HEALTHCARE TRANSFORMATION COLLABORATIVES

March 12, 2021

Welcome

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Housekeeping

Q&A Session

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

Stay Connected

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

Our Vision for the Future

IHFS ILLINOIS DEPARTMENT OF Healthcare and Family Services

WE IMPROVE LIVES

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

WE ACHIEVE THIS BY

- Valuing our staff as our greatest asset.
- Always improving.
- Inspiring public confidence.

Healthcare Transformation (noun)

'health-care trans-for-ma-tion'

a person-centered, integrated, equitable, and thorough or dramatic change in the delivery of healthcare at a community level

Healthcare Transformation Legislation Passed in January and Incorporated Feedback from Many Stakeholders

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

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

Thank You For Your Comments, Suggestions and Constructive Feedback

- Hospitals (Academic, Critical Access, Large, and Safety Nets)
- Customers
- Federally Qualified Health Centers
- Labor (SEIU)
- Legislators (MWG, Black, Latino, Women's Caucus Members, GOP, and More)
- Managed Care Organizations
- Philanthropic Organizations
- Providers
- Civic Institutions
- And More…

We also incorporated feedback community members and customers who want a shift from transactional to more integrated, relationship-based care

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

WHY TRANSFORMATION?

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

THE CURRENT LACK OF

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

LEADS TO

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

RESULTING IN

- **Poor Health Outcomes**

EXAMPLE: In some of the most socially-vulnerable areas of Illinois, we see high rates of Medicaid-enrollee hospitalizations for outpatient-treatable conditions

Top Most Frequent and Resource Intensive Hospitalization Diagnoses

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

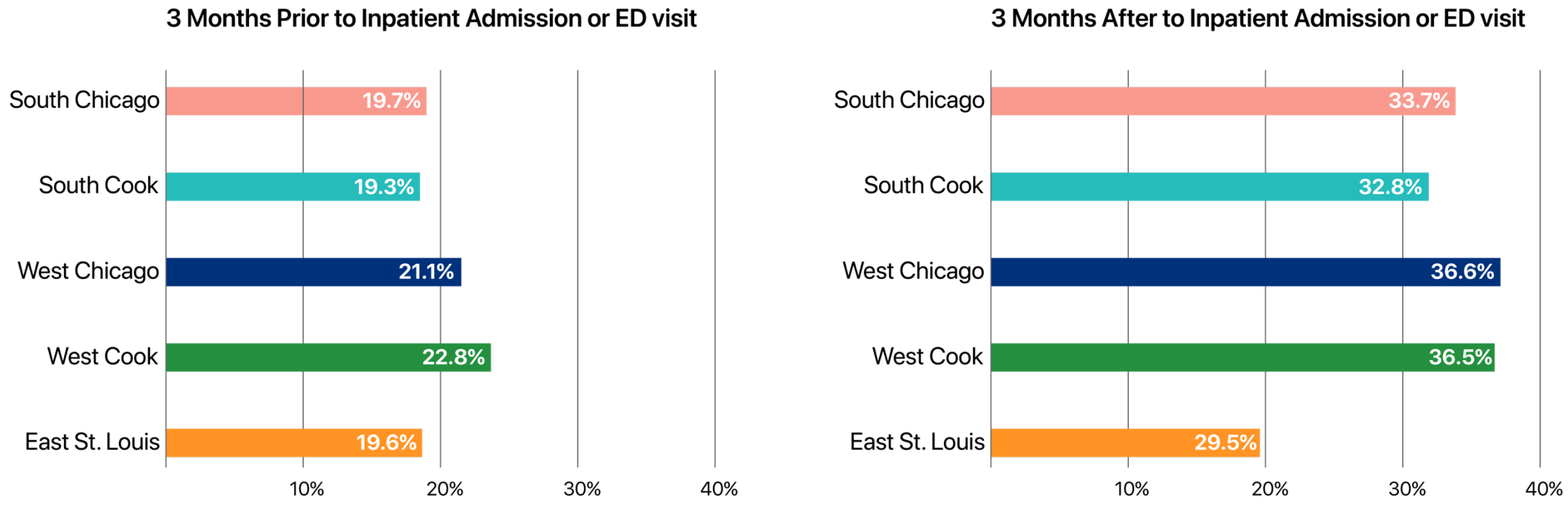
SO. CHICAGO	SOUTH COOK	WEST CHICAGO	WEST COOK	EAST ST. LOUIS
Mood affective disorders (bipolar, depression)	Mood affective disorders (bipolar, depression)	Mood affective disorders (bipolar, depression)	Mood affective disorders (bipolar, depression)	Mood affective disorders (bipolar, depression)
Schizophrenia, schizotypal disorders	Schizophrenia, schizotypal disorders	Schizophrenia, schizotypal disorders	Schizophrenia, schizotypal disorders	Psychoactive substance use disorders (alcohol, opioids)
Psychoactive substance use disorders (alcohol, opioids)	Psychoactive substance use disorders (alcohol, opioids)	Psychoactive substance use disorders (alcohol, opioids)	Other bacterial diseases (sepsis)	Schizophrenia, schizotypal disorders
Hypertensive diseases	Hypertensive diseases	Chronic lower respiratory diseases (asthma, COPD)	Psychoactive substance use disorders (alcohol, opioids)	Hypertensive diseases
Chronic lower respiratory diseases (asthma, COPD)	Chronic lower respiratory diseases (asthma, COPD)	Hypertensive diseases	Chronic lower respiratory diseases (asthma, COPD)	Diabetes mellitus
Diabetes mellitus	Diabetes mellitus	Diabetes mellitus	Hypertensive diseases	Hemolytic anemias
Cerebrovascular diseases	Cerebrovascular diseases	Cerebrovascular diseases	Diabetes mellitus	Child/adolescent behavioral & emotional disorders
Complications of surgical/ medical care	Complications of surgical/ medical care	Complications of surgical/ medical care	Cerebrovascular diseases	Noninfective enteritis and colitis
Hemolytic anemias	Hemolytic anemias	Hemolytic anemias	Complications of surgical/ medical care	Chronic lower respiratory diseases (asthma, COPD)

Treatable Conditions / Preventable Hospitalizations:

- Mental Illnesses (especially, bipolar and depression)
- Substance Use Disorders (especially, alcohol and opioid)
- Ambulatory Care Sensitive Conditions (especially, hypertension, asthma, COPD and diabetes)

EXAMPLE: And wee see low rates of engagement in outpatient care pre- and post-hospitalization

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



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

EXAMPLE:

Residents in these communities face multiple social-determinant-of-health barriers to staying healthy and getting care

BARRIERS BY SOCIAL DETERMINATNTS OF HEALTH

	Staying healthy	Recognizing a health need and deciding to get care	Arranging and getting to care	Getting care (point of service)	Managing the condition in daily life
Knowledge & Information	-Lack of factual and trustworthy health information	-Lack of knowledge of signs and symptoms of prevalent health conditions -Lack of knowledge of what is covered or not covered in insurance plan - Fear about getting healthcare as a result of the lack of knowledge of information (i.e., fear due to costs involved, bad diagnoses, etc.)	-Lack of awareness of healthcare services within community -Lack of awareness of where to seek care that fits one's needs	-Difficulty understanding technical medical terms and physician instructions	- Difficulty applying physician instructions to personal circumstances -Lack of knowledge of local resources to help manage condition
Economic	-Lack of time for self-care (i.e., exercise, preparing healthy food, preventative care, etc.) -Inability to afford healthy food -Unemployment, economic instability -Housing instability	-Inability to afford health insurance -Inability to afford out-of-pocket care costs (e.g., co-pays) -Inability to afford time off work to seek care	-Lack of insurance or under-insured -Lack of car or inability to afford transportation	-Inability to afford out-of-pocket care costs (for example, co-pays)	-Inability to afford treatment (e.g., medication, equipment, supplies, etc.)
Healthcare Service	-Lack of preventive screening or programming in the community	- Previous negative healthcare experience -Fear of going to healthcare facilities due to COVID-19	-Poor quality of local healthcare facilities (self-reported) - Long wait times for appointments - Scarcity of local healthcare facilities (lack of, or limited options due what health insurance is accepted) - COVID-19 closures or reduced appointments	-Long wait times at the point of care - Service quality disparities -"Transactional" experiences with providers (e.g., short facetime, bias towards medication, etc.) -Lack of trained, culturally competent providers - Discrimination due to race, socio-economic status and public insurance - Care that doesn't fit cultural context (e.g., language and behavioral norms)	-Lack of consistent healthcare support to help manage condition over time
Socio-Cultural	-Culturally ingrained food and cooking habits	- Healthcare system mistrust - Hesitancy to seek care until emergency (due to historic mistrust, cultural issues, immigration status, fear, stigma, or previous bad experience) - Concealing health issues from family &friends			- Social isolation (lacking a support system) - Strain on social support system (i.e., emotional, physical, economic)
Environmental	-Lack of resources (i.e., food, recreation, transportation, walking infrastructure, etc.) - Poor air quality due to local polluters - Presence of unhealthy foods - Prevalence of drugs and alcohol in communities - Exposure to ongoing crime, street violence, domestic abuse, neglect and discrimination		- Insufficient transportation options		-Lack of resources (i.e., food, recreation, transportation, walking infrastructure, etc.) - Poor air quality due to local polluters - Presence of unhealthy foods - Prevalence of drugs and alcohol in communities - Exposure to ongoing crime, street violence, domestic abuse, neglect and discrimination

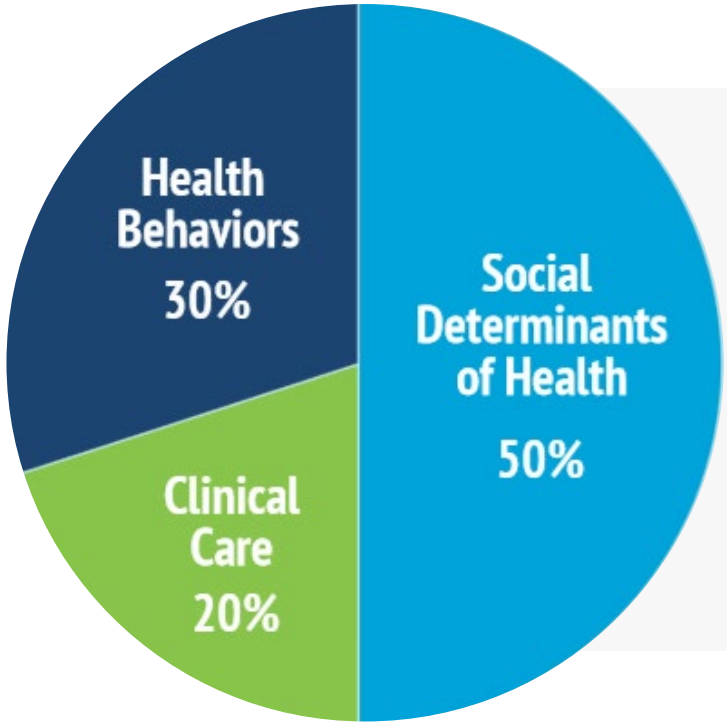
When people decide to seek care, they make an implicit cost-benefit analysis, trading off time, money and trouble against the value they expect to gain from care.

The barriers voiced by community residents in socially-vulnerable areas tip the balance toward the costs of seeking care and away from the value of getting healthcare.

Social determinants account for 50% of a person's health outcomes

Clinical care accounts for no more than 20% of a person's health and individual health behaviors, no more than 30%[1].

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



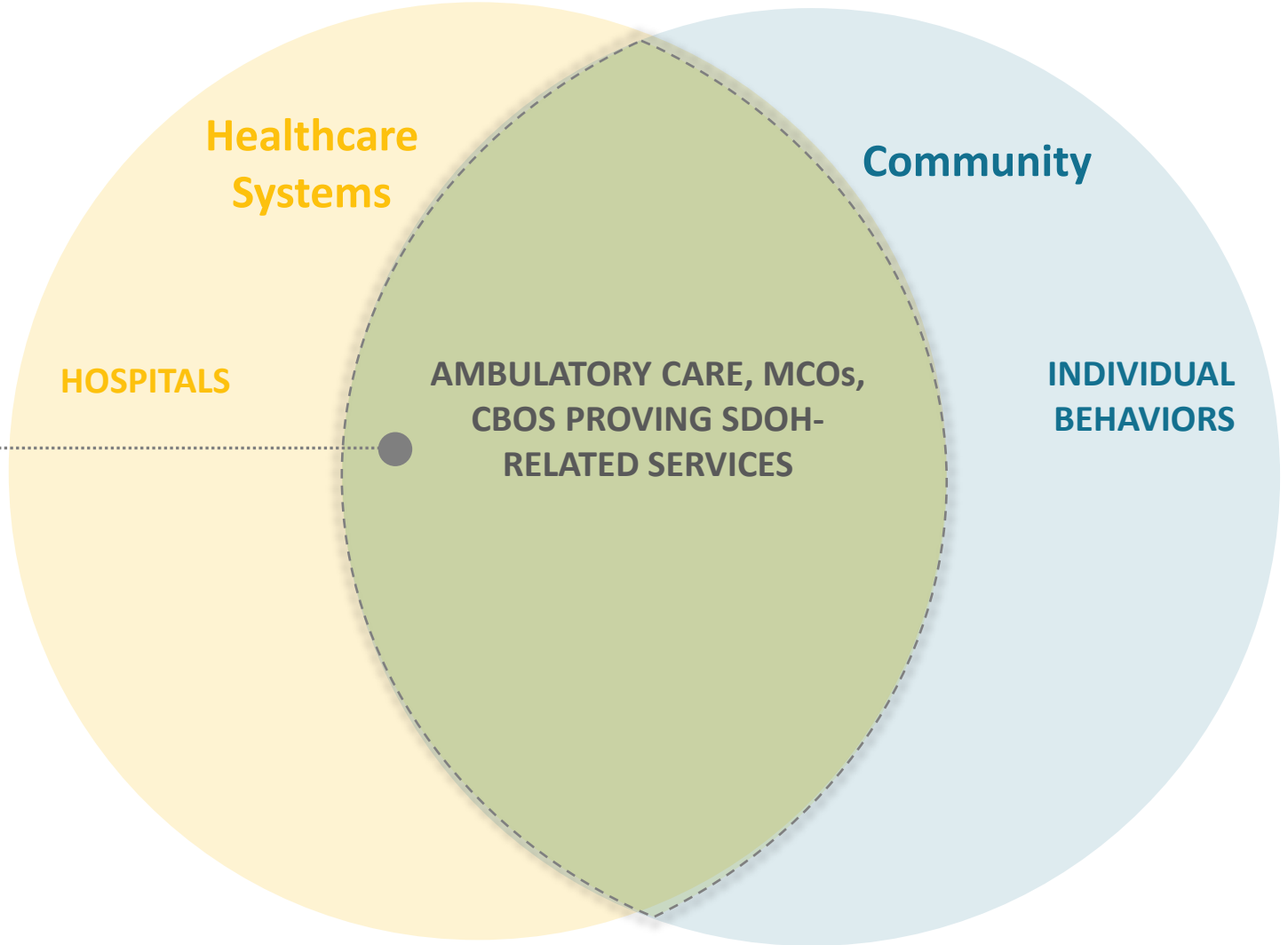
- Economic stability
- Education
- Housing
- Transportation
- Food security
- Social support networks
- Environmental quality

Health needs cannot be addressed by healthcare systems alone.

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

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

HFS is seeking partnerships that re-imagine the way healthcare is provided in communities by ***linking healthcare systems more tightly with community resources that address social determinants of health*** *in order to meet the needs of residents more holistically and reduce inequities in healthcare delivery.*



Healthcare Transformation Collaboratives (HTC) Overview

HTC Goal

Reorient Healthcare Delivery in Illinois around People and Communities

And do so through…

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

In order to create new ways to deliver healthcare that…

- Fit people's lives
- Solve complex healthcare access issues in holistic ways
- Improve health outcomes and reduce health inequities
- Address both healthcare needs and social determinants of health needs
- Are financially sustainable and racially equitable

FUNDING TARGETS

Allocate The Entire $150 Million With At Least A Minimum As Follows:

$30 Million

Safety Net Hospital Partnerships to Address Health Disparities

Particularly partnerships with community safety-net hospitals

Plus:
$40 Million in Capital
$65 Million CARES

$20 Million

Safety Net + Larger Hospital Partnerships to Increase Specialty Care

$30 Million

Hospital + Other Provider Partnerships in Distressed Areas to Address Health Disparities

Lead By CAHs, SNs or other hospitals in distressed communities

$15 Million

Critical Access Hospital Partnerships

Anchored By CAHs or with CAHs as significant partners

$15 Million

Cross-Provider Care Partnerships

Lead By Minority Providers, Vendors, or NFPs

To fill unmet needs with a special emphasis on cultural competency and/or social determinants of health

$5 Million

Workforce Development & Diversity Inclusion Collaborations

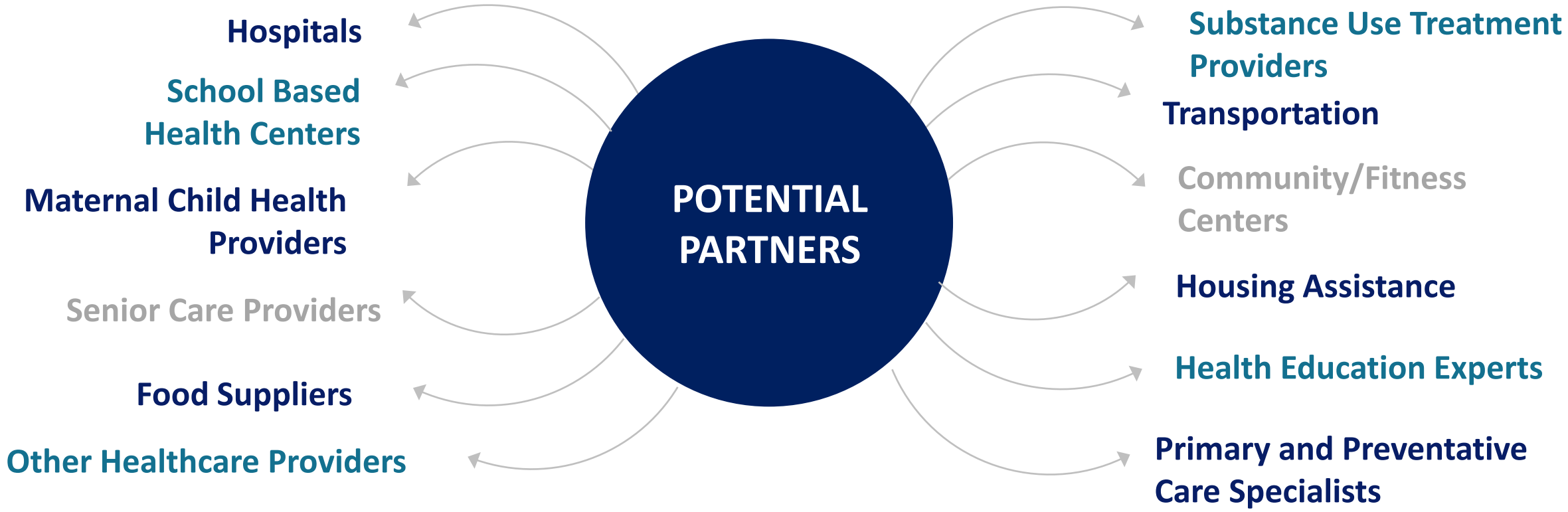
Must be in alignment with overarching innovation proposal strategy

Enhance Preventative and Specialty Care Access

Loan Repayment

Recruitment and Scholarships or similar ideas to enhance availability in distressed communities

Example Collaboration Partners



All collaborations must include a registered Illinois Medicaid Provider that is eligible to bill for Medicaid services.

PROPOSED FUNDING MIX

HFS believes **the $150 million as an annual transformation pool is a start to a realignment of resources.** Leveraging state resources to attract other investments including federal, state and private dollars.

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

State Collaboration

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

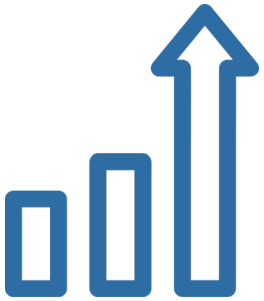
Business Community

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

Philanthropic

- Similar to the business community, non-profits and philanthropic efforts must be included to spur collaborative system investment.
- This strengthens sustainability in the system.

The Vision For Sustainability of Successful Partnerships/Collaborations



Sustainability, Expansion or Replication of Best Practices

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

Example Project
Linking healthcare and food access

Photo by gemma on Unsplash

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

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

Collaborators:

> Physicians and other healthcare system representatives
> Food growers, distributors and retailers
> Local entrepreneurs
> Food access activists and community residents
> Economic development entities
> Philanthropic organizations
> Local government / lawmakers

Example Project
Linking healthcare and housing

Photo by Madison County Housing Authority

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

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

Collaborators:

> Physicians and other healthcare system representatives
> Community and economic development entities
> Community housing activists and residents
> Philanthropic organizations
> Local government / lawmakers

Example Project
Peer counselors workforce trained to provide behavioral healthcare

Photo by Christina @ wocintechchat.com on Unsplash

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

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

Collaborators:

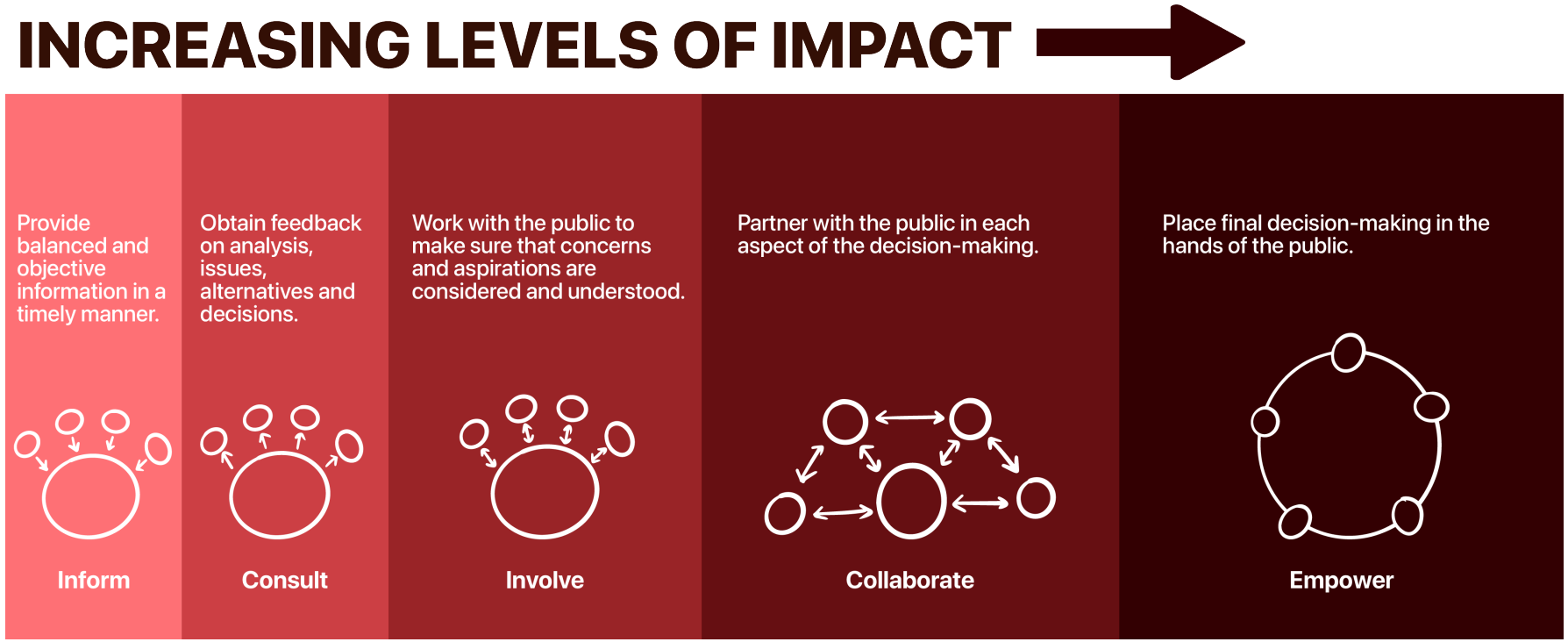
> Hospitals
> Residential/outpatient rehabilitation facilities
> Behavioral healthcare providers
> Mental health activists and community residents
> Faith organizations
> Workforce development specialists
> Philanthropic organizations

Healthcare Transformation Collaboratives: Application Requirements

Collaborations must take a "community-first" approach to proposed projects

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

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



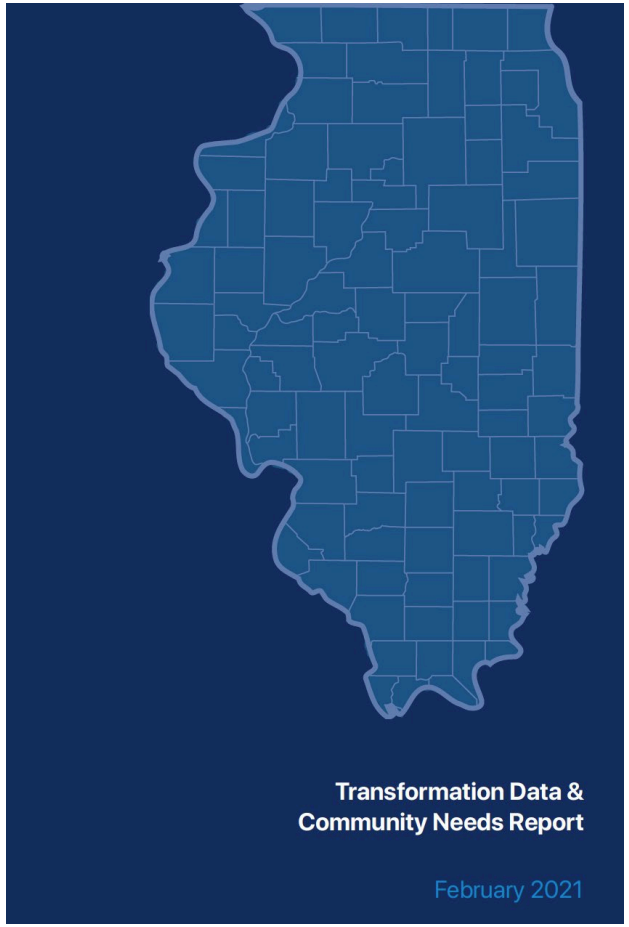
Projects must improve health outcomes and reduce disparities

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

- Access to care
- Social determinants of health
- And/or care integration and coordination

Projects must be driven by data

The focus of transformation efforts must be supported by data



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

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

- Chicago-South Side
- Chicago-West Side
- East St. Louis Metropolitan Area
- South Cook County
- West Cook County[1]

For efforts outside these areas:

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

[1]Claims data was analyzed in West Cook County but community input sessions were not conducted in this area.

Projects must align with and use HFS Quality Pillars and Metrics

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

and track metrics to show impact on outcomes and equity

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

At a minimum, proposals must . . .

Be financially sustainable within 5 years

Bolster or retain jobs in the community

Incorporate racial equity in the project

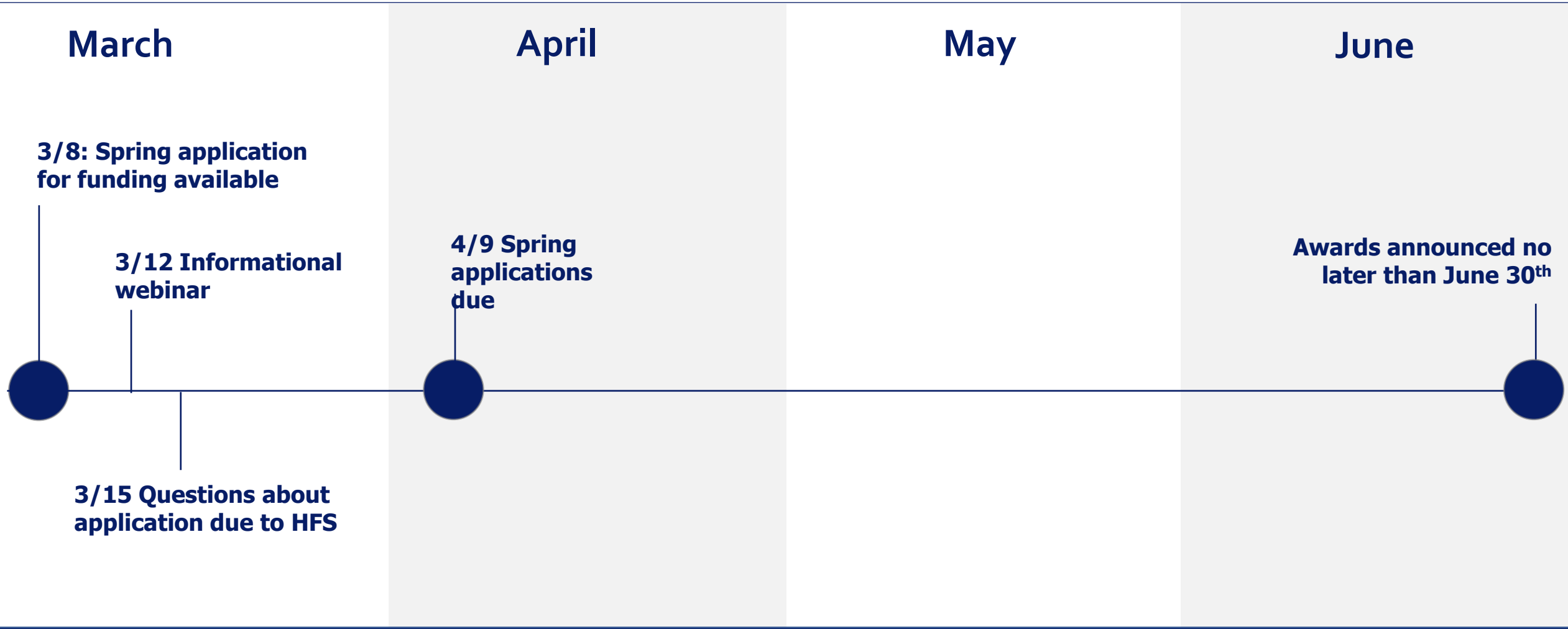
Demonstrate appropriate minority business participation in projects

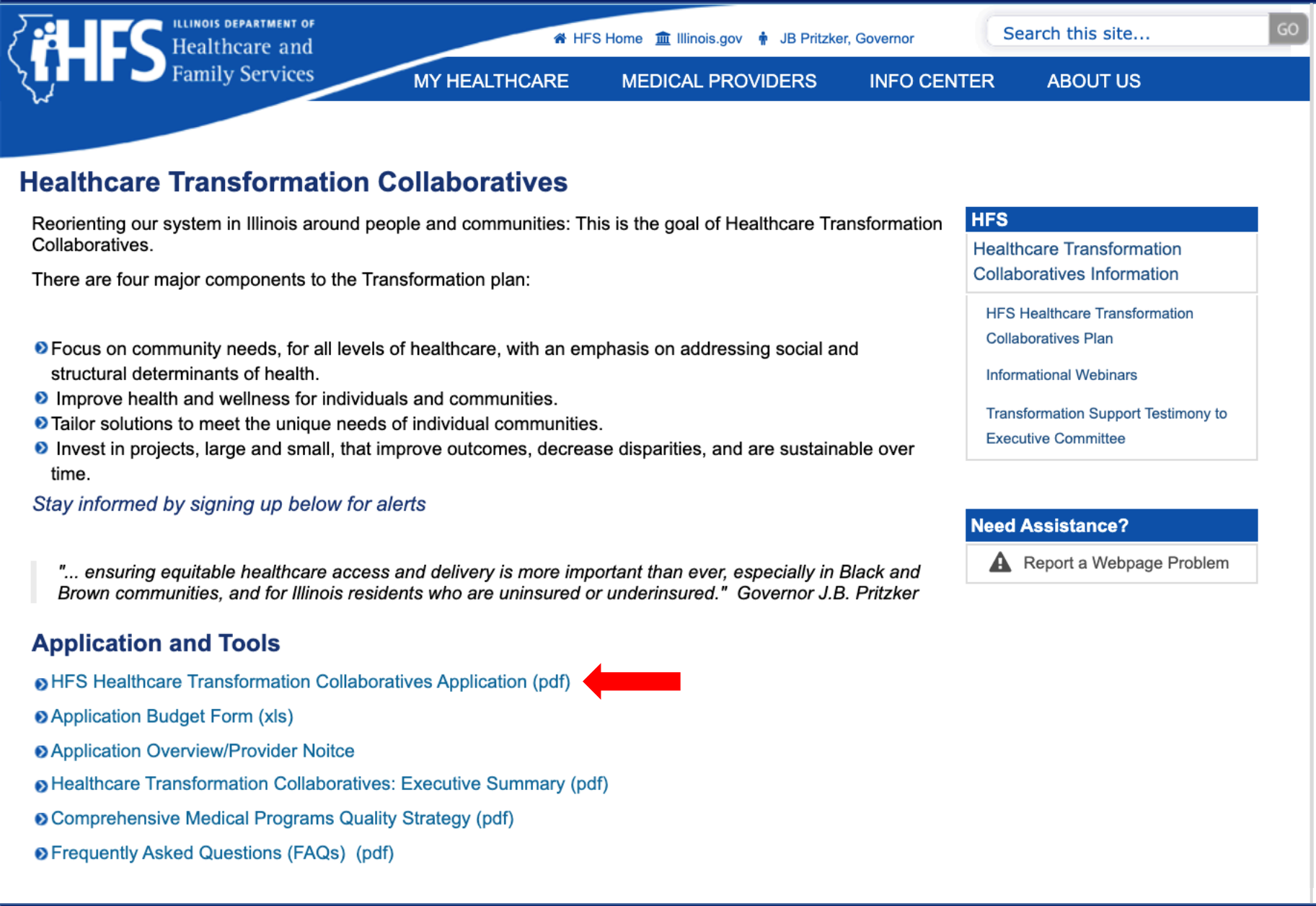
SUMMARY OF REQUIREMENTS

- Meaningfully engage community members to address health and healthcare access challenges
- Improve health outcomes and reduce disparities by addressing access, social determinants of health and/or care integration and coordination
- Provide data that supports the need for the project
- Establish metrics to show impact on health outcomes and equity
- Show a path to sustainability
- Bolster or retain jobs in the community
- Incorporate racial equity in the project
- Demonstrate minority participation in the project

Healthcare Transformation Collaboratives: Logistics

Key Dates: Spring 2021 Funding Cycle





- FY2021 application is available now on **HFS.illinois.gov/Transformation** as a downloadable PDF (supporting materials can be found here as well)
- Questions about the application should be submitted via email to **HFS.Transformation@Illinois.gov**
- Completed applications should be submitted via email to **HFS.Transformation@Illinois.gov**

Not ready now? No problem.

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

Future Funding Cycles:

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

Consulting support:

- Application for consulting support will be announced soon
- For Fall 2021 applicants, consulting support will be available starting in June

More on consulting support

- Consulting support will be available for funding application for Fall 2021 and beyond
- Requests for consulting support will require a ***separate application*** (application to launch soon)
- Example types of consulting support to be provided:
  - Support for creating a governance structure for collaborations
  - Assistance with developing a Clinically Integrated Network
  - Data analytics
  - Healthcare IT infrastructure
  - Community engagement
  - Evaluation of physical plant improvement for capital funding
  - Racial equity

STAY CONNECTED

Register for HTC updates at

HFS.illinois.gov/Transformation

Email Questions No Later Than Monday, March 15, 2021 to:

HFS.Transformation@illinois.gov

Q&A