performance on CART and Relative Value Units (RVU) at the physician and department level.</p> <p><b>4.4 E</b> Mature health plan network strategy to assure access, quality, and value.</p>	<p>Reduce nursing overtime by 25%, decrease agency usage by 50% by 2021.</p> <p>Establish defined process for approval of new programs and initiatives.</p> <p>Provided actionable analysis of the efficacy of care coordination strategies.</p> <p>Annual review of CART expectations to be part of the annual performance appraisal of clinical chairs as a routine review of results against expectations. Provide and mature Relative Value Units (RVUs) reports for providers and managers. Establish RVU reporting with accurate information routinely reported using data in Cerner system.</p> <p>Develop and implement a managed care strategic roadmap to address payor prioritization/portfolio, matching the delivery system to managed care opportunities to increase year-over-year increase in utilization of CCH as a provider.</p>
<p><b>4.5</b> Utilize CCDPH data and experience to address health inequities to conceptualize and plan robust interventions to improve population health.</p>	<p><b>4.5 A</b> Develop system-wide strategies to reduce transmissible infections.</p> <p><b>4.5 B</b> Maximize local health collaboration, partnership and alignment in Cook County to inform services, with local health departments such as City of Chicago Department of Public Health and local resources such as the University of Illinois School of Public Health.</p> <p><b>4.5 C</b> Explore establishing additional injury-prevention partnerships and programs.</p>	<p>Pilot two mass screenings events in high-risk communities by 2021. Institute expedited partner therapy in 100% of CCH community health centers by 2020. Establish media/social media campaign to raise awareness and promote testing of sexually active adolescents and adults. Establish walk-in diagnostic and treatment capacity at all CCH primary care sites with expedited results.</p> <p>Continue collaborative work on public health initiatives and identify additional areas for collaboration and/or synergy of efforts at shared objectives.</p> <p>Develop program to reduce injuries, improve population health and identify external funds.</p>
<p><b>4.6</b> Increase community engagement.</p>	<p><b>4.6 A</b> Leverage outpatient health centers as community anchors by partnering with community organizations. Continue rolling out community advisory boards for all outpatient health centers. Develop a strategy to ensure community engagement across the county.</p>	<p>Establish community advisory boards at all outpatient health centers.</p>
<p><b>4.7</b> Align extramural funding efforts with core competencies and strategies.</p>	<p><b>4.7 A</b> Mature grant opportunity review process to include an evaluation of potential grants based on CCH strategy, expected cost/benefit and clinical or research alignment.</p>	<p>Establish process to evaluate grant opportunities to ensure alignment with strategic priorities, organizational leadership and cost/benefit. Establish a minimum grant value.</p>



**FOCUS AREA 5**

# **Impact Social Determinants and Advocate for Patients**

**DRAFT**

# Impact Social Determinants and Advocate for Patients

Health equity has been at the center of CCH's mission for more than 180 years. CCH is proud of its work to provide care to all regardless of a patient's income, insurance or immigration status and will continue to advocate at all levels of government until everyone has adequate coverage for comprehensive care including access to preventive care.

Rather than waiting for uninsured patients to present with acute needs in the emergency room, CCH expanded its charity care program, CareLink, to provide enrollees with primary care, behavioral health and care management for the most complex patients with the goal of preventing expensive emergency room visits and improving outcomes. More than 31,000 Cook County residents have been enrolled in the program since it started in 2017. CCH has seen a concerning increase in its uninsured population since the individual mandate under the Affordable Care Act was repealed in 2017. This is an area that CCH is monitoring closely. Local, state and federal policy changes should be enacted to ensure that CCH can continue to deliver care to all who need it in a timely fashion.

CCH fully recognizes that health equity goes beyond the walls of a hospital or the doors of a clinic. Providing "whole person" care means understanding the circumstances of every individual and working to address the issues that impact their health status. Access to nutritious food and stable housing, economic opportunity, safe neighborhoods with access to public transportation, education and gender equity are all social determinants of health impacting the health status of an individual. CCH has expanded efforts in addressing food and housing insecurity over the past three years and has ambitious plans for the next three years including placing hundreds of individuals in stable housing.

Perhaps there is nothing that illuminates the intersection of social determinants of health and CCH's role in advocating for its patients more than the epidemic of gun violence in the communities CCH serves. As the busiest trauma center in Illinois, Stroger Hospital cares for approximately 1,000 victims of gun violence each year at an annual cost upwards of \$50 million, yet the real cost of violence is the impact it has on the

victims, their families and their communities. Healing Hurt People (HHP), CCH's violence prevention program, provides violently injured youth with support and addresses the psychological trauma that can drive or result from the cycle of violence. HHP makes a positive impact on patients: increasing their safety, providing opportunities for support and peer learning, helping them to enroll in or stay in school, find jobs, navigate medical systems and link them to social services and trauma-specific mental health services. For participants who received HHP services for at least six months, 84% experienced decreases in Post-Traumatic Stress Disorder (PTSD) symptoms, 89% exhibited increased self-efficacy, 80% engaged in less aggressive behavior and 8% were reinjured, far below historical reinjury rates. Gun violence and injury prevention require a multi-faceted approach. CCH intends to leverage the work of its Trauma-informed Taskforce, an IMPACT 2020 initiative, to broaden its efforts in the coming years.

CCH's work in the justice-involved population is making a difference in the lives of individuals who find themselves incarcerated as the result of undiagnosed or untreated mental health or substance abuse disorders. From increased services in the community to prevent unnecessary detention, comprehensive care during detention and connections to care upon release, CCH believes there is a real chance to break the cycle of recidivism.

In 2020, the U.S. Census will take center-stage throughout the country. The importance of an accurate "count" is critical to CCH and its patients therefore CCH will work closely with the Cook County Complete Count Committee to identify opportunities to engage patients and staff in the process.

Ultimately, there must be large-scale efforts that provide solutions, improvements and opportunities for all residents of Cook County to achieve their highest potential. To that end, Cook County Health is committed to advancing a Health In All Policies (HIAP) approach that incorporates health, equity and sustainability considerations into decision-making across sectors and policy areas to improve the quality of life for its residents.

## IMPACT SOCIAL DETERMINANTS OF HEALTH AND ADVOCATE FOR PATIENTS

### IMPACT 2020 ACCOMPLISHMENTS:

- Established the direct access plan for CCH CareLink patients
- Started developing a program to address medical needs of children who have experience ACEs
- Expanded “Food as Medicine” to all outpatient sites
- Aligned WIC services with health center locations
- Partnered with other organizations to established a flexible housing pool to address homelessness issues of patients/members
- Established pilot program to improve the health status of African American men at Woodlawn Health Center
- Established four community health center advisory boards
- Legislation to require influenza vaccines for all health care workers passed and was implemented
- Establish care coordination program in bond court to link individuals with services

DRAFT

# Focus Area 5: Impact Social Determinants and Advocate for Patients

OBJECTIVE	HIGHLIGHTED STRATEGIES	EXPECTED OUTCOMES
<p><b>5.1</b> Tailor Social Determinant of Health strategies to achieve the most impact on CCH patients and Health Plan members.</p>	<p><b>5.1 A</b> Establish cross-departmental stakeholder group to create a plan to address social determinants of health for CCH populations.</p> <p><b>5.1 B</b> Leverage CountyCare data, including Health Risk Assessments (HRAs) to identify needed value-added benefits to membership related to social determinants of health and serve that improve health status.</p> <p><b>5.1 C</b> Partner with other organizations to address population health care needs outside of the health care system, including those related to food insecurity.</p> <p><b>5.1 D</b> Grow and mature the housing strategy to improve patient outcomes.</p> <p><b>5.1 E</b> Educate local, state and federal officials on policies and practices that affect CCH populations.</p> <p><b>5.1 F</b> Collaborate nationally with county government stakeholders and large urban health care systems to garner congressional support to garner support for legislation that furthers the mission of CCH on shared policy priorities and targeted advocacy efforts.</p> <p><b>5.1 G</b> Utilize CCH data and experience to address health inequities to conceptualize and plan robust interventions to improve population health and trauma-informed approaches.</p> <p><b>5.1 H</b> Develop focused program on populations that would benefit from better engagement in health care who are less likely to engage in appropriate preventive care.</p>	<p>Create work group. Understand the needs of specific populations and develop tailored service plans.</p> <p>Routine review of CountyCare data to make recommendations on additional value-added benefits that may be needed.</p> <p>Continue “Food as Medicine” program to all outpatient sites. Evaluation complete related to onsite food pantries. Increase clients receiving Women, Infants and Children (WIC) services by 3% year over year. Convene CCDPH Food Summit and develop and distribute CCDPH Food Summit report. Organize and facilitate quarterly Cook County Good Food Task Force meetings and implement recommendations.</p> <p>Create criteria for long-term care (custodial) admissions to divert to housing with support services. Facilitate housing for CCH patients in CCH permanent supportive-housing models. Reduce unnecessary visits to the Emergency Department by homeless individuals by partnering with community-based organizations on innovative care solutions.</p> <p>Gain auto-assignment for eligible justice-involved in Cook County.</p> <p>Advocate for reinstating county eligibility in the National Health Services Corps (NHSC) loan forgiveness program.</p> <p>Successfully implement strategies identified in the CCH Trauma-Informed Approaches Taskforce report. Track the number of staff trained in trauma-informed approaches and the number of designated trauma champions in each department.</p> <p>Expand pilot program to provide outreach and engagement of 100 African American men by 2023 on hypertension and apply lessons learned across all outpatient sites.</p>
<p><b>5.2</b> Elevate organizational contributions to mitigate disparities.</p>	<p><b>5.2 A</b> Maximize external recognition of CCH best practices.</p> <p><b>5.2 B</b> Work with Cook County government to advance a Health in All Policies (HiAP) approach that incorporates health, equity and sustainability considerations into decision-making across sectors and policy areas to improve the quality of life of its residents.</p> <p><b>5.2 C</b> Support the Cook County Complete Count Census Commission in their efforts to ensure that all Cook County residents are counted in the 2020 Census.</p>	<p>Establish center for Health Equity and Innovation. Convene quarterly research and innovation summits. Present CCH correctional best practices to other correctional health departments (e.g. Naloxone distribution, dental health, women’s health).</p> <p>Convene internal CCDPH team to lead research and process development and implementation. Outreach to other local governments implementing HiAP to obtain lessons learned. Propose process to Cook County government to explore advancement of HiAP. Implement process with Cook County government to identify best mechanism to advance HiAP.</p> <p>Share CCH and CCDPH information with patients, providers, and community stakeholders on the importance of Census participation.</p>



OBJECTIVE	HIGHLIGHTED STRATEGIES	EXPECTED OUTCOMES
<p><b>5.2</b> Elevate organizational contributions to mitigate disparities.</p> <p><b>5.3</b> Utilize CCH data and experience to address health inequities to conceptualize and plan robust interventions to improve population health.</p>	<p><b>5.2 D</b> Increase MBE/WBE participation on contracts.</p> <p><b>5.3 A</b> Advocate for the adoption of a Cook County Lead Poisoning Prevention Ordinance.</p> <p><b>5.3 B</b> Expand the use of population and epidemiologic data to identify upstream drivers of chronic diseases and conditions, improve birth outcomes and enhance childhood development.</p> <p><b>5.3 C</b> Identify opportunities to partner with other governments and organizations to address gun violence, opioid abuse, and sexually transmitted infections.</p>	<p>Steadily increase MBE/WBE participation annually through an enhanced CCH outreach efforts and targeted programs with Group Purchasing Organizations (GPOs).</p> <p>Complete steps necessary for adoption, approval and implementation.</p> <p>Increase resources for patients and the community. Develop new partnerships to address key drivers of health inequity.</p> <p>Develop two initiatives that promote partnership with shared objectives.</p>

DRAFT

# APPENDIX

## Appendices

- 34** Glossary
- 38** Organization Structure
- 39** Demographics, Utilization and Membership Data
- 45** Community Town Hall Summary
- 46** Employee Town Hall Summary
- 47** Employee Survey
- 51** Timeline
- 52** Presentation List
- 53** Enabling Ordinance

DRAFT

# Glossary

**Federal 1115 Waiver** – A demonstration waiver approved by the US Centers for Medicare and Medicaid Services (CMS) to expand Medicaid coverage to adults in Cook County whose income was at or below 133% of the federal poverty level (FPL). This waiver allowed CCH to begin enrolling these individuals in CountyCare before Medicaid expansion in Illinois took effect.

**Accredited Public Health Department** – A public health department that has had its performance measured against a set of nationally recognized, practice-focused and evidence-based standards that include an issuance of recognition of achievement of accreditation within a specified time frame by a nationally recognized entity as well as the continual development, revision and distribution of public health standards. The Cook County Department of Public Health is accredited by the Public Health Accreditation Board (PHAB).

**Adverse Childhood Experiences (ACEs)** – A traumatic experience in a person’s life occurring before the age of 18 that the person remembers as an adult.

**Adverse Pregnancy Outcomes Reporting System (APORS)** – This reporting system collects information on Illinois infants born with birth defects or other abnormal conditions. The purpose of APORS is to conduct surveillance on birth defects, to guide public health policy in the reduction of adverse pregnancy outcomes and to identify and refer children who require special services to correct and prevent developmental problems and other disabling conditions.

**Behavioral Health** – Includes both mental health and substance use-related issues and describes the connection between behaviors and health and well-being.

**Benefits Improvement and Protection Act (BIPA)** – Additional funding provided to health centers or clinics that service medically underserved areas and populations to operate in a financially efficient manner.

**CareLink** – CCH’s charity care program that extends financial assistance based on income.

**Capital** – Investment made in a brand-new initiative, program or service line.

**Capital Improvement** – Investment in upgrades on existing initiatives or service lines, providing added value to a business.

**Cerner** – CCH’s electronic medical record that enables physicians, nurses and other authorized users to securely share patient data electronically across an organization. An online “digital chart” displays up-to-date patient information in real time, complete with decision-support tools for physicians and nurses.

**Certified Public Health Department** – A local health department that has received certification from the Illinois Department of Public Health (IDPH) after meeting its requirements for employing a qualified executive officer and achieving public health practice standards (including, completion of an internal organizational capacity assessment and a community health needs assessment, development of a community health plan and compliance with required activities).

**Charity Care** – Services rendered to a patient where the hospital did not receive nor expected payment, based on the patient’s inability to pay.

**Chronic Conditions Special Needs Plan (C-SNP)** – C-SNPs enroll special needs individuals who have one or more comorbid and medically complex chronic conditions that are substantially disabling or life threatening; have a high risk of hospitalization or other significant adverse health outcomes; and require specialized delivery systems across domains of care. One example would be someone living with HIV. (Source: Centers for Medicaid and Medicare Services)

**Clairvia™** – An information technology program that focuses on nurse scheduling management.

**CLAS** – The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services. Adoption of these standards are intended to help advance better health and health care in the United States.

**Clinical Trials** – Research using participants (human volunteers) to advance medical knowledge

**Community Acute Care Hospital** – An acute care hospital where patients receive active, but short-term care for a condition and are discharged once they are healthy.

**Data Warehouse** – A combination of many different databases across an entire enterprise. It serves as a centralized repository of data generated by all units within an enterprise optimized for and dedicated to analytics.

**Disproportionate Share Hospital (DSH)** – Disproportionate Share Hospitals serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicare and Medicaid Services to cover the costs of providing care to uninsured patients. Disproportionate share hospitals are defined in Section 1886(d)(1)(B) of the Social Security Act.

**Dwell Time** – Length of time spent during one specific stage or interaction of a visit.

**Electronic Medical Records (EMR)** – A digital version of the traditional paper-based medical record for patients that resides in a system specifically designed to support users by providing access to medical history, diagnoses, medications, allergies, alerts, reminders, decision support systems, links to medical knowledge and other aids. CCH uses Cerner’s EMR.

**Federally Qualified Health Center (FQHC)** – Health centers or clinics that serve medically-underserved areas and populations. Federally Qualified Health Centers provide primary care services on a sliding scale fee basis or regardless of one’s ability to pay. FQHC is a reimbursement designation from the U.S. Department of Health and Human Services (HHS) Bureau of Primary Health Care and CMS. This designation is significant for several health programs funded under the Health Center Consolidation Act (Section 330 of the Public Health Service Act).

**Food Insecurity** – A set of circumstances where an individual lacks consistent access to enough food, affordable food, or healthy food.

**Goal** – An aspirational statement that combines an indicator with a desired level of achievement.

**Health Equity** – The opportunity for every person to attain his or her full health potential regardless of socioeconomic status and other factors.

**HealthIntent™** – A multi-purpose, programmable Cerner platform designed to scale at a population level while

facilitating health and care at a person and provider level. This cloud-based platform enables health care systems to aggregate, transform and reconcile data across the continuum of care. A longitudinal record is established, through that process, for individual members of the population that the organization is held accountable for; helping to improve outcomes and lower costs for health and care. It enables organizations to identify, score and predict the risks of individual patients, allowing them to match the right care programs to the right individuals.

**Health Risk Assessment (HRA)** – A survey-based screening tool designed to evaluate patients’ health attitudes, behaviors, risks and quality of life.

**Healthcare Information and Management Systems Society (HIMSS)** – The entity that specifies a way to measure the progress of health care organizations towards achieving the ideal paperless patient record environment.

**Health Maintenance Organization (HMO)** – An organization interposed between providers and payers that attempts to “manage the care” on behalf of the health service consumer and payor. HMOs usually limit coverage to care from doctors who work for or contract with the HMO. It generally does not cover out-of-network care except in an emergency. An HMO may require a member to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

**High-Reliability Organizations** – Organizations that operate under challenging conditions yet experience fewer problems than would be anticipated as they have developed ways of “managing the unexpected” better than most organizations. (Source: *Patient Safety Primer, U.S. Department of Health and Human Services*)

**Institutional Equivalent Special Needs Plan (IE-SNP)** – Medicare plan designed for people living in their own homes who require a higher level of care similar to services provided at a long-term care facility.

**Institutional Special Needs Plan (I-SNP)** – Medicare plan specific to those needing specialized care for 90 days or more in a long-term care facility such as a nursing home.

**Intensive Care Unit (ICU)** – A unit that provides intensive/complex care to patients with critical injuries or illnesses.

**Intergovernmental Transfers (IGTs)** – Transfers of funds from one level of government to another. IGTs may be used to fund general government operations or for specific purposes.

**Joint Commission** – The Joint Commission is a national independent organization that accredits and certifies health care organizations.

**Long-Term Services and Supports (LTSS)** – Long-term services and supports encompasses the broad range of paid and unpaid medical and personal care assistance that people may need – for several weeks, months, or years – when they experience difficulty completing self-care tasks as a result of aging, chronic illness, or disability. (Source: Kaiser Family Foundation)

**Magnet Recognition Program®** – A designation from the American Nurses Credentialing Center (ANCC) that represents nursing excellence and high quality care delivery. Only 8% of US hospitals have earned this designation.

**Medicaid** – A state and federal program that provides health coverage for those with very low income.

**Medicaid Managed Care** – Services provided through an arrangement between a state Medicaid agency and managed care organizations (MCOs) that accept a set payment – “capitation” – for these services. The state pays the MCO a monthly premium to cover the services provided to a beneficiary. There are two main forms of Medicaid managed care, “risk-based MCOs” and “primary care case management (PCCM).” In a risk-based MCO system, the State pays a flat per-member-per-month rate and the MCO pays for health care services rendered to the member. In a PCCM system, the State pays for services on a fee-for-service basis as well as a monthly fee to a contracted primary care provider to coordinate care for the beneficiary.

**Medicare** – A federal health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant); coverage is regardless of income.

**Medicare-Medicaid Alignment Initiative (MMAI)** – One of Illinois’ managed care programs, specifically designed for seniors and individuals with disabilities receiving full Medicare and Medicaid coverage, that wraps coverage into one health plan, including prescription drugs.

**National Health Service Corps** – A federal program that promotes improved access to primary care by providing scholarships and loan repayment for medical professionals who have committed to working in underserved urban, rural and frontier areas.

**Network** – The group of providers in a plan. A network may include physicians, physician groups, hospitals, clinics, etc.

**Objective** – Total or partial attainment of a goal within a specified time.

**Outpatient Services** – Medical services or procedures that do not require a patient to stay overnight in a health care facility.

**Primary Care Medical Home (PCMH)** – A care delivery model whereby patient treatment is coordinated through a primary care team to ensure the patient receives the necessary care when and where they need it, in a manner they can understand. Patients are ‘empaneled’ or part of a ‘panel’ with a specific provider.

**Patient Protection and Affordable Care Act (ACA)** – The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law. The law seeks to decrease the number of uninsured, improve health outcomes and streamline the delivery of health care.

**Payer Mix** – The distribution of revenue across payer sources – e.g., Medicare, Medicaid, private, or commercial insurance.

**Per-Member-Per-Month (PMPM)** – One of the most common payment arrangements for managed care. A PMPM agreement is when a health care provider is paid a set amount for each individual enrolled or “empaneled” with them. The PMPM remains the same for an individual whether they receive no health care services in a month, or very intensive health care services.

**Population Health** – The health outcomes of an entire population or an approach that aims to improve the health of an entire population.

**Relative Value Units (RVU)** – An RVU is a dollar amount that is assigned to each encounter, procedure, or surgery. The value is standardized, but the way the value is used in the compensation formula may vary from employer to employer.

**Shakman Decrees** – A series of Federal court orders regarding government employment in Chicago, which were issued in 1972, 1979, and 1983, in response to a lawsuit filed by civic reformer Michael Shakman. The decrees barred the practice of political patronage, under which government jobs are given to supporters of a politician or party, and government employees may be fired for not supporting a favored candidate or party.

**Six Sigma** – A process-improvement methodology that relies on a collaborative team effort to improve performance by systematically removing waste.

**Social Determinants of Health** – According to the World Health Organization (WHO), the social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

**Tertiary Care** – Health care delivered by specialists. Patients are often referred to these specialists by their primary care physicians for consultations on advanced medical treatments.

**Trauma Center** – A hospital equipped and staffed to provide care for patients suffering from major traumatic injuries such as falls, motor vehicle collisions, or gunshot wounds. Trauma centers vary in their specific capabilities and are identified by the Illinois Department of Public Health by “Level” designation: Level-I (Level-1) being the highest, to Level-III (Level-3) being the lowest (some states have five designated levels, in which case Level-V (Level-5) is the lowest). Stroger Hospital is home to the busiest Level-I trauma center in Illinois and one of the busiest in the nation.

**Triple Aim** – The Institute for Healthcare Improvement’s (IHI) Triple Aim is a framework that describes an approach to optimizing health system performance. It includes designs that must be developed to simultaneously pursue three dimensions to: 1) improve the patient’s experience including quality and satisfaction; 2) improve the population’s health; and 3) reduce the per capita cost of health care.

**Uncompensated Care** – Health care or services provided by hospitals or health care providers that are not reimbursed from the patient or from third-party payers. Often uncompensated care arises when people are uninsured or underinsured and cannot afford to pay the cost of care. Some costs for these services may be covered through cost shifting.

**Underinsured** – People with public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay.

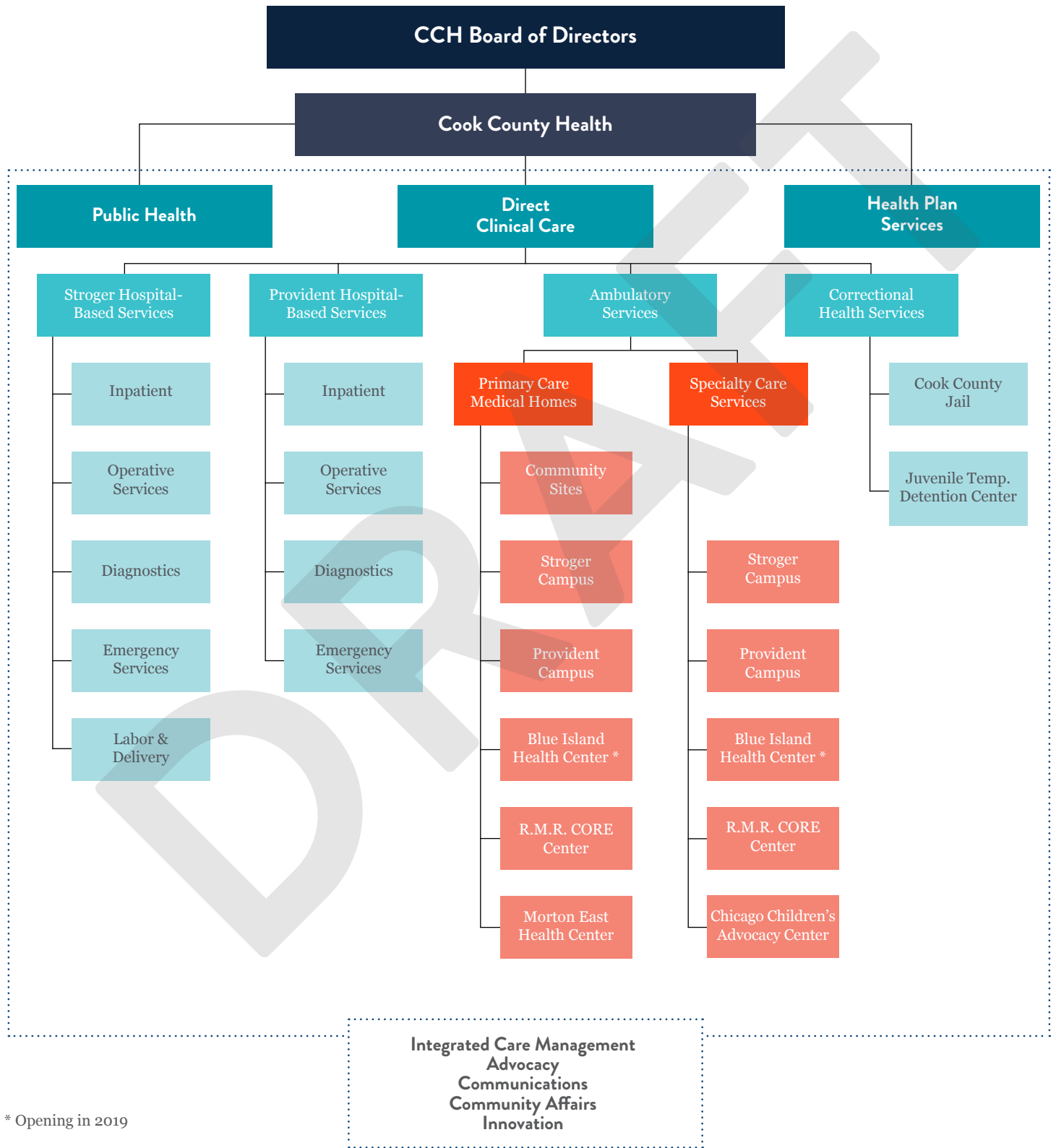
**Vizient™** – A company that focuses on health care data sharing to allow health care providers relevant benchmarking data.

**Wait Time** – Period of time before a patient is seen by a medical professional.

**WEPlan** – A process mandated by the State of Illinois for local health department certification conducted every five years.

**WIC** – The Special Supplemental Nutrition Program for Women, Infants, and Children offers grants to States to provide pregnant and postpartum women and children up to age 5 at nutritional risk with supplemental foods, health care referrals and nutrition education.

# Organization Structure



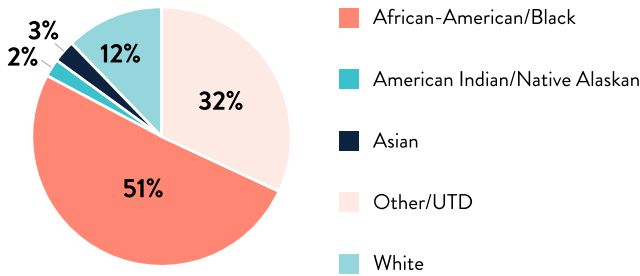
\* Opening in 2019

# Demographics, Utilization and Membership Data

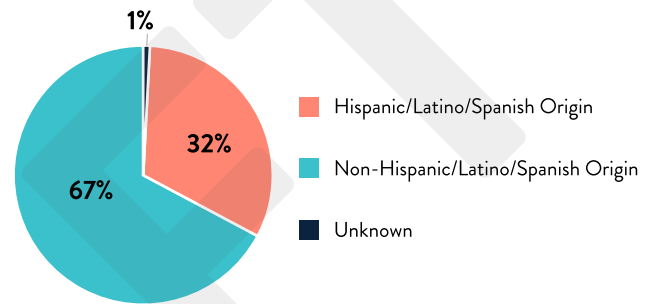
## OVERVIEW OF CCH PATIENT DEMOGRAPHICS \*

FY2018

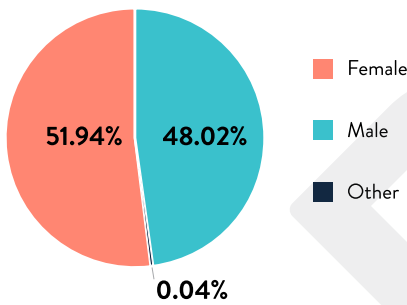
### RACE



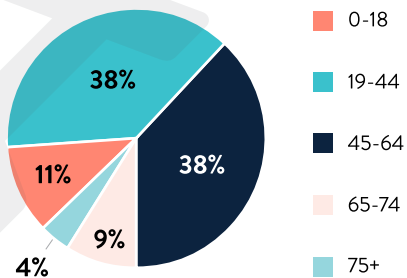
### ETHNICITY



### GENDER



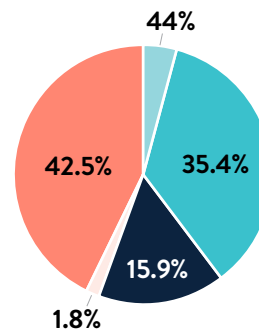
### AGE GROUPS



\* Self Reported

## FY2018 CCH VISITS BY PAYER GROUP

PAYER	TOTAL VISITS
Commercial	4.4%
Medicaid*	35.4%
Medicare*	15.9%
Others	1.8%
Uninsured	42.5%

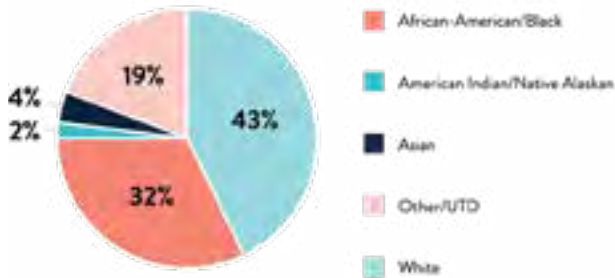


\*Medicaid and Medicare include Fee For Service and Managed Care

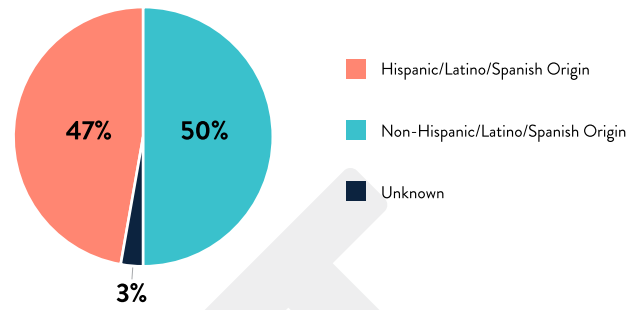


FY2018 SUMMARY OF CCH UNINSURED PATIENTS\*

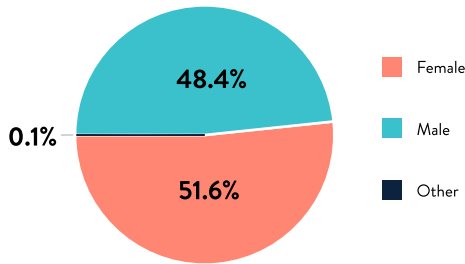
RACE



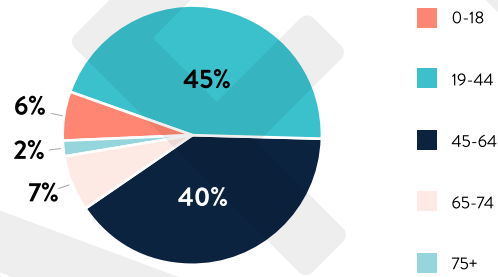
ETHNICITY



GENDER

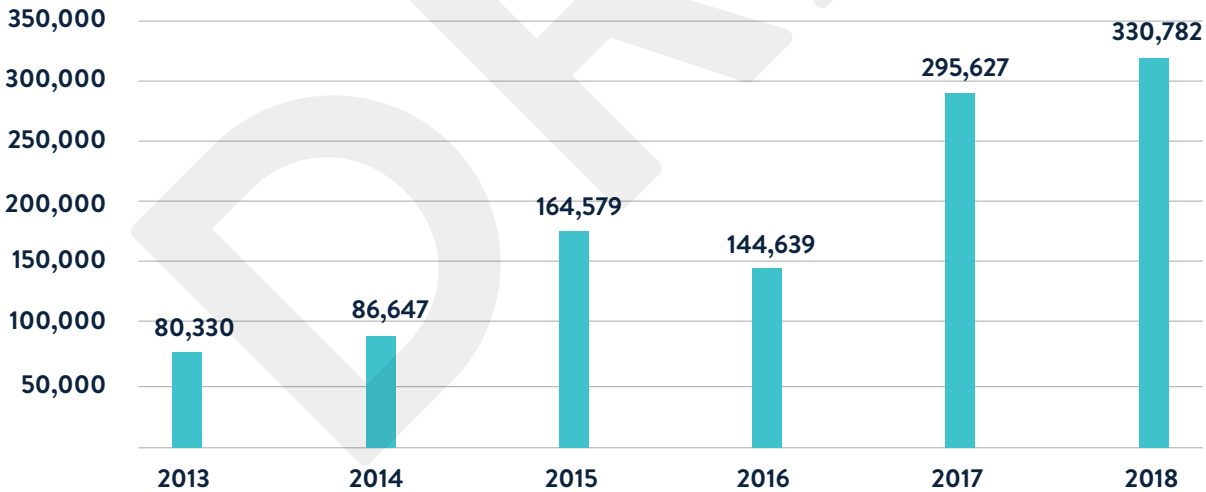


AGE GROUPS

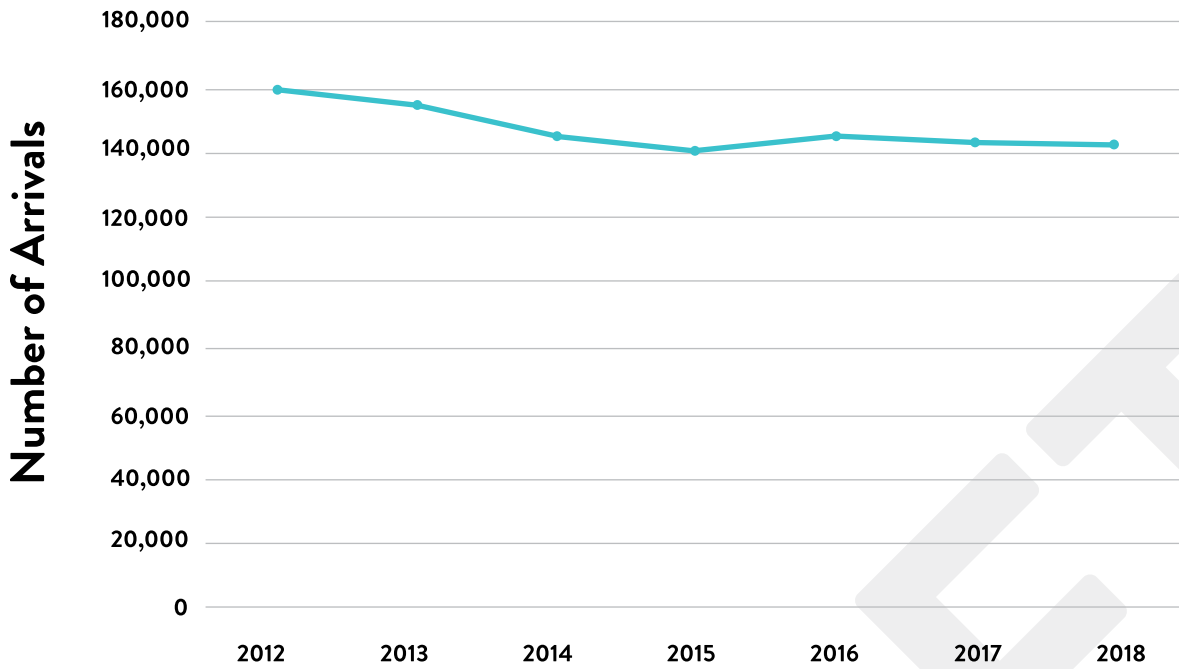


\*Self Reported

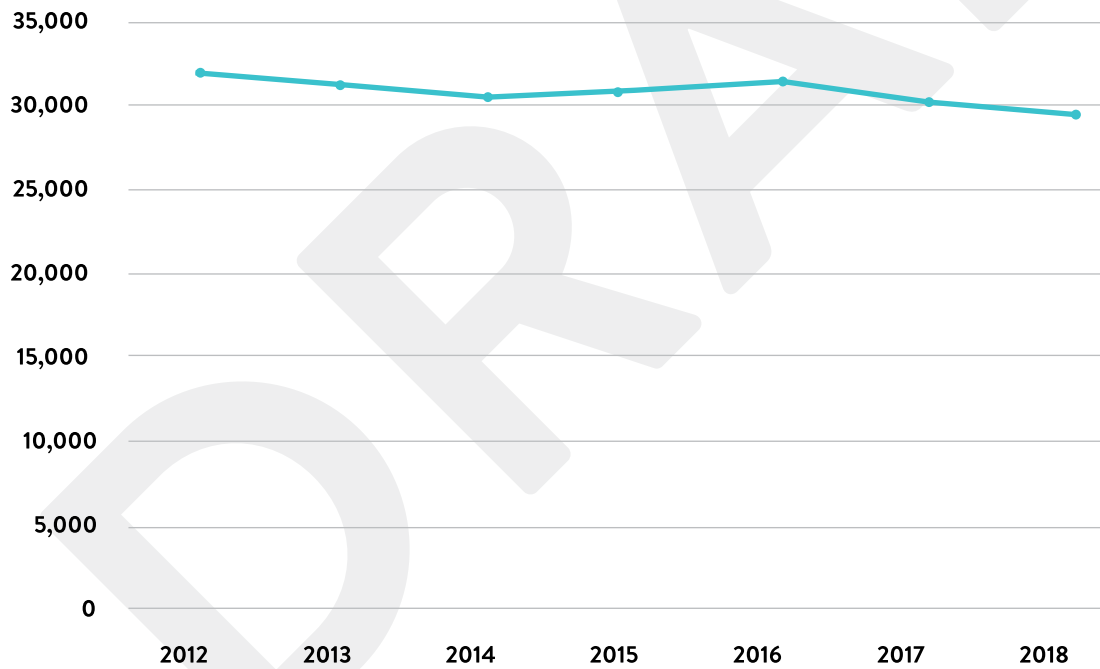
COUNTYCARE YEAR END MEMBERSHIP



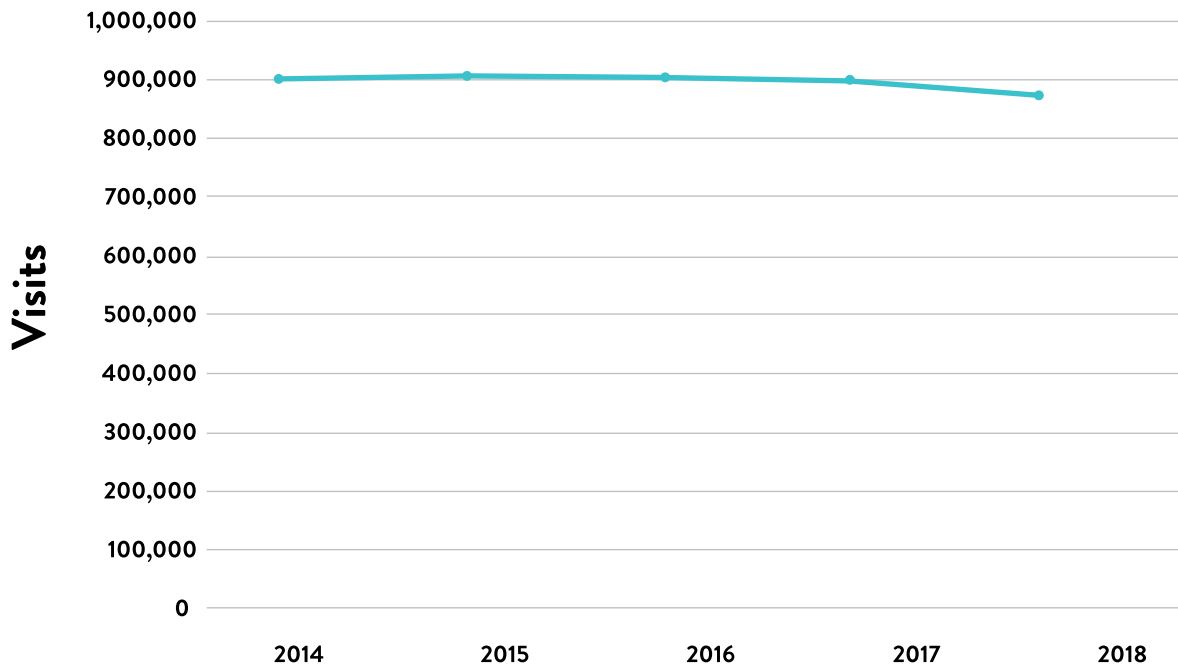
## EMERGENCY SERVICES



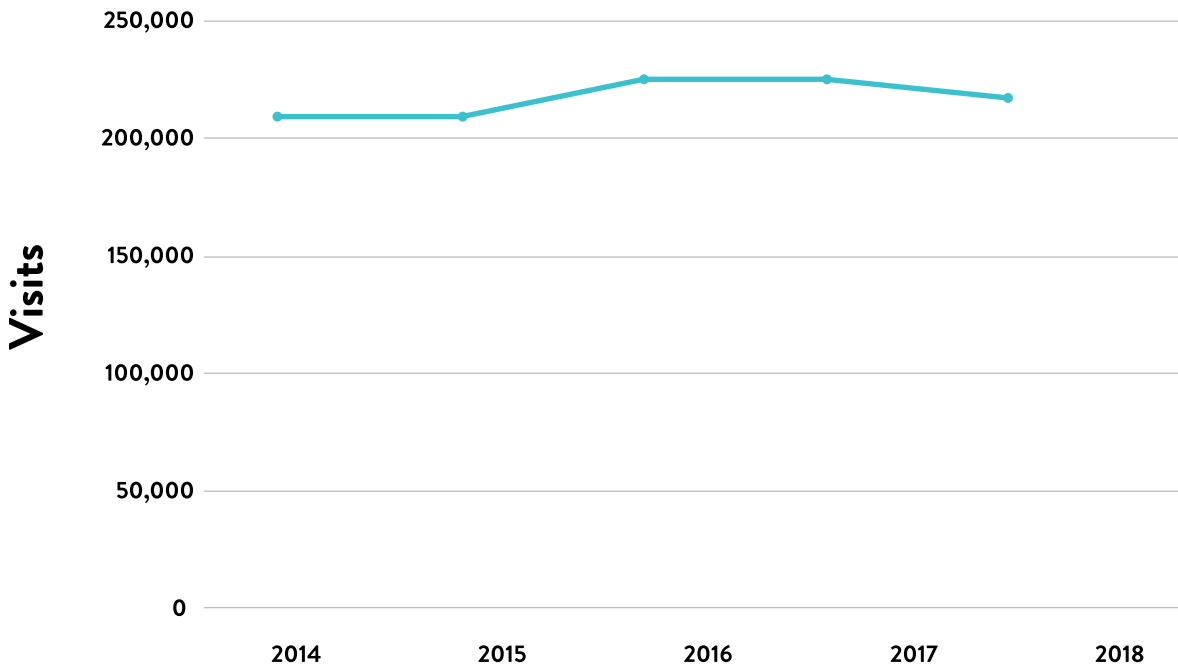
## INPATIENT/OBSERVATION SERVICES



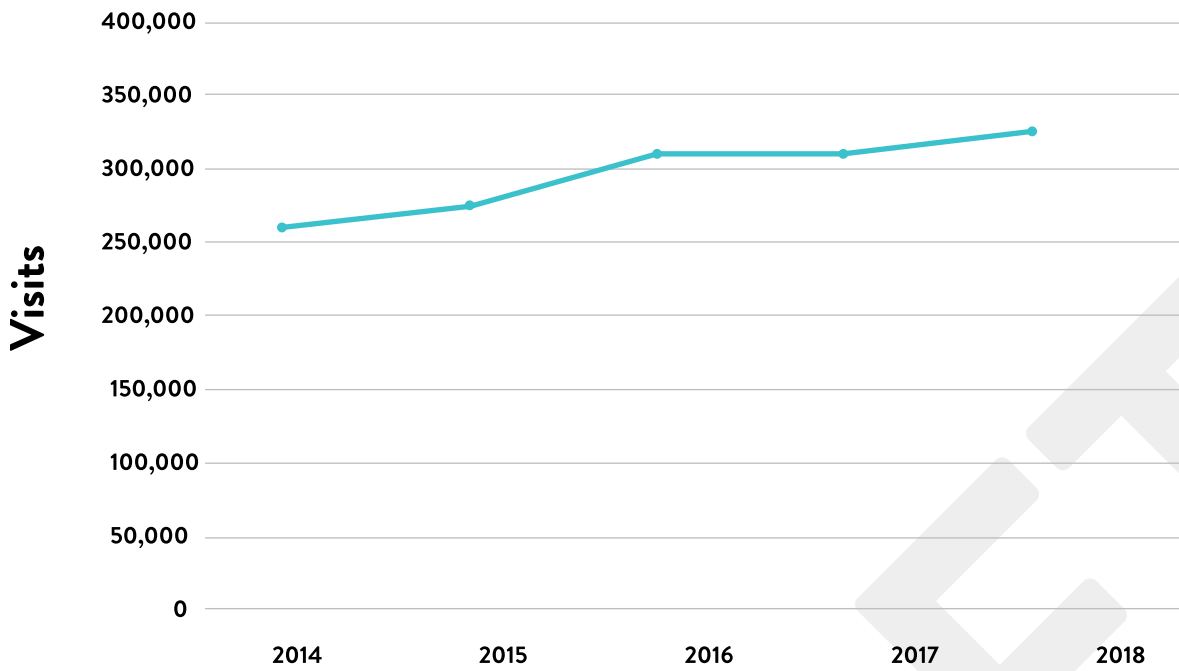
## TOTAL OUTPATIENT VISITS



## PRIMARY CARE PROVIDER VISITS



## SPECIALITY CARE PROVIDER VISITS



## CORRECTIONAL HEALTH

CATEGORY	VOLUME
Intake Screenings	41,730
Detoxification	10,619
Mental Health Visits	27,401
Dental Visits	13,685
Medication Orders	693,737
Medication Doses Dispensed	5,378,941
Methadone Doses Dispensed	14,287
Suboxone	15,550
Naloxone	2,332
Radiology	45,931

## FY2018 VOLUME BY ENCOUNTER TYPE

Outpatient Registrations	873,822
Emergency	142,735
Inpatient	18,146
Observation	10,971

\*Calendar Year 2018

## CCH OPERATING ROOM PROCEDURES – FY2018

MODALITY	STROGER	PROVIDENT
Breat Oncology	255	–
Burn	158	–
Cardiac Surgery	227	–
Colorectal	600	49
Ear Nose Throat	691	4
Gastroenterology	10	514
General Sugery	1,525	236
Neuro Surgery	310	–
Obstetrics/Gynecology	1,288	306
Oncology	134	–
Ophthalmology	1,315	1,115
Oral Maxillofacial	395	50
Orthopedics	1,660	–
Other	126	62
Pediatrics General	70	–
PEDS Urology	123	–
Plastics	471	–
Podiatry	176	216
Thoracic	189	–
Trauma	505	–
Urology	1,425	244
Vascular	658	–
<b>TOTAL</b>	<b>12,311</b>	<b>2,796</b>

## DIAGNOSTIC, THERAPEUTIC AND PROCEDURAL SERVICES – FY2018

### Radiology

Ultrasound	31,408
Nuclear Medicine	6,518
Mammography	16,852
Magnetic Resonance Imaging	9,135
Interventional Radiology	3,540
Diagnnestic Radiology	175,300
Computerized Tomography	58,970
<b>TOTAL</b>	<b>301,723</b>

Lab Studies Performed	1,570,040
Cardiac Catheterization	1,144
Deliveries	1,002
Dialysis Treatments	3,059
Outpatient Infusion Center	14,160
Laser Eye Treatments	1,170
Gastrointestinal Procedures	7,046
Pain Management	4,076

# Community Town Hall Summary

As part of the community input process, Cook County Health (CCH) hosted four Strategic Planning Town Halls. CCH sent out more than 12,000 Town Hall email invites through our community email distribution list. In addition, Community Affairs staff contacted partner organizations to ensure that they would disseminate the schedule to their constituencies and to encourage their participation at these meetings.

Torrential rains and storms affected the participation at the Central Campus and Provident Town Halls. The Town Halls brought a mixture of community members, partner organizations and representatives from different health care entities and medical insurance plans. At each town hall, Dr. Shannon presented an overview of the focus areas and major initiatives the system has identified for 2020-2023. Participants were able to make comments and/or ask questions at each of the events.

## **STROGER HOSPITAL/CENTRAL CAMPUS TOWN HALL (APRIL 30, 2019)**

- 7 people attended the Town Hall.
- The Chicago Hispanic Health Coalition brought 3 representatives who spoke about access to medical insurance by the uninsured.
- 7th District Commissioner Alma Anaya attended the meeting.
- Dr. Shannon stressed that Stroger and Provident Hospitals provide 50% of the uncompensated care in Cook County.

## **PROVIDENT HOSPITAL TOWN HALL (MAY 2, 2019)**

- 14 people attended the Town Hall.
- This Town Hall sought input from residents in the southern portions of the City of Chicago, mostly encompassing the CCH South Cluster.

- One audience member mentioned that CCH needs to be a leader in ensuring that minorities, enter the medical field.
- Dr. Shannon emphasized that Provident Hospital is not closing and that CCH is planning a new facility on the campus with expanded services.

## **CICERO COMMUNITY CENTER TOWN HALL (MAY 7, 2019)**

- 23 people attended the Town Hall.
- This Town Hall sought input from residents from a Latino/Hispanic background, mostly encompassing the CCH North West Cluster. The presentation was presented and distributed in Spanish to attendees.
- Enlace Chicago brought several representatives who advocated for health insurance coverage for the undocumented and those who do not have access to health insurance.

## **OAK FOREST HEALTH CENTER TOWN HALL (MAY 9, 2019)**

- 12 people attended the Town Hall.
- This Town Hall sought input from residents in the southern suburban portions of Cook County, mostly encompassing the CCH South Suburban Cluster.
- 6th District Commissioner Donna Miller attended the meeting.
- A representative of National Alliance on Mental Illness (NAMI) was concerned about where people with mental illness can obtain the help that they need.

# Employee Town Hall Summary

## EMPLOYEE SURVEY AND TOWN HALL MEETINGS SUMMARY

To receive employee input during the strategic planning process, the Cook County Health and Hospital System (CCH) hosted three employee Town Hall meetings in advance of drafting IMPACT 2023 and conducted an employee survey to obtain valuable feedback. CCH emailed employees and advised them of the opportunity to participate in "System Briefs" and in flyers distributed throughout the organization. In total, 187 individuals attended the employee Town Hall meetings:

- Provident Hospital Town Hall: May 2, 2019  
64 employees
- Oak Forest Health Center Town Hall: May 9, 2019  
55 employees
- Stroger Hospital Town Hall: April 30, 2019  
68 employees

### Employee Survey

There were a total of 169 employees who completed the Employee Strategic Planning Survey.

- Of these, only 45 or 27% had attended a Town Hall meeting where the strategic priorities were discussed.

With regard to the priorities, employees were asked to rate each of them from 1 to 5.

PRIORITY	NUMBER/PERCENT WITH A SCORE OF 5	AVERAGE SCORE
Deliver High Quality Care	50%	4.2
Grow to Serve and Compete	60%	4.4
Foster Fiscal Stewardship	42%	4.0
Invest in Resources/Leverage Valuable Assets	53%/43%	4.3/4.1
Impact Social Determinants of Health/Advocate for Patients	62%	4.4

- 35 or 21% of the employees who completed the survey are in a supervisory role.
  - Of these, 48% documented monthly staff meeting with supervisor and 29% had weekly meetings.
- 132 or 79% of these employees who completed the survey are in a non-supervisory role.
  - Of these, 30% documented monthly staff meeting with supervisor and 13% had weekly meetings.
- 49 or 29% of employees that completed the survey work primarily at Stroger Hospital, 9% at community health centers, and 49% each from CDDPH, Carmax Health Services and Provident Hospital.
- 62% of employees were identified as clinical and 38% as non-clinical.
- For the clinical roles:
  - 52 or 50% are nurses
  - 1 or 1% are pharmacists
  - 14 or 13% are physicians
  - 4 or 4% are PA/CNPs
  - 10 or 10% are technicians/aide

# Employee Survey

Confidential

Page 1 of 4

## CCH Strategic Plan - Employee Feedback Survey

CCH is in the process of developing its 2020-2022 strategic plan. In addition to more than 20 presentations to the CCH Board of Directors, CCH has held town hall meetings for staff and the community.

It is important for us to hear from as many employees as possible as we develop specific strategies to guide our success in the coming years. Additionally, the strategic plan will serve as the foundation for our 2020-2022 budgets.

This survey should take no longer than 20 minutes and does not require any personal contact information. Your engagement and feedback are greatly appreciated. Please complete this survey by 5/27/2019.

Thank you!

---

Are you in a supervisory role?

Yes  No

---

If yes, how often do you hold regular meetings with your team?

- Daily
- Weekly
- Every other week
- Monthly
- Every other month
- Quarterly
- Twice a year
- Once a year
- As needed
- Never

---

If no, how often does your supervisor hold regular meetings with your team?

- Daily
- Weekly
- Every other week
- Monthly
- Every other month
- Quarterly
- Twice a year
- Once a year
- As needed
- Never

07/02/2019 4:53pm

projectredcap.org





Where do you primarily work?

- Administration Building
- Arlington Heights Health Center
- Austin Health Center
- Cermak Health Services
- Central Campus Specialty Care Clinics
- Central Campus Primary Care
- Children's Advocacy Center
- Cicero Health Center
- CORE Center
- Cottage Grove Health Center
- Englewood Health Center
- JTDC
- Logan Square Health Center
- Morton East
- Near South Health Center
- Oak Forest Health Center
- Prieto Health Center
- Professional Building
- Provident Hospital
- Public Health
- Robbins Health Center
- Sengstacke Health Center
- Stroger Hospital
- Woodlawn Health Center

Do you consider your role:

- Clinical
- Non-Clinical

If clinical, what is your role?

- Nurse
- Pharmacist
- Physician
- Physician Assistant/Nurse Practitioner
- Technician/Aide
- Others, please specify:

Others, please specify:

\_\_\_\_\_

Please choose your clinical department (if applicable)

- Anesthesiology
- Employee Health Services
- Emergency Medicine
- Family Medicine
- General Medicine
- Lab
- OBGYN
- Oral Health
- Pediatrics
- Pharmacy
- Psychiatry
- PT/OT/Speech
- Radiology
- Surgery
- Trauma
- Other, please specify:

Other Clinical Department

\_\_\_\_\_

Please choose your non-clinical department (if applicable)

- Administration- System
- Administration- CountyCare
- Care Coordination
- Facilities (B&G, environmental service, police, etc.)
- Finance
- Human Resources
- IT
- Support Services (transport, interpreters, etc.)
- Other, please specify:

Other Non-Clinical Department

\_\_\_\_\_

How long have you worked at Cook County Health?

- Less than 1 year
- 1-5 years
- 5-10 years
- 10-20 years
- More than 20 years

What one word comes to mind when you think about CCH?

(Type in one word here)

What one word comes to mind when you think about your role at CCH?

(Type in one word here)

What can you do to contribute to the success of CCH?

Have you attended a recent Town Hall meeting?

- Yes
- No

If yes, did you find it informative?

- Yes
- No

The 2020-2022 strategic plan will have six focus areas. Please rate how important each of the CCH focus areas are to you personally - - 1 being the least important, 5 being the most important.

Deliver High Quality Care

- 1
  - 2
  - 3
  - 4
  - 5
- (1 - Least important, 5 - Most important)

Grow to Serve and Compete

- 1
  - 2
  - 3
  - 4
  - 5
- (1 - Least important, 5 - Most important)

Foster Fiscal Stewardship

- 1
  - 2
  - 3
  - 4
  - 5
- (1 - Least important, 5 - Most important)

Invest in Resources

- 1
  - 2
  - 3
  - 4
  - 5
- (1 - Least important, 5 - Most important)

Leverage Valuable Assets

- 1
  - 2
  - 3
  - 4
  - 5
- (1 - Least important, 5 - Most important)

Impact Social Determinants of Health/Advocate for Patients

- 1
  - 2
  - 3
  - 4
  - 5
- (1 - Least important, 5 - Most important)

The population is aging. What are we doing to attract these patients?

\_\_\_\_\_

How do we stay true to our mission to care for all under these circumstances:

- Uninsured volumes are up (charity care and self-pay)
- No additional local tax payer support can be expected
- Competition for Medicaid exists
- Patient experience is not helping volumes

\_\_\_\_\_

What should CCH's highest priority be in the next three years?

\_\_\_\_\_

What services are needed in the community?

\_\_\_\_\_

What are we doing well? Not so well?

\_\_\_\_\_

How do we treat patients who come from different races, religions and ethnicities?

\_\_\_\_\_

What must we do to thrive in an environment where reimbursements will be driven by outcomes without regard for how sick the patient is or his/her social supports?

\_\_\_\_\_

What programs and services do we offer that set us apart?

\_\_\_\_\_

Other comments:

\_\_\_\_\_

# Timeline

## 2008

- Cook County Board of Commissioners adopt enabling ordinance to create the Cook County Health & Hospital Systems (CCHHS) and its independent Governance Board referred to as the CCHHS Board of Directors.
- Insular safety net provider with little to no competition.
- Majority of patients uninsured. Provision of more than \$600 million in uncompensated care annually.
- Focus on sick care.
- Reliant on more than \$500 million in local tax allocation supporting operations.

## 2011

- Illinois General Assembly mandates that 50% of Illinois Medicaid beneficiaries move into managed care by 2015. To achieve this, nearly all Cook County Medicaid beneficiaries are required to enroll in a managed care health plan.

## 2013

- CCHHS provides 37% of all charity care in Cook County.

## 2014

- ACA takes full effect.
- 1115 Waiver ends and CountyCare transforms into a County Managed Care Community Network (MCCN) allowing traditional Medicaid populations to enroll in the plan.
- Majority of CCHHS patients insured.
- CCHHS and CountyCare competing with private health care providers and commercial insurance plans for CCHHS' traditional patients.
- State of Illinois changes rules for Accountable Care Entities and causes significant consolidation in the Medicaid market.

## 2017

- Cook County tax allocation supporting operations decreases to \$102M representing less than 5% of CCHHS operating revenues.
- CCHHS expands CareLink program to provide emphasis on care-coordinated primary care.
- CCHHS provides 53% of all charity care in Cook County.
- State of Illinois issues Medicaid Managed Care Organization Request for Proposals and subsequently awards seven four-year contracts for Medicaid Managed Care services in Cook County effective January 1, 2018.
- CountyCare acquires Medicaid members of Family Health Network.

## 2009

- First budget created by independent CCHHS Board of Directors. Cook County tax allocation supporting operations was \$480 million representing nearly half of its operating revenues.

## 2010

- Adoption of Vision 2015 with increased focus on ambulatory services.
- Affordable Care Act (ACA) passed by Congress and signed by President Obama.

## 2012

- State of Illinois and Cook County granted a federal 1115 Waiver to create CountyCare to enroll those newly eligible for Medicaid prior to the full implementation of the ACA.
- CCHHS moves from provider role to provider and plan, expanding patient reach.

## 2015

- CountyCare membership approximately 160,000.
- Further consolidations in the Managed Care Organization market occur.
- Bruce Rauner sworn in as Illinois Governor.

## 2016

- Uninsured rate dips to 6% in Illinois, a historic low yet 40% of CCHHS' patients are uninsured.
- Hospital industry sees decrease in charity care and increase in bad debt as a result of the ACA.
- CCHHS provides 49% of all charity care in Cook County.

## 2018

- Cook County tax allocation supporting operations remains flat at \$102M representing less than 3% of CCH operating revenues.
- CountyCare acquires Medicaid members of Aetna Better Health.
- JB Pritzker sworn in as Illinois Governor.

## 2019

- Cook County tax allocation supporting operations remains flat at \$102M representing less than 3% of CCH operating revenues.
- Medicaid enrollment in Cook County declines to fewer than one million. Media reports indicate that initial eligibility and redetermination application backlogs at state contributing to decline. Slow gains in April, May and June as new leadership prioritizes eligibility and redetermination application processing.
- Repeal of the Affordable Care Act's Individual Mandate takes effect January 1, 2019.

- More than 31,000 individuals enrolled in CCH's expanded CareLink program.
- With 316,000 members (April, 2019), CountyCare is largest Medicaid managed care plan in Cook County.
- Centene announces plans to acquire WellCare/Meridian. If approved by regulators, this would reduce the number of Medicaid plans operating in Cook County to five, down from seven when the state awarded contracts in 2017.

# Presentation List

DATE	TOPIC	PRESENTER
November 30, 2018	Population Overview and Projections	Doug Elwell
December 21, 2018	Environmental Assessment: Epidemiology, Health Status and Disparities in Cook County	Terry Mason, MD
December 21, 2018	Information Technology Overview	Donna Hart
January 18, 2019	Financial Status and Pressures	Ekerete Akpan
January 25, 2019	State and Federal Issues	Paul Beddoe, Letty Close
February 19, 2019	Human Resources	Barbara Pryor
February 22, 2019	Pension Overview	Ammar Rizki, CFO
February 22, 2019	Quality and Reliability	Ron Wyatt, MD
February 27, 2019	Extramural Funding	Leticia Reyes Nash
February 27, 2019	Health Equity and Social Determinants	Dr. Mason, Mary Sajdak
February 27, 2019	Correctional Health	Linda Follenweider
February 27, 2019	Behavioral Health	Diane Washington, MD
February 28, 2019	Safety Net Strategies/Vulnerabilities, Local Market Realities, Partnerships	John Jay Shannon, MD
March 15, 2019	Integrated Care Management	Mary Sajdak
March 15, 2019	Medicaid Managed Care	Jim Kiamos
March 22, 2019	Research	William Trick, MD
March 29, 2019	Clinical Activity, Utilization & Operational Efficiency	Debra Carey
March 29, 2019	Medical Practice	Claudia Fegan, MD
April 16, 2019	Nursing Management	Beena Peters, DNP, RN
April 18, 2019	Graduate Education	John O'Brien, MD
April 18, 2019	Capital Equipment	Ekerete Akpan
April 18, 2019	Primary Care/Maternal Child Care	Iliana Mora
April 18, 2019	Diagnostic/Specialty Services	Jarrold Johnson
April 26, 2019	Marketing, Communication, Branding	Caryn Stancik
April 26, 2019	Cook County Department of Public Health	Dr. Mason
May 31, 2019	Strategic Planning -- Priorities, Financial Impact	Dr. Shannon

# Enabling Ordinance

## ARTICLE V.-- COOK COUNTY HEALTH AND HOSPITALS SYSTEM<sup>[1]</sup>

Sec. 38-70. - Short title.

This Ordinance shall be known and may be cited as the “Ordinance Establishing the Cook County Health and Hospitals System.”

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-71. - Declaration.

(a) The County Board hereby establishes the Cook County Health and Hospitals System (“CCHHS or System”) which shall be an agency of and funded by Cook County. All personnel, facilities, equipment and supplies within the formerly constituted Cook County Bureau of Health Services are now established within the CCHHS. Pursuant to the provisions contained herein, the CCHHS and all personnel, facilities, equipment and supplies within the CCHHS shall be governed by a Board of Directors (“System Board”) as provided herein. The System Board shall be accountable to and shall be funded by the County Board and shall obtain County Board approval as required herein. The County Board hereby finds and declares that the CCHHS shall:

- (1) Provide integrated health services with dignity and respect, regardless of a patient’s ability to pay;
- (2) Provide access to quality preventive, acute, and chronic health care for all the People of Cook County, Illinois (the “County”);
- (3) Provide quality emergency medical services to all the People of the County;
- (4) Provide health education for patients, and participate in the education of future generations of health care professionals;
- (5) Engage in research which enhances its ability to meet the healthcare needs of the People of the County; and,
- (6) Perform, through the Cook County Department of Public Health, essential services of a local public health authority as provided in the Cook County Board of Health Ordinance, Sections 38-26 through 38-40 of the Cook County Code, other Cook County Ordinances imposing duties upon the Cook County Department of Public Health, and the regulations of the Cook County Department of Public Health promulgated thereunder; the Department of Public Health Act, 20 ILCS 2305/1 et seq.; the Civil

Administrative Code of Illinois, 20 ILCS 2310/2310-1 et seq.; and as further detailed in regulations promulgated by the Illinois Department of Public Health under the Certified Local Health Department Code, 77 Ill. Adm. Code 600.110 et seq.; provided, however, that the County Board shall continue to serve as the Board of Health of Cook County.

(b) This article recognizes the essential nature of the Mission of the CCHHS as set forth in Section 38-74, and the need for sufficient and sustainable public funding of the CCHHS in order to fulfill its mission of universal access to quality health care.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-72. - Definitions.

For purposes of this article, the following words or terms shall have the meaning or construction ascribed to them in this section:

*Chairperson* means the chairperson of the System Board.

*Cook County Code* means the Code of Ordinances of Cook County, Illinois.

*Cook County Health and Hospitals System also referred to as “CCHHS”*, means the public health system comprised of the facilities at, and the services provided by or through, the Ambulatory and Community Health Network, Cermak Health Services of Cook County, Cook County Department of Public Health, Oak Forest Hospital of Cook County, Provident Hospital of Cook County, Ruth M. Rothstein CORE Center, and John H. Stroger, Jr. Hospital of Cook County, (collectively, the “CCHHS Facilities”).

*County* means the County of Cook, a body politic and corporate of Illinois.

*County Board* means the Board of Commissioners of Cook County, Illinois.

*Director* means a member of the System Board.

*Fiscal Year* means the fiscal year of the County.

*Ordinance* means the Ordinance Establishing the Cook County Health and Hospitals System, as amended.

*President* means the President of the Cook County Board of Commissioners.

*System Board* means the 11-member board of directors charged with governing the CCHHS.

[1] Editor’s note— Ord. No. 08-O-35, adopted May 20, 2008, set out provisions intended for use as Art. IV, §§ 38-70–38-93. Inasmuch as this article so numbered already exists, to avoid duplication and at the editor’s discretion, these provisions have been included as Art. V, §§ 38-70–38-93.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-73. - Establishment of the Cook County Health and Hospitals System Board of Directors (“System Board”).

(a) The System Board is hereby created and established. The System Board shall consist of 11 members called Directors. The County Board delegates governance of the CCHHS to the System Board. The System Board shall, upon the appointment of its Directors as provided herein, assume responsibility for the governance of the CCHHS.

(b) Notwithstanding any provision of this article, the Cook County Board of Health Ordinance, Sections 38-26 through 38-40 of the Cook County Code of Ordinances, and other provisions of the Cook County Code of Ordinances conferring authority and imposing duties and responsibilities upon the Board of Health and the Cook County Department of Public Health, shall remain in full force and effect.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-74. - Mission of the CCHHS.

(a) The System Board shall have the responsibility to carry out and fulfill the mission of the CCHHS by:

- (1) Continuing to provide integrated health services with dignity and respect, regardless of a patient’s ability to pay;
- (2) Continuing to provide access to quality primary, preventive, acute, and chronic health care for all the People of the County;
- (3) Continuing to provide high quality emergency medical services to all the People of the County;
- (4) Continuing to provide health education for patients, and continuing to participate in the education of future generations of health care professionals;
- (5) Continuing to engage in research which enhances the CCHHS’ ability to meet the healthcare needs of the People of the County;
- (6) Ensuring efficiency in service delivery and sound fiscal management of all aspects of the CCHHS, including the collection of all revenues from governmental and private third-party payers and other sources;
- (7) Ensuring that all operations of the CCHHS, especially contractual and personnel matters, are conducted free from any political interference and in accordance with the provisions of the Supplemental Relief Order and Consent Decree established in the federal civil litigation filed in the

Northern District of Illinois under Case No. 69 C 2145 and titled Shakman, et al. v. Democratic Organization, et al. and all applicable laws; and,

(8) Perform, through the Cook County Department of Public Health, essential services of a local public health authority as provided in the Cook County Board of Health Ordinance, Sections 38-26 through 38-40 of the Cook County Code, other Cook County Ordinances imposing duties upon the Cook County Department of Public Health, and the regulations of the Cook County Department of Public Health promulgated thereunder; the Department of Public Health Act, 20 ILCS 2305/1 et seq.; the Civil Administrative Code of Illinois, 20 ILCS 2310/2310-1 et seq.; and as further detailed in regulations promulgated by the Illinois Department of Public Health under the Certified Local Health Department Code, 77 Ill. Adm. Code 600.110 et seq.; provided, however, that the County Board shall continue to serve as the Board of Health of Cook County.

(b) The System Board shall be responsible to the People of the County for the proper use of all funds appropriated to the CCHHS by the County Board.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-75. - Nomination and appointment of directors.

(a) Upon confirming that a vacancy in the office of Director has occurred or will occur, a Nominating Committee of 14 persons including a Chair shall be appointed by the President and convene to prepare a list of nominees consisting of a total of three nominees per vacancy. This list shall be provided within 45 days of the President’s request. If the number of nominees accepted by the President is fewer than the number of vacancies, the Nominating Committee will submit replacement nominees until the President has accepted that number of nominees that corresponds to the number of vacancies.

(b) Nominating Committee.

(1) The Nominating Committee shall consist of one representative from the following organizations:

- a. Civic Federation of Chicago;
- b. Civic Committee of the Commercial Club of Chicago;
- c. Chicago Urban League;
- d. Healthcare Financial Management Association;
- e. Suburban Primary Healthcare Council;
- f. Illinois Public Health Association;

- g. Metropolitan Chicago Healthcare Council;
- h. Health and Medicine Policy Research Group;
- i. Chicago Department of Public Health;
- j. Cook County Physicians Association;
- k. Chicago Federation of Labor;
- l. Chicago Medical Society;
- m. Association of Community Safety Net Hospitals; and
- n. Midwest Latino Health Research Center.

(2) All decisions of the Nominating Committee shall be by majority vote of the membership.

(c) The President shall submit the nominees he/she selects to the County Board for approval of appointment. The President shall exercise good faith in transmitting the nomination(s) to the County Board.

(d) Appointment of Directors. The County Board shall approve or reject each of the nominees submitted by the President within 14 days from the date the President submitted the nominees, or at the next regular meeting of the County Board held subsequent to the 14-day period. Where the County Board rejects the President's selection of any nominee for the office of Director, the President shall within seven days select a replacement nominee from the remaining nominees on the list received from the Nominating Committee. There is no limit on the number of nominees the County Board may reject. The County Board shall exercise good faith in approving the appointment of Directors as soon as reasonably practicable. In the event the nominees initially submitted to the President by the Nominating Committee are exhausted before the county Board approves the number of nominees required to fill all vacancies, the President shall direct the nominating Committee to reconvene and to select and submit an additional three nominees for each Director still to be appointed.

**(Ord. No. 08-O-35, 5-20-2008;  
Ord. No. 11-O-55, 5-17-2011.)**

Sec. 38-76. - Members of the System Board.

(a) General. The appointed Directors are not employees of the County and shall receive no compensation for their service, but may be reimbursed for actual and necessary expenses while serving on the System Board. Directors shall have a fiduciary duty to the CCHHS and the County; and Directors shall keep confidential information received in close sessions

of Board and Board Committee meetings and information received through otherwise privileged and confidential communications.

(b) Number of Directors. There shall be 11 Directors of the System Board.

(c) Ex Officio Director. One of the 11 Directors shall be the Chairperson of the Health and Hospitals Committee of the County Board who shall serve as an ex-officio member with voting rights. This Director shall serve as a liaison between the County Board and the System Board.

(d) Terms of Directors .

(1) Ex Officio Director. Upon appointment or election of a successor as Chairperson of the health and Hospitals Committee of the County Board, the successor shall immediately and automatically replace the prior Director as ex officio Director with voting rights.

(2) The Remaining Directors . The remaining ten Directors of the System Board shall serve terms as follows. For purposes of this section, Initial Directors means the Directors who were appointed to serve on the System Board when it was first established:

a. For the initial Directors,

1. Three of the Initial Directors serving at the time this amendment is enacted, other than the ex officio Directors, shall serve terms that expire June 30, 2012.

2. Three of the Initial Directors serving at the time this amendment is enacted, other than the ex officio Directors, shall serve terms that expire June 30, 2013.

3. Four of the Initial Directors serving at the time this amendment is enacted, other than the ex officio Directors, shall serve terms that expire June 30, 2014.

4. The System Board shall vote upon and submit the list of names of the Directors whose terms shall expire June 30, 2012, the list of names of the Directors whose terms shall expire June 30, 2013, and the list of names of Directors whose terms shall expire June 30, 2014, to the President for approval and subsequent recommendation to the County Board for its approval.



b. Thereafter: Directors appointed shall serve four-year terms.

1. Each appointed Director, whether Initial or subsequent, shall hold office until a successor is appointed.
2. Any appointed Director who is appointed to fill a vacancy, other than a vacancy caused by the expiration of the predecessor's term, shall serve until the expiration of his or her predecessor's term.

(e) Vacancy . A vacancy shall occur upon the:

- (1) Expiration of Director's Term,
- (2) Resignation,
- (3) Death,
- (4) Conviction of a felony, or
- (5) Removal from the office of an appointed Director as set forth in paragraph (f) of this section.

(f) Removal of Directors . Any appointed Director may be removed for incompetence, malfeasance, neglect of duty, or any cause which renders the Director unfit for the position. The President or one-third of the members of the County Board shall provide written notice to that Director of the proposed removal of that Director from office; which notice shall state the specific grounds which constitute cause for removal. The Director, in receipt of such notice, may request to appear before the County Board and present reasons in support of his or her retention. Thereafter, the County Board shall vote upon whether there are sufficient grounds to remove that Director from office. The President shall notify the subject Director of the final action of the County Board.

**(Ord. No. 08-O-35, 5-20-2008; Ord. No. 08-O-37, 6-3-2008; Ord. No. 11-O-55, 5-17-2011.)**

Sec. 38-77. - Qualifications of appointed directors.

(a) The appointed Directors shall include persons with the requisite expertise and experience in areas pertinent to the governance and operation of a large and complex healthcare system. Such areas shall include, but not be limited to, finance, legal and regulatory affairs, healthcare management, employee relations, public administration, clinical medicine, community public health, public health policy, labor affairs, patient experience, civil or minority rights advocacy and community representation.

(b) Criteria to be considered in nominating or appointing individuals to serve as Directors shall include:

- (1) Background and skills needed on the Board;
- (2) Resident of Cook County, Illinois;
- (3) Available and willing to attend a minimum of nine monthly Board meetings per year, and actively participate on at least one Board committee; and
- (4) Willingness to acquire the knowledge and skills required to oversee a complex healthcare organization.

The Nominating Committee, the President and the County Board shall take this section into account in undertaking their respective responsibilities in the recommendation, selection and appointment of Directors.

(c) Duties of individual Directors include, but are not necessarily limited to, the following:

- (1) Regularly attend Board meetings including a minimum of nine meetings per year;
- (2) Actively participate on and attend meetings of committee(s) to which the Director is assigned;
- (3) Promptly relate community input to the Board;
- (4) Represent the CCHHS in a positive and effective manner;
- (5) Learn sufficient details about CCHHS management and patient care services in order to effectively evaluate proposed actions and reports; and
- (6) Accept and fulfill reasonable assignments from the Chair of the Board.

**(Ord. No. 08-O-35, 5-20-2008; Ord. No. 11-O-55, 5-17-2011.)**

Sec. 38-78. - Chairperson/officers of the System Board.

(a) The Directors shall select the initial Chairperson of the System Board from among the initial Directors. The Chairperson shall serve a one-year term and, thereafter, the System Board shall annually elect a chairperson from among the Directors.

- (1) The Chairperson shall preside at meetings of the System Board, and is entitled to vote on all matters before the System Board.
- (2) A Director may be elected to serve successive terms as Chairperson.

(b) The Directors may establish such additional offices and appoint such additional officers for the System Board as they may deem appropriate.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-79. - Meetings of the System Board.

(a) The President shall call the first meeting of the System Board. Thereafter, the Directors shall prescribe the times and places for their meetings and the manner in which regular and special meetings may be called.

(b) Meetings shall be held at the call of the Chairperson, however, no less than 12 meetings shall be held annually.

(c) A majority of the voting Directors shall constitute a quorum. Actions of the System Board shall require the affirmative vote of a majority of the voting members of the System Board present and voting at the meeting at which the action is taken.

(d) To the extent feasible, the System Board shall provide for and encourage participation by the public in the development and review of financial and health care policy. The System Board may hold public hearings as it deems appropriate to the performance of any of its responsibilities.

(e) The System Board shall comply in all respects with “An Act in relation to meetings,” as now or hereafter amended, and found at 5 ILCS 120/1, et seq.

(f) The System Board shall be an Agency to which the Local Records Act, as now or hereafter amended, and found at 50 ILCS 205/1, et seq. applies.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-80. - General powers of the System Board.

Subject to the Mission of the CCHHS and consistent with this article, the System Board shall have the following powers and responsibilities:

(a) To appoint the Chief Executive Officer of the CCHHS (“CEO”) or interim CEO, if necessary, as set forth in Section 38-81 hereinafter, to hire such employees and to contract with such agents, and professional and business advisers as may from time to time be necessary in the System Board’s judgment to accomplish the CCHHS’ Mission and the purpose and intent of this article; to fix the compensation of such CEO, employees, agents, and advisers; and, to establish the powers and duties of all such agents, employees, and other persons contracting with the System Board;

(b) To exercise oversight of the CEO;

(c) To develop measures to evaluate the CEO’s performance and to report to the President and the County Board at six-month intervals regarding the CEO’s performance;

(d) To authorize the CEO to enter into contracts, execute all instruments, and do all things necessary or convenient in the exercise of the System Board’s powers and responsibilities;

(e) To determine the scope and distribution of clinical services; provided, however, if the System Board determines that it is in the best interest of the CCHHS to close entirely one of the two CCHHS hospitals, such closure will require County Board approval; provided further, however, that if the System Board determines it is in the best interest of the CCHHS to purchase additional hospitals, or to add or reduce healthcare-licensed, risk-bearing entities in CountyCare, the CCHHS shall, 15 calendar days before final approval, provide notice to the President and the Cook County Board of Commissioners, informing such persons as to the basic nature of any such transaction and shall offer to meet with such persons to brief them in more detail on specifics relating to such a transaction;

(f) To provide for the organization and management of the CCHHS, including, but not limited to, the System Board’s rights and powers to approve all personnel policies, consistent with existing state laws, collective bargaining agreements, and court orders;

(g) To submit budgets for the CCHHS operations and capital planning and development, which promote sound financial management and assure the continued operation of the CCHHS, subject to approval by the County Board;

(h) To accept any gifts, grants, property, or any other aid in any form from the federal government, the state, any state agency, or any other source, or any combination thereof, and to comply with the terms and conditions thereof;

(i) To purchase, lease, trade, exchange, or otherwise acquire, maintain, hold, improve, repair, sell, and dispose of personal property, whether tangible or intangible, and any interest therein;

(j) In the name of the County, to purchase, lease, trade, exchange, or otherwise acquire, real property or any interest therein, and to maintain, hold, improve, repair, mortgage, lease, and otherwise transfer such real property, so long as such transactions do not interfere with the Mission of the CCHHS; provided, however, that transactions involving real property valued at \$100,000.00 or greater shall require express approval from the County Board;

(k) To acquire space, equipment, supplies, and services, including, but not limited to, services of consultants for rendering professional and technical assistance and advice on matters within the System Board’s powers;

(l) To make rules and regulations governing the use of property and facilities within the CCHHS, subject to agreements with or for the benefit of holders of the County Board's obligations;

(m) To adopt, and from time to time amend or repeal bylaws and rules and regulations consistent with the provisions of this article;

(n) To encourage the formation of a not-for-profit corporation to raise funds to assist in carrying out the Mission of the CCHHS;

(o) To engage in joint ventures, or to participate in alliances, purchasing consortia, or other cooperative arrangements, with any public or private entity, consistent with state law;

(p) To have and exercise all rights and powers necessary, convenient, incidental to, or implied from the specific powers granted in this article, which specific powers shall not be considered as a limitation upon any power necessary or appropriate to carry out the CCHHS' Mission and the purposes and intent of this article;

(q) To perform, through the Cook County Department of Public Health, essential services of a local public health authority as provided in the Cook County Board of Health Ordinance, Sections 38-26 through 38-40 of the Cook County Code, other Cook County Ordinances imposing duties upon the Cook County Department of Public Health, and the regulations of the Cook County Department of Public Health promulgated thereunder; the Department of Public Health Act, 20 ILCS 2305/1 et seq.; the Civil Administrative Code of Illinois, 20 ILCS 2310/2310-1 et seq.; and as further detailed in regulations promulgated by the Illinois Department of Public Health under the Certified Local Health Department Code, 77 Ill. Adm. Code 600.110 et seq.; provided, however, that the County Board shall continue to serve as the Board of Health of Cook County; and

(r) To be the governing body of the licensed hospitals or other licensed entities within the CCHHS.

**(Ord. No. 08-O-35, 5-20-2008;**

**Ord. No. 18-1126, 9-12-2018.)**

Sec. 38-81. - Chief executive officer.

(a) The System Board shall appoint a Chief Executive Officer of the CCHHS ("CEO") or an interim CEO as necessary.

(b) The System Board shall conduct a nationwide search for a CEO which shall be concluded no later than 180 days from the date of the County Board's approval of the appointment of the initial System Board.

(c) The CEO shall have the responsibility for:

(1) Full operational and managerial authority of the CCHHS, consistent with existing federal and state laws, court orders and the provisions of this article;

(2) Preparing and submitting to the System Board the Budgets and Strategic and Financial Plans required by this article;

(3) Operating and managing the CCHHS consistent with the Budgets and Financial Plans approved by the County Board;

(4) Overseeing expenditures of the CCHHS;

(5) Subject to Subsection 38-74(a)(7) of this article, hiring and discipline of personnel in conformity with the provisions of this article, all state laws, court orders, and collective bargaining agreements;

(6) Negotiating collective bargaining agreements as set forth in Section 38-84(c); and

(7) Carrying out any responsibility which the System Board may delegate; however, said delegation shall not relieve the System Board of its responsibilities as set forth in this article.

(d) The CEO shall report to the System Board.

(e) The CEO shall provide, through the System Board, quarterly reports to the County Board concerning the status of operations and finances of the CCHHS.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-82. - Strategic and financial plans.

(a) As soon as practicable following the establishment of the System Board, the President shall provide to the System Board copies of the audited financial statements and of the books and records of account of the Bureau of Health Services for the preceding five Fiscal Years of the County.

(b) The System Board shall recommend and submit to the President and the County Board Strategic and Financial Plans as required by this section.

(c) Each Strategic and Financial Plan for each Fiscal Year, or part thereof to which it relates, shall contain:

(1) A description of revenues and expenditures, provision for debt service, cash resources and uses, and capital improvements, each in such manner and detail as the County's Budget Director shall prescribe;

(2) A description of the strategy by which the anticipated revenues and expenses for the Fiscal Years covered by the Strategic and Financial Plan will be brought into balance;

(3) Such other matters that the County Board, in its discretion, requires; provided, however, that the System Board shall be provided with a description of such matters in sufficient time for incorporation into the Strategic and Financial Plan.

(d) Strategic and Financial Plans shall not have force or effect without the approval of the County Board and shall be recommended, approved and monitored in accordance with the following:

(1) The System Board shall recommend and submit to the President and the County Board, on or before 180 days subsequent to the date of the appointment of the initial Directors or as soon as practicable thereafter, an initial Strategic and Financial Plan with respect to the remaining portion of the Fiscal Year ending in 2008 and for Fiscal Years 2009 and 2010. The Board shall approve, reject or amend this initial Strategic and Financial Plan within 45 days of its receipt from the System Board.

(2) The System Board shall develop a Strategic and Financial Plan covering a period of three Fiscal Years.

(3) The System Board shall include in each Strategic and Financial Plan estimates of revenues during the period for which the Strategic and Financial Plan applies. In the event the System Board fails, for any reason, to include estimates of revenues as required, the County Board may prepare such estimates. In such event, the Strategic and Financial Plan submitted by the System Board shall be based upon the revenue estimates prepared by the County Board.

(4) The County Board shall approve each Strategic and Financial Plan if, in its judgment, the Strategic and Financial Plan is complete, is reasonably capable of being achieved, and meets the requirements set forth in this section. After the System Board submits a Strategic and Financial Plan to the President and the County Board, the County Board shall approve or reject such Strategic and Financial Plan within 45 days or such Strategic and Financial Plan is deemed approved.

(5) The System Board shall report to the President and the County Board, at such times and in such manner as the County Board may direct, concerning the System Board's compliance with the Strategic and Financial Plan.

The President and the County Board may review the System Board's operations, obtain budgetary data and financial statements, require the System Board to produce reports, and have access to any other information in the possession of the System Board that the President and the County Board deem relevant. The County Board may issue recommendations or directives within its powers to the System Board to assure compliance with the Strategic and Financial Plan. The System Board shall produce such budgetary data, financial statements, reports and other information and comply with such directives.

(6) For each Strategic and Financial Plan applicable to a Fiscal Year subsequent to the current Fiscal Year, the System Board shall regularly reexamine the revenue and expenditure estimates on which it was based and revise them as necessary. The System Board shall promptly notify the President and the County Board of any material change in the revenue or expenditure estimates in that Strategic and Financial Plan. The System Board may submit to the President and the County Board, or the County Board may require the System Board to submit, modified Strategic and Financial Plans based upon revised revenue or expenditure estimates or for any other good reason. The County Board shall approve or reject each modified Strategic and Financial Plan pursuant to paragraph (d)(4) of this section.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-83. - Preliminary CCHHS budget and annual appropriation ordinance.

(a) The System Board shall not make expenditures unless such expenditures are consistent with the County's Annual Appropriation Bill ("Annual Appropriation Ordinance") as provided in 55 ILCS 5/6-24001 et seq.

(b) The System Board may, if necessary, recommend and submit to the President and the County Board, for approval by the County Board, a request for intra-fund transfers within the Public Health Fund to accommodate any proposed revisions by the System Board to the line items set forth for the Bureau of Health Services in the existing Fiscal Year 2008 Annual Appropriation Ordinance.

(c) For Fiscal Year 2009 and each Fiscal Year thereafter, the System Board shall recommend and submit a Preliminary Budget for the CCHHS to the President and the County Board, for approval by the County Board, not later than 45 days prior to the first date for submission of budget requests set by the County's Budget Director.

(d) Each Preliminary Budget shall be recommended and submitted in accordance with the following procedures:

(1) Each Preliminary Budget submitted by the System Board shall be based upon revenue estimates contained in the approved Strategic and Financial Plan applicable to that budget year.

(2) Each Preliminary Budget shall contain such information and detail as may be prescribed by the County's Budget Director. Any applicable fund deficit for the Fiscal Year ending in 2008 and for any Fiscal Year thereafter shall be included as an expense item in the succeeding Fiscal Year's Budget.

(e) The County Board shall approve each Preliminary Budget if, in its judgment, the Budget is complete, is reasonably capable of being achieved, and will be consistent with the Strategic and Financial Plan in effect for that Fiscal Year. The Board shall approve or reject each Preliminary Budget within 45 days of submission to the County Board or such Preliminary Budget is deemed approved. Such Preliminary Budget shall be included in the President's Executive Budget Recommendation.

(f) The CCHHS's Annual Appropriation shall be monitored as follows:

(1) The County Board may establish and enforce such monitoring and control measures as the County Board deems necessary to assure that the revenues, commitments, obligations, expenditures, and cash disbursements of the System Board continue to conform on an ongoing basis with the Annual Appropriation Ordinance. If, in the discretion of the County Board, and notwithstanding the approved Annual Appropriation Ordinance, the County Board imposes an expenditure limitation on the System Board, the System Board shall not have the authority, directly or by delegation, to enter into any commitment, contract, or other obligation that would result in the expenditure limitation being exceeded. Any such commitment, contract or other obligation entered into by the System Board in derogation of this section shall be voidable by the County Board. An expenditure limitation established by the County Board shall remain in effect for that Fiscal Year or unless revoked earlier by the County Board.

(2) The System Board shall report to the President and the County Board at such times and in such manner as the County Board may direct, concerning the System Board's compliance with each Annual Appropriation Ordinance.

The President and the County Board may review the System Board's operations, obtain budgetary data and financial statements, require the System Board to produce reports, and have access to any other information in the possession of the System Board which the President and the County Board deem relevant. The County Board may issue recommendations or directives within its powers to the System Board to assure compliance with the Annual Appropriation Ordinance. The System Board shall produce such financial data, financial statements, reports and other information and comply with such directives.

(3) After approval of each Annual Appropriation Ordinance, the System Board shall promptly notify the President and the County Board of any material change in the revenues or expenditures set forth in the Annual Appropriation Ordinance. In Fiscal Year 2009 and thereafter, the System Board has the authority to make intra-fund transfers within the Public Health Fund, if necessary, to accommodate any proposed revisions by the System Board to the line items set forth in the Annual Appropriation Ordinance. Such transfers shall be reported by the CEO in the quarterly reports required in Subsection 38-81(e) of this article.

(4) The County Comptroller is hereby authorized to process invoices and make payments against line items set forth in the Annual Appropriation Ordinance at the direction of the System Board or, if authorized by the System Board, at the direction of the CEO. The System Board shall provide the Comptroller with all documentation necessary for the Comptroller to perform this accounts payable function and to perform the budget control function. The Comptroller shall also issue payroll checks for employees within the CCHHS.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-84. - Human resources.

(a) Notwithstanding the provisions of the Cook County Code, including, but not limited to, provisions pertaining to Personnel Policies, the System Board shall have authority over all human resource functions currently performed by the Cook County Bureau of Human Resources with regard to all employees, including physicians and dentists, within the CCHHS, including, but not limited to, position classification, compensation, recruitment, selection, hiring, discipline, termination, grievance, affirmative action, performance management, probationary periods, training, promotion and maintenance of records. The System Board shall adopt

written rules, regulations and procedures with regard to these functions. Until such time as the System Board adopts its own rules, regulations or procedures with regard to these functions, the existing Personnel Rules, regulations and procedures of the County shall apply. The System Board may exercise the authority granted in this section, in whole or in part, pursuant to its discretion and consistent with existing collective bargaining agreements and obligations.

(b) Employees within the CCHHS are employees of the County, and as such, shall be free from any political interference in accordance with the Supplemental Relief Order and Consent Decree established in the federal civil litigation filed in the Northern District of Illinois under Case No. 69 C 2145 and titled “Shakman, et al. v. Democratic Organization, et al.”

(c) The CEO shall participate with the County in negotiating collective bargaining agreements covering CCHHS employees. All such collective bargaining agreements must be approved by the System Board and the County Board.

(d) The System Board or the CEO shall not hire or appoint any person in any position in the CCHHS unless it is consistent with the Annual Appropriation Ordinance in effect at the time of hire or appointment.

(e) Nothing herein shall diminish the rights of Cook County employees who are covered by a collective bargaining agreement and who, pursuant to this article, are placed under the jurisdiction of the System Board, nor diminish the historical representation rights of said employees’ exclusive bargaining representatives, nor shall anything herein change the designation of “Employer” pursuant to the Illinois Public Labor Relations Act. The System Board shall honor all existing collective bargaining agreements, between Cook County and exclusive bargaining representatives, which cover employees under the jurisdiction of the System Board.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-85. - Procurement and contracts.

(a) The System Board shall have authority over all procurement and contracts for the CCHHS. The System Board shall adopt written rules, regulations and procedures with regard to these functions, which must be consistent with the provisions set forth in the Cook County Code on Procurement and Contracts; provided, however, that approval of the County Board or County Purchasing Agent required under the Cook County Code on Procurement and Contracts is not required for procurement and contracts within the CCHHS. The System

Board shall act in place of the County Board in any contract, bylaws or agreement with the County which requires the approval or other action of the County Board unless expressly prohibited otherwise in this article or unless the contract expressly provides that the System Board shall not have such authority. Until such time as the System Board adopts its own rules, regulations or procedures with regard to Procurement and Contracts, the existing provisions of the Cook County Code pertaining to Procurement and Contracts shall apply. The System Board may exercise the authority granted in this section, in whole or in part, pursuant to its discretion.

(b) No contract or other obligation shall be entered into by the System Board unless it is consistent with the Annual Appropriation Ordinance in effect.

(c) Any multiyear contracts entered into by the System Board must contain a provision stating that the contract is subject to County Board approval of appropriations for the purpose of the subject contract; and that in the event funds are not appropriated by the County Board, the contract shall be cancelled without penalty to, or further payment being required by, the System Board or the County. The System Board shall give the vendor notice of failure of funding as soon as practicable after the System Board becomes aware of the failure of funding. Multiyear contracts shall also contain provisions that the System Board’s or County’s obligation to perform shall cease immediately upon receipt of notice to the vendor of lack of appropriated funds; and that the System Board’s or County’s obligation under the contract shall also be subject to immediate termination or cancellation at any time when there are not sufficient authorized funds lawfully available to the System Board to meet such obligation.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-86. - Disclosure of interests required.

(a) Any Director, officer, agent, or professional or business adviser of the System Board, or the CEO who has direct or indirect interest in any contract or transaction with the CCHHS, shall disclose this interest in writing to the System Board which shall, in turn, notify the President and the County Board of such interest.

(b) This interest shall be set forth in the minutes of the System Board and the Director, agent, or professional or business advisor or CEO having such interest shall not participate on behalf of the CCHHS in any way with regard to such contract or transaction unless the System Board or County Board waives the conflict.

(c) The Cook County Board of Ethics shall have jurisdiction over the investigation and enforcement of this section and over the sanctions for violations as set forth in Sections 2-601 and 2-602 of the Cook County Code of Ethical Conduct.

(d) Employees of CCHHS shall be bound by the Cook County Code of Ethical Conduct set forth in the Cook County Code, Article VII, Ethics.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-87. - Annual report of the System Board.

(a) The System Board shall submit to the President and the County Board, within six months after the end of each Fiscal Year, a report which shall set forth a complete and detailed operating and financial statement of the CCHHS during such Fiscal Year.

(b) Included in the report shall be any recommendations for additional legislation or other action which may be necessary to carry out the mission, purpose and intent of the System Board.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-88. - Managerial and financial oversight.

(a) The County Board may conduct financial and managerial audits of the System Board and the CCHHS.

(1) The County Board may examine the business records and audit the accounts of the System Board or CCHHS or require that the System Board examine such business records and audit such accounts at such time and in such manner as the County Board may prescribe. The System Board shall appoint a certified public accountant annually, approved by the County Board, to audit the CCHHS' financial statements.

(2) The County Board may initiate and direct financial and managerial assessments and similar analyses of the operations of the System Board and CCHHS, as may be necessary in the judgment of the County Board, to assure sound and efficient financial management of the System Board and the CCHHS.

(3) The County Board shall initiate and direct a management audit of the CCHHS at least once every year. The audit shall review the personnel, organization, contracts, leases, and physical properties of the CCHHS to determine whether the System Board is managing and utilizing its resources in an economical and efficient manner. The audit shall determine the causes of any

inefficiencies or uneconomical practices, including inadequacies in internal and administrative procedures, organizational structure, uses of resources, utilization of real property, allocation of personnel, purchasing policies and equipment.

(4) The County Board may direct the System Board to reorganize the financial accounts and management and budgetary systems of the System Board or CCHHS in a manner that the County Board deems appropriate to achieve greater financial responsibility and to reduce financial inefficiency.

(b) The System Board and the CCHHS shall be subject to audit in the manner now or hereafter provided by statute or ordinance for the audit of County funds and accounts. A copy of the audit report shall be submitted to the President, the Chairperson of the Finance Committee of the County Board, the Chairperson of the Health and Hospitals Committee, and the Director of the County Office of the Auditor.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-89. - Indemnification.

(a) The County shall defend and indemnify patient care personnel and public health practitioners, including, but not limited to, physicians, dentists, podiatrists, fellows, residents, medical students, nurses, certified nurse assistants, nurses' aides, physicians' assistants, therapists and technicians (collectively "practitioners") acting pursuant to employment, volunteer activity or contract, if provided for therein, with the County with respect to all negligence or malpractice actions, claims or judgments arising out of patient care or public health activities performed on behalf of the CCHHS. The County shall also defend and indemnify such practitioners against liability arising out of the preparation or submission of a bill seeking payment for services provided by such practitioners for the CCHHS, to the extent such liability arises out of the negligent or intentional acts or omissions of a person or persons, other than the practitioner, acting on behalf of the CCHHS. The County shall also defend and indemnify the members of the Nominating Committee and the System Board with respect to all claims or judgments arising out of their activities as members thereof which defense and indemnification shall be subject to the same provisions which apply to the defense and indemnification of practitioners as set forth below.

(b) The County shall not be obligated to indemnify a practitioner for:

- (1) Punitive damages or liability arising out of conduct which is not connected with the rendering of professional services or is based on the practitioner's willful or wanton conduct.
  - (2) Professional conduct for which a license is required but the practitioner does not hold a license.
  - (3) Conduct which is outside of the scope of the practitioner's professional duties.
  - (4) Conduct for which the practitioner does not have clinical privileges, unless rendering emergency care while acting on behalf of the CCHHS.
  - (5) Any settlement or judgment in which the County did not participate.
  - (6) The defense of any criminal or disciplinary proceeding.
- (c) To be eligible for defense and indemnification, the practitioner shall be obligated to:
- (1) Notify, within five days of receipt, the Cook County Department of Risk Management and the Civil Actions Bureau of the Cook County State's Attorney's Office of any claim made against the practitioner and deliver all written demands, complaints and other legal papers, received by the practitioner with respect to such claim to the Department of Risk Management.
  - (2) Cooperate with the State's Attorney's Office in the investigation and defense of any claim against the County or any practitioner, including, but not limited to, preparing for and attending depositions, hearings and trials and otherwise assisting in securing and giving evidence.
  - (3) Promptly notify the Cook County Department of Risk Management and the Civil Actions Bureau of the Cook County State's Attorney's Office of any change in the practitioner's address or telephone number.
- (d) All actions shall be defended [by] the Cook County State's Attorney. Decisions to settle indemnified claims shall be made by the County or the State's Attorney's Office, as delegated by the County, and shall not require the consent of the indemnified practitioner. If a practitioner declines representation by the State's Attorney's Office, the County shall have no obligation to defend or indemnify the practitioner.

**(Ord. No. 08-O-35, 5-20-2008;  
Ord. No. 11-O-90, 10-18-2011.)**

Sec. 38-90. - Applicability of the Cook County Code.

Except as otherwise provided herein, provisions of the Cook County Code shall apply to the System Board and the CCHHS and their Directors, officers, employees and agents. To the extent there is a conflict between the provisions of this article and any other provision in the Cook County Code, the provisions in this article shall control.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-91. - Transition.

(a) The County Board recognizes that there will be a necessary transition period between the adoption of this article and the point at which the System Board is capable of assuming all of its powers and responsibilities as set forth in this article. The Office of the President shall cooperate with the System Board during this transition to enable the System Board to assume fully its authority and responsibilities in as timely a manner as practicable. Such cooperation shall include accommodating requests from the System Board to provide adequate staffing at the CCHHS through the transfer or reassignment of personnel to the CCHHS, including, but not limited to, personnel to perform human resource and procurement/contracting functions.

(b) In order to avoid unnecessary duplication of services, the System Board, on behalf of the CCHHS, may, at its discretion, continue to utilize various ancillary services provided through the Office of the President, including, but not limited to, those services provided by the Office of Capital Planning and Policy, the Bureau of Information Technology, the Department of Risk Management, the Department of Facilities Management, the Department of Real Estate Management, the Office of the Comptroller, and the Office of the County Auditor.

(c) Any contracts entered into by the County on behalf of the Bureau of Health prior to the adoption of this article shall remain in effect; provided, however, that the System Board shall act in place of the County Board in any contract, bylaws or agreement with the County which requires the approval or other action of the County Board unless expressly prohibited otherwise in this article.



**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-92. - Severability.

Any provision of this article declared to be unconstitutional or otherwise invalid shall not impair the remaining provisions of this article.

**(Ord. No. 08-O-35, 5-20-2008.)**

Sec. 38-93. - Making CCHHS permanent.

The Cook County Health and Hospitals System and this article shall continue, unless the Cook County Board of Commissioners acts to revoke its powers and responsibilities.

**(Ord. No. 08-O-35, 5-20-2008;  
Ord. No. 10-O-30, 6-1-2010.)**

Sec. 38-94. - Quarterly reporting.

(a) The Health and Hospitals System shall report to the Board of Commissioners quarterly on the cost that the office incurs due to processing medical cases involving firearms.

**(Ord. No. 18-1750, 2-7-2018.)**

Secs. 34-95—34-108. - Reserved.

# COOK COUNTY HEALTH BOARD OF DIRECTORS

M. Hill Hammock, *Chair*  
Mary B. Richardson-Lowry, *Vice Chair*  
Hon. Dr. Dennis Deer, LCPC, CCFC  
Mary Driscoll, RN, MPH  
Ada Mary Gugenheim  
Mike Koetting  
David Ernesto Munar  
Heather M. Prendergast, MD, MS, MPH  
Robert G. Reiter, Jr.  
Layla P. Suleiman Gonzalez, PhD, JD  
Sidney A. Thomas, MSW



COOK COUNTY  
**HEALTH**