Integrated Clinical Solutions, Inc.

Cook County Health and Hospitals System

Phase II Strategic Planning: CURRENT STATE + FUTURE DIRECTION

(Progress Report for Board Retreat)

April 30, 2010

Agenda

Topics to Discuss:

- CURRENT STATE: The Case for Change
- PROPOSED SYSTEM DIRECTION
- SCENARIOS + FINANCIAL IMPACTS
- DISCUSSION
- NEXT STEPS

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- **CURRENT STATE: The Case for Change**
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A Compelling case for Change

1. There are significant unmet healthcare needs in Cook County.
2. There are large disparities in health by region.
3. In addition, there are disparities in access.
4. As need has risen, CCHHS volumes have trended downward.
5. CCHHS access points are not aligned geographically.
6. System resources are disproportionately centered around the hospital environment.
7. The System is not deploying providers and facilities effectively.
8. The current CCHHS delivery configuration is not sustainable.
9. The current cost structure is not sustainable.
10. A redirection of inefficient IP resources to OP modalities could substantially increase the volumes of services overall.

1. Significant unmet healthcare needs in Cook County…

Cook County ranked in the bottom tier for health outcomes in Illinois (81 out of 101)

Health Outcomes Snapshot: Cook County

	Cook County	Target Value*
Health Outcomes		
Mortality		
Premature death	7,701	5,694
Morbidity		
Poor or fair health	18%	9%
Poor physical health days	3.3	2.4
Poor mental health days	3.2	2.0
Low birthweight	9%	6%

* Reflects 90th percentile
Source: www.countyhealthrankings.org

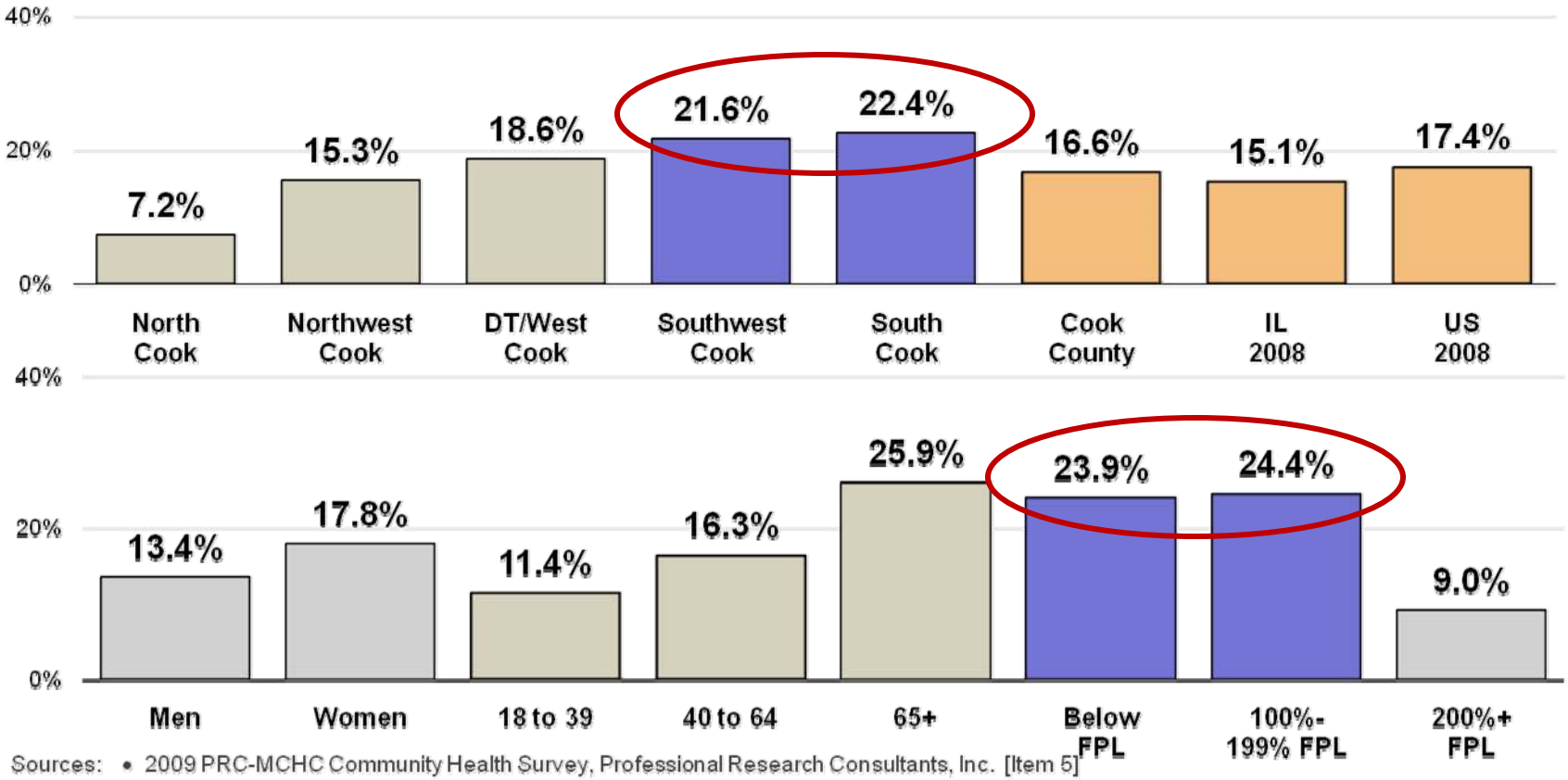
The DT/West and South Cook regions face greater health challenges

North Cook	Northwest Cook	Downtown/ West Cook	Southwest Cook	South Cook
Difficulty Accessing Healthcare (Adults & Children)	Children's Routine Medical Care	Childhood ADD/ADHD	Arthritis & Osteoporosis	Arthritis
Mold in the Home	Eye Exams	Childhood Asthma	Environmental Tobacco Smoke	Chronic Lung Disease
Routine Medical Care	HIV Testing	Children's Bicycle Helmet Usage	High Blood Cholesterol	Dental Care
	Smoking Cessation	Diabetes Management	Lack of Health Insurance Coverage	Emergency Room Utilization
		Lack of Health Insurance Coverage		Environmental Tobacco Smoke
		Prostate Screenings		Family Violence
		Seat Belt Usage		Fruit/Vegetable Consumption
				Hypertension
				Mental Health Status
				Obesity
				Perceptions of Local Healthcare
				Senior Flu Shots
				Tobacco Use
				Violent Crime

Source: 2009 PRC-MCHC Community Health Report

The highest percent of reporting "Fair or Poor" health are those in Southland communities and in the low-income cohorts

Respondents That Experience "Fair" or "Poor" Overall Health By Cook County Region

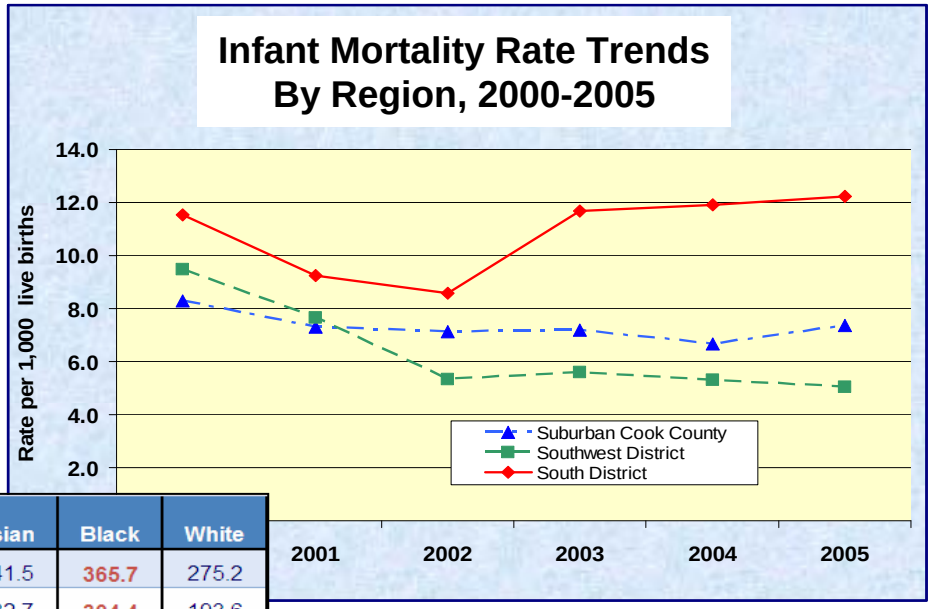


Sources:
- 2009 PRC-MCHC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
- 2008 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2008 Illinois data.

Notes:
- Asked of all respondents.

2. Large disparities in health…

Health outcomes, such as IMR and leading causes of death, demonstrate the disparities by region and race



SOURCE: CCDPH

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

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

SOURCE: CDPH RS = Rate Suppressed because the number of deaths < 21

Note: interventions to address disparities goes beyond the health system and must target the intersections between biology, behavior, and social circumstances to reduce the unequal burden

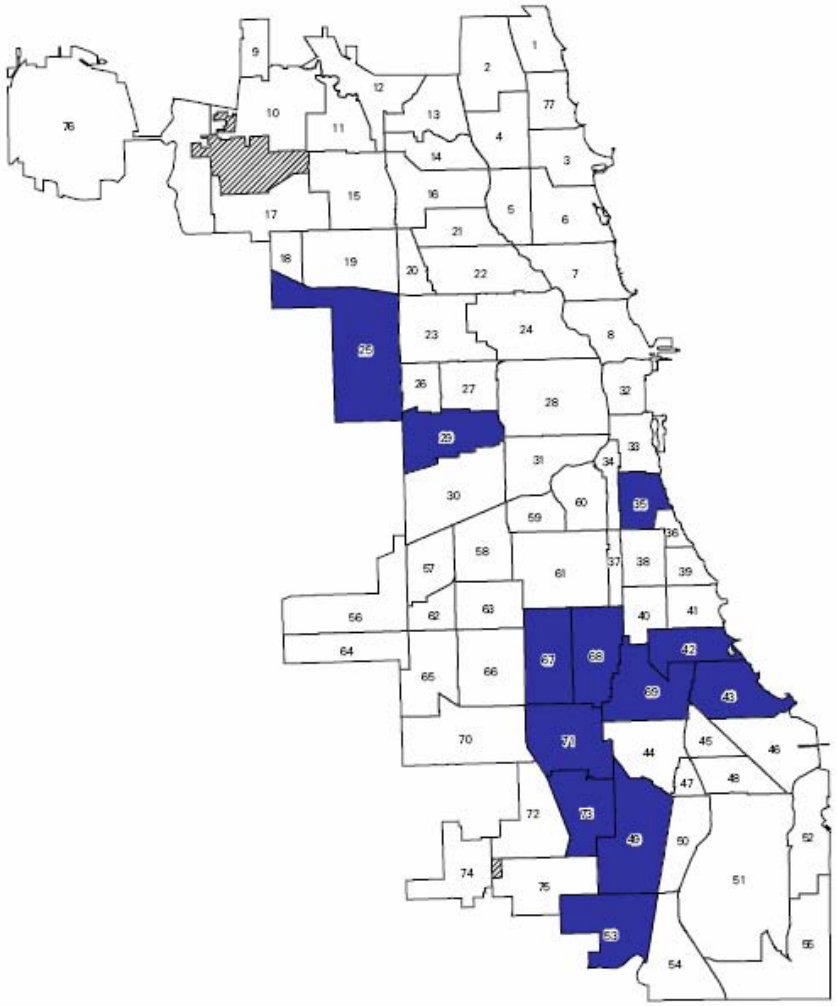
The disease burden is greater in key communities

The areas with the lowest health rankings have the fewest health resources and also where CCHHS draws the majority of its patients.

Chicago Community Areas with the Lowest Health Ranking Composite, 2004

1 – Englewood (68)
2 – West Englewood (67)
3 – Auburn Gresham (71)
4 – North Lawndale (29)
5 – West Pullman (53)
6 – Greater Grand Crossing (69)
7 – Woodlawn (42)
8 – Roseland (49)
9 – Washington Heights (73)
10 – South Shore (43)

Source: Chicago Department of Public Health



3. There are disparities in access

CCHHS access points are not aligned with the poorer parts the county, many of which have seen considerable population migration

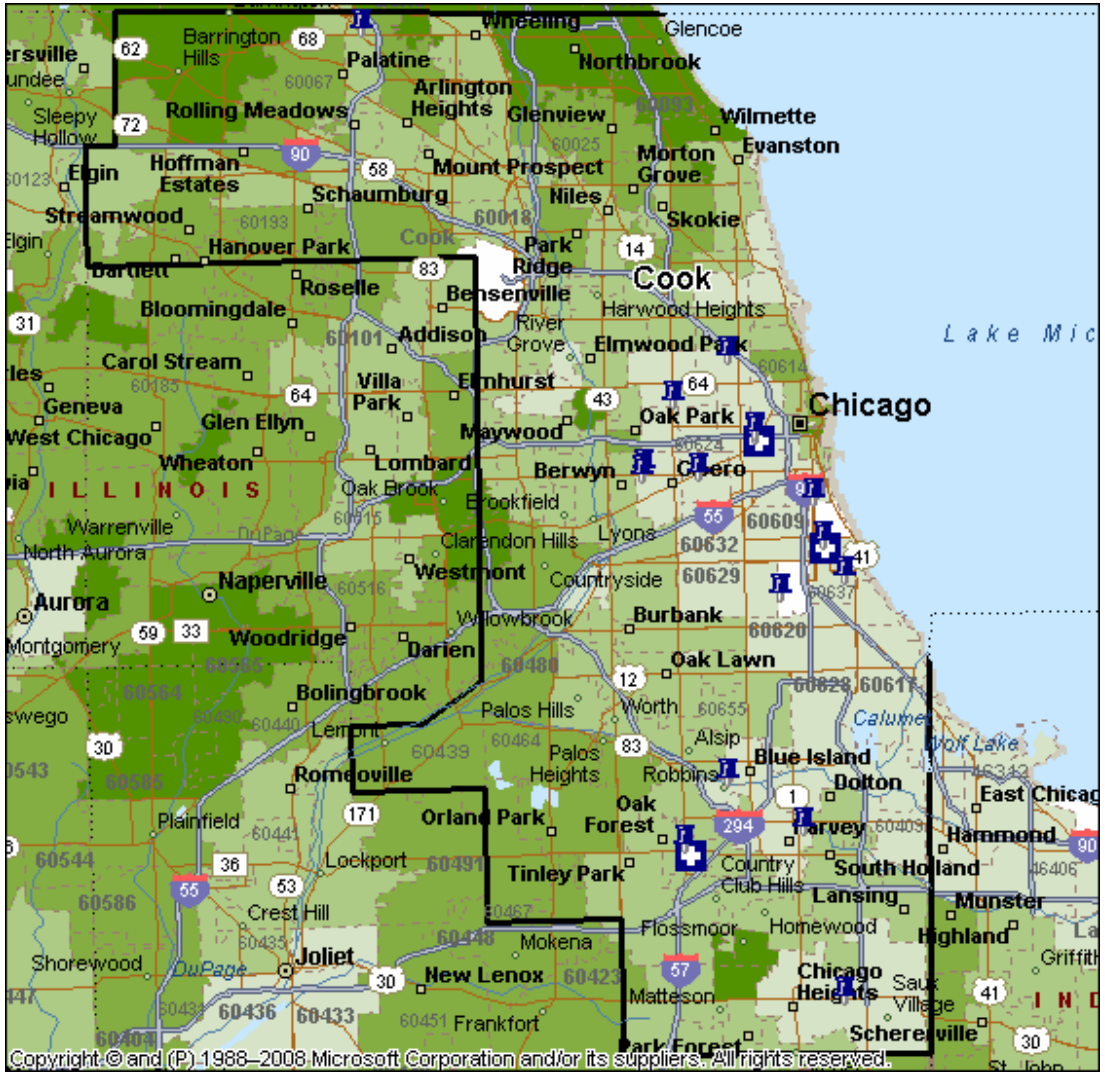
CCHHS Locations and Median Household Income by ZIP Code

ACHN Locations

Hospitals

Median HH Income (2007)

- $100,000 to $500,000
- $75,000 to $99,999
- $50,000 to $74,999
- $25,000 to $49,999
- $0 to $24,999



Sources: CCHHS; Microsoft MapPoint data

The south/southwest parts of the county clearly have gaps in primary care access points

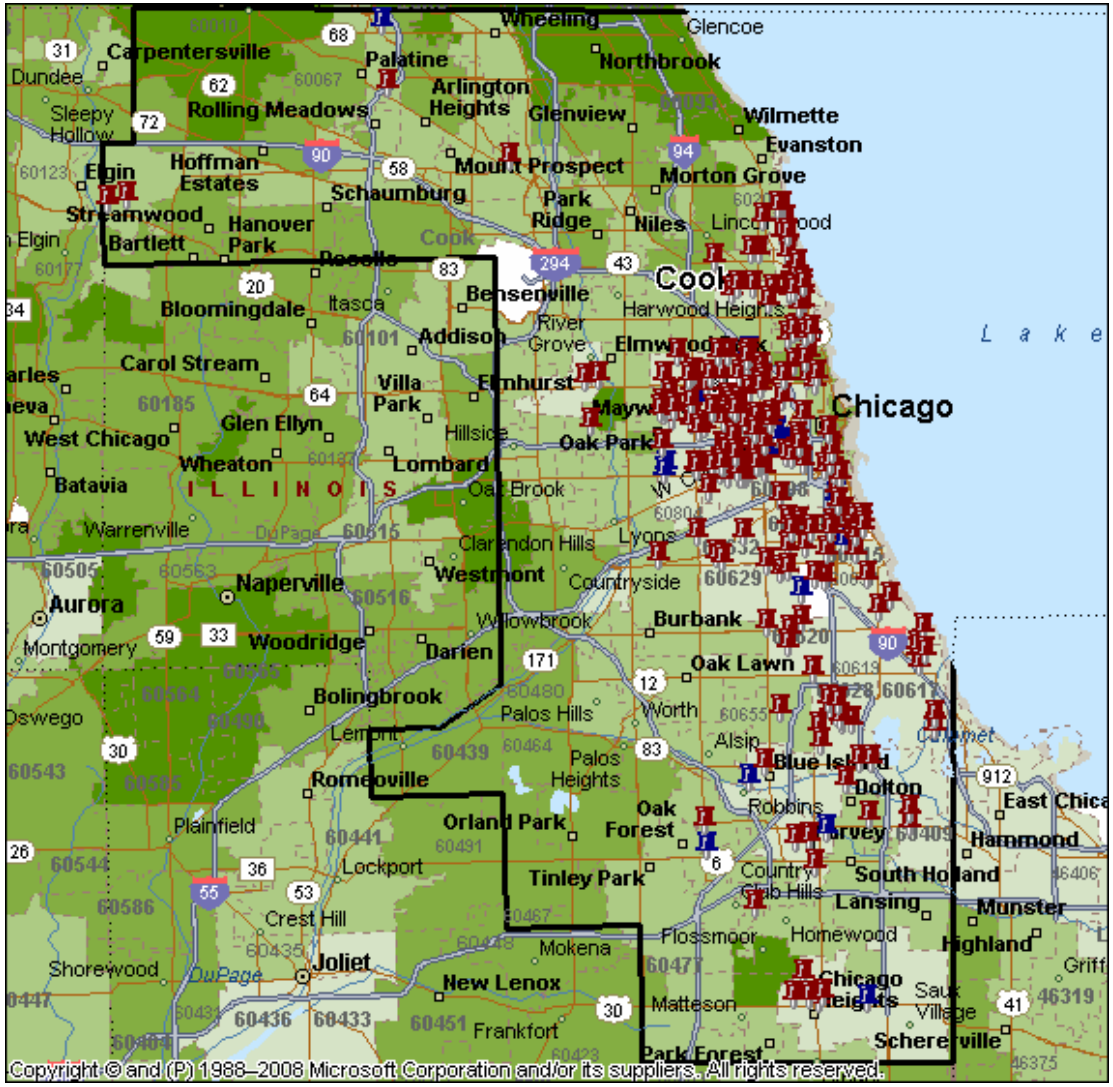
Overlaying FQHC/CHC locations displays the relative lack of primary care facilities in the poorer Southern regions.

FQHC/CHC Locations and Median Household Income by ZIP Code

- FQHC/CHC Locations
- ACHN Locations

Median HH Income (2007)

- $100,000 to $500,000
- $75,000 to $99,999
- $50,000 to $74,999
- $25,000 to $49,999
- $0 to $24,999

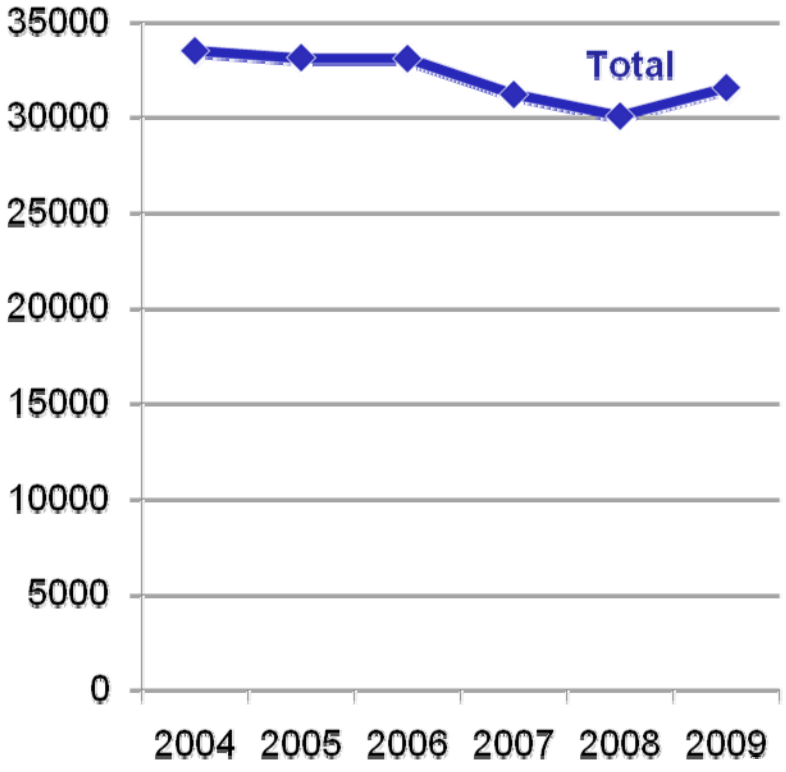


Sources: CCHHS; Microsoft MapPoint data; Illinois Primary Healthcare Association

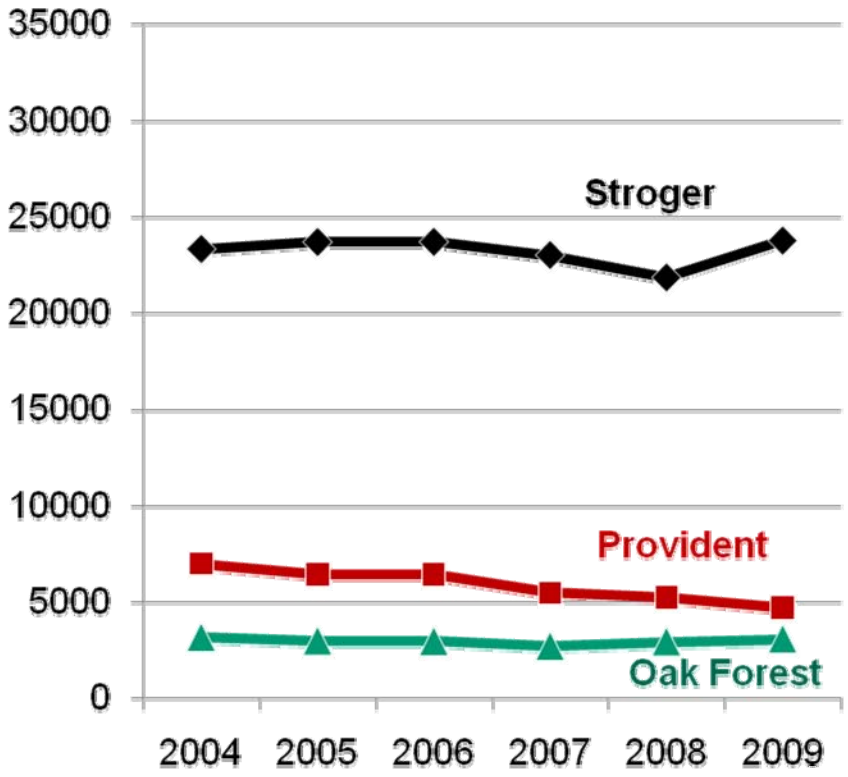
4. In a time of rising need, CCHHS volumes have trended downward, although 2009 has showed some sign of reversal

While healthcare needs in the County have grown, budget cuts have contributed to a decline in CCHHS inpatient and outpatient activity over the last five years.

Trended IP Discharges



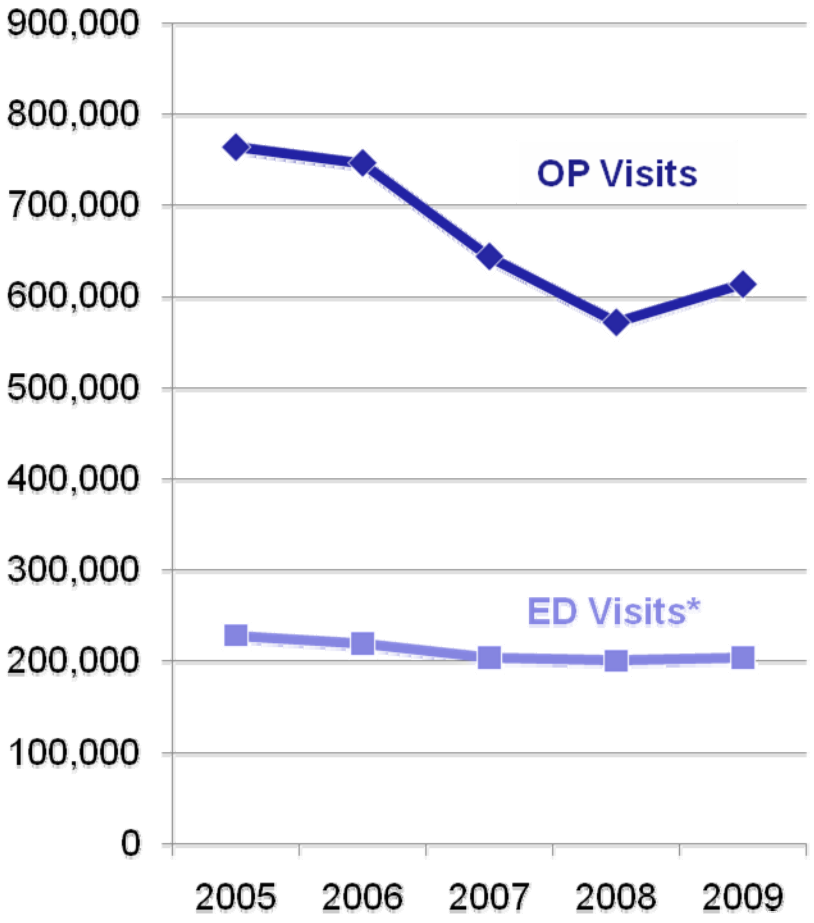
Trended IP Discharges by Site



Source: CCHHS

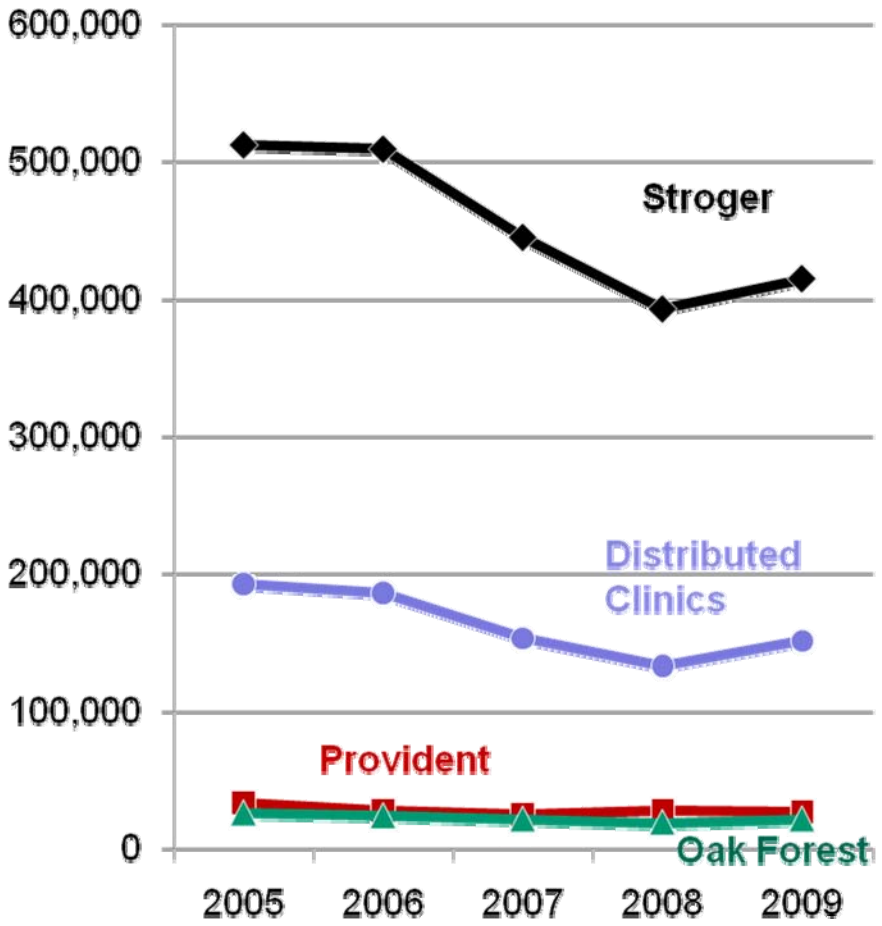
OP activity has also seen a considerable decline over the last five years, primarily due to budget cuts and related staffing reductions

Trended OP and ER Visits



* Excludes Trauma
Source: CCHHS

Trended OP Visits by Site



5. CCHHS access points are not aligned geographically

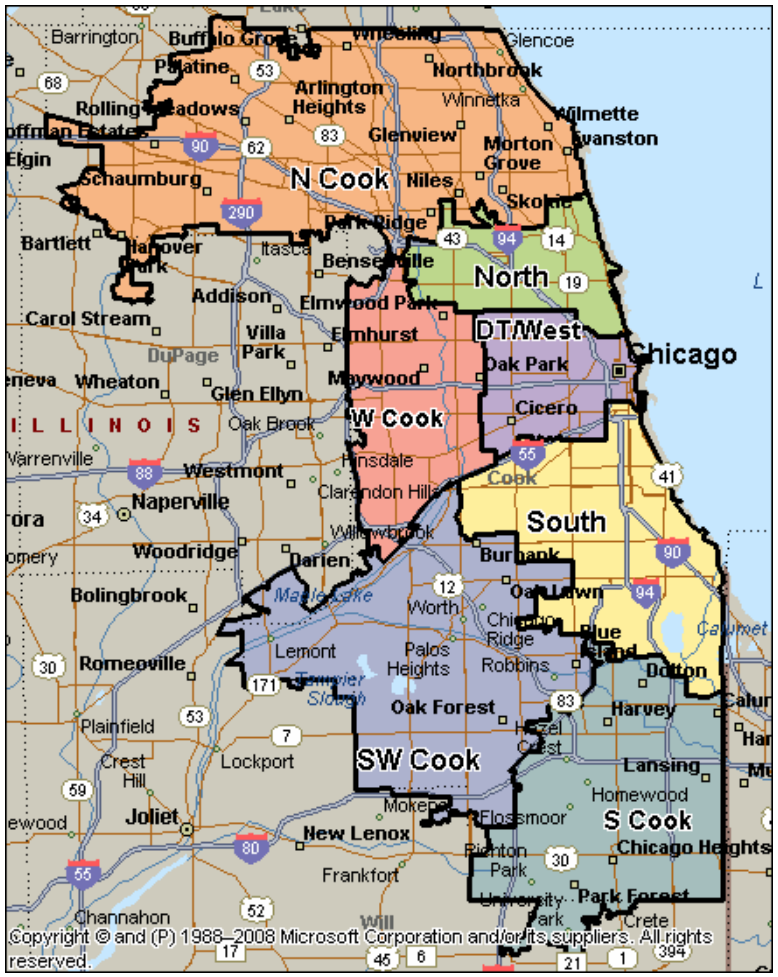
There has been a significant geographic redistribution of the vulnerable population over the past 20+ years, with significant shifts to:

- South/South Cook
- Downtown/West
- North Cook

Population (2007) by Region

Region	Population
North	918,942
DT/West	898,509
South	1,116,319
N Cook	981,695
W Cook	444,107
S Cook	398,037
SW Cook	484,294
TOTAL	**5,241,903**

Source: MapPoint Population data



Over 60% of CCHHS' clinical activity comes from patients residing in the South and Downtown/West regions

CCHHS Clinical Activity by Region, 2008

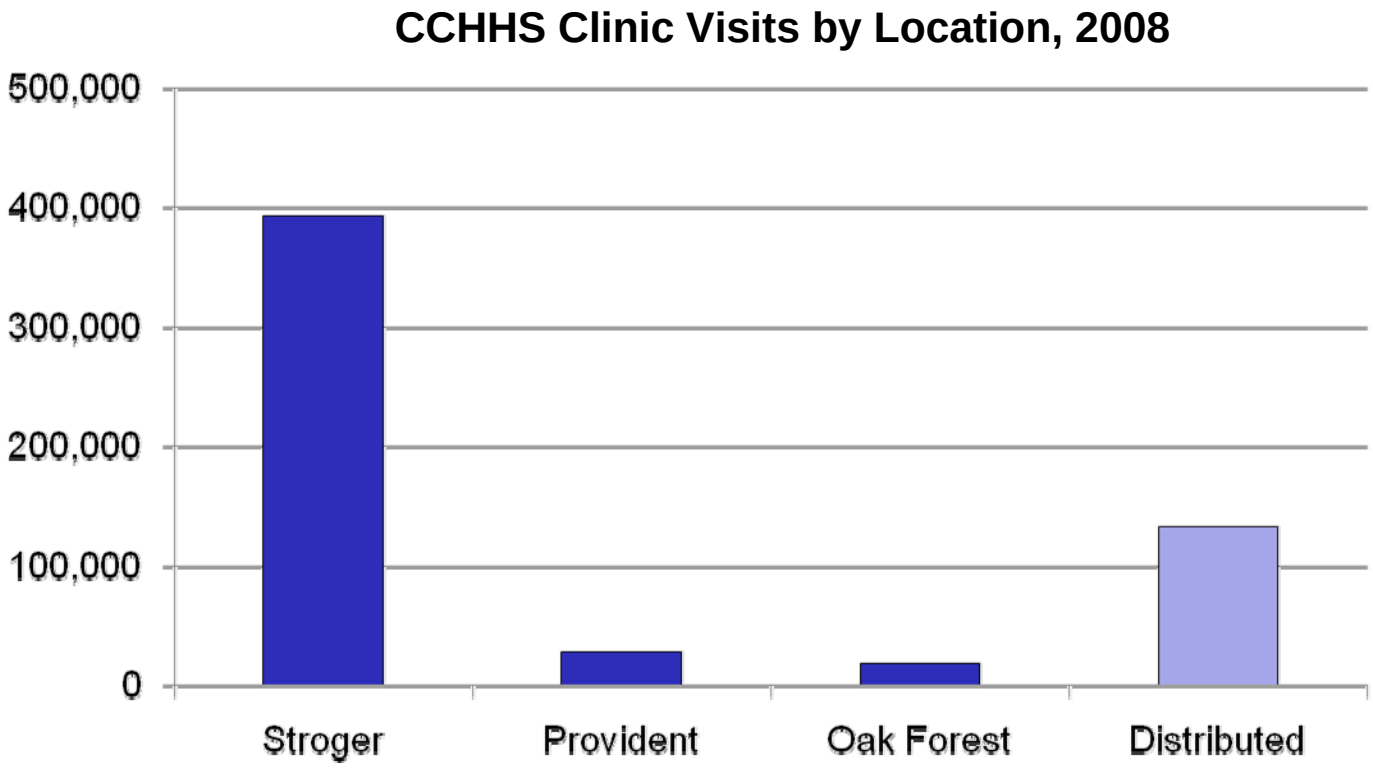
Region	Population	ACHN Visits	ED Visits	IP Dischgs	OP Surgeries	Existing ACHN Locations
South	1,116,319	249,137	71,001	13,809	3,195	3 PC and 1 Spec. Care
DT/West	898,509	183,579	45,603	8,685	1,757	6 PC and 1 Spec. Care
North	918,942	78,110	14,077	3,033	1,170	No Locations
S Cook	398,037	48,398	16,709	2,205	620	2 PC Sites
N Cook	981,695	35,244	3,341	976	396	1 PC Site
W Cook	444,107	32,687	5,817	1,190	437	No Locations
SW Cook	484,294	28,827	9,925	1,336	430	1 PC and 1 Spec. Care
Other/NA		22,678	7,945	436	450	
TOTAL	**5,241,903**	**678,660**	**174,418**	**31,670**	**8,455**	

Region	Population	ACHN Visits	ED Visits	IP Dischgs	OP Surgeries	Existing ACHN Locations
South	21%	37%	41%	44%	38%	3 PC and 1 Spec. Care
DT/West	17%	27%	26%	27%	21%	6 PC and 1 Spec. Care
North	18%	12%	8%	10%	14%	No Locations
S Cook	8%	7%	10%	7%	7%	2 PC Sites
N Cook	19%	5%	2%	3%	5%	1 PC Site
W Cook	8%	5%	3%	4%	5%	No Locations
SW Cook	9%	4%	6%	4%	5%	1 PC and 1 Spec. Care
Other/NA		3%	5%	1%	5%	
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**	

Source: CCHHS Experian database

6. System resources are disproportionately centered around the hospital environment…

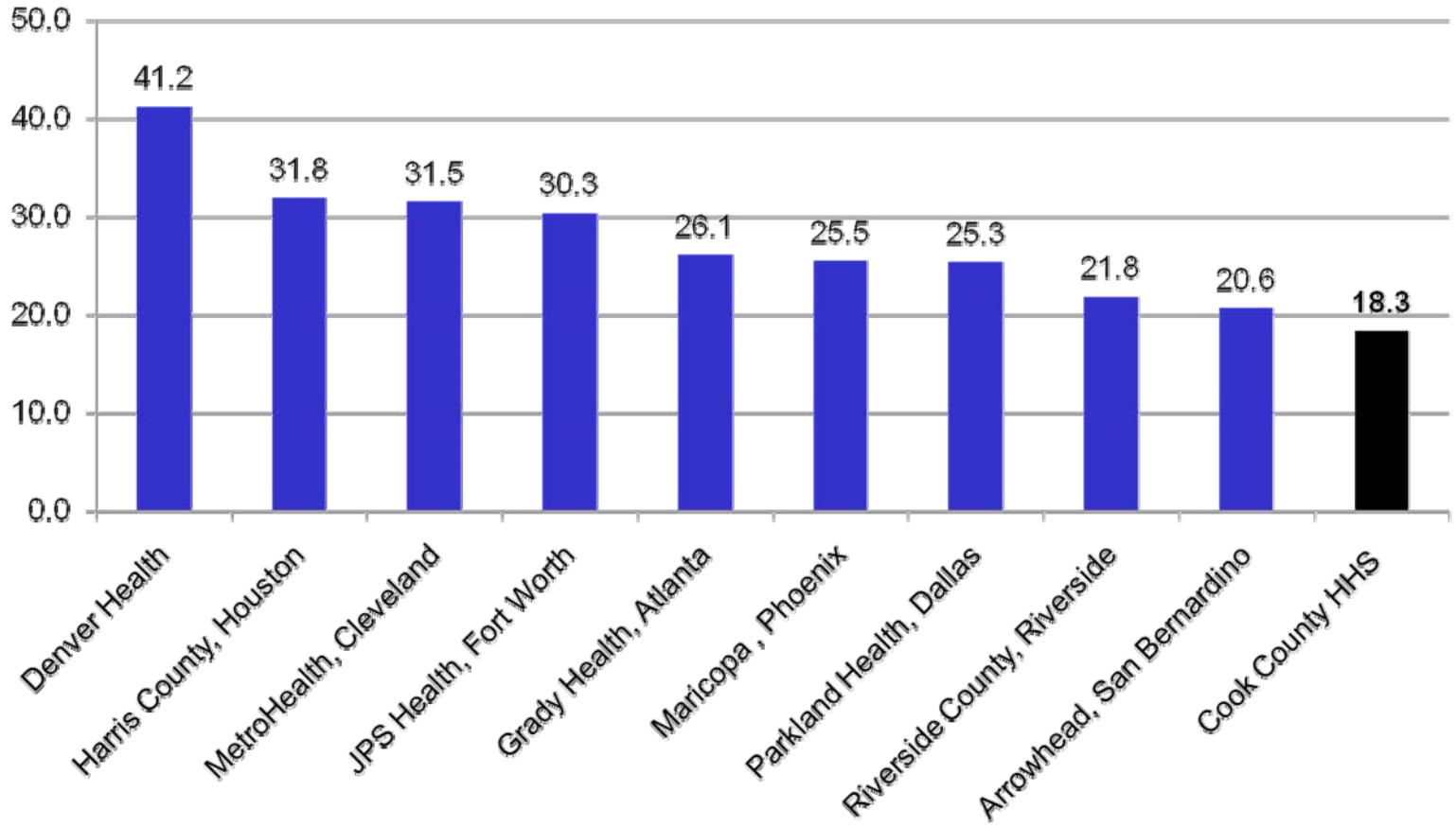
CCHHS has devoted considerable resources at the John H. Stroger, Jr. Hospital campus for outpatient care, contributing to congestion, backlogs, and patient dissatisfaction.



Source: CCHHS

…and fewer resources are devoted to outpatient care in general, compared to other public health systems

Ratio of OP Visits to IP Discharges, 2008

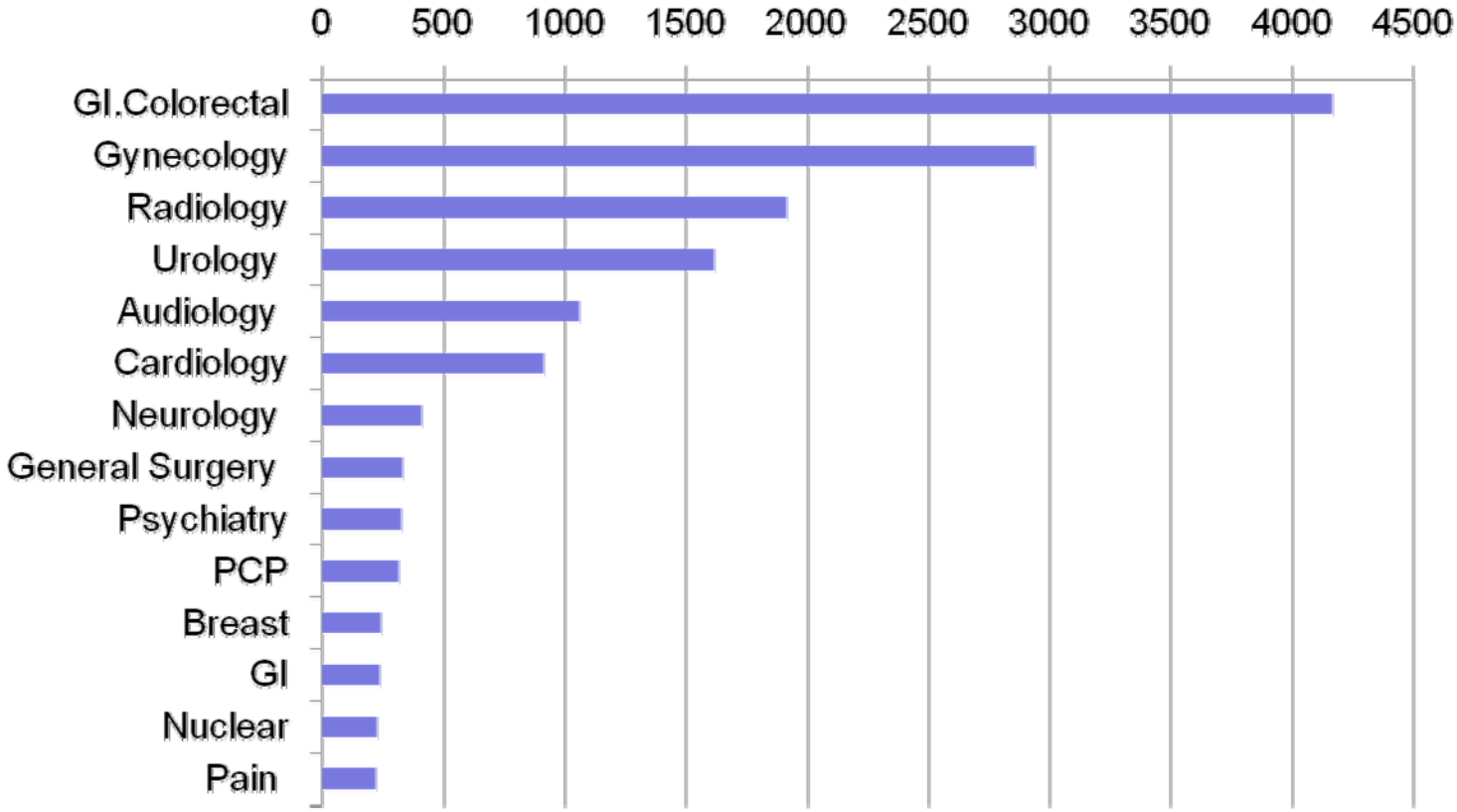


Source: Data from "America's Public Hospitals and Health Systems, 2008", Results of the Annual NAPH Hospital Characteristics Survey, February 2010

7. The System has not deployed providers and facilities effectively…

There is a substantial backlog for procedural and other services

Specialties and Associated Clinics,
IRIS Referrals Greater Than 21 Days Old (as of Feb. 2010)

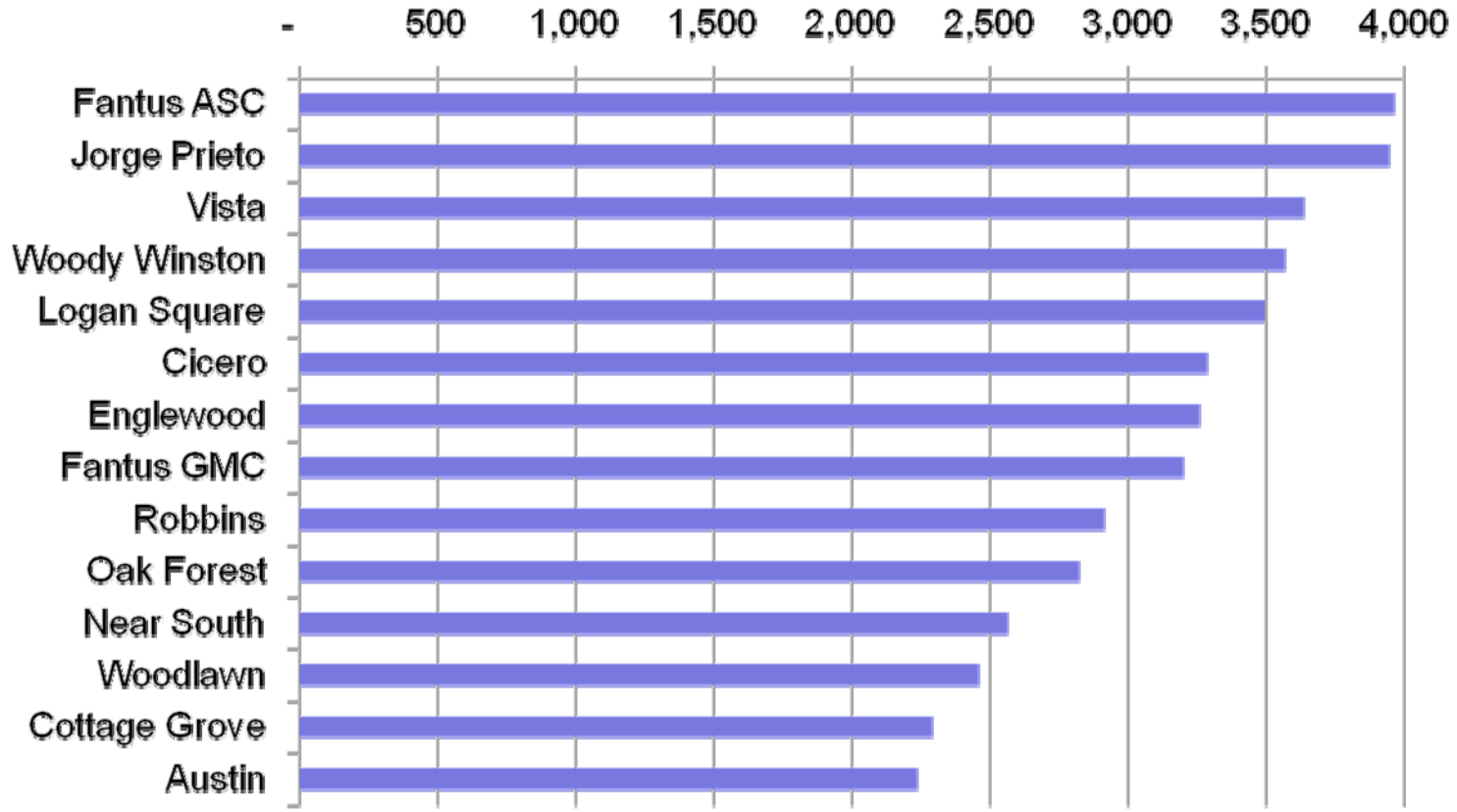


Source: IRIS, CCHHS

Backlog and productivity issues highlight need for stronger outpatient capability and performance

Primary care productivity varies greatly by location, which is sometimes a function of the availability of support staff

Visits per Provider FTE by ACHN Clinic, 2009



Source: CCHHS

8. Current CCHHS delivery configuration is not sustainable

Health care reform…how will it impact CCHHS?

Market Impacts

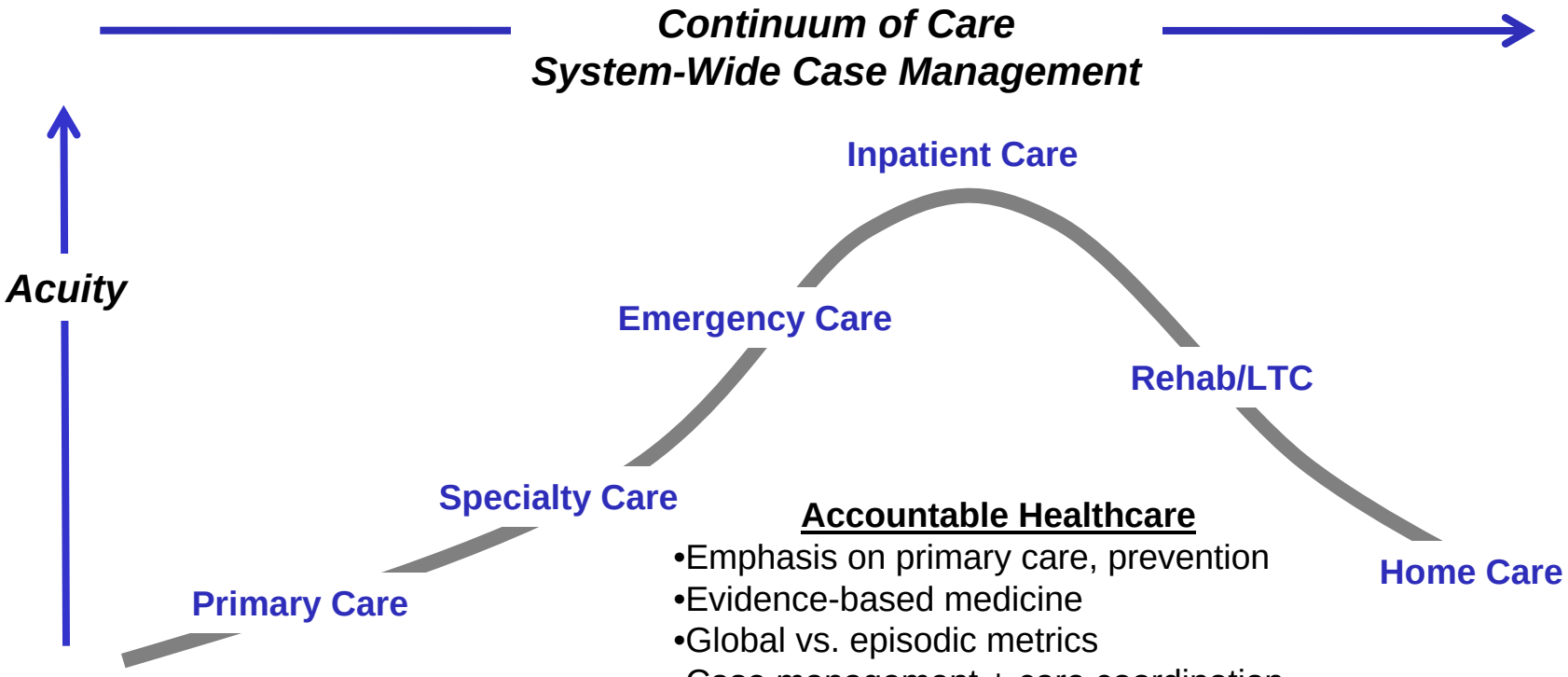
- ✓ Fewer un-/underinsured
- ✓ Medicaid expansion
- ✓ More healthcare $$
- ✓ Increased demand for healthcare
- ✓ More "choice-enabled" patients

CCHHS Impacts

- ✓ Substantial #'s remain uncovered
- ✓ DSH cuts + state freezes
- ✓ Declining special payments & subsidy revenues
- ✓ Growing volumes, esp. OP care
- ✓ Higher consumer expectations

Health reform will emphasize accountability for healthcare across the delivery spectrum

The future-state evolution of health care will place increased emphasis on the non-acute/outpatient spectrum of care…

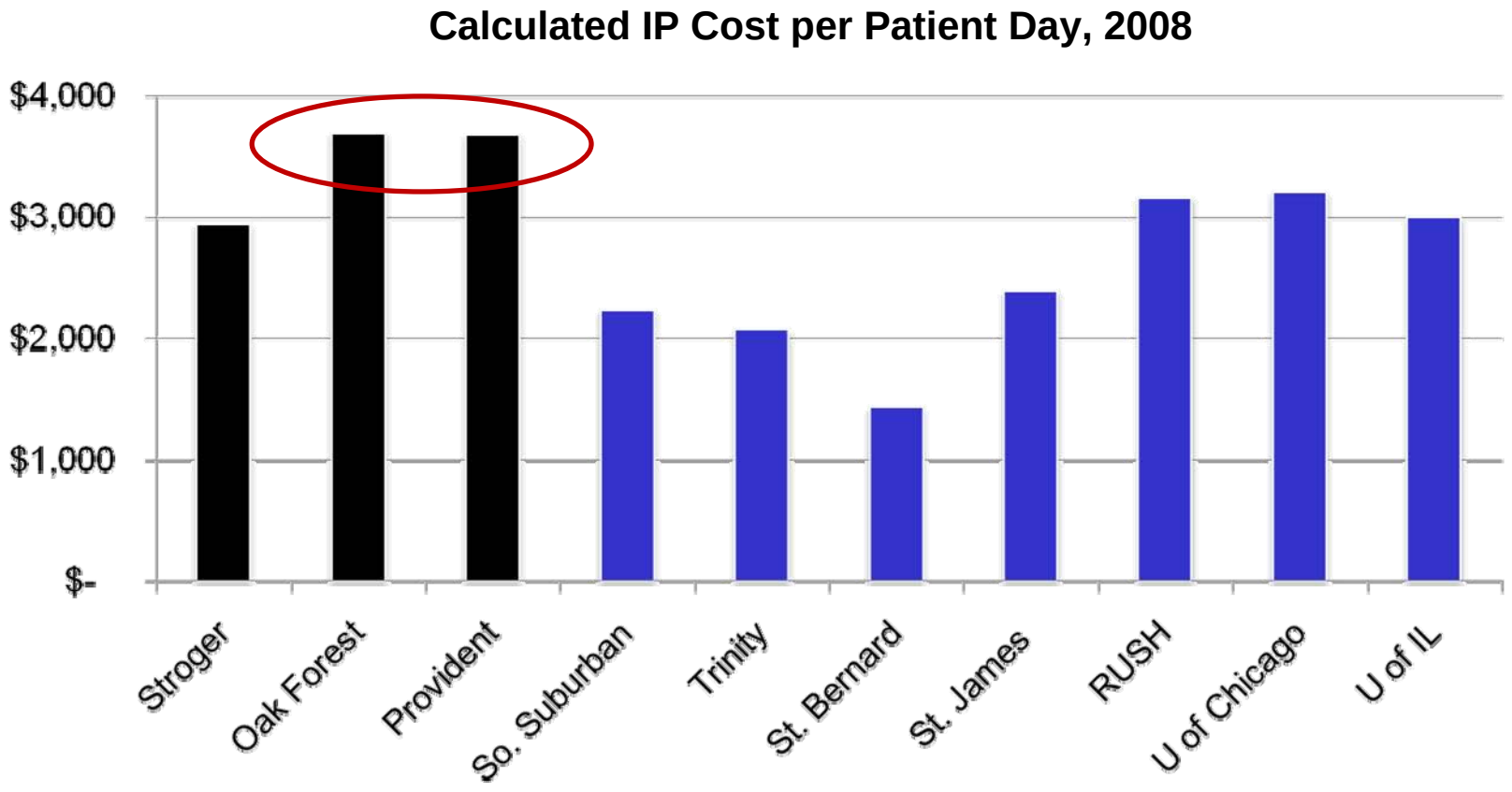


Accountable Healthcare

- Emphasis on primary care, prevention
- Evidence-based medicine
- Global vs. episodic metrics
- Case management + care coordination
- Integrated patient records
- Medical home as patient focal point
- High consumer expectations

9. The current cost structure is not sustainable

Provident and Oak Forest Hospitals have a much higher IP cost per patient day, even when compared to area teaching hospitals



Source: Mike Koetting analysis

Maintaining the current hospital-centered model will continue to demand substantial subsidy requirements, while Cook County contributions are declining

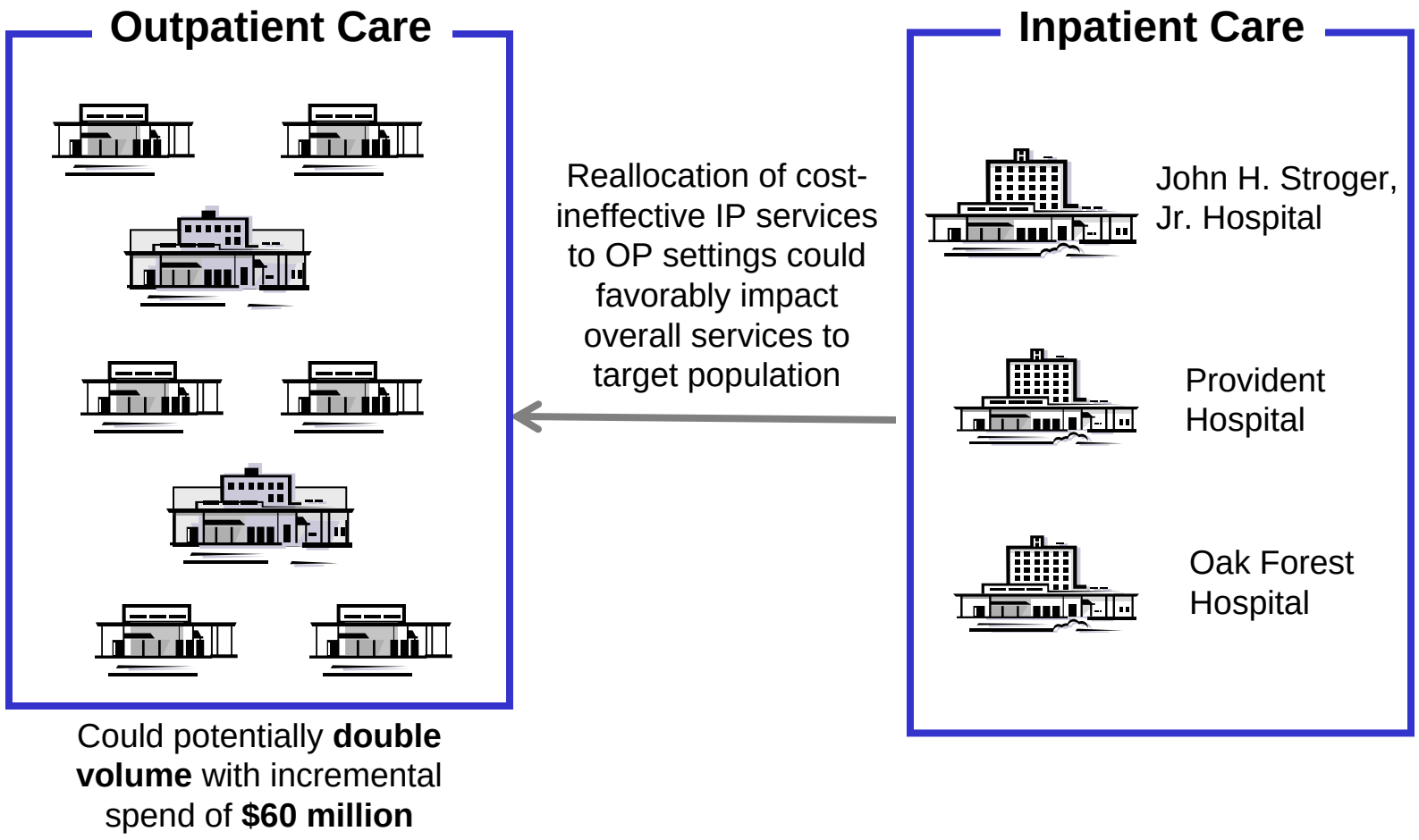
Forecasted CCHHS Pro Forma – Momentum Scenario

Hospital Centered Model - Maintain Inpatient Platform								
	Actual (UA)	Budget	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
	2009	2010	2010	2011	2012	2013	2014	2015
Operating Revenue								
Patient Service Revenue	$ 237,988	$ 259,000	$ 219,000	$ 266,770	$ 274,773	$ 283,016	$ 291,507	$ 300,252
FMAP	35,785	38,582	38,582	39,000	-			
Inter-Governmental Transfers (IGT)	131,300	131,250	131,250	131,250	131,250	131,250	131,250	131,250
NetDSH	258,316	150,000	150,000	150,000	150,000	150,000	150,000	150,000
Other revenue	7,290	3,569	3,569	3,676	3,786	3,900	4,017	4,137
Total operating revenue	670,678	582,401	542,401	590,696	559,809	568,166	576,774	585,639
Operating expenses								
Salaries and wages	527,596	*515,000*	*515,000*	560,835	577,660	594,990	612,840	631,225
Supplies	157,716	*160,000*	*160,000*	167,652	172,682	177,862	183,198	188,694
Purchased services, rental and other	159,290	*175,000*	*175,000*	169,325	174,405	179,637	185,026	190,577
Utilities	15,749	*18,000*	*18,000*	16,742	17,244	17,761	18,294	18,843
Total operating expenses	860,352	868,000	868,000	914,554	941,991	970,250	999,358	1,029,339
Operating Loss (before initiatives)	**(189,673)**	**(285,599)**	**(325,599)**	**(323,858)**	**(382,181)**	**(402,084)**	**(422,584)**	**(443,699)**
Performance Improvement								
Revenue Cycle			Work in Process					
Productivity								
Supply Chain								
Other								
Total performance improvement	-	-	-	-	-	-	-	-
Net Loss (required subsidy)	**$ (189,673)**	**$ (285,599)**	**$ (325,599)**	**$ (323,858)**	**$ (382,181)**	**$ (402,084)**	**$ (422,584)**	**$ (443,699)**

Source: ICS analysis

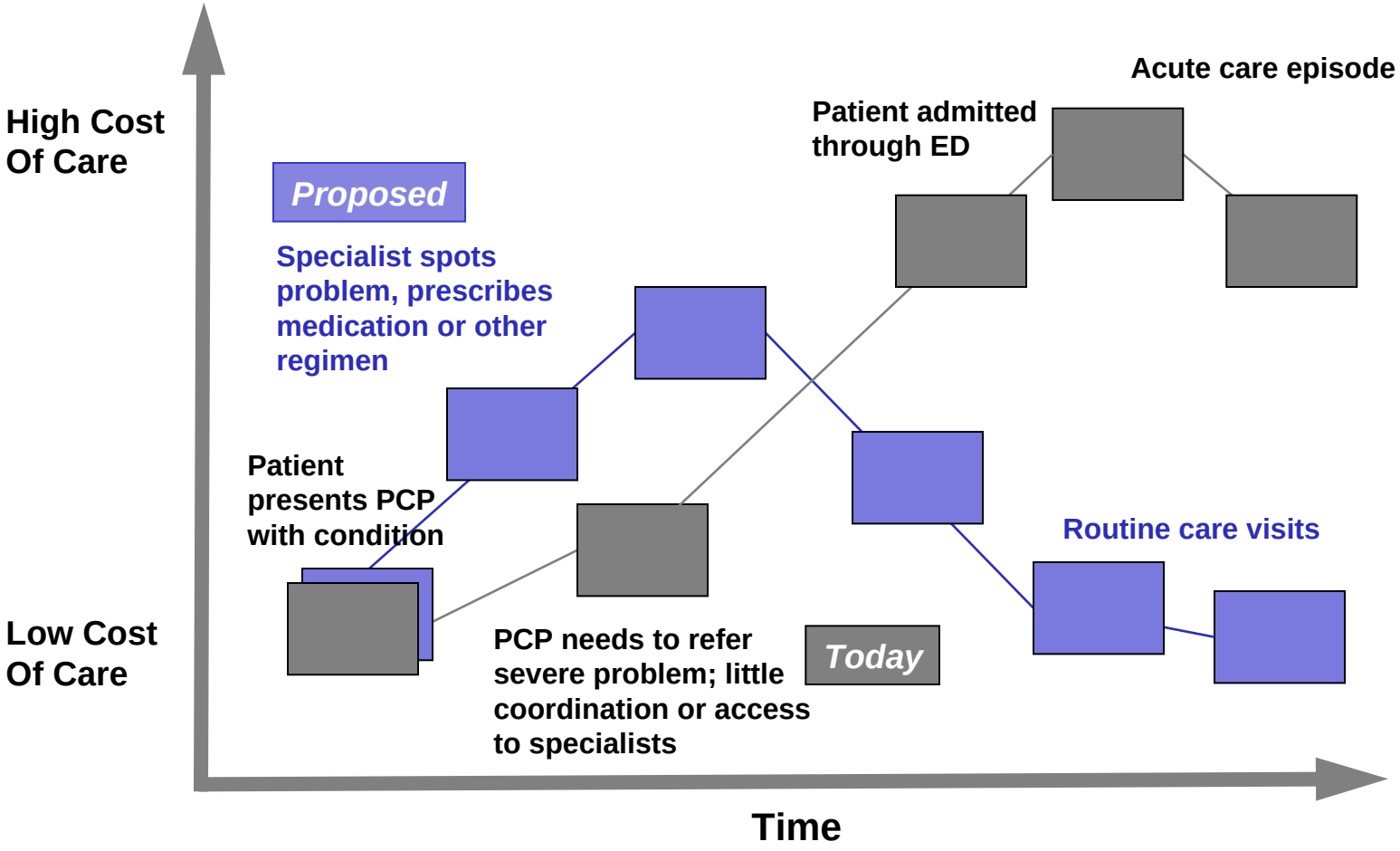
10. Redirection of inefficient IP resources to OP modalities could substantially increase the volumes of services overall

A portion of reallocated capital can support substantial outpatient expansion.



Primary care and specialty access, along with the related process of getting the patient down an appropriate care path, will be key to managing cost and quality

Adequate access to primary care and specialty care is key to managing cost and quality…



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Strategic Plan: VISION 2015

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 which promote and protect the physical, mental and social well being of the people of Cook County.

Vision 2015

In support of its public health mission, CCHHS 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 healthcare system focused on assuring high-quality care and improving the health of the residents of Cook County.

Core Goals	Strategic Initiatives
I. Access to Healthcare Services	• Eliminate System access barriers at all delivery sites. • Designate and develop 3-5 regional delivery sites for provision of comprehensive outpatient services. • Rebuild Fantus Clinic and expand parking capacity; evaluate optimal long-term development of Provident, Oak Forest, and ACHN sites.
II. Quality, Service Excellence & Cultural Competence	• Develop an integrated, System-wide approach and supportive infra-structure for patient-centered care coordination. • Implement a System-wide program of continuous process improvement: patient care quality, safety, and outcomes. • Develop a comprehensive program to instill cultural competency.
III. Service Line Strength	• Develop/strengthen clinical service lines in needs-based areas such as cancer, cardiac, diabetes, emergency/trauma, burn, HIV/AIDS, rehabilitation and surgery; evaluate optimal development of OB, pediatrics, neonatal care. • Pursue mutually beneficial partnerships with community providers. • Assure the provision of the Ten Essentials of Public Health.
IV. Staff Development	• Implement a full range of initiatives to improve caregiver/employee satisfaction. • Focus on effective recruiting and retention processes. • Develop a robust program for in-service education and professional skill building.
V. Leadership & Stewardship	• Foster leadership development and succession planning. • Develop long-term financial plans and sustaining funding. • Hold Board and management leadership accountable to agreed-upon performance targets.

Conceptual Framework for System Design

Overarching Goal:

Provide the best possible health care for the vulnerable population of Cook County within the constraints of dollar resources available to the System.

Key System Design Principles

- Accessible Care
  - Most-needed services are readily accessible to target populations
  - Ease of entry and navigation
- Accountable Care
  - Best practices, outcomes on System-wide basis
  - Integrated, patient-centered care with appropriate follow-up and continuity
  - High patient and caregiver satisfaction levels
- Cost-Effective Care
  - Efficient processes
  - Optimal use of System resources

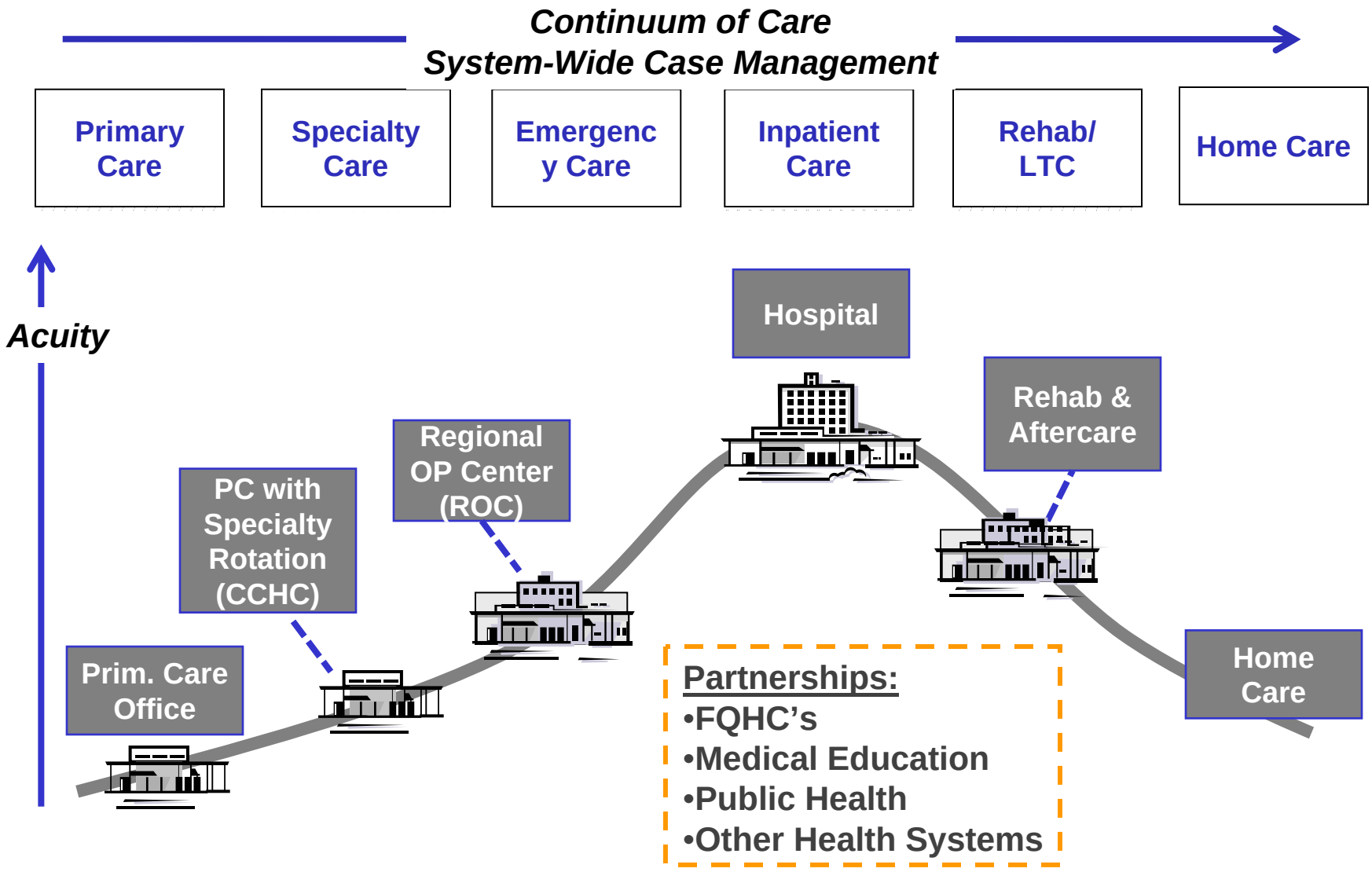
Corollary Design Principles

- Population-Centered vs. Hospital-Centered
  - Accountability to population served
  - Needs-driven vs. institutionally-driven
- Responsible Stewardship
  - Best/highest-impact use of finite resources
  - Importance of partnerships to complement System capabilities

System Design— Old vs. New

Current State HOSPITAL-CENTERED MODEL	Future State POPULATION-CENTERED MODEL
■ Resources are focused largely on inpatient care services. ■ Existing hospital campuses are principal delivery sites.	■ Resources are reallocated to emphasize broad spectrum of health care delivery. ■ Resources are located in geographic settings accessible to population segments having the greatest needs.

Population-Centered Model Assumes Accountability Across the Care Spectrum…



A population-centered System would locate major assets where the needs concentration is greatest…

Regional Outpatient Centers (ROC's)

Two strategically-located ROC's include:

- Primary Care/Prevention/Screening
- Multi-specialty Care
- Urgent Care
- Mental Health
- Oral Health
- Outpatient Surgery
- Imaging
- Pharmacy
- Public Health
- Heath Education/Community Rooms

Comprehensive Community Health Centers (CCHC's)

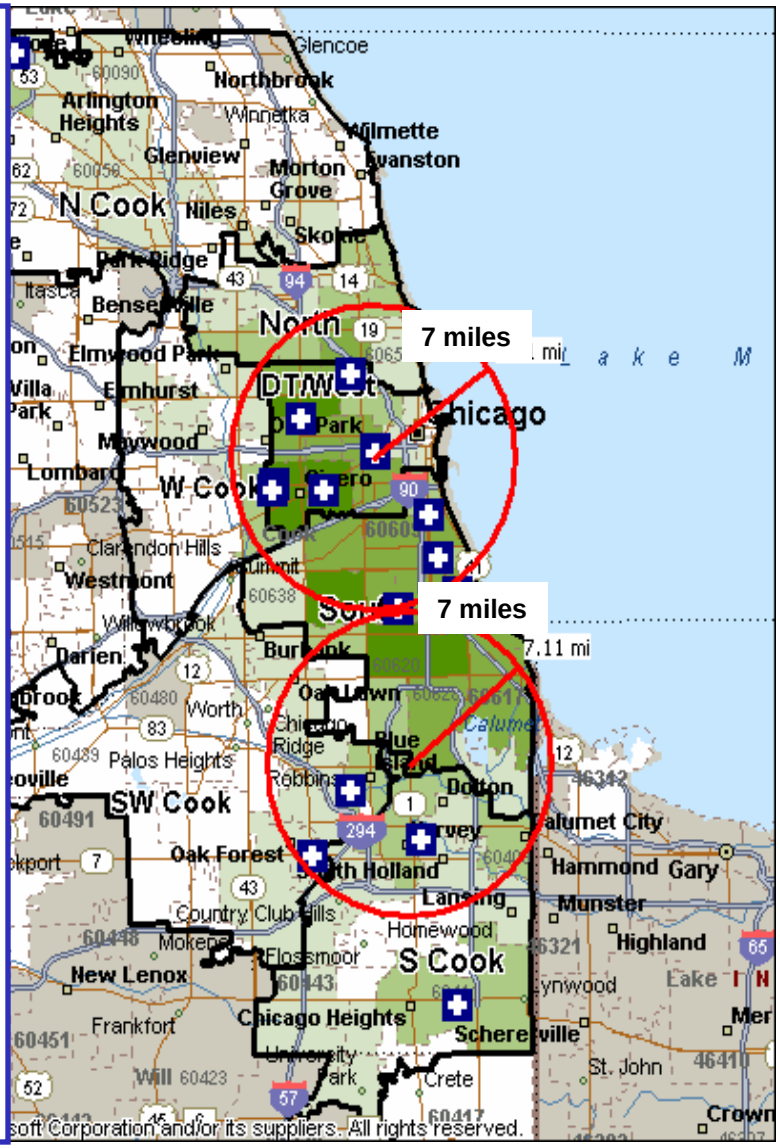
OFH, PH, and selected ACHN clinic sites include:

•Primary Care
•Urgent Care
•Rotating Specialists
•Basic D&T

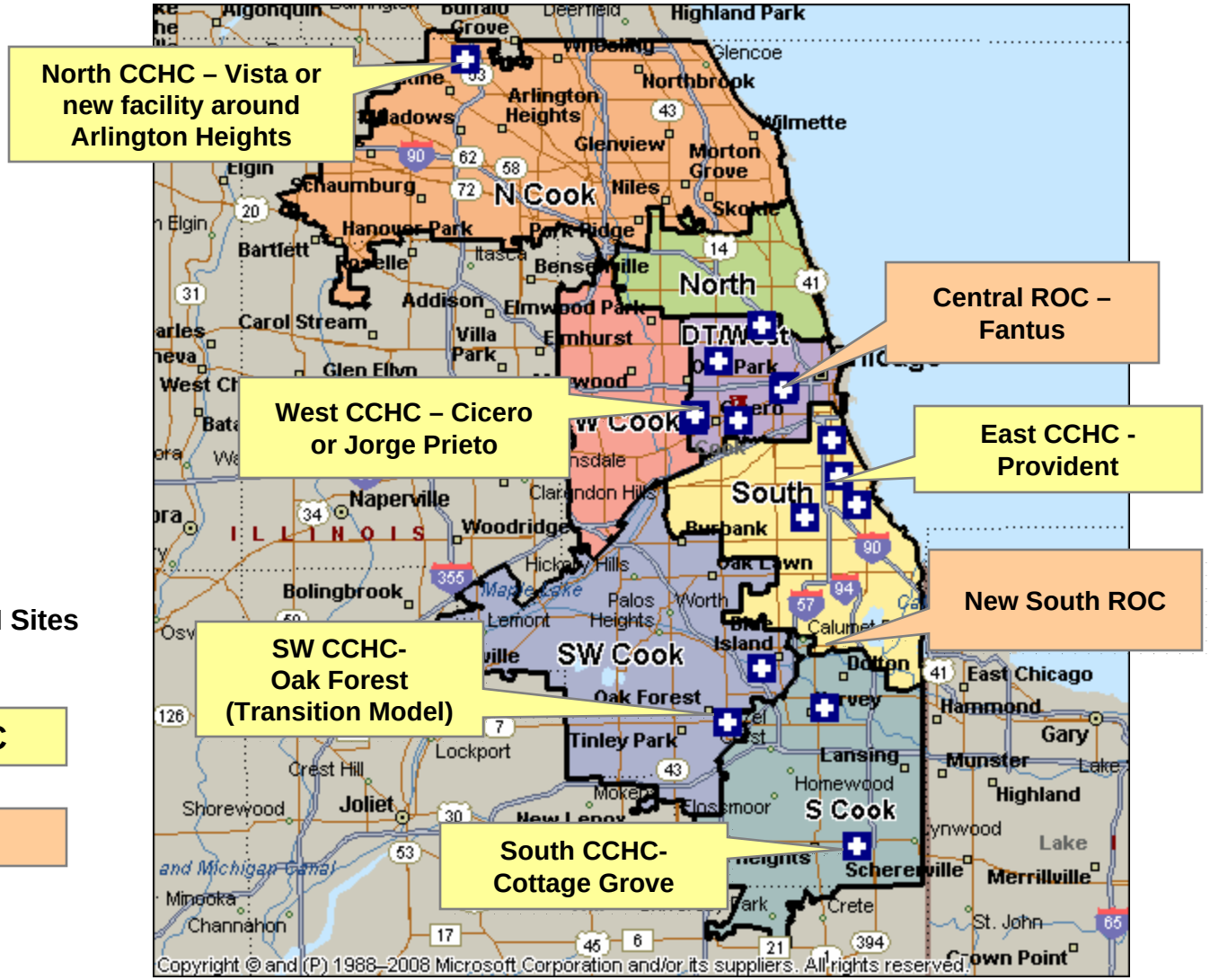
Trauma/Acute Care→ JHSJH is strengthened through development of key service lines; defined relationships with community hospitals to complement bed capacities as needed

Rehabilitation Care→ Developed as System resource or through partnerships

Care Integration→ Care is coordinated and integrated across the System and with partnering provider organizations

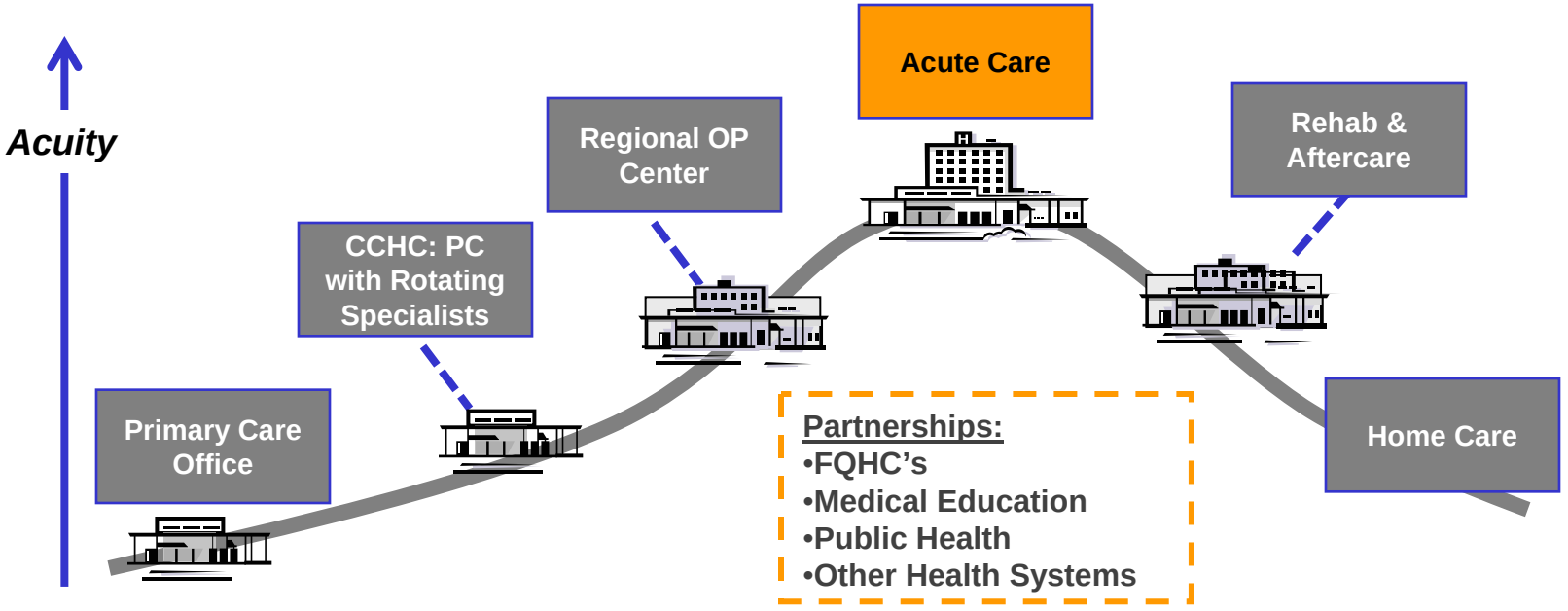


Proposed CCHHS outpatient locations



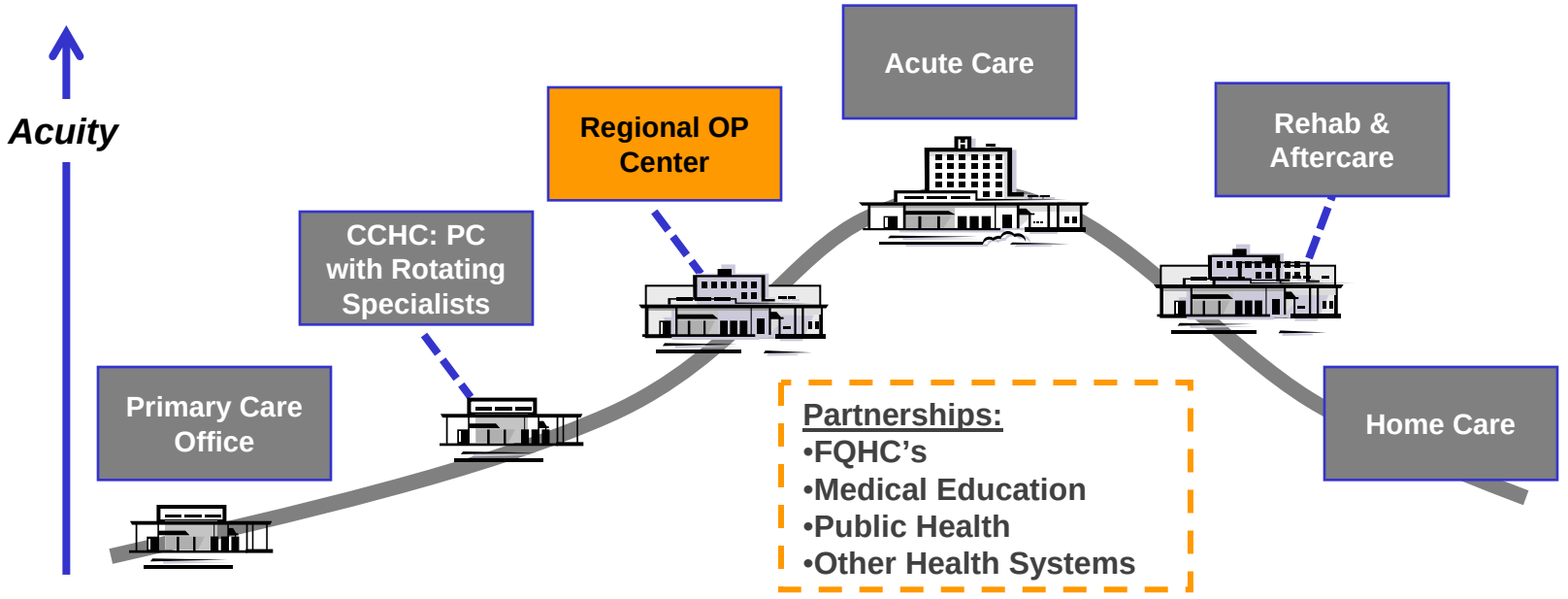
Executive Summary—Proposed System Design Overview

- **Acute Care:**
  - Continue to strengthen JHSJH through enhancement of key service lines, reduced length-of-stay/capacity utilization, capital equipment, parking, etc.
  - Evaluate possible scenarios and best-case approaches for realignment of Oak Forest and Provident hospitals, consistent with overall System direction.
  - Evaluate potential partnerships with community health system(s) for utilization of available bed capacities as needed.



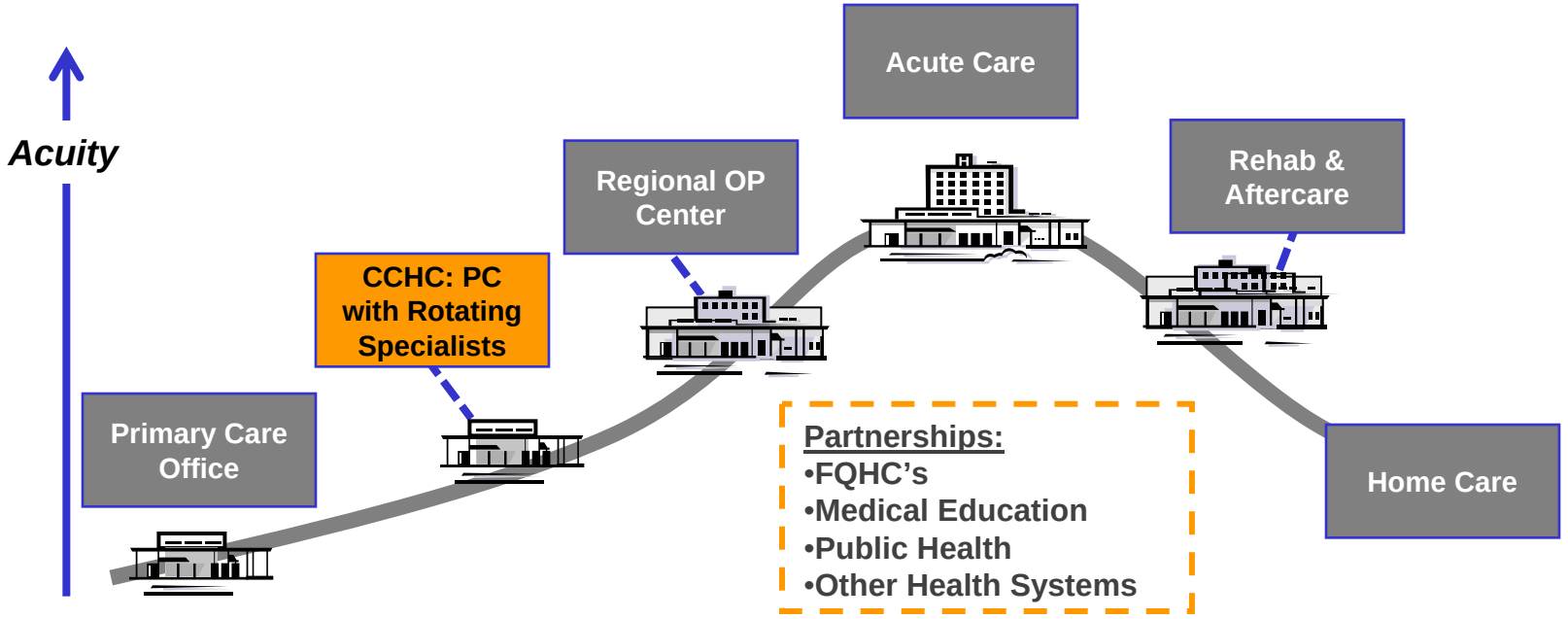
Executive Summary—Proposed System Design Overview

- **Regional Outpatient Centers:**
  - Develop Regional Outpatient Centers (ROC's) that are accessible to geographic areas with greatest needs—South & DT/West/North regions.
  - Develop/acquire new, geographically accessible site as location for South region ROC (possibly in conjunction with existing health facility).
  - Redevelop Fantus as ROC serving DT/West/North community areas.
  - Formalize referral relationships with FQHC's to provide FQHC patients with needed specialty services at ROC sites, with CCHHS being a preferred partner for inpatient care and other System services.



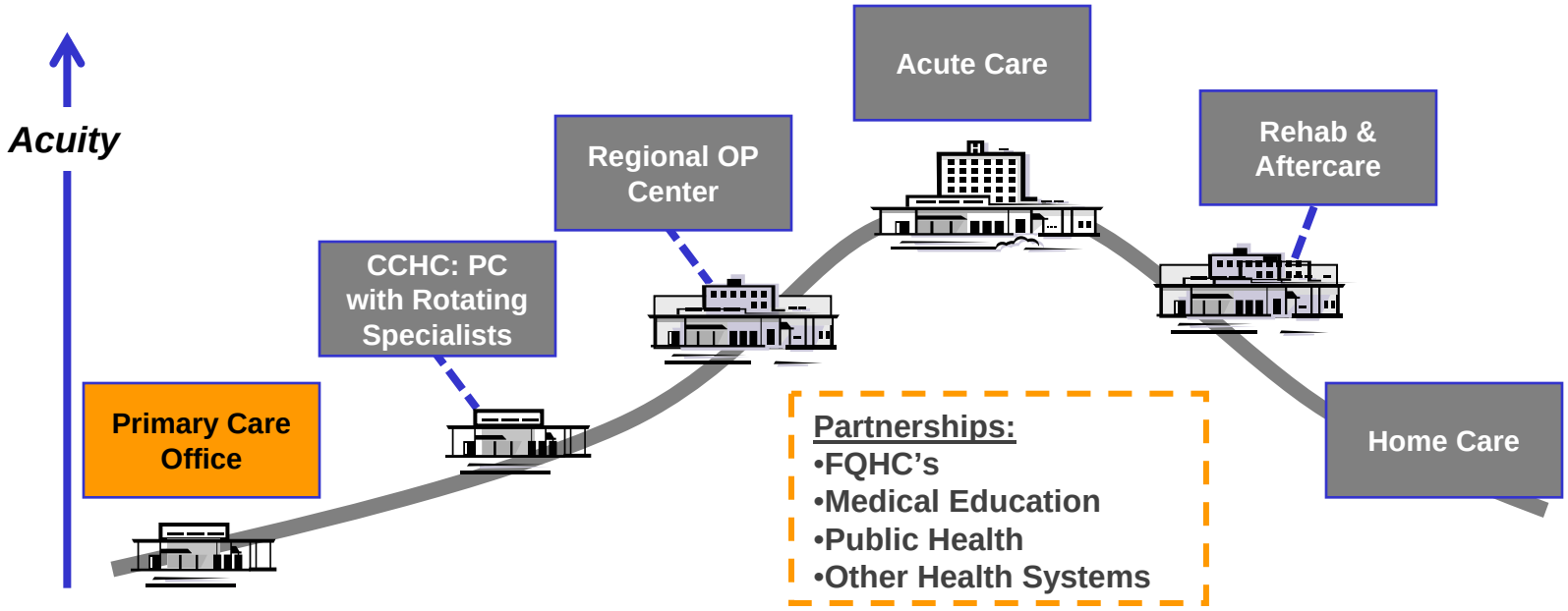
Executive Summary—Proposed System Design Overview

- **Comprehensive Community Health Centers:**
  - Expand service scope of strategically-located ACHN clinics to include rotating specialists, basic diagnostics & treatment services.
  - Target CCHC development for East (Provident Hospital site), West (Cicero or Jorge Prieto), North (new site, circa Arlington Heights), South (Cottage Grove), and Southwest (Oak Forest).



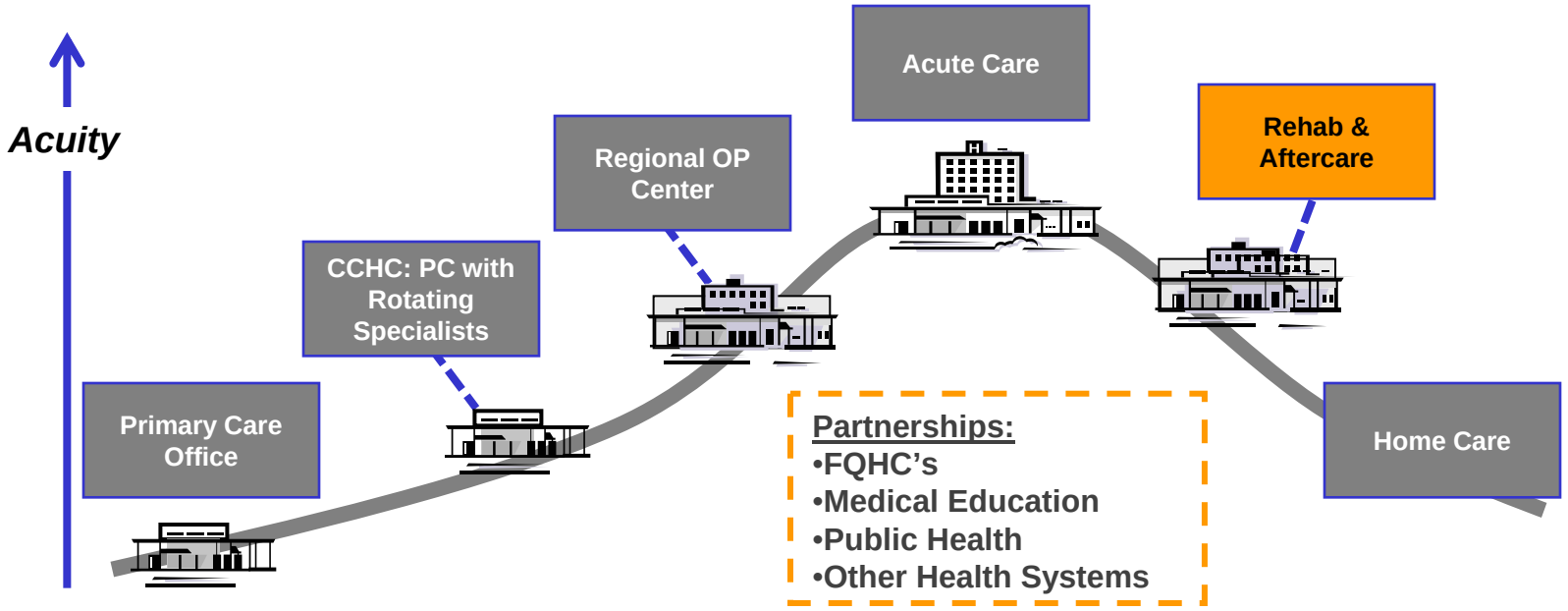
Executive Summary—Proposed System Design Overview

- **Primary Care:**
  - Maintain ACHN clinics as local primary care access points.
  - Explore potential partnerships with FQHC's for clinic staffing and operations at selected sites.



Executive Summary—Proposed System Design Overview

- **Rehabilitation:**
  - Continue to provide or otherwise ensure provision of top-ranked rehabilitation care as part of CCHHC delivery spectrum.
  - Utilize rehabilitation and aftercare services to help reduce average length of stay and increase effective capacity at JHSJH.
  - Explore best-case options for long-term development of rehabilitation care.



Agenda

Topics to Discuss:

- CURRENT STATE: The Case for Change
- PROPOSED SYSTEM DIRECTION
- **SCENARIOS + FINANCIAL IMPACTS**
- DISCUSSION
- NEXT STEPS

Oak Forest Hospital: Possible Scenarios

SCENARIO	SERVICE IMPACT	OPTION CASH IMPACT	CUMULATIVE FINANCIAL RESULTS (2015)	COMMENTS
A. Current State	Maintains current low IP census at sub-optimal level		**$(65M)***	Large losses divert resources from services having greater impact and cost-benefit, high cost modality.
B. Expand IP	Would require major program/facility investments			Physical plant not conducive to cost-effective operations in any scenario; poor location, spread -out footprint, aging plant
C. Transfer Services & Patients to Other Settings	Outpatients would be accommodated in expanded ROC; IP transfer arrangements would be put in place.	**$59M**	**$(6M)**	Eliminates direct patient revenue and direct patient expenses. Remaining costs are basic carrying costs for the facility. (See appendix A.)
D. Close IP, Develop as CCHC	Expands OP services while closing cost-ineffective IP units	**$(3.5M)**	**$(9.5M)**	Assumes increase in volume from 21K to 30K visits annually, urgent care, basic imaging, pharmacy, basic lab. See appendix B.
E. CCHC w/ ED, Short-Stay Beds	Increases service capabilities beyond current urgent care	**$(23.5M)**	**$(33M)**	Assumes 30K ED visits annually, operation of a 15 bed observation/short stay unit. See Appendix C.
F. E above, with Rehab	Utilizes available beds for Rehab, uses ED infrastructure.	**$(4M)**	**$(37M)**	Only feasible if in tandem with an operating ED/SS beds. Assumes census of 13. See appendix D.

** Note: Considers direct patient revenue; excludes benefits, pension, malpractice, depreciation, most allocated bureau costs.*

Oak Forest Hospital of Cook County
Service Impact and Transition

	2009 Patient Activity		Transition	Future State
Inpatient	Acute Days Acute ADC	16,576 45	→ Stroger/ Partner Hospital(s)	
	Rehab Days Rehab ADC	4,745 13	→ Provident Hospital	
Surgeries	Inpatient	282	→ Stroger Hospital	
	Outpatient	1,171	→ Stroger Hospital	→ South ROC **(expanded volume)**
Outpatient	ED Visits - Level 1-3 - Level 4-5*	32,970 46% 54%	→ Area Hospitals → Oak Forest CCHC	→ South ROC **(expanded volume)**
	OP Clinic Visits	21,473	→ Oak Forest CCHC **(expanded volume)**	→ South ROC **(expanded volume)**

* Lower acuity visits; could be seen in urgent care setting

Sources: Inpatient and surgical data from CCHHS Finance department. ED visits provided by ED department. OP visits provided by ACHN.

Provident Hospital: Possible Scenarios

SCENARIO	SERVICE IMPACT	OPTION CASH IMPACT	CUMULATIVE FINANCIAL RESULT (2015)	COMMENTS
A. Current State	Maintains current low IP census at sub-optimal level		**$(73M)***	Large losses divert resources from services having greater cost-benefit
B. Expand (with UCMC)	Could potentially improve service scope & quality	**$(36M)**	**$(109M)**	Assumes census of 160 (280% of current volume), incremental cost per pt day at $1,500, 80% of patients are Medicaid/other insured. See appendix E.
C. Close Completely	Would have negative impact on service access, esp. OP/ED services	**$68M**	**$(5M)**	Eliminates direct patient revenue and direct patient expenses. Remaining costs are basic carrying costs for the facility. See appendix F.
D. Close IP, Develop as CCHC	Could expand OP services while closing high-cost services	**$(7.5M)**	**$(12.5M)**	Assumes doubling current Sengstacke volume, large urgent care center. See appendix G.
E. CCHC w/ ED, Short-Stay Beds	Continues PH role as local emergency services resource	**$(26M)**	**$(38.5M)**	Assumes 40K ED visits annually, operation of a 20 bed observation/short stay unit. See appendix H.
F. E above, with Rehab	Utilizes available beds for Rehab	**$(4M)**	**$(42.5M)**	Assumes Oak Forest IP rehab volume is relocated to Provident, census of 13. See appendix D.

** Note: Considers direct patient revenue; excludes benefits, pension, malpractice, depreciation, most allocated bureau costs.*

Provident Hospital of Cook County
Service Impact and Transition

	2009 Patient Activity		Transition	Future State
Inpatient	Patient Days ADC	18,569 51	OB to Stroger Hospital 20 Obs/short stay beds Rehab unit	
Surgeries	Inpatient	300*	Stroger Hospital	
	Outpatient	1,600*	Stroger Hospital	South ROC
Outpatient	ED Visits - Level 1-3 - Level 4-5	42,938 42% 58%	ED with 20 bed Obs/ short stay unit	Additional urgent care growth at South ROC
	OP Clinic Visits	26,805	Provident CCHC **(doubling of volume)**	Additional growth at South ROC

* Annualized

Sources: Inpatient and surgical data from CCHHS Finance department. ED visits provided by ED department. OP visits provided by ACHN.

Ambulatory Development: ROC, CCHC and Primary Care

OPTION	NET FINANCIAL RESULTS (2015)	COMMENTS
ROC - South Side	**$(29M)**	Newly developed comprehensive ambulatory center with primary care, specialty care, urgent care, full imaging, surgical suites, PT/OT, basic lab and pharmacy. 280K patient visits annually. See appendix I.
ROC – Fantus Clinic		Rebuilt Fantus clinic will serve same volume of patients (415K annually, likely relocation of OB, potentially pediatrics.
CCHC - Vista Health Center	**$(2.5M)**	Increase of 7 physician FTEs, primary and specialty care, urgent care, basic imaging and lab, pharmacy. 36K patient visits annually. See appendix J.
CCHC - Cottage Grove Health Center	**$(4M)**	Increase of 11 physician FTEs, primary and specialty care, urgent care, basic imaging and lab, pharmacy. 45K patient visits annually. See appendix K.
CCHC - Jorge Prieto Health Center	**$(3M)**	Increase of 7 physician FTEs, primary and specialty care, urgent care, basic imaging and lab, pharmacy. 40K patient visits annually. See appendix L.
CCHC - Sengstacke	**$(7.5M)**	Newly developed/expanded space with primary and specialty care, urgent care, basic imaging and lab, pharmacy. 65K patient visits annually. See appendix G.
Primary Care Clinics	**$(4M)**	Based on suggested ratios for support staff per physician FTE, estimated increase of 70 support staff FTEs. See appendix M.

ROC's & CCHC's
Service Impact and Transition

	2009 Patient Activity		Transition	Future State
Fantus	Fantus SCC	191,480 223,089	→ Maintain volumes Relocate OB/Peds to West CCHC	
South ROC				**Addition of 280,000 OP clinic visits (increase of 45%); ~90 addl. FTE providers**
CCHCs	N - Vista W - Jorge Prieto E - Sengstacke S - Cottage Grove	14,922 19,348 26,805 10,768	→ Addition of CCHC Service Complement	**Addition of 114,000 OP clinic visits (increase of 150% ~ 39 addl. FTE providers**

Sources: OP visits provided by ACHN.

Capital Reallocation - Strategic Direction (2015 Overview)

PROJECT	Cash Source	Cash Use	COMMENTS
OFH Service Relocations; Discontinuance of Campus Operations	**$58M**		Shift OP operations to expanded base in new S. ROC site; relocate rehab. unit to Provident Hospital; execute transfer agreements for IP care; discontinue all operations on the Oak Forest campus.
Realignment of Provident Hospital Services	**$30M**		Upgrade/expand Sengstacke clinic (2X volume), support strong ED with 20 obs. beds; discontinue M/S + OB IP units; develop IP rehab unit .
Regional Outpatient Center Development– South		**$(29M)**	Develop comprehensive outpatient center including: surgical suites, primary and specialty care, urgent care, PT/OT, basic imaging, CT/MRI, pharmacy and basic lab.
CCHC Development – Vista, Cottage Grove and Jorge Prieto		**$(10M)**	Expand to include primary care, specialty care, pharmacy and basic imaging. Budget to include expansion of bi-lingual staff/patient advocacy skills.
Primary Care Expansion		**$(4M)**	Invest in support staff to improve productivity and patient care.
Service Line Development at John H. Stroger, Jr. Hospital		**$(20M)**	Make investment in key service lines: Women's health, pediatrics, emergency medicine/trauma and surgical services. In addition, provide for service/quality improvements and multicultural initiatives.
Revenue Shortfall/Other Strategic Investment		**$(25M)**	Revenue shortfall for FY2010 is estimated to be $40M; provides flexibility to adapt / respond to health care reform.
TOTAL	**$88M**	**$(88M)**	

Strategic Plan: Capital Requirements

PROJECT	ESTIMATED COSTS	SQUARE FOOTAGE	COMMENTS
ROC – South Side	**$45M**	**120,000**	Assumes $375 per square foot, 2/3s the size of Fantus, serving roughly 2/3s the volume of Fantus.
ROC – New Fantus	**$67.5M**	**180,000**	Assumes $375 per square foot, based on current footprint and square footage.
CCHC – Vista, Cottage Grove and Jorge Prieto	**$9M**	**N/A**	Assumes a $3M investment in each of the 3 CCHC locations to update clinic, expand services and space..
CCHC - Sengstacke	**$18.75**	**50,000**	Assumes $375 per square foot, roughly double the square footage needed for clinic that services 30K visits.
PC Expansion	**$9M**	**N/A**	Assumes a $1.5M investment in each of the 6 primary care locations to update clinic, expand services and space..
Capital Avoidance, Provident and Oak Forest	**?**	**?**	If IP services are limited or discontinued at either or both locations, future capital requirements will be less or eliminated all together.
TOTAL, ROUNDED	**$150M**		

Agenda

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Agenda

Topics to Discuss:

- CURRENT STATE: The Case for Change
- PROPOSED SYSTEM DIRECTION
- SCENARIOS + FINANCIAL IMPACTS
- DISCUSSION
- **NEXT STEPS**

Next Steps

- ➔ Refine direction based on Board input.
- ➔ Continue meetings/discussions with various constituency groups, internal and external.
- ➔ Complete Recommendations & Action Plan.
- ➔ Complete 5-Year Financial Plan.