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Health Policy Report

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Protecting the Legacy of Caring for Vulnerable Populations: Essential Priorities for the Cook County Health Care System

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INTRODUCTION

For more than 170 years, the Cook County government has been providing a healthcare safety net for those without the ability to afford private health care. Over these years, the County's health care system has evolved into one of the most comprehensive public hospital systems in the nation. However over the past few years, the rapidly changing healthcare environment, changing population health care needs, and health care market are creating fundamental threats to the County's ability to serve its mission.

The Institute for Healthcare Studies at Northwestern University Feinberg School of Medicine was commissioned by the Otho S.A. Sprague Memorial Institute, a 96 year old independent Chicago-based foundation, to conduct a study of the challenges facing the Cook County health care system, anticipating the critical juncture that system faced. Health Management Associates (HMA) was engaged by the Institute to assist in the preparation of this report because of its experience with the Cook County health care system, the Illinois Department of Healthcare and Family Services and peer, public health systems across the country. For the past three years, HMA has been contracted by a number of local (mostly county) governments with comparable demographic and fiscal issues to assess their health and hospital systems and to develop (and, in most cases, implement) strategies that help these institutions provide care to the most vulnerable residents of their communities. The shared purpose of this project is to assist Cook County, the leadership of the Bureau of Health Services, its health and hospital system, and the broader community to assure a sustainable health care resource for the most vulnerable residents of the community. This document represents an attempt to inform and accelerate local discussions of the issues already debated in communities nationwide: *in the face of enormous pressures exerted by the cost and demand of health care, how will the health care system for vulnerable populations (hereafter referred to as the health care safety net) continue to serve the increasing number of medically uninsured and under-insured people?*

The Cook County health care system, embodied in the Cook County Bureau of Health Services, is not the only health care provider caring for poor and/or uninsured or under-insured persons in the metropolitan community, and other providers are referenced in this report as being vital components of the broader health care safety net. This

analysis, however, is focused on the County system for three reasons: 1) it is the largest provider of health care for low income persons in need of medical services, 2) the system's sustainability has significant implications for the entire community; and 3) it is a public enterprise that is accountable to the people who use it, pay for it and elect its governing officials. A premise for this report is that the future of the Cook County health care system should be based on a well informed public discussion.

The full report includes an overview of the status of national and state health care (and the resulting implications for Cook County), the changing nature of the populations and communities for which Cook County health services are most important, the broader scope of health care resources available to meet the demand of these populations and communities, the role of the Cook County government as both a health care provider and an advocate for the public's health, Cook County's current assets and challenges, and potential strategies to overcome those challenges.

The project was developed in three phases. The first phase was a data gathering exercise that included culling publicly available information on the County's financial and non-financial performance as well as information on Federal and State support of the County's health facilities. A large number of interviewers with Cook County Commissioners, and Chicago-area leadership, civic and healthcare community. This was followed by two focus groups conducted with physicians at the Stroger Cook County Hospital. From this first phase, a draft report was developed. The second phase of the project included a two-stage peer review process; (a) peer-review by a panel of national experts including safety net providers from other communities, as well as scholars in the field of health care provision for the uninsured, and (b) a second round of "blinded" peer review from Chicago-area community leaders with experience in healthcare delivery for the safety net populations. Based on this peer-reivew process a revised draft report was completed. The last phase of this project was directed at review of a final draft report with a complete set of recommendations. This phase was also conducted in two parts including a series of focus groups with leaders in health care for Chicago's uninsured, as well as a series of one-on-one reviews with selected civic, business and health care leaders. Following this last stage of review, the final version of this report was completed.

Despite our best efforts to prepare a well-informed report, this document may still be criticized as imperfect. To that we would agree. First, the six month timeline outlined by the project's sponsor limited the scope and depth of any primary data gathering and interview process. Additionally, we were limited to easily accessible public data for this analysis, as there was little cooperation from the Office of the President of Board or the State Department of Healthcare and Family Services for more detailed, but otherwise difficult to access public data. Although many individuals were willing to discuss the pressing issues facing the Cook County health system, including Cook County Commissioners, civic leaders, other health care providers, and, notably, physicians who work in Cook County hospitals and clinics, we have been unable to secure the timely cooperation of the leadership of the Bureau of Health Services in the preparation of this report. Therefore, there may be facts and Bureau-based initiatives that are unknown to those we interviewed or otherwise unavailable to us. We sincerely hope that this report stimulates public discussion about the future sustainability of the Cook County health care system, the hub of the region's health care safety net. Finally, this report was developed with the underlying belief that the believe the residents of Cook County should view as a public resource, just as they do their schools, their public safety departments, and other public services essential to daily life.

There are many individuals who made this report possible. First and foremost are —Pat Terrell, Dr. Terry Conway, and Matt Powers at Health Management Associates who were responsible for the principal drafting of the document. In addition, significant contributions were made by other HMA senior staff, including Steve Scheer, Steve Perlin, Lori Weiselberg, Gaylee Morgan, Doug Elwell, Dave Ferguson, Jack Meyer, and Kate Kirchgraber. Also, for the efforts of Ms. Sarah Rittner who coordinated all aspects of the project. Thanks to Dr. Whitney Addington, James N. Alexander, and the members of the Board of the Otho S.A. Sprague Memorial Institute for their support and counsel. The Institute for Healthcare Studies is grateful to all those who generously participated in the three phases of this study. We look forward to the broadened dialogue that we hope this report will stimulate among the people of Cook County.

EXECUTIVE SUMMARY

Over the past decade, the national health care crisis has escalated. The forum for deciding an effective response to this crisis, however, has shifted from Congress to state capitols to local communities In many such communities, particularly those in which the local government supports a public health care system, efforts have focused on determining the most effective way to sustain these systems as foundations of the broader safety net, as they are confronted with escalating costs and increased demand. As the magnitude of these economic pressures increases, so too does the urgency. The situation facing other communities around the nation also is mirrored in Cook County. This report should be viewed by the broader community as a call for action before a serious disruption occurs in the health care infrastructure that serves the most vulnerable people and communities in Cook County.

The Cook County Bureau of Health Services is one of the largest and most comprehensive public health and hospital systems in the country. It provides a full range of hospital inpatient and emergency care services at Stroger, Provident, and Oak Forest hospitals. It also includes the following: community primary care clinics in the most vulnerable neighborhoods in the city and suburbs; specialty outpatient services used by both the County health system and private community providers serving vulnerable populations; the largest jail health facility in the nation; public health services for the suburbs; long-term care and rehabilitation services; and a unique facility intended for the care of patients with HIV/AIDS and other infectious diseases. It is the predominant provider of care for medically indigent persons in Cook County, and its viability has a significant impact on both the patients who rely on it and other hospitals and clinics that would be overwhelmed if it failed or did not exist.

Although this report addresses other aspects of the health care safety net in Cook County (e.g., community health centers, private hospitals, academic medical centers, and the public health department), and although cooperation between the Bureau of Health Services and these other providers is absolutely essential to satisfying the increasing demand for health care services, this report is focused on the Cook County system. There are two reasons for this targeted analysis. First, the Bureau plays a critical role in the preservation of the broader safety net. If the Bureau's emergency

departments begin diverting persons in need of care because they have insufficient resources, as has happened in other communities across the country, or if budgetary constraints result in the closure of clinics or limitations of other services, most every other provider in the region will be affected. Second, it is important and responsible to review the operations of public institutions that serve the public's interest using tax dollars. The Cook County Bureau of Health Services is a public enterprise that is accountable to the people who use it, pay for it, and elect its governing officials.

The Cook County health care system is facing an impending crisis, and it will require the leadership, creativity, and the attention of the broader civic community to overcome the challenges ahead. The crisis consists of the following external pressures, some which are being addressed by local communities across the country, others are unique to our State and local environment:

- Acknowledged significant decreases in revenue generated from the State Medicaid program, the health system's primary source of patient revenue, and an emerging financial crisis for the County government.
- Growing demand for health services from an increasing number of uninsured and under-insured people.
- Escalating costs that approach double digits annually and that are burdening the entire industry.
- New regulatory requirements related to quality of care and patient safety that will require significant changes in how care is given and documented.
- Changing demographic characteristics of populations and communities that depend on the services provided by the County health system.
- The increasingly frequent inability of other not-for-profit hospitals and clinics in Cook County to meet the growing demand.
- The lack of a comprehensive solution from Washington and emerging national policies that may further strain public health systems, such as Cook

County's (e.g., immigration restrictions and the curtailment of financing mechanisms that recognize the unique role of public hospitals).

- The State of Illinois' movement to implement changes in the model for delivering care that will require innovation for the Cook County system to respond effectively.

Cook County government is now undergoing transition. It has a long history of directly supporting and operating the health care system and has stewarded the system through extraordinary challenges. However, while local governments across the United States have moved to allow more-concentrated oversight by people with expertise in the complexities of health care delivery, Cook County has not. Rather, Cook County continues to operate in a mode that is less transparent and, therefore, less accountable to its population. Cook County does not appear to have a structure adequate to incorporate the planning, efficiency, innovation, and leadership that are needed to navigate the emerging health care crisis. In addition, the unique authority of the Office of the President and the changes in that office present opportunities for both rapid reform re-organization. The archaic approaches to health care governance and administration in Cook County require attention now

FINDINGS

The key findings of this report are:

- The County health system ("The Bureau") has assets that are likely envied by similar health systems across the country. Its physicians, for the most part, are full-time employees of the system's hospitals and clinics and are of extremely high quality, whereas other systems primarily must contract with medical schools for physician time. Its buildings are relatively new. The Bureau's network services range from primary and specialty outpatient clinics to inpatient acute care to long-term and rehabilitation care. The Bureau has entered into nationally recognized partnerships with other providers to rationalize the delivery of care in many underserved communities. Without intervention, however, Cook County risks losing these assets.

- The demographic characteristics of patients and communities who depend most on the Bureau's services are shifting. Aggressive and ongoing planning to accommodate these dynamic populations and to enable the County health system to effectively respond to such changes is needed. For example, the number of uninsured and under-insured people has increased in the suburbs, where many people have relocated from poor communities in Chicago and where immigrants are moving in large numbers. Because of such population fluctuations, substantially fewer resources are available. The Bureau must continuously assess its strategy for addressing the flux in the demand for health services, and it should report its findings to the broader community.

- The County must respond quickly to impending financial pressures that have several components, including securing the Medicaid revenue available from the State of Illinois; a consistent and well-designed approach to revenue generation; a concentrated effort to maintain the number of paying patients to mitigate the system's dependence on County tax dollars; and a fiscal strategy based on a thorough analysis of where investment is needed, where Bureau institutions can better coordinate their services, and where costs can be consolidated to assure long-term efficiency.

- An analysis of the accountability of current tax dollars is necessary to improve public confidence and the role of the County local tax subsidy of the health care system. Despite the growth of the delivery system, the increased demand, and the double-digit annual inflation of health care costs, there has not been a substantial increase in the County's tax subsidy for more than fifteen years. Currently, the County's per-person contribution to health care is well below that of other large urban counties. The modest local subsidy has been justified by the fact that the County and the State have succeeded in the past fifteen years in maximizing the federal contribution and increasing Medicaid payments for County services, which are circumstances that do not exist to the same extent for other systems. Cook County's dependence on Medicaid, however, is diminishing.

- The Bureau's capacity to operate efficiently has been hampered by many factors, including the system's dated human resources system, which prevents timely hiring and firing of employees, and limits the flexibility needed to attract and retain highly competent employees. With the President's Office as the sole hiring authority, there is a clear opportunity to use the system for political hiring at the expense of best qualified health management leadership. And while this report did not directly explore the issue of patronage, most of those interviewed for this report perceived patronage was engaged by the President's Office to staff a number of key positions within the Bureau. If true, some people may rationalize that such approaches to hiring are simply the nature of government, but such hiring practices at all levels of government are being challenged, and more importantly, they are not likely effective for managing a complex health care system that depends on highly skilled, experienced, and creative staff.

- Ensuring a high level of quality, respect for patient safety and needs, and operational efficiency must be the Bureau leadership's top priority. Effective operations are critical to both retaining public confidence and validating potential needs for additional subsidy. There have been examples (including a focused effort made by the Bureau's medical staff and administration to resolve problems in the pharmacy system) where operations can be improved. These efforts must be replicated and reported on an ongoing basis.

- The Bureau alone cannot meet the demand for health care services. It must nurture its existing partnerships with other hospitals, clinics, and physicians and forge new alliances to ensure that all available resources are being used.

- The Cook County Board's direct governance (by means of the Office of the President) over the increasingly complex health care system is a model that nearly every other major urban community in the United States has abandoned. Public health authorities, hospital districts, public benefit corporations, and other systems have all been created to ensure highly qualified and focused oversight of the financial, clinical, regulatory, academic, and structural aspects of the public health care system. Public discussion

regarding the governance of the health care system in Cook County, however, has not occurred.

PROPOSED ACTION AGENDA

From this perspective on the treats to the success of the Bureau a series of recommendations have been developed. In the section below we have organized those recommendations in the report into a proposed 10-point action agenda. Some of these items will require immediate attention, whereas the benefits of others will not be realized anytime soon. Implementing them will have to be done by members of the civic community, the Cook County Board, and the leadership of the Bureau of Health Services.

Issues for the Civic Community

1) Create a civic "Blue Ribbon Commission," preferably in collaboration with the President of the County Board's Office and the Cook County Board of Commissioners, that is dedicated to the future of the Cook County health care delivery system. Having a civic organizational "home" for this body and providing it with a sufficient number of staff will be important. The Commission should be co-chaired by a key civic and/or business leader and a representative of the Cook County Board of Commissioners, preferably a leader of its Health and Hospitals Committee. In the next three years, the Commission would accomplish the following:

a) Establish performance measures that include clinical, patient satisfaction, operational, quality, and cost-effectiveness benchmarks that would form the basis of a annual publicly available "report card" for the County's health care system.

b) Provide recommendations for restructuring the governance of the health care delivery system subsidized by Cook County taxpayers that incorporate elements of models used in other communities, but that ultimately are tailored around this community's best interests.

c) Assess the current local tax subsidy of the Cook County health care system and provide recommendations regarding potential future increases.

d) Provide assistance in developing and implementing a comprehensive financial strategy for the Bureau., as an urgent priority

e) Convene a group of human resources and health care professionals both from within the Cook County system and outside the system to restructure the County's personnel administration of the Bureau, to free it from its current bureaucratic and political constraints so that the Bureau can more effectively and efficiently respond to the needs of the health care delivery system.

f) Assess the Bureau's health care workforce needs and staffing issues and affiliations; including the training of physicians, nurses, and other personnel, and determine the existing and future roles of the Bureau in addressing those issues.

g) Coordinate a community forum to assess the way in which the Cook County government handles issues related to health care, including its oversight of individual components of the delivery system, its receptiveness to creative solutions for insurance coverage, and its effectiveness in ensuring the public's health.

Issues for the Cook County Board

2) Direct the Bureau and provide its leadership with financial and staff support to produce, within a few months, a comprehensive fiscal strategy for resolving anticipated shortfalls in Medicaid reimbursement.

3) Direct the Bureau and provide its leadership with financial and staff support to produce, within six months, a plan to investigate public health care needs caused by changes in the community population, as well as advice for re-allocating the Bureau's resources to meet those needs. Discover challenges impeding such a plan and provide goals for its successful implementation, as well as goals for the system's clinical, quality, financial, and operational performance, which will be developed by the Blue Ribbon Commission and will be used as a "report card" for quarterly, public assessments. Public reporting should be based on measurable outcomes and benchmarks.

4) Work in coordination with the "Blue Ribbon Commission" to accomplish the following:

a) Immediately identify elements of the County system that have the most direct impact on the Bureau's ability to effectively fulfill its mission, which include but are not limited to human resources operations, information technology, operations, and budgeting processes.

b) Assess the effectiveness of current roles for the County Board and the Office of the President in the governance of the health care delivery system, and develop an alternative leadership structure that will ensure administrative transparency, accountability, and effective leadership.

c) Evaluate the appropriateness of the County tax subsidy of the health care system.

Issues for the Bureau of Health Services

5) Initiate a major strategic planning process with support from the Cook County Board. The plan should include a thorough assessment of the demand for services, the locations of new concentrations of people in need of care, the potential for partnering with other institutions, reconfigurations of existing Bureau facilities and programs to better serve patients who need health services most, and changes in the organization of care that are necessary to ensure effectiveness. Within six months, the Bureau should present this plan—with steps for its implementation and its objectives—to the Cook County Board.

6) Develop a comprehensive fiscal plan for the health system using external expertise supported by the County Board. The plan should address the following: (a) a Medicaid reimbursement strategy; (b) goals for generating revenue, including investments in systems and personnel that contribute to such goals; and (c) a defensible assessment of local subsidy required to meet projected demand and cost. This plan should be presented to the Board's Finance Committee, in addition to monthly updates for monitoring purposes.

7) In collaboration with the Cook County Board, establish a new mode of budgeting that is based on the demand for services, the need for new treatment and diagnostic capabilities, and expansion in new locations, and that includes intensive assessments of cost, coordination across Bureau facilities and programs, and quarterly benchmarks. This budget would become the purview of the Bureau, and it would not include hiring and expenditure constraints currently imposed by the County system.

8) Immediately engage the State of Illinois to measure the potential for future alternative strategies for protecting and maximizing Medicaid revenue for the Bureau, which may include (but are not limited to) geographic- or provider-specific waivers. Furthermore, the Bureau should assure the State that it wants a role as a prominent player in the State's new management of care initiatives, including disease management and primary care case management.

9) Convene key representatives of the Bureau's medical and administrative staff, including leaders and front-line workers, to develop an operational priority agenda. These priorities should be decided using an evaluation of data (and direct contact with patients) on real problems faced by patients within the system and should include the

creation of a "report card" intended for internal and external use. Targets for improvement should be established, and progress should be reported regularly to managers within the system, as well as to the system's governing entity, the Cook County Board.

10) Assemble key provider partners with whom the Bureau has historic ties such as community hospitals, the Chicago Department of Public Health, Federally Qualified Health Centers, the Access to Care program—for an open conversation about the status of their current relationships, to identify areas where collaboration can be improved, and to set priorities for future collaborative planning. Participants of this meeting also should identify gaps in the "virtual network," identify additional partners to assist in meeting growing and changing needs (particularly in the suburbs), explore how to incorporate community involvement, and set goals for the implementation of strategies. A formal structure and protocol should be established for this group of partners, through which they meet at least quarterly to assess the strength of their relationships.

CONCLUSION

This document presents a framework for improvement and thereby a call to action intended for the leadership of the Cook County health care system, the Cook County government, and the civic community. There is a clear and growing health care crisis in the health care safety net Cook County. The "solutions" to this crisis will need to be multifaceted and will require community and business leaders, health care providers, and elected officials to be creative and assimilate other communities' best ideas. Any plan to successfully manage the public health care problems in Cook County must have the Bureau as its foundation. Yet both the immediate and long term success of the Bureau will depend on new stewardship and management that is able to steer a course through the internal and external factors that are threatening its survival.

WHY HAVE THIS DISCUSSION NOW?

Current Conditions in Cook County

The Cook County government operates one of the largest public health and hospital systems in the country, the Cook County Bureau of Health Services. Over the past several decades, the system has expanded from its original, massive hospital on Harrison Street to a vast complex of hospitals and clinics located throughout the City of Chicago and its suburbs. The system is now faced with extreme pressures, including those caused by the following:

- A looming and potentially significant decrease in revenue generated from the State Medicaid program, the health system's primary source of patient revenue.
- A growing demand for emergency, hospital, and clinic services for uninsured people in the community.
- Escalating costs of personnel, technology, and pharmaceutical supplies, which are burdening the entire industry.
- New regulatory requirements for more-stringent quality and performance measures that generate a need for more-effective documentation practices and organization of care delivery.
- Changing demographic characteristics of the populations needing the services provided by the County system, which is mainly due to people moving out of Chicago public housing projects and the increased number of new immigrants in the Cook County suburbs.
- The overall increasing inability of other not-for-profit hospitals and clinics in Cook County—which have traditionally provided service to low income, under- or uninsured persons —to continue to meet growing demand.
- The federal government's lack of a comprehensive solution to the health care crisis. To date, instead of initiating reform to ease the burden on local communities, Washington has offered only incremental fixes, many of which,

including incipient policies regarding immigration-related changes for Medicaid and the curtailment of financing mechanisms beneficial to public hospitals, may actually create additional strain on public systems like Cook County's.

- The State of Illinois' movement to implement changes in the model for care delivery that will require innovation for the Cook County system to respond effectively.

To continue fulfilling its mission, Cook County must focus its effort to overcome these challenges. Cook County government is undergoing a transition. It has a long history of providing direct support for and operating the health care system, and it has successfully carried the system through extraordinarily difficult circumstances. However, while other local governments across the United States have begun creating forms of governance that allow more-concentrated oversight of their health care systems by people with expertise in the complexities of health care delivery, Cook County has not yet altered its approach. Rather, Cook County persists in operating in a non-transparent mode that is, by extension, not accountable to its constituency. The County does not incorporate the planning, efficiency, innovation, and, most significantly, the leadership that is necessary to resolve the imminent health care crisis. Now is our chance to extend the legacy of the Cook County health services, by ensuring its sustainability in the future.

National and State Issues Affecting Local Health Care

The National Climate

The federal government's message is clear regarding the financial goals for the Medicaid program, the health care payer most responsible for providing coverage for low income and underserved people in this country. The federal government is focusing its efforts on improving financial predictability, slowing the rate of cost increases, and developing mechanisms to ensure accountability. Flexibility for states is such a high priority for the President Bush's Administration that the very nature of Medicaid

entitlement is being reconsidered, if only indirectly. Executive and legislative branches have committed to budget reductions, and the Medicaid program has been specifically targeted for extensive cuts in the coming years.

The recently enacted Deficit Reduction Act will affect low income populations, as well as how health care is delivered, although it will not target safety-net and public-hospital systems. One item that must be noted in budget reconciliation is the provision related to "Improved Enforcement of Documentation Requirements," which prohibits states from receiving matching funds for Medicaid services provided to individuals who have not provided satisfactory proof of US citizenship and sets forth new higher documentation standards for health care reimbursement. It is too early to determine the extent to which this will affect the Cook County health care delivery system, but it is apparent that there has been a significant change in tone. In addition, the Act may affect the Cook County health system by allowing and encouraging more "cost sharing" by patients. These types of measures have been shown to increase the number of uninsured persons who are cared for by the Cook County system.

Generally, the federal government occupies itself with health insurance portability, information technology, health savings accounts, and tax incentives for purchases of private insurance. But these matters have a less-direct effect on large public health care systems. Discussed below are issues that more-immediately impact public hospital systems, including immigration-related issues, "special financing," and the inexorable increase in the number of uninsured persons.

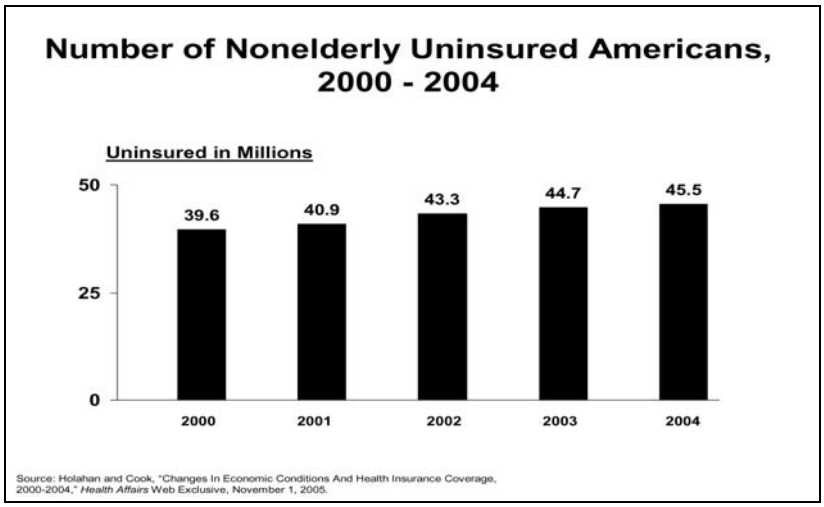
The Centers for Medicare and Medicaid Services (CMS) has repeatedly identified Illinois as being at high risk with respect to certain aspects of its health care financing. A 2002 Urban Institute study indicated that only New Jersey and Georgia enhanced federal matching funds to a greater degree than Illinois.[1] In addition to CMS indications that certain "special financing arrangements"—such as those used by Cook County—are being greatly scrutinized, federal law specifically phases out a portion of financing related to Illinois Medicaid. Pressure on the CMS to carefully review "special financing arrangements" seems to be greater than ever. Criticism of state plan amendments,

[1] States' Use of Medicaid Maximization Strategies to Tap Federal Revenues, June 2002.

waivers, and care coordination decisions and their relationship to "special financing" arrangements continues to get louder.

The population of uninsured persons continues to grow at a consistent rate. In Washington, competition among advocates for foreign affairs, budgetary matters, and disaster relief issues have taken precedence over large-scale reform intended to help uninsured persons. Meanwhile, state and local governments attempt to manage the problem. Figure 1 demonstrates the steady growth of the population of uninsured Americans.

Figure 1



Aggregate numbers of uninsured persons, however, do not reveal the entire problem. Segments of the uninsured population vary greatly with respect to the formulation of policy options. For example:

- Nationally, approximately 9 million children are eligible for Medicaid or the State Children's Health Insurance Program.
- Nationally, approximately 8 million uninsured persons are 19–24 years old.

Populations without United States citizenship or those with pre-existing medical conditions are perhaps more difficult to deal with, and they are perhaps more relevant to a large public hospital system:

- Nationally, 10 million uninsured persons are currently non-U.S. citizens.

- Among people who are uninsured or under-insured, a significant number of persons have difficulty obtaining insurance because of pre-existing health conditions.

People in these groups often have profound effects on the safety net and the public health system, because the public system is often their only option. Although the nature of retroactive eligibility for Medicaid mitigates difficulties experienced by children and others whose profiles match the categories for eligibility, non-citizens and individuals who are effectively "uninsurable" in the commercial market face great challenges that, in many cases, are only solved by safety net health systems.

One of the major causes of the increasing number of uninsured persons has been the slow erosion of employer-sponsored health insurance. Changes in the manufacturing and service sectors, as well as the emergence of Medicaid as an alternative for high income individuals, have contributed to this problem. Figure 2 from Crain's[2] identifies Chicago's largest employers, and figure 3 shows how Medicaid has supplanted employer-sponsored health insurance as a major source of health insurance.

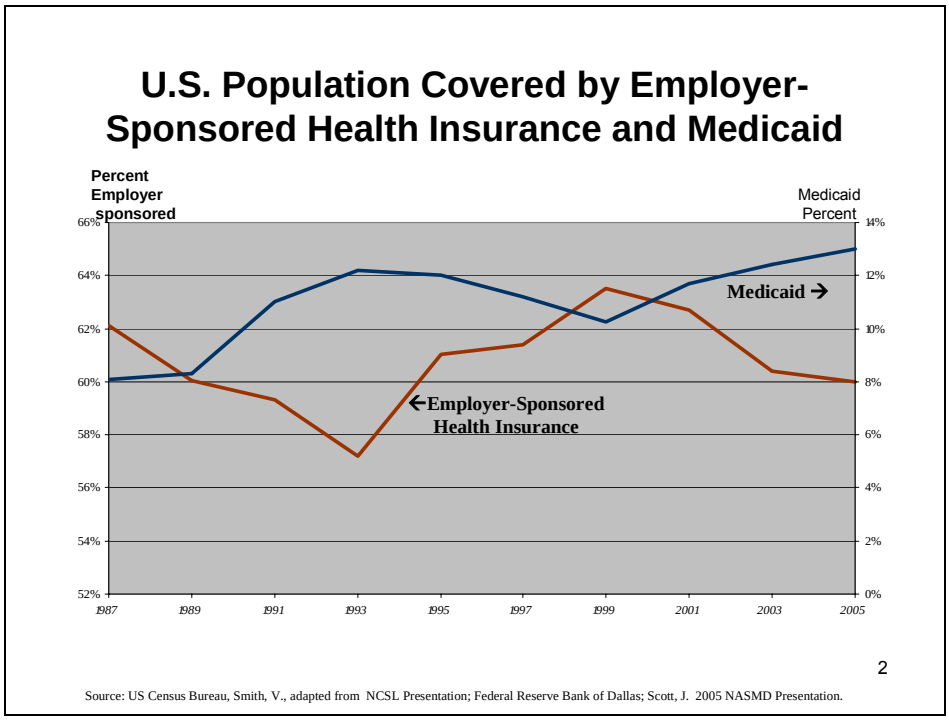
Figure 2

*1987**		*1995*		*2005*	
1. Sears, Roebuck and Co.	37,416	1. Chicago Public Schools	43,404	1. US Government	78,000
2. Jewel	28,500	2. City of Chicago	41,328	2. Chicago Public Schools	43,783
3. AT&T	24,000	3. US Government	34,456	3. City of Chicago	39,675
4. Illinois Bell	18,731	4. Cook County	27,849	4. Jewel-Osco	34,037
5. Dominick's	18,000	5. US Postal Service	25,083	5. Cook County	25,482

*No government information provided.

[2] 1987/1995: Crain's Archives; 2005: Crain's Chicago Business, October 3, 2005 *http://www.chicagobusiness.com/cgi-bin/redirect.pl?portal_id=45&id='/cgi-bin/article.pl?portal_id=173fLaVmOpage_id=1806'*

Figure 3



A recent survey of businesses provided insight into an employer's perspective of how health care has become the most important policy issue on business agendas for policy makers. Business leaders rated health care reform as being the most preferred U.S. legislative issue that they wanted addressed this year, followed by tax reduction and budget deficit reduction.[3]

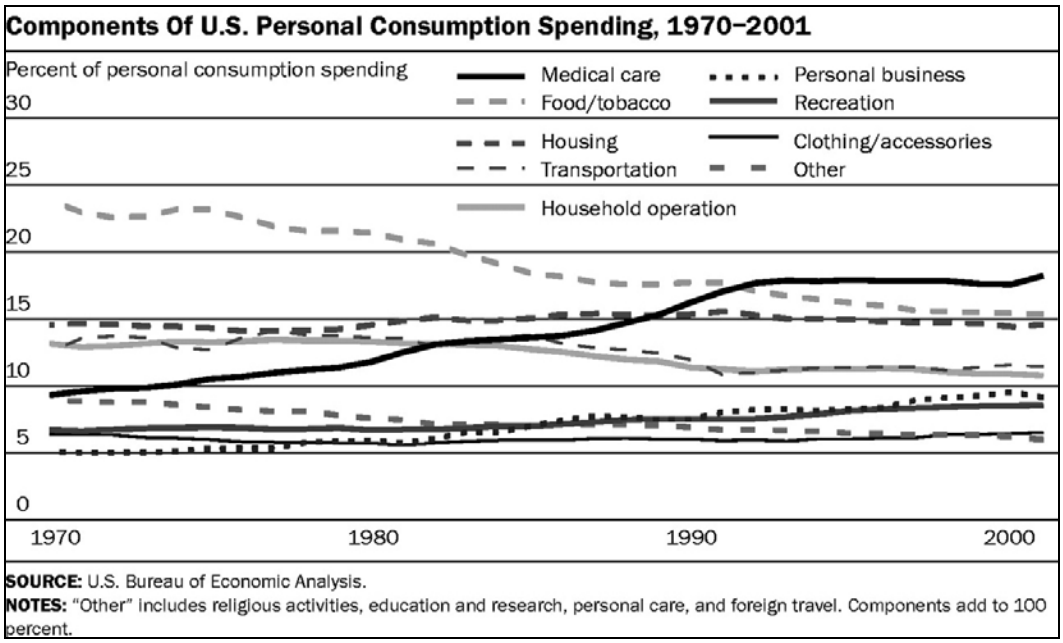
Americans are spending a greater proportion of their incomes on health care than they have in the past. Potential consequences of the unfettered increase in the cost of health care include several scenarios. Perhaps the worst-case scenario would be an increase in the population of uninsured persons, with a greater disparity in their overall health than currently exists. In addition, the burden of uncurbed health costs will, over time, put America at risk of becoming less competitive in the global economy. But the most immediate consequence involves the incremental deterioration of the health care

[3] http://www.prnewsire.com/cgi-bin/stories.pl?ACCT=104&STORY=/www/story/90-31-2

system, as we have known it. Closely monitoring contemporary policy debates (e.g., debates regarding Massachusetts health reform, intergovernmental transfers, and safety-net funding), novel developments in the health care market (e.g., health savings accounts), and ways that innovation and technology are integrated with public systems are crucial to formulating effective responses to the unfolding health care crisis.

Figure 4 from the U.S. Bureau of Economic Analysis shows how spending among U.S. consumers has changed since 1970. As the chart demonstrates, medical care has ascended as a major cost for consumers.

Figure 4



The State Climate

Illinois Governor Rod Blagojevich and the Illinois General Assembly authorized the AllKids initiative in the Fall of 2005. The initiative will provide and subsidize health insurance for approximately 250,000 uninsured children, the bulk of whom reside in Cook County.

To help fund the program, the State seeks to enroll most Medicaid recipients in primary care case management (PCCM), and disease management programs. The program will be rolled out in the summer of 2006 for Medicaid recipients who choose to have clinic-based medical home, and most other patients will be enrolled in December 2006.

In its goal of providing a medical home, PCCM, as well as the Disease Management contractor's care coordination initiative, could certainly become a positive force in coordinating care and promoting cost-effectiveness. The creation of the PCCM network and allowing patients to have choice in their care, however, will have a less than certain effect on patient utilization of these services. Additionally, the effect of changes in patient utilization on Intergovernmental Transfer will be a key issue.

The challenges of balancing the demands of the public system and the safety net, as well as those of other Illinois providers with larger commercial populations are described in Illinois Attorney General Lisa Madigan's Tax-Exempt Hospital Responsibility Act. Specifically, these challenges are mentioned in discussions regarding tax-exempt status and the percentage of free services (i.e., community benefit) required to maintain a tax-exempt status. Madigan has maintained that, on average, Illinois hospitals spend <1% of revenue generated by hospital charges on services for uninsured persons. Although the statistics and assumptions related to this issue are debatable, at a minimum it provides valuable insight and promotes dialogue regarding issues related to the provision of care for uninsured persons.

Certainly, the work of the Adequate Health Care Task Force, which was created by the Health Care Justice Act, is critical to the future of uninsured persons in Illinois. The Task Force is currently crafting a plan that will provide Illinois residents with access to a full range of preventative, acute, and long-term health care by 1 July 2007.

Trends in other states reflect philosophical shifts that occur as they try to control the unabated increases in health care spending. Although employers experience the same fundamental pressures, problems in state government health care systems are typically more visible. There is a tremendous amount of activity related to health reform among states. Especially visible initiatives include the Massachusetts universal health care model and the Florida Medicaid Modernization Proposal.

Common themes among state reform measures include the protection of "special financing" (Intergovernmental Transfers), increased cost sharing, financial predictability, and an increased emphasis on quality of care and care coordination initiatives, including managed care. Common to many reform measures are attempts to do more with less and improve accountability. Whereas deliberate coverage initiatives were central to reforms of the mid to late 1990's (e.g., State Children's Health Insurance Program and Illinois KidCare) that benefited large public systems, such initiatives are now secondary considerations to more-philosophically driven initiatives.

The Changing Nature of the Populations and Communities Needing Cook County Health Services

It is critical for a health system like Cook County's to understand and monitor the medically underserved populations, know where they live, and know what their health care needs are. Such populations are rapidly changing. Over the past decade, the Bureau of Health Services operated with the knowledge that requiring people to travel long distances to seek care at the old Cook County Hospital campus was placing an undue burden that caused suffering and that imposed barriers to appropriate care. However, these patients have relocated over time, and failing to address such changes will cause replication of past mistakes. Furthermore, knowing these patients and their health care needs is imperative to developing effective methods of health care delivery.

Who are the Patients?

Who are the people served by the Cook County Bureau of Health Services? As the flagship of the health care safety net for metropolitan Chicago, the Bureau of Health Services has a commitment and an obligation to provide health care for uninsured and underinsured persons; the demographic characteristics of this population have undergone constant change for the 150 years that Cook County has been providing health and medical care. Over time, socioeconomic conditions and their effects, such as rapid economic development or in-migrations of new populations, have shaped the health care challenges that Cook County health facilities and programs confront.

A fear of disease epidemics spreading to the general population is the reason why the Cook County Hospital was established. Citizens of Chicago had suffered from several devastating outbreaks of cholera,[4] and typhoid, scarlet fever, diphtheria, and tuberculosis were common causes of death, especially among young and poor persons.[5] At the time, civic leaders were determined to protect citizens against "pestilential" or infectious diseases. At a time when most medical care was received in the home, the first hospital was built and mainly served poor immigrants who lived

[4] Beatty, William K. "When Cholera Scourged Chicago." Chicago History 11. 1982.

[5] Report[s] of the Board of Health of the City of Chicago. 1870.

relatively near the hospital, on the west and near-south sides of the city. Cases of infectious disease and trauma were seen most often, both of which were risks for people working in the rapidly growing industrial district that neighborhoods in the west and near-south sides had become. The patients were often young and had a short life expectancy.

The threat of an epidemic was the reason why Cook County began delivering health care in earnest. The County responded to this perceived threat and cared for persons with infectious disease. Ultimately, however, several different factors led to the emergence of a comprehensive health care system, including the improvement of economic conditions for poor persons, public health measures, and civic planning. For instance, the spread of water-borne illnesses, such as cholera, was halted by reversing the direction of the Chicago River. But health conditions in Cook County are constantly fluctuating, primarily in tandem with changes in demographic characteristics and behaviors of the Cook County population.

Chicago experienced a significant increase in its African American population during and after the Second World War.[6] For many years, African Americans were excluded *de facto* from most private hospitals in Cook County. Bureau hospitals and older health centers, however, are mostly located in or near African American communities, which continue to be the predominant patient population served by the Bureau of Health Services. There have been massive disparities between the health status of African Americans and that of other Chicagoans. During the 1920s, 60 of every 100,000 whites died of tuberculosis, whereas 1000 of every 100,000 African Americans died.[7] Improvement in housing and socioeconomic conditions and health services have shrunk this disparity, but not eliminated it. The African American population now suffers from new health threats that have emerged because of infectious disease and the aging of the population.

The population of Cook County and metropolitan Chicago would have decreased between 1990 and 2000 without a sharp increase in the Hispanic population. During this

[6] Grossman, James R. Land of Hope: Chicago, Black Southerners and the Great Migration. 1989.

[7] McBride, David. From TB to AIDS: Epidemics Among Urban Blacks. 1991.

period, the Hispanic population increased by 600,000, two-thirds of whom moved into the suburbs. The population of Hispanics is now split evenly between city and suburbs, and more than one-quarter of the County's total population is Hispanic. This group is now equal to or larger in size than the African American population. The population of Hispanics in Cook County is younger than the remainder of the county population, and it is growing at a faster pace. Approximately 75% of Hispanics in metropolitan Chicago are of Mexican descent.[8] This increase in the proportion of the Hispanic population in the metropolitan area is mirrored in the proportions of the various populations who use Bureau facilities. The Mexican population is young and likely to use fewer health services than an elderly population. The majority of children are citizens, having been born in the United States, and may qualify for publicly funded health insurance if household income is low. However, for various reasons, a substantial number of eligible children are not enrolled in these programs.[9] In fact, Hispanic adults are the most likely persons in the United States to lack health insurance.[10] In Cook County, most Hispanics are employed, often in jobs that do not offer health insurance; therefore, they do not qualify for public programs.

Cook County has served other populations throughout the years, including recent immigrants. The second-most commonly requested language to be interpreted at the Bureau is Polish, followed by Mandarin Chinese. In addition, it is not uncommon for other Asian or Middle Eastern patients to be admitted to Bureau hospitals. Ambulatory services, on the other hand, care for a more diverse population. The growth of the service economy, which includes many occupations that do not include health insurance benefits, has contributed to the diversity of persons seeking ambulatory care, pharmaceuticals, diagnostics, and other treatments from the Bureau.

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[8] Paral, Ready, Sun, Chun. Latino Growth in Metropolitan Chicago. Institute for Latino Studies. U of Notre Dame, 2004.

[9] Ku, Blaney. Health Coverage for Legal Immigrant Children. New Census Data Highlight, Center on Budget and Policy Priorities, 2000.

[10] Schur, Feldman. How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured. Commonwealth Fund, 2001.

Where do Medically Underserved Persons in Cook County Live?

The neighborhoods and communities that utilize the Bureau's health services have shifted in the past decade. African Americans, who were concentrated on the west and south sides of Chicago and in the south suburbs, contribute the largest share of patients seeking Bureau health care services.

Within the city, the west and south sides still have the greatest number of persons in need of medical services. However, the greatest increase in the number of medically underserved persons in the city has occurred in neighborhoods on the southwest and northwest sides. Currently, Chicago's poorest racially segregated inner-city neighborhoods still exist, but a decrease in available housing and gentrification have caused them to shrink. The "bungalow belt" of the northwest and southwest side neighborhoods, however, where the city's large ethnic working class traditionally lived, is now largely Hispanic, and it has the fastest growing population of persons with unmet medical needs.[11] In addition, a corridor of Hispanic residencies has developed along Clark Street and Ashland Avenue in the north side, to the northern city limit. Lastly, many African Americans that lived on the south side of Chicago have now relocated to suburban communities, such as Country Club Hills, Hazel Crest, and Park Forest.

Considering Cook County overall, the suburban communities are experiencing impressive increases in medical need, especially the south and southwest suburbs, as well as certain west and northwest suburbs. Increases in Hispanic populations in suburbs and increases in the numbers of medically underserved persons living in the suburbs have been noted throughout the United States. Currently, African Americans constitute at least 15% of Cook County's suburban population. Typically, health care organizations that have served vulnerable populations have not followed the needs of those populations into the suburbs. Most health care providers in the suburbs are

[11] Casting Chicago's Safety Net: A 12-Year Review of Chicago's Community-Based Primary Care System. Salem, Ferguson, Chicago Dept Public Health, 2005.

privately financed and are located in and oriented to communities with higher incomes and better-financed health insurance profiles.[12]

The Cook County health system faces the challenge of serving populations in need of medical care that are, in many ways, different than the patient population of 10 years ago, with respect to where they live, their ethnic backgrounds, and their occupational and socioeconomic statuses. Although the number of persons under the federal poverty level has decreased in the past decade in the City of Chicago, the number of persons with incomes between 100% and 200% of the poverty line has increased. By anyone's reckoning, these persons are poor, but adults with such incomes do not usually qualify for public health insurance. These working poor adults also are unlikely to be covered by health insurance sponsored by their employers, but their incomes do not allow for substantial contributions toward even modest health care costs.

What are the Health Needs and Health Statuses of Persons Dependent on Cook County for Health Care?

In a report published in 2000, the U.S. Public Health Services' Health Resources and Services Administration compared Cook County's overall health to that of other U.S. counties similar with respect to size and demographic characteristics. For many categories, they found that the health of Cook County was less favorable that that of the other counties. For example, the death rate (all causes) was found to be greater in Cook County than in other peer counties.[13] The age-adjusted mortality rate was even higher in Cook County (605 deaths per 100,000 persons), compared with that of the United States overall (497 deaths per 100,000 persons).[14]

The leading causes of death in Cook County are the same as those in any large population center in the United States. Cardiovascular disease is the most common

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[12]Andrulis, Duchon. Hospital Care in the 100 Largest Cities and Suburbs, 1996-2000: Implications for the Future of the Hospital Safety Net in Metropolitan America. SUNY Downstate Medical Center, 2005.

[13] Community Health Status Report: Cook County IL, DHHS, HRSA, Wash. D.C. 2000.

[14] Mortality Patterns-United States 1997. JAMA 1997: 282, 1512-13.

cause, followed by cancer. However, in Cook County, as in other large metropolitan areas, there are differences in the prevalence and impact of these and other chronic conditions among residents who are poor and/or racial minorities, compared with the population overall. The disparities of overall health status between populations served by the Cook County Bureau of Health Services and the remainder of County's population are enormous, and they contribute greatly to the overall poor health ranking of the metropolitan community. The conditions that contribute to this disparity are chronic illnesses that are treatable by self-management and behavior change. In addition to cardiovascular disease and cancer, stroke, diabetes, and chronic respiratory diseases are major causes of Cook County's poor health.

The stereotype patient with heart disease is of a hard working, type A, male executive who suffers a heart attack. On the contrary, heart disease is more common among minorities and poor people. African Americans with the condition die at rate that is 30% higher than the rate for whites, and women die at a higher rate than men.[15] African Americans have the highest prevalence of hypertension of any group. Cancer is a greater burden on the poor and minorities than it is on the rest of the population. African American men develop cancer 25% more frequently than white men.[16] Generally, minority survival rates of cancer are lower than the general population. What should be especially noted, however, is that heart disease and cancer are chronic illnesses. They can be prevented outright, or detected early and managed effectively. Treating these conditions at a late stage is costly and often futile. The same populations that experience a greater burden of these chronic conditions are also least likely to receive early and effective prevention, detection, and treatment. Historically, the County's mission was to care for those who "truly needed care" and had nowhere else to go. Currently, this approach is widely recognized as being outdated and expensive, and it is agreed that disparities in health status across different populations and escalating health care costs cannot be solved without focusing on chronic illnesses. Yet, the County's health system typically focuses on care for persons with illnesses in late stages.

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[15] Centers for Disease Control and Prevention, National Center for Health Statistics, Mortality U.S 2004.

[16] Center to Reduce Health Care Disparities, National Cancer Institute, National Institutes of Health, 2006.

Often, the effect of an illness is described in terms of the number of deaths caused by a specific condition. However, these same conditions also cause disability and suffering that decrease earnings, productivity, and the quality of life of individuals, families, and communities. The prevalence of diabetes is 70% higher among African Americans and 100% higher among Hispanics than it is among whites in the United States.[17] Although diabetes may cause death or may be a powerful contributor to the development of heart disease, it is also associated with several other serious health problems when it is poorly controlled. When persons in the community are seen with legs amputated at or below the knee, diabetes is far-more often the cause than trauma. The minority community served by Cook County experiences amputations at a rate that is 2–3 times that of white patients. Diabetes is preventable if it is effectively controlled, and it might also be ameliorated with adequate specialty care.[18]

Asthma is a major public health issue of increasing concern. Cook County and Chicago have been identified to have a higher prevalence, death rate, and health care utilization associated with asthma than other areas of the United States.[19] The burden of asthma falls heaviest on poor people in urban areas of the County.[20] It is the leading cause of school absenteeism due to chronic illness in the Chicago Public Schools. However, this completely treatable disease has not been adequately addressed in Cook County, and the appropriate methods of doing so are not being used.[21]

Patients served by the County system are more likely to experience arthritis than the general population. More than one-half of adults >45 years old in the primary service

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[17] Centers for Disease Control and Prevention, National Center for Health Statistics, 2004.

[18] Feinglass J, Rucker-Whitaker C, Lindquist L, McCarthy WJ, Pearce WH. Racial differences in primary and repeat lower-extremity amputation: results from a multihospital study. J Vasc Surg 2005;41:823-9.

[19] Weiss KB, Wagener DK. Changing patterns of U.S. asthma mortality: identifying target populations at high risk JAMA 1990;264:1683-7. Sandra D. Thomas and Steve Whitman. "Asthma Hospitalizations and Mortality in Chicago, An Epidemiologic Overview" CHEST/ 116/ 4 / OCOTBER, 1999.

[20] Marder, D, Targonski, P, Orris, P, et al (1992) Effect of racial and socioeconomic factors on asthma mortality in Chicago. Chest 101,426S-429S.

[21] Grant EN, Malone A, Lyttle CS, Weiss KB. Asthma morbidity and treatment in the Chicago metropolitan area: one decade after national guidelines, Ann Allergy Asthma Immunol. 2005;95:1-3.

areas of the Bureau have arthritis and chronic joint symptoms.[22] Perhaps these conditions are so ubiquitous that their contribution to the health status of the metropolitan area is overlooked. Arthritis, after all, is the leading cause of disability in the United States.[23] But whatever the case, the pervasiveness of these conditions are certain to increase as the population ages and as the prevalence of obesity increases.

Infant mortality among African Americans in Cook County is more than double the rate among whites.[24] There has been an impressive decrease in infant mortality overall in the last fifteen years in Cook County, but the high level of deaths among African Americans is striking; such deaths are primarily caused by congenital abnormalities, pre-term/low birth weight, sudden infant death syndrome (SIDS), problems related to complications of pregnancy, and respiratory distress syndrome.[25] Preconceptual care, early and high quality prenatal care, and expert management of high-risk deliveries and intensive care of babies with very low birth weights are effective ways to decrease infant mortality.

Injury, both intentional and unintentional, is an important health condition in the communities served by the Bureau. Homicide is a factor with the third-highest health status disparity, exceeded only by cancer and heart disease. Young African American males are at highest risk for homicide. They are at highest risk for homicide-related death between the ages of 18 and 24 years, and they are more than eight times more likely to be murdered than white males of the same ages.[26] Actually, there is a paradox among homicide levels nationwide. The rate of aggravated assault has increased, and the potential for firearms to be used in a lethal manner is much greater when death rates

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[22] Feinglass J, Nelson C, Lawther T, Chang RW. Chronic joint symptoms and prior arthritis diagnosis in community surveys: implications for arthritis prevalence estimates. Public Health Rep 2003;118:230-9.

[23] Disability and associated health conditions—United States, 1991–1992. Morb Mortal Wkly Rep 1994;43: 730–1, 737–9.

[24] Chicago Dept. of Public Health, Cook County Dept. of Public Health online vital statistics, 2005.

[25] National Center for Health Statistics (NCHS), 2005.

[26] Influence of homicide on racial disparity in life expectancy—United States 1998. Morb Mortal Wkly Rep 2001;50:780. Bureau of Justice Statistics. Homicide Trends in the United States, U.S. Government Printing Office, Washington, DC, 2004.

decrease. Health analysts consider the presence of trauma centers and the use of highly technological treatments of injury to be the reasons why homicide rates have decreased.[27] Childhood accident rates disproportionately affect minority children. More than eight of every ten children who die by accidents in the metropolitan area are minorities.[28]

People of different races and ethnicities have been disproportionately affected by the HIV/AIDS epidemic in Cook County, as they have throughout the United States. African American and Hispanic persons are most likely to be newly infected with HIV.[29] Almost eighty percent of newly infected women are minorities. Primary prevention is the solution to this epidemic, but treatment of infected persons can significantly extend life, improve the patient's quality of life, and decrease infectivity.

Of minorities, the largely Mexican and/or Hispanic populations have the best health status. A population consisting largely of immigrants is expected to be healthier than persons of the same race or ethnicity who did not emigrate from their home country. Wide health status disparities exist between minorities and the majority population in the United States, but to some extent the gap has been narrowed. However, for Hispanics, most disparities regarding quality and access to health care are growing wider.[30] The African American elderly population is growing rapidly, and it is associated with poverty and poor health.

What is Happening to the Health Care Safety Net in Cook County?

This report is focused on the Cook County Bureau of Health Services. However, it is important to note other components of the health care delivery system that have a critical role in ensuring access to care for medically vulnerable people. Just as non-County elements of the safety net system would likely collapse without the County's

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[27] Trunkey D. Trauma Centers and Trauma Systems. JAMA 2003;289:1566-7.

[28] Most Accidents Still Claim Minority Children. Chicago Reporter, July/August, 1999.

[29] National Center for Health Statistics (NCHS). Health, United States, 2004.

[30] National Healthcare Disparities Report 2005. AHRQ, PHS.

services, the Bureau would fail to meet the broader demand if non-County providers significantly reduced their contributions. They are mutually beneficial. A more-detailed description of other components of the "virtual safety net," including maps, is included in the Appendices section.

It is also important to understand that the inter-relationships between these institutions—both formal and informal—is essential to ensuring that scarce resources are used most efficiently, that duplication of services is minimized, and that gaps in the continuum of health care offered by the various providers are closed. There are indications that this alliance becomes strained as demand for health services increases. For example, although there are a significant number of clinics (e.g., County, City, federally-supported, VA, and free clinics) providing primary care to medically indigent patients, nearly all of which depend heavily on the Cook County system for outpatient specialty care and diagnostic services for their uninsured patients. Despite nationally recognized efforts to ensure that referrals for such specialty care are appropriate, patients must wait long periods of time for appointments because the County system simply cannot keep in step with the enormous demand. The situation is exacerbated by the fact that many specialists do not accept patients who rely on Medicaid and have fled inner-city communities that most need their specialty services. Finally, because a large proportion of the growing population of uninsured persons is chronically ill adults who require ongoing specialty care, the demand for specialized services will continue to increase (e.g., every diabetic should see an ophthalmologist every year to prevent blindness).

The relationships between these institutions must be thoroughly understood and well coordinated, and new relationships must be forged to ensure the effectiveness of the safety net. The first step in this direction is learning the role of each of each institution and the scope of each system.

Cook County Bureau of Health Services

The Cook County Bureau of Health Services, one of the largest public health and hospital systems in the country, serves as a foundation for the broader health care safety net for the communities that comprise Cook County. The Bureau is an executive

agency of the Cook County government, under the aegis of the President of the Cook County Board of Commissioners. The Board of Commissioners acts as the governing board for the Bureau's operating entities.

The Bureau provides a full continuum of public health services to medically underserved persons with its seven operating entities:

- John H. Stroger, Jr., Hospital of Cook County: an acute care teaching hospital on the west side of Chicago, formerly known as the Cook County Hospital. This facility is the flagship hospital for the Bureau. It is widely know for its emergency, trauma, and burn services. It has 464 beds serving mostly uninsured patients or persons covered by Medicaid or Medicare. Stroger Hospital also houses the specialty care outpatient clinics and diagnostic services used by both primary care providers in Bureau clinics and other clinics and physician groups who also care for disproportionately underserved populations. Finally, in association with its medical school partner, Rush Medical College, it is the training site for hundreds of residents and fellows.

- Provident Hospital of Cook County: a community hospital on the south side of Chicago. Provident was acquired and reopened as part of the County system in the mid-1990s. It operates one of the busiest emergency departments in Chicago and provides space for additional specialty outpatient resources.

- Oak Forest Hospital of Cook County: a long-term care hospital and skilled-nursing facility in the southwest suburbs of Chicago. It is a destination for other Bureau hospitals that send patients for convalescent care, thereby increasing capacity at acute care hospitals for sicker patients. In recent years, as the demographic characteristics of the communities around Oak Forest have changed, the hospital has attempted to adapt its services to accommodate the increasing numbers of patients seeking emergent, outpatient specialty, and acute inpatient care.

- The Ambulatory and Community Health Network (ACHN): created in the mid-1990s, ACHN is a system of community- and hospital-based, primary and specialty care clinics located in medically underserved areas and schools

throughout Cook County, the City of Chicago, and the suburbs. It now provides more than 800,000 visits annually, making it the largest provider of ambulatory care to underserved populations in the County and one of the largest in the country.

- The Cook County Department of Public Health (CCDPH): CCDPH is the public health entity providing a full range of public health screening, disease prevention, and health education services and regulatory services for suburban Cook County.

- Cermak Health Services: Cermak is the single-largest correctional health facility in the nation, with >100,000 people passing through it every year. It provides public health screening, primary and specialty care, and mental health services for detainees in the Cook County Department of Correction facilities.

- The Ruth M. Rothstein CORE Center: a facility established as a unique public-private venture between Cook County and Rush University Medical Center. The CORE Center is a free-standing facility on the west side of Chicago, adjacent to Stroger Hospital, providing comprehensive treatment of HIV/AIDS and related infectious diseases.

For more than one hundred and fifty years, Cook County has provided public health services to persons in medical need, regardless of their ability to pay. Today, the Bureau of Health Services provides a full range of primary and specialty outpatient services, inpatient acute care, long-term, and rehabilitation services. Over the past decade, it has become the dominant provider of community-based ambulatory care in Cook County, particularly for uninsured persons. Outpatient clinic visits to the 90+ primary and specialty care clinics located at Fantus Health Center and Stroger Hospital alone totaled nearly one-half million visits last year, with nearly that many provided in the 30 other clinics throughout the system. Emergency room volumes at Stroger Hospital, which remain at approximately 160,000 visits per year, outnumber those at the next three largest local providers combined, and the annual number of visits between the Bureau's three hospitals together total nearly one-quarter of a million. More than 70% of the emergency department and clinic visits are uncompensated by insurers.

By a wide margin, the Bureau is the largest provider of health care services to Medicaid-dependent and uninsured persons in the area. In addition, the Bureau has increased the effectiveness and the reach of its programs by means of explicit partnerships with other safety net health providers. There are formal clinical partnerships between the Bureau, community hospitals, and Federally Qualified Health Centers that are intended to make efficient use of scarce resources and minimize duplication of services.

In 1993, the Cook County Bureau of Health Services was created by an ordinance of the Cook County Board of Commissioners to serve as an umbrella agency. It was intended to consolidate each of the County's health care entities into a comprehensive organization able to address health priorities for the most vulnerable patient populations in Cook County.

Oversight of the Bureau

The Bureau is governed by the 17 member Cook County Board of Commissioners which is the governing policy board and legislative body of the County. The Commissioners have authority over and final approval of the County's fiscal year budget and appropriations. The County Board's oversight of each County office's budgeted dollars is accomplished through in its Finance Committee where all County proposed contracts and expenditures over a significant amount are discussed and considered for the Board's approval. The Board conducts its business at regularly held bi-monthly meetings. Business items not approved by the Board at these regularly held bi-monthly meetings are to be referred to one of the Board's eighteen standing legislative committees and thirteen subcommittees for further discussion, public comment and recommended action by the full Board. These committees meet at the discretion and call of the committee's and subcommittees respective Chairmen. In addition to meetings called by the Chairman, the Board's Finance committee also conducts business at regularly held bi-monthly meetings that immediately precede the County Board meetings.

The Bureau's oversight by the Board is conducted primarily through the Health and Hospitals Committee (HHC) a standing committee of the whole (all seventeen commissioners). The committee is responsible for reviewing all matters that relate to the quality and availability of health care services for county residents as recommended by

the Bureau of Health Services. The HHC has a number of subcommittees that relate to specific facilities within the Bureau; *Stroger & Cermak Hospitals Committee*, *Oak Forest Hospital Committee*, *Provident Hospital Committee*, and the *Public Health Committee which is* reviews matters referred to it by the Cook County Board or the Health & Hospitals Committee that relate to the Cook County Department of Public Health.[31] Review of the agendas of these Committees suggest a while they are operational, little substantive oversight is occurring. It should be noted, that while the above noted process for oversight seems well specified, review of minutes from the HHC over the past two years, does not suggest detailed oversight is actually occurring through these committees.

In addition members of the Board of Commissioners, Cook County's government organization falls under eleven elected offices of which the President of the County is the most relevant to this report. The President of the Board has direct authority over 41 departments; most are organized into six bureaus: Administration, Finance, , Human Resources, Information Technology and Automation, and Public Safety/Judicial Coordination, and Health Services. With the consent of the Cook County Board, the President appoints the Chiefs of the County bureaus and Directors of the departments. Through this organizational structure, the President of the Board has direct and sole authority over all hiring in the County. [32]

The Cook County Budget ($2.999 billion in FY 2005) covers the activities of the County itself, including expenses for the Circuit Court of Cook County and all the independently elected county officials, but not for the Cook County Forest Preserve District (which is a special taxing district with a separate budget). The largest of the restricted funds is that for the County Health Facilities, which has a tax levy separate from that of the County.[33]

Cook County uses revenue sources available to a home rule county. In addition to property and sales taxes, funds also come from state and federal government matching

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[31] [REF:http://cookcountygov.com/secretary/CommitteePages/default.htm]

[32] [REF: http://www.co.cook.il.us/secretary/HomePage_Links/six_county_bureaus_under_the_pr.htm]

[33][ref:http://www.co.cook.il.us/secretary/HomePage_Links/whats_cookin_in_cook_county_book]

dollars, appropriations and grants; fees for services and statutory percentages of certain court fines; interest on investments; and from sale or lease of land and/or property. The County can also collect fees for licenses, parking, permits and franchises, and income from fines in unincorporated areas where no municipality is collecting such charges. The County does not receive any portion of local government taxes placed on telecommunication or utility bills.

In FY2006 the County government will spend approximately $926 million dollars for health care services. The health care portion of the County Budget represents approximately 41 percent of the general fund budget of the County.[34]

Other Components of the Safety Net in Cook County

The Chicago metropolitan area is fortunate, because it has a significant number of providers who play crucial roles in ensuring that people without insurance have access to health care services. These hospitals and clinics are described more fully in the Appendices section at the end of the text.

Disproportionate Share Hospitals

Under the Medicaid Disproportionate Share Hospital (DSH) program, hospitals that care for a large number of Medicaid-dependent and uninsured patients are eligible for additional Medicaid payments. Twenty-nine hospitals in Cook County meet the minimum federal requirements for DSH.[35] Because the majority of DSH payments in Illinois go to the Cook County Bureau of Health Services hospitals as part of an Intergovernmental Transfer agreement, the State of Illinois has created a its own program, modeled after DSH, to support other safety net hospitals. As a result, many safety net hospitals in

[34] http://www.co.cook.il.us/2006_budget2.htm

[35] Federal law specifies that hospitals meeting one of the following conditions must qualify for Medicaid DSH payments: (1) have a Medicaid inpatient use rate of at least one standard deviation above the mean for the state or (2) have a low income utilization rate of at least 25%. In addition, states may designate other criteria to allow additional hospitals to qualify for DSH.

Cook County—including all 29 DSH hospitals and 9 non-DSH hospitals—receive a majority of their funding through this Medicaid Percentage Adjustment (MPA) program. These hospitals provide a significant amount of care to both Medicaid-dependent and uninsured persons.

Academic Medical Centers

Academic Medical Centers also play a critical role in the Cook County health care safety net by providing primary, specialty, and tertiary care to Medicaid-dependent and uninsured patients, in addition to fulfilling their pedagogical and research missions. Cook County Academic Medical Centers include Rush University Medical Center, University of Illinois Medical Center, the Loyola University Health System, Northwestern Memorial Hospital, and the University of Chicago Hospitals.

Veterans' Administration (VA)

The VA operates 2 hospitals (Edward Hines, Jr., and Jesse Brown) and 6 clinics in Cook County by means of its Veterans Integrated Services Network. Edward Hines, Jr., VA Hospital is located 12 miles west of downtown Chicago and offers primary, extended, and specialty care, and it serves as a tertiary care referral center for the network. Hines Hospital also operates several community-based outpatient clinics, including clinics in Oak Park and Oak Lawn. Hines had nearly 512,000 patient visits in its network of outpatient clinics during the 2004 fiscal year.

Chicago Department of Public Health (CDPH)

The CDPH operates seven clinics that provide primary care services to severely indigent populations. In 2003, three of these clinics partnered with other hospitals to improve the comprehensiveness of their services and improve continuity between inpatient and outpatient services. For these clinics, the City of Chicago contracts private hospitals to provide primary care doctors who attend these patients when they are hospitalized. All seven City of Chicago health centers work with the Cook County Bureau of Health Services to provide specialty care. The City of Chicago clinics also facilitate access to behavioral health services, through one of the city's 13 behavioral health clinics. The

City of Chicago's seven health centers include five primary health care centers: Englewood, Uptown, Lower West Side, West Town, and Roseland; and two maternal/child health centers, South Lawndale and South Chicago.

Federally Qualified Health Centers (FQHCs)

FQHCs are primary care facilities that usually have independent community boards and that provide access to health care services to underserved populations and communities. According to the Health Resources and Services Administration in the U.S. Department of Health and Human Services, there are 21 FQHCs and other similar health care clinics in Cook County that provide services at 78 separate sites. These sites include the seven CDPH primary care clinics, which are designated as being Look-Alikes. FQHCs and similar health care clinics in Cook County annually serve >475,000 patients, the vast majority of whom have incomes below 200% of the federal poverty level. In 2004, approximately 40% of patients treated at FQHCs were uninsured, 41% were covered by Medicaid, and the remaining 19% had other public or private coverage.

Non-FQHC and Free Clinics

There are eight free clinics in Cook County: six in Chicago (Community Health, Pacific Garden Mission Clinic, Pilsen Homeless Health Services, St. Basil's Free People's Clinic, Chinese Community Center, and the Free Health Clinic operated by the New Life Volunteering Society); one in LaGrange (LaGrange Community Nurse Health Association), and one in Rolling Meadows (Neighborhood Health Resource Center). Free clinics typically do not accept government funds and are operated by volunteers. In 2005, these clinics provided a total of >34,000 patient visits for primary care and dental services.

Access to Care in Suburban Cook County

The Suburban Primary Health Care Council operates the Access to Care program, which is funded significantly by a line-item in the Cook County Bureau of Health Services budget, is a unique public-private partnership that makes primary health care, pharmacy, laboratory, and radiology services available to low income, uninsured

persons in suburban Cook County and northwest Chicago. Although the Access to Care program relies on Cook County specialty and inpatient services, it organizes the provision of charitable primary health care services by contracting local physicians and compensating them at a discounted rate ($68 per patient per year). A modest enrollment fee and a small co-payment is requested of program enrollees. Eligibility requirements include the following: having a family income less than twice the federal poverty level and no health insurance (or a deductible of ≥$500 per person), being ineligible for Medicare or Medicaid, and having a residence in suburban Cook County or northwest Chicago (defined as being located west of Pulaski Road and north of North Avenue).

In 2004, nearly 12,000 individuals were served by the Access to Care program, with a total of 44,925 prescriptions that were dispensed and 9917 laboratory and 919 radiology procedures that were performed. Single adults (38% of enrollees) were the largest group of individuals served by the Access to Care program in 2004, because they are categorically ineligible to receive Medicaid unless they are pregnant or permanently disabled. The Access to Care program experienced a continued decrease in the number of eligible children (11.8% of enrollees) as a result of increasing enrollment in KidCare. The majority of enrollees (>61%) live in a household in which someone was working but did not have health insurance; however, in 2004, the program experienced the largest increase in the percentage of unemployed enrollees (30.6%) that have been served since the program's inception in 1988.

COOK COUNTY AS HEALTH CARE PROVIDER

Assets of the Cook County Bureau of Health Services

The Cook County Bureau of Health Services has many assets, which are envied by public health and hospitals systems across the United States. Its facilities are either relatively new or have been renovated in recent years, and its services are located across the County, with hospitals and clinics being located in some of the most medically underserved communities in the County. In the Bureau system, there is a full scope of available clinical services, ranging from community-based primary care and preventive services to outpatient specialty and diagnostic care to acute inpatient, long-term, and rehabilitation services. Such a range of services presents an enormous opportunity to coordinate and manage the care of patients at the appropriate facility and to an appropriate extent. The Bureau has established nationally recognized partnerships with private hospitals and community health centers to foster a more-efficient use of scarce resources. Other health care providers serving similar populations are open to partnerships and prefer coordinating with rather than competing against each other.

The Bureau's physicians are salaried, and this is considered to be an enormous asset, compared with other public systems where physicians are employed by medical schools. In the latter case, differences in the goals of the public system and the university often strain the medical staff. To prevent such problems, the Bureau's medical school affiliation with Rush Medical College has built-in protections to ensure that each institution's mission is enhanced, not compromised, by the relationship. Previously, the County has been able to maximize revenue through the federal match of local government subsidy of the health care system. Thus, while other systems have had major budget shortfalls for many years, the Cook County system is only recently beginning to experience similar problems, as a result of increasing costs and as creative funding resources become exhausted. This respite from financial woe has allowed the Bureau to build a new hospital, acquire and reopen Provident Hospital, establish new clinics throughout the County, and develop other service expansions, without extending the costs of those expansions to taxpayers.

Finally, all testimony and research associated with this study reflects unequivocal public support for the County's role in providing health care services to ensure access for the most vulnerable populations and communities. Such a benefit is not offered in all communities with public health systems. The Cook County Board of Commissioners—consisting of both Republicans and Democrats—has been unwavering in its commitment to maintain the public health care delivery system as the hub of the broader health care safety net, a commitment that was reiterated in interviews conducted for this report. The value of this commitment should not be underestimated.

Challenges Facing the Cook County Bureau of Health Services

Despite the assets of the Cook County Bureau of Health Services, there are very real challenges that could undermine the system's ability to satisfy growing demand for and increasing costs of services provided by the system's hospitals and clinics. These challenges will need to be identified, understood, and addressed.

Planning for the Needs of the Population

All public hospital systems should periodically assess their missions and thoroughly assess the following issues: who are the populations that need to be served (Where do they live, and what are their particular needs?); what health care services do these populations require; what resources are available that public system can defer to or partner with; and what priorities for the public system's resources can be established on the basis of this assessment. This planning process is critical to ensuring that resources are not wasted and that gaps in the safety net do not exist. By all accounts of our review of the public record and of people we interviewed for this report, the Bureau of Health Services simply has not initiated such planning in any comprehensive way.

The planning process should encompass a geographic assessment to ensure that facilities and services are in the right places, a cultural investigation of patients' needs to ensure that the most effective care is provided, a familiarity with changes in the health system to ensure that opportunities are maximized for both financial reimbursement and effective health care delivery, and a determination of clinical priorities to ensure that the types and allocation of resources are based on medical evidence and a mutually agreed (medical staff, administration, and governance) scope of services.

Planning for the geographic location of Bureau services should be based on demographic trends of medically vulnerable populations, coupled with an assessment of other providers available to provide services to these populations. For example, new clusters of uninsured residents are emerging in suburban Cook County, where there is no acute care Bureau hospital. The planning process needs to determine how many people require inpatient care (or other specialty and diagnostic services routinely provided in a hospital), other options available in each community, and the feasibility of either partnering with existing providers or establishing public services (e.g., converting more of Oak Forest's beds to accommodate acute care inpatients). This assessment needs to be exhaustive, and it should include discussions with local communities, staff and leadership from other health care providers, and, ultimately, the governance of the County.

As emphasized previously in this report, the cultural and ethnic make-up of the patient populations using the Bureau's services are constantly changing. It is clear that the growing Hispanic population will likely comprise an increasingly larger proportion of patients treated at the Bureau's clinics and hospitals, as will other ethnic groups. Planning for the particular needs of these populations will be critical to the effective delivery of care. In addition, many African American patients who usually used the County health system while living on the south and west sides of the City of Chicago have now moved into the south and western suburbs, where few services are available. And the increase in the number of uninsured persons is especially large among working class populations, whose employers are discontinuing or limiting health care coverage. The population of uninsured persons includes people from all ethnic groups and geographic areas of the County. Effectively providing services to this diverse population will require partnerships with other providers in the metropolitan area, to ensure the efficient use of resources.

Changes in the health care delivery system—such as disease management and primary care case management practiced by State of Illinois' Medicaid system and the Medicare drug benefit offered by the federal government—provide financial opportunities for the Bureau, as well as opportunities to improve the organization of patient care. Capitalizing

on such opportunities, however, requires planning, because such changes require significant restructuring of how care is delivered.

A major function of planning within a public system is determining the clinical priorities to which it dedicates its resources. The most effective systems make informed decisions about the services that they will provide on the basis of a planning process that partners clinical and administrative leadership and that incorporates information regarding the population served, clinical appropriateness, operational efficiencies, financing, and the mission of the system. Some entities have determined, for example, that they will no longer provide certain services, such as pediatrics and maternal health services, which are more easily accessible from other providers, because such patients are more likely to be covered by Medicaid. For example, the Bureau currently serves as a provider of care for high-risk pregnant women and infants in need of intensive care. Nationwide, there are limited numbers of specialist physicians with such clinical expertise, and the private system is bidding to recruit specialists now employed by the public system. If the Bureau is to continue offering such services, it must assess the situation and respond quickly. Clinical decisions regarding new technologies, highly specialized care (e.g., transplantation), pharmaceuticals, and the appropriate use of specialty referrals are only some of the clinical priorities that need to be determined in a formal planning process that is based on real information, focused on the Bureau's continuum of care, and continually revisited. The people included in this planning process should be accountable to the governing body of the Bureau and to the public at large.

Planning Recommendations:

1) The Cook County Board should direct the Bureau to initiate a major strategic planning process that addresses the issues described above. The plan should include a thorough assessment of the demand for services, locations of new concentrations of populations in need of care, the potential for partnering with other institutions, the reconfiguration of existing Bureau facilities and programs to better meet the needs of persons who most need services, and changes needed in the organization of care to ensure effectiveness. The Bureau should present this plan—with implementation steps, goals, and objectives—to the Cook County Board within six months.

2) The Cook County Board should provide a vehicle—perhaps through its Health and Hospitals Committee—to quarterly assess the Bureau's success in the implementation of its strategic plan. That assessment should include monitoring the restructuring of any of the County's processes (personnel, information technology, or purchasing) that contribute to the successful implementation of the plan.

3) The Cook County Board and the Bureau of Health Services should actively engage other safety net providers, representatives of communities that have problems accessing health services, and civic and business leadership to address the future of the entire health care safety net.

Paying for Care: The Taxpayers View

Cook County government is now facing what comparable counties across the country have been grappling with for several years: how to pay for the cost of providing health care services to a growing number of uninsured and under-insured people. The challenge has five fronts: (1) addressing major national- and state-level policy changes that primarily affect Medicaid reimbursement; (2) giving an appropriate amount of aggressive attention to revenue generation; (3) systematically formulating the budget to ensure efficiency within the system and sound decision-making regarding the allocation of resources; (4) retaining a patient-payer combination that will maximize additional resources to counteract dependence on the County taxpayer; and (5) assessing and pursuing the need for additional local taxpayer subsidy if it is deemed necessary to satisfy the demand for health services.

Medicaid

States finance their Medicaid programs from a variety of sources. Common methods include income, sales, and property taxes. However, two alternative financing techniques have been used by a majority of state Medicaid programs as a means of increasing federal funding: (1) taxes on health care providers, and (2) intergovernmental transfers (IGTs) with public entities. Illinois has used both strategies, enabling the state to enhance rates to levels that would not have been possible with traditional financing.

This additional money has allowed the State and the Cook County Bureau of Health Services to enhance the health care safety net rather than just maintain it.

In 1991, the first Cook County IGT program was created. Medicaid payments that had been fully financed with state general revenue funds were converted to IGTs, and rates of payments paid to Cook County were increased. As part of the agreement, the State and County agreed to finance special Medicaid payments to other safety net hospitals that were disproportionately affected by the elimination of the general assistance program, which happened at about the same time.

Over the years, the continued use of IGTs has been threatened, but the State of Illinois and Cook County have diligently worked together to create reimbursement structures to increase revenue and allow the Bureau of Health Services to continue caring for the already large and increasing number of Medicaid-dependent and uninsured patients. This collaboration was not simply a coordinated lobbying effort; it was an earnest attempt to develop mechanisms for continued revenue approved by the federal government. The plans that were developed (and approved) were implemented with full knowledge of each plan's constraints. The County-State collaboration and the development of alternative strategies were the keys to success. All plans were approved by the Center for Medicaid and Medicare Services (CMS).

In theory, Medicaid reimbursement should increase each year because Medicaid costs increase and the uninsured population continues to grow. Unfortunately, a provision in the federal law that allows public hospitals to receive some of these Medicaid payments is being phased out. As a result, the Bureau experienced a significant decrease in federal funding during the State's fiscal year 2006. In FY 2006, the County is expected to have a decrease in revenue from this mechanism of approximately $70 million.[36] The phase-out of these payments will be complete by the end of the fiscal year 2009. Thus, the Bureau will experience a continued decrease in Medicaid revenue and will need to develop strategies with the State and federal governments to address this shortfall.

[36] http://www.co.cook.il.us/2006_budget2.htm

Because of its dependence on Medicaid revenue, the Bureau must aggressively pursue all Medicaid-related financing strategies, including other potential reimbursement programs including (but not limited to) Physician UPL, School Based Services Graduate Medical Education, transportation programs, clinic programs, and administrative programs. In addition, recent actions by other states have found CMS to be receptive to waivers (demonstration programs) that are restricted to limited geographic areas and/or specific providers. In theory, for example, a Cook County waiver could be created that expands eligibility to uninsured adults to receive only services provided by the Cook County System. Such large-scale waiver programs that include protections for special financing have been initiated in other states and may be suitable to Cook County.

Furthermore, the Bureau also needs to recognize the implications and opportunities related to the State's care-coordination proposals. Both disease management and primary care case management strategies could have a significant effect on both the Bureau's revenue and on the organization of the care it provides. As the State's largest Medicaid provider, the Bureau should help guide the implementation of such strategies and ensure its ability to participate.

Revenue

To fulfill its mission in an optimal way, an efficient public hospital system must take full advantage of its revenue opportunities. Apart from the creative Medicaid financing strategies described above, The Bureau's ability to generate revenue is unknown. Conversations we have participated in and knowledge from previous experiences indicate that revenue generation is not emphasized across all Bureau institutions in the way that it is across other public hospital systems. Other public systems have initiated major revenue-cycle analyses and processes to assure that the system receives every dollar to which it is entitled.

Beginning with each patient's initial point of access to a Bureau hospital or clinic, care should be taken to positively identify and pursue revenue opportunities. Such methods should be positive and comprehensive without throwing up barriers to patients seeking care. Any attempt to collect revenue from patients must be sensible and carried out efficiently. Sufficient investment must be made in the staff and systems that assess whether patients who present to Bureau institutions are enrolled in programs for which

they might be eligible. Funds for such investments have been included in recent budget requests but have been removed before being considered by the County Board of Commissioners. Other public systems and most Federally Qualified Health Centers have intake staff who use standardized patient processing procedures to evaluate available payment resources in an efficient, persistent, and respectful way. This process is integrated into regular protocols and does not interfere with service delivery. The point is to help the patient identify resources to offset the cost of treatment that they will receive, not to determine whether they pass an eligibility "test" for the Bureau's resources. Currently, there are not adequate staff, systems, and policies for effective eligibility screening in Bureau institutions.

The Bureau must also begin performing routine follow-up and confirmation of patient information. The amount of money that patients are determined to be capable of paying, as well as their eligibility for coverage, must be verified. Opportunities not explored at the initial patient assessment may eventually need to be pursued because a patient's information was initially incomplete or inaccurate. Timeliness is essential to maximizing the thoroughness of the documentation that is obtained. Follow-up with patients who have documentation in the Bureau's system is certainly easier to do than tracking individuals in subsequent weeks or months. Vendors are contracted by many health care systems, including Cook County's, to perform these functions. The most effective role for an external contractor in the updating of patient information is in the post–hospital discharge period, when such work is likely to be labor intensive and less successful. In situations in which payment for services is less than the amount anticipated, reassessment of eligibility, particularly for Medicaid coverage, is appropriate.

Maximizing reimbursement is contingent on the timely preparation of accurate and complete service descriptions and corresponding charge structures. Continuous evaluation of the billing process is critical to overall reimbursement and daily cash flow. Optimal billing operations include integrated information systems capabilities in addition to well-developed positive communication protocols for clinical providers and the staff who generate invoices. Timely identification and resolution of flaws in the billing process are highly desirable. For example, if reimbursement-denial rates increase because of

lacking the authorizations for services, the source of the problem must be identified and addressed in a punctual manner.

Tracking the effectiveness of efforts to determine coverage eligibility and of billing processes requires the timely collection of accurate information. External payers will conduct post-payment audits and validation of payments. The system should anticipate such reviews and should minimize the potential for eligibility rejections by initiating perpetual internal audits and validations of claims and payments. As the federal government expands legislative authority and resources to police fraud and abuse, Cook County should prepare itself for more-intensive reviews.

Well-designed methods for consistent patient billing are needed in all Bureau institutions. It would be instructive to observe and learn from practices at other public systems. At Parkland Hospital in Dallas, for example, uninsured patients who wish to avoid being charged for health services at a rate of 100% are told that they can receive discounted or free health care if they enroll in a Parkland Hospital–managed care plan. Such a requirement allows Parkland to better manage patient care and minimize duplication of services. In addition, policies related to sliding fee scales and collection practices should be consistent throughout the Bureau and uniformly enforced.

Generating revenue must involve front-line employees and practitioners who may have additional ideas regarding opportunities for new sources of financial support. In interviews we conducted with physicians, numerous ideas regarding sources of revenue emerged; it seems that only few of these ideas were followed up. For example, it was suggested that the Bureau could be receiving reimbursement for every ambulance run made with its staff, which could generate a significant amount money. A commitment to increasing the Bureau's revenue, particularly for services already being provided, must be unequivocal and persistent and must be infused into the Bureau's operations at every level.

Budgeting

For decades, most public systems have devoted more resources to increasing revenue than to improving cost savings. Given the constraints in securing special Medicaid financing, these health care systems have begun to take a more systematic approach to

sustaining themselves. To identify where resources are needed, where they are wasted, and where duplication of services occurs, the Bureau must implement similar policies.

Developing cost-saving strategies and reallocating funds to priority clinical and health service needs must be ongoing and must involve administrative and clinical leadership. Historically, the Bureau's budget was prepared in an annual exercise, that starting point of which was the previous year's budget. Equipment or personnel additions needed to meet new diagnostic or therapeutic needs were included only as new funds became available. To a certain extent, this approach was successful during a period of increasing revenue. Occasionally, revenue from grants was the main source of funding for new programs, such as those that were created in response to the HIV/AIDS epidemic. When a deficit occurred, the chief method of reducing the budget was freezing or eliminating vacant positions, despite that such positions possibly served critical functions. Sometimes, such positions remained unfilled simply because qualified workers were in short supply throughout the health care industry and, therefore, difficult to recruit.

A budget reduction method used by the County involves decreasing funding by a flat percentage across the system. Compared with other more-thoughtful methods used in other public and not-for-profit health systems, however, such a method is rather crude. Methods used by other health care systems include a thorough assessment of the operations of the health care network and the management of care and their efficacy in fulfilling the network's goals. If the Bureau budget was based on the changing health needs of the County's population, for example, the budget would reflect the expanding needs of the Hispanic population (e.g., by hiring additional language interpreters) and the increasing need for services in the suburbs, where there has been an enormous increase in underserved populations.

Most health care systems also continue to judiciously invest in programs that contribute to operational efficiency (particularly with respect to information technology) or revenue maintenance and generation. The purposes of such programs include ensuring that requirements are met for participation in state Medicaid initiatives, such as Primary Care Case Management and Disease Management.

If the Bureau were to emulate the best public system budget programs, a budget would be constructed on the basis of strategic priorities and would contain fixed operational benchmarks (e.g., length of hospital stay). Such a budget would include an ongoing program to assess how successful the Bureau was in meeting its fiscal goals. Simultaneously, systems would be established to implement specific financial strategies, including revenue generation, and to make decisions regarding the allocation of budgeted resources on the basis of need and performance. The governing body of the Bureau, as well as every department within and available to the public, would be familiarized with such a budget.

Patient Payer Mix

Like most other public hospital systems in the United States, the Bureau's patient population largely consists of uninsured patients, patients covered by Medicaid, Medicare beneficiaries, and a small percentage of patients with private insurance (primarily patients treated in the trauma and burn units). Although our experience does not suggest that a significant increase in the number of commercially insured patients treated by the public system is likely, efforts should be made to retain Medicaid- and Medicare-dependent patients who previously have used the Bureau's services. For example, the Bureau cares for many uninsured adults in its clinics and hospitals. When these patients reach 65 years old and are eligible for Medicare, they often seek services elsewhere. These patients should be encouraged to continue using the Bureau's services by ensuring timely appointments, providing case management for the most frail of these patients, and implementing other operational changes that, ultimately, would require an investment to achieve a long-term gain.

Furthermore, despite the changes likely to occur in the unique Medicaid financing arrangement that Cook County has enjoyed for the past decade, Medicaid is still the most important source of patient revenue. The majority of Medicaid-dependent patients are either pregnant women or children, two patient groups whose numbers have dramatically decreased in the Bureau system over the past decade. It is important for the Bureau to understand why it has treated fewer pregnant women and children, and, again, it is important for the Bureau to invest in the changes necessary to keep these patients in its system. As the state begins offering disease management and primary

care case management to its Medicaid-dependent patients, the Bureau needs to be negotiating with the state and instituting changes that will ensure its future as the provider of choice for these populations.

Local Tax Subsidy

As in most major metropolitan areas, Cook County tax dollars have, historically, been used to subsidize the cost of caring for uninsured persons in the Cook County Bureau of Health Services' hospitals and clinics. It is instructive to note that the proportion of the health system's budget subsidized with Cook County tax dollars has actually decreased over the past fifteen years, despite that health care costs have been increasing annually at double-digit rates for years, and despite that the County expanded its clinic network across the City and suburbs, opened Provident Hospital, built a new Cook County jail health facility, and established the free-standing CORE center, all while it was building Stroger Hospital.

When one considers the rising costs of medical services and the increasing demand for the Bureau's services, whether the Bureau of Health Services is under-funded and whether the tax subsidy of the system should be increased are very expedient questions. New taxes and increases in existing levees are occurring in counties across the United States (e.g., Los Angeles County voters recently overwhelmingly approved an increase in the tax subsidy for their trauma system, increasing its annual subsidy by $172 million).

Compared with other major public health systems, local funding of the Bureau appears to be modest, at best, given what it is asked to provide. Formulating and implementing financial strategies, increasing revenue, and improving operational efficiency are the solutions to this problem. As figure 6 illustrates, although local tax dollars are important, the amount of tax dollars contributed is less per capita than the amount contributed in Dallas, Atlanta/Fulton County, Miami/Dade County, Indianapolis/Marion County, Houston/Harris County, and Denver. In fact, the budget for the entire Bureau of Health Services (three hospitals, thirty clinics, the jail health services, the public health department, and the CORE Center) is less than the budget for just one of Los Angeles County's hospitals.

Figure 6

Comparison of Local Tax Dollar Subsidy of Health Care Services

Hospital	County	2003 Population	Below 100% FPL*	Below 200% FPL*	2003 State/Local Subsides Hospital**	Subsidy per capita	Subsidy per person <100% FPL	Subsidy per person <200% FPL
Parkland	Dallas	2,241,032	366,554	878,039	$321,387,200	$143	$877	$366
Grady	Fulton	787,576	124,616	253,216	$103,269,315	$131	$829	$408
Jackson Memorial	Miami Dade	2,283,925	419,750	962,390	$246,271,747	$108	$587	$256
Cook County* **	**Cook**	**5,240,918**	**697,812**	**1,662,932**	**$227,412,121**	**$43**	**$326**	**$137**
Wishard	Marion	841,276	112,772	278,693	$53,878,681	$64	$478	$193
Harris County	Harris	3,542,924	540,808	1,334,372	$334,732,000	$94	$619	$251
LA County USC****	Los Angeles	9,652,638	1,584,053	3,748,367	$187,094,976	$19	$118	$50
Denver Health	Denver	541,494	68,072	176,942	$26,900,000	$50	$395	$152
Total/Median		**25,131,783**	**3,914,437**	**9,294,951**	**$1,500,946,040**	**$79**	**$532**	**$222**

*Source: US Census Bureau, 2003 American Community Survey

**Source: NAPH 2003 Annual Member Survey

***Includes Stroger, Oak Forest and Provident hospitals

****Includes only the LA County Hospital, not the rest of the system

Note: Many states (including Texas) have not maximized their federal share of Medicaid dollars; thus, local communities subsidize low Medicaid reimbursement rates. FPL, federal poverty level.

Financing Recommendations:

1) The Cook County Board should require the preparation of a comprehensive financing plan for the health system using external expertise, if necessary. That plan should address the following: (a) Medicaid strategy; (b) revenue goals, including investments necessary to meet those goals; and (c) a defensible assessment of local subsidy needed to meet projected demand and projected cost. This plan should be presented to the Board's Finance Committee, with monthly updates for monitoring purposes.

2) The Cook County Board should appoint an independent body of civic and business leaders to assess the appropriateness of the local tax dollar subsidy for the County's health care system. This body should draw on the experiences of other comparable communities and develop recommendations for the Board regarding the amount of subsidy necessary for Cook County and indicators for determining future subsidy amounts.

3) The Bureau should work with the Cook County Board to produce a way of budget preparation that is based on the demand for services, the need for new treatment and diagnostic capabilities, and expansion in new locations, and which includes intensive assessment of cost, coordination between Bureau facilities and programs, and quarterly benchmarks. This budget should thereby become the purview of the Bureau and should exclude the hiring and expenditure constraints currently imposed by the County system.

4) The Bureau should immediately and aggressively engage the State of Illinois to determine potential alternative strategies to maximize Medicaid revenue for the Bureau, including (but not limited) geographic- or provider-specific waivers. Furthermore, the Bureau should secure for itself a prominent role in new management of care initiatives, including disease management and primary care case management.

5) The Bureau should immediately and aggressively pursue potential benefits to be obtained through the Medicare Part D benefit option that might cover a significant portion of pharmaceutical costs.

Operating as an Effective Health Care System

The Bureau is in the enviable position of having soundly operated, well-located clinics and hospitals, a what is perceived as a high quality committed medical staff, a full range of services for its patients, and strong community support. It must now focus on key operational issues to maximize efficiency. Given the mounting financial pressures, coupled with the increased demand for and escalating costs of health care, it is extremely important that every effort is made to maximize the health system's operational efficiency.

Management/Personnel /Jobs/Training

According to our review of various United States county governments' and the extent to which they influence decisions regarding personnel changes in their local public health systems, the Cook County government has the most. As noted above, for many of the interviews we conducted for this study, there was a sense that hiring decisions were made according to levels of patronage or political loyalties. The Shakman decree[37] is designed to limit politically related hiring within the Cook County government to a few exempted high-level positions. However these include virtually all leadership and key management positions across the County. These except positions are at the sole discretion of the Office of the President. These can be filled without openly competing in a candidate search such as those conducted by other health systems. This type of hiring system has a long history in the Cook County government, but it was abandoned long ago by most other county governments in the United States. If the Cook County system is to overcome the challenges facing health care systems everywhere, the

[37] the 1983 Shakman decree stemming from the landmark 1969 lawsuit filed by Michael Shakman against the Cook County Democratic Organization, et al. A decision on the case was handed down in 1972 prohibiting hiring and firing of non-policy-making city employees for political reasons. In 1972 a U.S. District Court judge also ruled this type of hiring unconstitutional. Then in 1983 the court issued an extended ruling laying out specific instructions for public hiring. On March 30, 2004, a U.S. District Court Judge refused Mayor Daley's request to overturn the ban and Daley signed an agreement confirming his commitment to the rules set in the 1983 decision.

County government will need to rethink its current hiring system. In the private sector, finding people who are qualified to effectively respond to the clinical, regulatory, and financial challenges in health care industry is difficult enough; the County's political and bureaucratic hiring practices can only constrain the health care system's ability to recruit people with the expertise needed to make the system efficient.

The Bureau's leadership must be highly skilled, experienced, and creative to excel in the increasingly complex and technical healthcare marketplace. The Bureau's leadership need to be allowed to recruit and retain the best possible and most competent managers and administrators. The Bureau must be allowed to develop its own job descriptions and alter them if necessary, on the basis of changing demands. Managers must be held accountable to performance standards, and their employment must be terminated if they perform inadequately. It should be noted that hiring concerns are not limited to managers. Clerks, environmental workers, computer programmers, and finance staff all must be held accountable to similar performance standards, but allowing political factors to influence the hiring of persons in leadership roles restricts the extent to which the entire organization is held accountable to performance measures.

As noted above, the County is one of the largest single employers in the region. As health services expand into new communities, people in those communities should be able to compete for those jobs. As people are hired into entry-level jobs, they should be held accountable to a level of performance that will advance their careers and that will provide patients with service of the highest quality. Reconfiguring the County's human resources objectives in this way would benefit employees and their communities.

Cook County has had a long history of job training. Tens of thousands of physicians have done their internships and residencies at Cook County facilities. If medical students are included in these numbers, Cook County is one of the largest training sites for future practicing physicians in the United States. A full spectrum of primary and specialty training programs are available there. One of first urban Family Medicine programs was launched at Cook County Hospital. In addition, there was a time when Cook County operated a nursing school and a school for radiology technicians. It is widely agreed that hospitals such as Stroger Hospital and systems with a scope of services that includes ambulatory and long-term care are well-served by having training

programs. Many of the medical staff that work in County health programs desire to be associated with training programs.

Communities in Cook County have also been well-served by graduates of its training programs, especially in centers that provide community-based primary care for the underserved. However, the benefits of such training are not routinely evaluated or explicitly discussed in the context of future planning for the County's institutions and health care programs. There are multiple subspecialty training programs that are operated at Stroger Hospital. At the same time, there is a shortage of such specialists in the institutions that comprise the safety net. Specific planning to recruit, help direct, and seek or provide incentives for graduates of these programs in order to fill needs in underserved communities, is worth pursuing.

If Cook County were to hire a pool of employees that reflected the communities of the patients they serve, the County and its patients would benefit from it, particularly if entry-level employees were offered opportunities for training and career advancement within the system. A program that was launched in collaboration with the Malcolm X College Nursing Program for Bureau employees has accomplished just this. The program should be extended to other areas where health care staff is scarce or difficult to recruit.

Finally, it is important to note that our concern is not that there are too many management positions; our concern is with the hiring practices by which such positions are often filled. Actually, it appears that there are less than an adequate number of staff in some areas and too many in others, compared with other public health systems. This is a major problem that Bureau leadership and the Cook County Board must address together.

Establishing and Focusing on Operational Priorities

When a system-wide focus is given to an operational issue, it is clear that a significant change can be made within the Bureau. Pharmacy problems in the system seem to be a good example. By all accounts, physicians and administrators under the direction of Bureau leadership who work together to resolve well-publicized bottlenecks in the County's pharmacy distribution system have made demonstrable improvements.

As has been discussed, many public health and hospital systems have been removed from the direct control of local government expressly to extricate them from the constraints of the government personnel, purchasing, and other bureaucratic systems that hinder efficiency in a health care system. Periodic hiring freezes, enormously complex and time-consuming hiring procedures (that often require many months to complete), and rigid job descriptions, all of which are only further exacerbated by political factors, create operational problems for the Bureau's human resources. Although departments such as human resources are duplicated at each Bureau entity, they must each fulfill certain requirements and follow protocols that are mirror copies of protocols followed by the County government's central offices. Purchasing protocols, information technology that meets the government's requirements but that may not be best-suited to health care delivery systems, and other systemic operational impediments all conspire to make the County's health system inflexible and inefficient.

A great deal of work remains to ensure that patients' medical information and billing data is accessible at any access point in the system. The Bureau simply cannot achieve clinical and operational efficiency and quality with less than a the highest functioning system. Furthermore, because most of the Bureau's patients are chronically ill and require their care to be managed so that the best possible care is provided with maximum efficiency, having information technology capable of tracking patients through the system and maintaining registries of patients with diseases (so that care and referrals can be easily tracked to ensure that the appropriate services are received) will be imperative. This operational issue should be a top priority for the Bureau, just as it is for most public and private hospital systems across the country.

When the new Stroger Hospital was opened in 2002, it was apparent early that the number of beds available for medical and surgical patients would not be adequate to meet the demand. The Bureau has been creative in establishing "observation beds" (a model that is now being replicated by other public systems) to decrease the number of unnecessary hospital admissions, and most physicians we interviewed talked about how patients who do get admitted to the hospital are much sicker than they had been in the old facility, where there were significantly more available beds. However, the demand for inpatient beds is likely to increase in the coming months and years among

underserved populations, because the vast majority of uninsured persons are chronically ill adults. In terms of operations, it is imperative for the Bureau to fully utilize all available beds in its three hospitals (Provident and Oak Forest) in order to ensure hospital access for this population, because most of these people have no other source for health care. Further integrating services between these three institutions is an opportunity that many systems would be very grateful for, and it is one that should be aggressively pursued.

Structure for Addressing Operational Improvement

Most effective operational improvement efforts require a clear understanding of the problems being addressed, focused attention, leadership, tools to assess the effectiveness of improvement efforts, and ongoing monitoring to ensure that changes are institutionalized. In most public health care systems, indices such as length of stay, occupancy rates, operating room efficiency, and other measurements are routinely monitored in hospitals, whereas outpatient facilities are assessed for waiting times for appointments, provider productivity, and referral to diagnostics. Likewise, quality issues such as patient safety, emergency preparedness or infection surveillance and control, and patient satisfaction are monitored by leadership, and their findings are presented to the governing board. More importantly, attention to these indices, which include variability within and between different facilities, prompts action to ensure efficiency and quality of care.

In systems such as the Bureau's, it is critical for the medical staff and the administration to be partners in these efforts. Furthermore, the "siloing" of individual departments and facilities causes opportunities to create system-wide solutions and to ensure that all parts of the Bureau are pulling in the same direction to be missed. A Bureau-wide structure (or structures) will need to be created to formalize the medical staff and administration's efforts, to ensure that the quality improvement process is ongoing. Lastly, such a process will need to be accountable to the health system's governing body.

Operations Recommendations:

1) The Cook County Board should appoint an independent commission, including human resource professionals with significant health care delivery system expertise and labor union representatives, to develop a plan for restructuring the entire Cook County Bureau of Health Services human resources system and for mitigating the influence of Cook County policies and practices on the Bureau's ability to guarantee flexibility, competence, and accountability at all levels of the system. This commission should also address employee development and advancement, policies ensuring that employment opportunities are targeted toward communities most directly served by the Bureau, and policies ensuring open channels for advancement and career development. The County should implement the recommendations.

2) The Bureau should convene key representatives of its medical and administrative staff—leaders and front-line workers—to develop an operational priority agenda. These priorities should be determined by evaluating data (and having direct contact with patients) regarding real problems patients face within the system and should be used to construct a "report card" for internal and external distribution. Targets for improvement should be established, and progress should be regularly reported to managers within the system and to the Cook County Board.

3) The Bureau and the County together should identify procedures imposed on the Bureau by the County government that significantly affect the efficiency of the Bureau's operations, and they should implement structural changes to resolve these obstacles.

Managing the Market: Developing Partnerships

No system can meet the growing demand for health care services of medically fragile communities and populations alone. The Bureau has a history of collaborations and real operational clinical partnerships that need to be nurtured and expanded in order to most effectively address the increasing need for health care in Cook County. In discussions with leaders throughout the community, the topic of partnerships was consistently identified as an issue of concern, primarily because the Bureau has been so aggressive about creating these relationships in the past.

The Bureau has established partnerships with private community hospitals throughout the City of Chicago and suburban Cook County. These partnerships have been developed to expand primary care, expand access to mental health services for Bureau patients, coordinate maternal health services, and ensure the appropriate provision of specialty care services. These partnerships need to be continually assessed by both involved parties to determine their effectiveness and to seek new opportunities. For example, the recent decision by Advocate Health Care regarding Bethany Hospital, one of the Bureau's partners, to discontinue most acute care services and convert the hospital into a long-term acute care facility will affect the Bureau. Advocate has provided a primary care clinic on the Bethany campus, and in exchange, Cook County has covered their neonatal intensive care unit. Transfers of high-risk mothers and infants were made to Stroger Hospital, which offered its expertise to meet such needs in the community. Neonatal intensive care unit services generated substantial revenue for the Bureau. The Bureau would be well served to maintain these ambulatory care and high-risk maternal and child health services, if it is not too late to do so. Perhaps Bethany's conversion into a long-term care provider offers opportunities for new clinical relationships and requires other decisions to be made about the current relationship. Simply put, these opportunities should not be missed.

In addition to its hospital partnerships, the Bureau has a twenty-year history of formal affiliation with Federally Qualified Health Centers (FQHCs), through its Neighborhood Referral Program, in which the Bureau diverted patients occupying emergency department rooms for primary care to FQHCs if the patients lived in communities where no Bureau clinics existed. In return for accepting these referrals (which primarily consisted of uninsured patients), the FQHC patients were given pharmaceutical and lab support. In recent years, proposals have been made within the Bureau to curtail the Neighborhood Referral Program. In addition, the Bureau and the FQHCs have attempted to rationalize referrals to the Bureau for specialty services. This partnership between the public hospital system and FQHCs is one of the most extensive anywhere in the United States and should be nurtured.

In interviews and focus groups that we have either coordinated or attended, the Bureau's relationships with other hospitals and community health centers have been

cited as areas in need of attention. There is concern regarding a lack of follow-up, a sense that partner relationships are "unraveling." Although it takes both partners' attention to ensure effectiveness, not exploring these affiliations to their fullest potential would be a great opportunity lost.

The Bureau also has the opportunity to further develop its relationship with Rush University Medical Center and Rush Medical College, its primary academic affiliate. The original affiliation agreement, which occurred in October 1994, called for significant interaction between the two institutions, both in academic planning and in the exploration of joint clinical ventures, such as the Ruth Rothstein CORE Center, which was established as a partnership between Cook County and Rush. Although the original agreement acknowledged the different missions of the two systems, it encouraged (and expected) synergies in faculty appointments, committee memberships, and system leaderships that seem to have not yet fully emerged. With the leadership of Rush, the Bureau has the potential to deepen the relationship by solidifying academic ties, expanding the potential for joint research initiatives, and, along with their other partners in the Illinois Medical Center District (University of Illinois and the Westside Veterans Administration), aggressively pursuing clinical collaborations and consolidations that would benefit all institutions.

Historically, the Cook County government has an advocacy role in establishing a partnership approach to health care access and health status improvement. In the late 1980s, the Cook County Board worked with and helped to fund the Suburban Primary Care Council to develop a quasi-insurance model (the Access to Care program) that linked private physicians with uninsured people in suburban Cook County. This model has continued to ensure a level of access to health care services in areas where adequate patient volume did not exist to justify County-operated clinics and/or hospitals. The County also had a key role, together with the State of Illinois and the City of Chicago, in coordinating the "Chicago/Cook County Health Care Summit," which was a gathering of health policy experts, community representatives, and health care providers that, in 1990, prepared a blueprint for a coordinated plan for the health care safety net. Many recommendations from that report have been implemented over the past fifteen years, many of which were implemented by the County. In addition, through the now

defunct Cook County Community Health Council, the County played a major role in reaching out to communities that are served by its health care system when it developed District Health Councils to receive direct input from communities regarding the priorities of the health care system. Finally, the negotiation of the County's Medicaid Intergovernmental Transfer Agreement, which occurred in early 1992, is another example of the how the County played a leading role in the region. The additional federal dollars generated by the IGT Agreement not only helped to support and expand the Bureau of Health Services; the new funding provided other safety net hospitals throughout the community and the state with funds that allowed them to remain in business. This broader concern for the health care delivery system is absolutely critical for meeting the growing demand for health services.

Partnership Recommendations:

1) The Bureau should assemble key provider partners with which they have a history of experience—community hospitals, the Chicago Department of Public Health, Federally Qualified Health Centers, and the Access to Care program—for an open dialogue regarding the state of their current relationships, to identify areas for improved collaboration, and to establish priorities for future collaborative planning. This meeting should also be used to discuss and identify gaps in the "virtual network," identify additional partners who can help meet growing and changing community needs (particularly in the suburbs), explore ways to include community involvement, and set goals and implementation strategies. A formal structure and procedures should be established, and these partners should meet at least quarterly to assess the strength of their relationships.

2) Together with the leadership of the Rush University Medical Center/Rush Medical College, the Bureau should co-convene a representative body of the two organizations' medical staffs and administrative leaderships to assess the strengths of the academic affiliation, to forge potential clinical partnerships (e.g., the CORE Center) to advance the missions of both systems, and to address potential research opportunities that may be untapped. This session should result

in a leadership being assigned, goals being set, and accountabilities being established, so that the new partnerships can be implemented.

3) The civic community, by means of its business groups, community organizations, editorial boards, philanthropic organizations, unions, and academic institutions, must call on the Cook County Board, in conjunction with and supported by the private sector and other key levels of government, to devise a coordinated, local (or even regional) solution to the disintegrating health care safety net in the metropolitan area. This initiative would take on such issues as the development of a financing strategy, a "virtual safety net" delivery system, and a collaborative business approach to affordable insurance products.

Leading and Governing for the Future

Leadership

In the Cook County system, leadership must be obtained simultaneously at two levels. First, under the current governance system, the President of the Cook County Board of Commissioners exercises leadership over the health system that is unprecedented in the United States. Although a Health and Hospitals Committee that consists of all Cook County Commissioners exists and is the recognized board of the County's hospitals and ambulatory health system for accreditation purposes, it does not function as a governing board; such a governing body would provide oversight of a private hospital system. The rest of the Board could play a significant leadership role with respect to instituting policy, ensuring strategic direction, and requiring accountability, but for the most part (excepting passage of the annual budget), leadership at the Board level, for all practical purposes, appears to be ceded to the President. Even in Los Angeles, the other community in which the health care delivery system is directly controlled by county government, such power over health care operations (e.g., the hiring of health care system leadership and preparation of the health system budget) is not consolidated in one person.

Leadership is essential to more than the effective operation of the health care delivery system. Ensuring the public health requires leadership that is beyond the scope of a single system, or even that of the health care sector. The Mayor of the City/County of San Francisco for example, recently assembled an expert panel to develop a plan over the next several months that will result in health care coverage for all uninsured residents of the community. In some smaller communities across the United States (including in Illinois), local governments have worked with businesses and provider organizations to develop models that will allow a significant number of people to buy into affordable health care coverage plans. In other communities, such as Dallas, County governance has joined with the governing boards of other safety net hospitals to generate new dollars for the care of uninsured or under-insured persons through an increase in the federal match of local health care dollars. All of these efforts required leadership at the level of local governance.

Another level of leadership needs to oversee the Bureau of Health Services. The Bureau leadership—both administrative and clinical—must have the skills, creativity,

and freedom to guide the delivery of health services in an increasingly complex environment. Leadership must be determined to take on the planning and implementation of internal systems operations and catalyzing the creation of a "virtual safety net" in the community that maximizes the contributions of all providers. Bureau leaders must be held accountable to their governing bodies (and, in the broadest sense, to the communities that they serve), but they must also be willing to remove existing obstacles (whether they are bureaucratic or political) standing in the way of the Bureau's mission.

Governance

Individual leadership is insufficient to ensure sound governance of a public health care delivery system. The Cook County Board is the governing body for the Cook County Bureau of Health Services, a complex system of hospitals, clinics, public health programs, correctional health services, and a long-term care and rehabilitation institution. The major health care–related areas of focus for the County are as follows: (1) operating an effective health care delivery system and maximizing the benefit of taxpayer subsidies; and (2) enacting policies that ensure the public health (regulatory action, such as the smoking ban).

Unlike many local communities around the country, the Cook County Board of Commissioners serves as the direct governance of the public health care delivery system. This model has been abandoned in many other counties and cities, where alternate structures have been established to provide more-focused oversight of the complexities of the public health care delivery system than can be provided by a County government, which usually has numerous other responsibilities (e.g., jails and courts). Among major urban areas, only Cook County and Los Angeles County have direct control of their health care delivery systems (and studies have been commissioned in Los Angeles County to explore the potential for a public health authority). Some examples of other structures include the following:

- **Public Health Authorities**

  Denver and Boston are two examples of communities in which new governance models were created by the local governments to ensure a more-focused oversight of the public health systems. In Denver, the public health authority, which was created by the City/County government, governs the hospital and clinics known as Denver Health. The City/County continues to subsidize the system for caring for uninsured persons. In Boston, the public health authority actually brought together the City's hospital and clinics and the private hospital operated by Boston University into one system that is governed by the public authority board. In both of these examples, the local government has retained some control over Board appointments.

- **Health/Hospital Districts**

  In some communities, including Dallas, Harris County (Houston), and Maricopa County (Phoenix), special "districts" have been created (usually by the vote of the local population) for health care delivery systems previously operated directly by the local government. Some of these districts have boards that are appointed by the counties (e.g., most Texas districts) while others (e.g., Maricopa districts) have elected board officials. The districts have the power to implement a tax (which is usually capped).

- **Not-for-Profit Conversions**

  In Shelby County (Memphis), the government has retained ownership and direct control of the clinics and the public health department but has converted the hospital into a semi-independent 501(c)(3) not-for-profit institution. The County subsidizes the hospital and appoints the members of its board of directors.

- **Other Governance Models**

  In other communities, models formed to directly govern the public hospital and delivery system include (but are not limited to) the following: (1) a city-appointed Health Commission in San Francisco, which serves as an

advisory body to the Board of Supervisors for budget and policy issues related to its health and hospital system; (2) a public benefit corporation in New York City, which has direct operational control over all public hospitals and clinics; and (3) a public health trust in Miami that was created by the State.

Themes common to all of these different governance models are: (1) having a governing body that is knowledgeable of the complexities of health care delivery systems (e.g., regulatory, financial, clinical, and academic), and (2) having a health system that is insulated against typical government bureaucratic procedures and processes (e.g., human resources) that cannot accommodate the complexities and changing nature of the delivery system.

As the cost of health care escalates and the County health care delivery system experiences more pressure to meet increasing demand with limited revenue, the effectiveness and efficiency of the Bureau of Health Services will need to be closely monitored by the Board. Adequately funding the system—and generating such funds—is surely a topic of immediate relevance. In addition, the County will need to put forth creativity and leadership to address community issues, such as access to health care services among vulnerable populations, as well as issues beyond the scope and capacity of the Bureau's own facilities and programs.

The Cook County Board—and the civic community—would be well-served to assess the ability of the current governance and oversight structure to ensure that these important functions are executed most effectively. Nearly all other urban governments, as discussed above, have determined that a governance structure other than the local government's direct oversight is the best way to ensure efficiency while maintaining accountability. The options are numerous, and each community has worked out its own solution. It is time for Cook County to work with the civic community to ensure that the governance of the health care delivery system funded by Cook County taxpayers is managed effectively.

Leadership/Governance Recommendations:

1) The broader civic community should initiate an independent assessment of public governance models utilized by other communities (many of which were initiated by the civic community) that most effectively serve to ensure the effectiveness and accountability of these complex health and hospital systems. This assessment should be presented to both the Cook County Board for review and should be widely discussed throughout the community. A recommendation of a change in health system governance should be made after this review and subsequent discussions.

The Politics of Change

It is not easy to change how things have operated for decades. In the preparation of this report, our questions were met with a common refrain: "That's just how things are done in the County." We hope that the issues raised in this report will be interpreted as opportunities for change—not just change for change's sake, but to ensure the future of a highly effective health care delivery system, one that is accountable to taxpayers and patients, that serves as a model for other public health systems, and that will be widely viewed as being among the best in the nation. This report should not be viewed as a condemnation of the current system; rather, it should be viewed as a plea to recognize and capitalize on real opportunities for improvement.

Everything with respect to public health care is changing. Persons in need of the County's health services are no longer the poorest of the poor. Often, in fact, they are people who work (sometimes more than one job) but who do not receive health benefits from their employer, and their low incomes prevent them from buying it. The communities who would benefit from the County's services are no longer limited to the west and south sides of the City of Chicago. Although those communities still require access to quality care, other communities in need of such services include the northwest side of the city and certain clusters that are emerging throughout the suburbs. The County's patient population, in addition to being African American, is white, Asian, and Hispanic.

More than the patients, however, is changing. Medical care is no longer simply hospital-based. Effective health care systems understand the need to prevent and treat disease. They understand that people with complex chronic conditions are better served if their care is well managed. They know that investment in medical technology will result in more efficient use of scarce resources. And they are well aware that they must adapt their quality and performance measures and methods of documentation to new demands.

In the past, it was assumed that the Cook County system would always exist, that it was unimportant to understand how resources were allocated and how the system's priorities were decided. Across the United States, however, public health care safety nets are threatened, and some have abrogated their role as hub of the health care safety net. Public health care systems that are surviving have recognized the need for change and realize that they need to function as efficiently and effectively. The community needs to understand the need for change as well, and it needs to help make such change happen.

Recommendations for Change:

1) Create a civic "Blue Ribbon Commission," preferably in collaboration with the Cook County Board of Commissioners, that is dedicated to the future of the Cook County health care delivery system. This Commission would, over the course of the next three years, assure that many of the recommendations contained in this report are implemented, including the following:

    - Make recommendations for restructuring the governance of the health care delivery system subsidized by Cook County taxpayers, using other communities' systems as models, but ultimately developing a plan that would best fit this community.

    - Assess the current level of the local tax subsidy of the Cook County health care system and make recommendations for any increases needed in the future.

- Provide assistance in developing and implementing a comprehensive financial strategy for the Bureau.
- Convene a group of human resources and health care professionals to restructure the County's personnel administration of the Bureau, so that the Bureau's human resources concerns are shielded from current bureaucratic and political constraints, and to recommend ways in which human resources can more effectively meet the needs of the health care delivery system.
- Coordinate a community forum to discuss the future of the health care safety net in Cook County, including the components of its delivery system, creative ways to provide insurance coverage, and ways of ensuring the public health.

CONCLUSION

This document is intended to call the attention of the leadership of the Cook County health care system, the Cook County government, and the civic community to the impending crisis of access to health care services that is affecting this community. Other cities and counties across the United States are no longer waiting for a national or a state solution, because it seems that one should not be expected. The solutions to this problem will be multi-faceted and will require community and business leaders, health care providers, and elected officials to be creative and absorb the best ideas of other communities to devise effective strategies. Our focus on the Cook County Bureau of Health Services is a testament to its vital importance. Any plan to successfully manage the public health care problems in this community must have the Bureau as its foundation; it is the region's preeminent civic resource for health care.

APPENDICES

1) National and State Issues Affecting the Local Health Care System

2) Other Components of the Health Care Safety Net in Cook County

3) List of Interviewees for this Report

Appendix 1: National and State Issues Affecting Local Health Care

The National Climate

The federal government's message is clear regarding the financial goals for the Medicaid program, the health care payer most responsible for providing coverage to low income and underserved people in this country. The federal government is focusing its efforts on improving financial predictability, slowing the rate of cost increases, and developing mechanisms to ensure accountability. Flexibility for states is such a high priority for the Bush Administration that the very nature of Medicaid entitlement is being reconsidered, if only indirectly. Executive and legislative branches have committed to budget reductions, and the Medicaid program has been specifically targeted for extensive cuts in the coming years.

In February 2006, President Bush signed S 1932, the Deficit Reduction Act of 2005 (DRA). Although there have been significant questions concerning the actual signing of the bill and the authority of what was passed, the financial savings associated with the DRA were reduced, compared with those of other scenarios previously discussed by Congress and others. In the current, final version of the act, Medicare is targeted for savings of approximately $6 billion over 5 years, whereas Medicaid funds are projected to be cut by $5 billion over 5 years. Medicaid savings will be generated primarily from prescription drug changes, creating a Medicaid Integrity Program that polices fraud and abuse (which is often the result of poor bookkeeping), changing eligibility requirements that will effectively delay Medicaid eligibility and other provisions for certain recipients. Although none of the provisions appears to be directly related to safety net and public hospital systems, as has been the case in the past, some of the provisions could certainly affect the revenue streams of those institutions.

One item that must be noted in budget reconciliation is the provision related to "Improved Enforcement of Documentation Requirements." This section prohibits states from receiving matching funds for Medicaid services provided to individuals who have not provided satisfactory documentation of US citizenship, and it establishes allowable documentation standards.

Satisfactory documentation is defined as having one of the following:

- U.S. passport
- Certificate of Naturalization
- Certificate of U.S. citizenship
- Valid state driver's license

The degree to which this provision will affect the Cook County health care delivery system is difficult to estimate at this time. However, given the federal government's mixed signals over the past decade with respect to immigration and health care, the provision is symbolically significant. While early enrollments in the State Children's Health Insurance Program (SCHIP), known as KidCare in Illinois, were low in Illinois and across the United States, in the late 1990s, the federal government encouraged flexibility with respect to enforcing immigration policy in state health care programs. Nationally, this encouragement was indicated by the federal government's exclusion of most Medicaid and SCHIP services from the definition of the term "public charge," which thereby limited the risk of deportation for non-citizens receiving such services. In a more straightforward example, "self-declaration" of citizenship became a common practice across the United States, as did crossing eligibility programs with different immigration standards, such as the school lunch program. This subtle point regarding immigration in the federal law could potentially turn out to be quite significant, as federal and state officials consider appropriate executive interpretation and responsibilities associated with the DRA. The current intensity of the immigration debate in Washington clearly will raise additional issues related to the use of public funds for the care of undocumented immigrants.

Targets of the budget reduction come at a time when the number of people eligible to be covered by Medicaid is projected to steadily increase and the number of people covered by insurance sponsored by employers decreases. Additionally, continued pressure for more adequate reimbursement comes from virtually all medical providers as health care costs continue to increase.

Health care remains on the national political agenda because of its substantial effect on the federal budget and the economy overall, and many ideas from administration officials have been aimed at health insurance portability, information technology, health savings accounts, and tax incentives for purchase of private insurance. These initiatives certainly influence what happens indirectly at a large public health care system, but topics such as immigration, "special financing" opportunities, and the increase in the number of uninsured people are much more relevant to the current crisis.

Closing Off "Loopholes"

The Centers for Medicare and Medicaid Services (CMS) has repeatedly identified Illinois as being at high risk with respect to certain aspects of its health care financing. A 2002 Urban Institute study indicated that only New Jersey and Georgia enhanced federal matching funds to a greater degree than Illinois.[38] In addition to CMS indications that certain "special financing arrangements"—such as those used by Cook County—will be greatly scrutinized, as federal law specifically phases out a portion of financing related to Illinois Medicaid.

To mitigate the effects of phasing out existing Medicaid financing arrangements and increased scrutiny, California, Iowa, and other states have worked directly with CMS to add predictability to their financial relationships Engaging CMS in a long-term relationship with this interest in mind might be preferable to CMS closely monitoring special financing arrangements. States that initiate such discussions early may end up in a better position than states that initiate them after the precedent is firmly settled.

Since the early 1990s, Illinois Medicaid (now under the Illinois Department of Healthcare and Family Services) has worked with the Cook County Bureau of Health Services to develop several intergovernmental transfer agreements (IGTs). These agreements maximize the federal matching of local government (Cook County) dollars spent on health care for poor persons. IGTs help Cook County pay for its Medicaid-covered and uninsured patients, and the transfer back of federal matching dollars to Illinois Medicaid helps the state support the cost of the Medicaid program. Illinois payments to the Cook

[38] States' Use of Medicaid Maximization Strategies to Tap Federal Revenues, June 2002.

County Bureau of Health Services and the upper payment limit (UPL) help maximize federal funding to both the State of Illinois and Cook County.

"IGT" and "UPL" are only two of many complex technical terms related to Illinois subsidization of health care for low income persons. Simply put, state Medicaid programs are able to pay certain public entities that specialize in treating Medicaid-dependent and uninsured persons, such as those in the Cook County system, at rates that are substantially higher than the rates that states pay for typical Medicaid services.

The following is one way that a "special financing" transaction may work: The state may receive federal approval for the reimbursement in its Medicaid state plan. Once the plan has been approved by CMS, the state can then make a payment at the higher rate to a public entity specializing in treating Medicaid-dependent and uninsured patients. Even if CMS approves the state-plan amendment, the terms of the payment must fit other specific federal reimbursement parameters and pass certain tests (e.g., the upper limit test, the disproportionate share hospital test, and the OBRA test). Frequently, public entities return a portion of the reimbursement to the state government through an IGT. States typically use the money to support health care programs for low income persons. Especially in the past several years, Illinois has for the most part shown a great deal of leadership with respect to funding health care programs. Therefore, although these higher payments have been controversial and have attracted scrutiny and auditing from several federal agencies, Illinois' use of resources for low-income health care has been undeniably strong.

One of the significant IGTs was authorized by Congress' Budget Implementation and Protection Act (BIPA). Although this federal law provided immediate relief to help care for health care of low income individuals in Cook County and Illinois, it also provided for a phase-out period that reduces payments by hundreds of millions of dollars over time, beginning in 2006. Communicating if and how this phase-out will affect Cook County will be an important issue to consider during the development of an overall Medicaid strategy.

Although the visibility associated with IGTs may be hindered at the national level, the attention garnered at the state and local levels has likely increased as IGTs have continued to be operationalized. Federal reviews associated with state-plan amendments, waivers, and care coordination decisions regarding "special financing" arrangements continue to reflect the increased level of scrutiny.

Medicare Drug Bill

In January 2006, direct oversight of the prescription drug benefit for hundreds of thousands of Medicare recipients was moved from the state Medicaid program to the federal government via 3rd parties called Prescription Drug Plans (PDPs). Nationally, millions of people have experienced difficulties during this monumental change, particularly people who are eligible for both Medicare and Medicaid. PDPs are risk-based entities that were created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Over one hundred thousand residents of Cook County are likely to be affected by the change. These individuals will likely receive an average of >40 prescriptions per year and are likely to have a diagnosis of diabetes, cardiovascular disease, or another chronic condition.

Whether the ultimate outcome of Part D is positive or negative, it is evident that the effect of this legislation will be historic. Approximately one-half of the funding will be channeled to low-income individuals through subsidies, and a similar proportion of the funding will be directed toward the sickest. The areas of Part D that should receive particularly close attention from the Cook County Bureau of Health Services include the following:

- *Education component during a fragile transition period:* Medicare/Medicaid recipients were automatically enrolled in PDPs from 15 November 2005 to 31 December 2005. Individuals with incomes that are below 150% of the federal poverty level have reduced cost sharing responsibilities. Coordinating with the state and federal governments, ensuring that patients know their rights (e.g., emergency prescriptions for 72 h), and coordinating with the PDPs are important as the process advances. During the transition, many states have made announcements that effectively enable low-income recipients to receive medications if the recipients were experiencing difficulties obtaining their

medications during the transition. On 12 January 2006, Illinois announced that it "will cover the cost of prescription drugs for dual eligible citizens—those enrolled in Medicare and Medicaid—who were otherwise being turned away from pharmacy counters across the state due to glitches in the new federal Medicare Part D drug program."

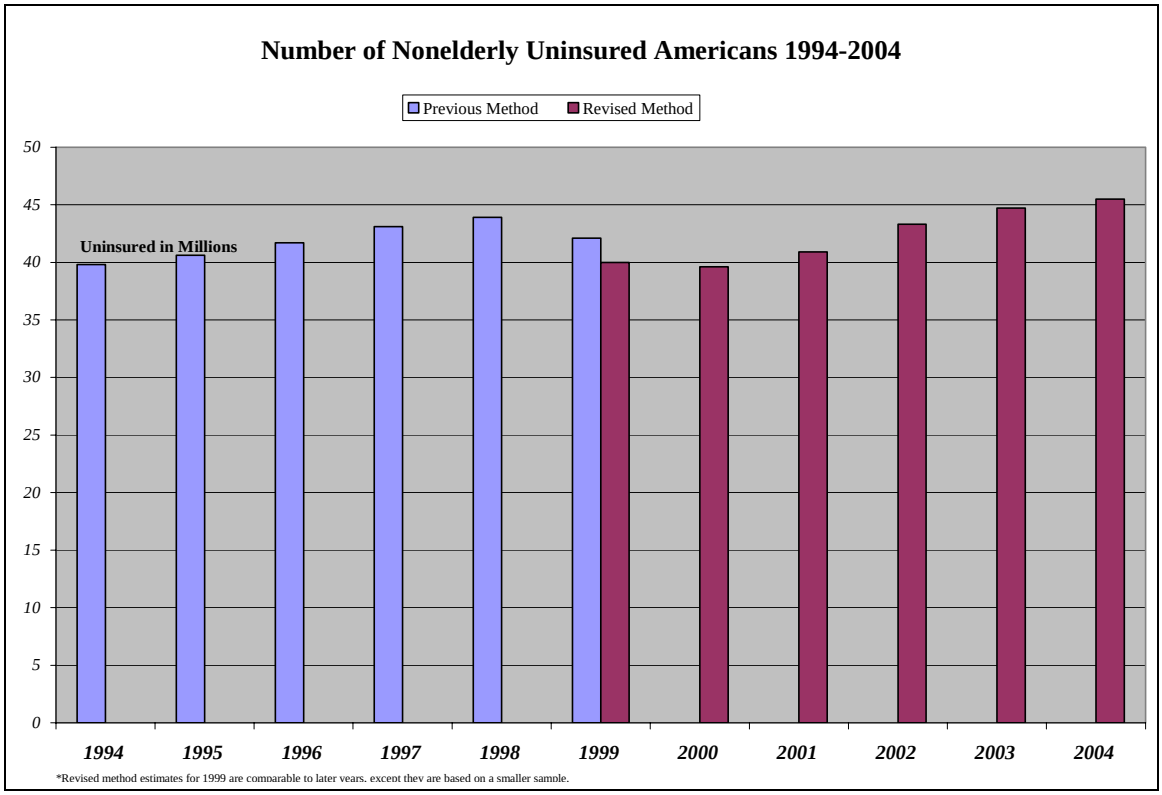
- *Direct financial effect on pharmacy operations:* Part of Cook County's Medicaid IGT agreement is related to clinic services and pharmacy visits. Because a significant number of dual-eligible patients obtain their prescriptions at Cook County clinics, Medicare's payments for these prescriptions will have a direct financial effect on Cook County revenues.

- *Indirect effect on the Medicare business line*: The effect of the Medicare drug bill on the overall Medicare business line may warrant the most attention. Medicare tends to be a strong payer—rates tend to be higher than many commercial and managed care payments, and they are certainly better than payments received for uninsured persons. Since the Medicare prescription drug benefit took effect in January 2006, Medicare-dependent patients who previously could only receive a drug benefit at Cook County are now able to receive prescriptions at virtually all commercial pharmacies (e.g., Walgreens and Osco). Medicare-dependent patients interested in receiving free or low cost drugs at Cook County will not have this incentive; thus, such patients may be less likely to seek other medical services at Cook County, which would negatively affect Medicare revenues coming into the system.

Growing Uninsured

The number of uninsured persons continues to increase at a consistent rate. The competing federal demands of the budget, disaster relief, foreign affairs, and judicial nominations of Congress seem to have shifted attention away from considering a large-scale reform package for uninsured persons. Meanwhile, state and local governments attempt to fill gaps in the system, with significant progress being made at the state level. Figure 1 demonstrates the steady increase in the number of uninsured Americans over the past decade.

Figure 1



The numbers in aggregate certainly do not reflect the entire story. Problems in some segments of the uninsured population are easier to address (in terms of policy options) than are problems in other segments, in terms of cost and platform options. For example:

- Nationally, approximately 9 million kids are eligible for Medicaid or SCHIP. As indicated in the Governor's AllKids initiative, 12% of kids are uninsured in Cook County.
- Nationally, approximately 8 million of uninsured persons are 19–24 years old.
- Nearly 40% of uninsured persons are children and persons 19–24 years old.

Perhaps the populations that present the greatest difficulty and that are most costly—and perhaps those that are more relevant to a large public hospital system—are

populations that have little or no opportunity to enroll in health care plans because of citizenship issues, or because of pre-existing health conditions.

- Nationally, 10 million uninsured persons are currently non-U.S. citizens.
- A significant number of uninsured persons are uninsured because of health conditions.
- Persons that are underinsured because of health status are a key population as well.

These groups have a profound effect on the health care safety net and the public system, because the public system is often their only option for health care. Although the nature of retroactive Medicaid eligibility alleviates difficulties for children and young adults, non-citizens and individuals who are "uninsurable" in the commercial market face great challenges that, in many cases, are only solved with safety net systems.

Increasing Numbers of Uninsured Persons, from the Employer Point of View

The slow erosion of employer-sponsored health insurance is one of the forces driving up the number of uninsured persons. A number of factors have contributed to this erosion: a general mellowing of the economy, changes in the manufacturing and service sectors, and the emergence of Medicaid as an alternative form of coverage for persons with higher incomes. Chart X shows how employer-sponsored insurance has deteriorated over time, with the percentage of the population covered by employers holding at about 60% of the U.S. population and moving toward coverage levels from the early 1990s. The Medicaid portion of the chart shows how Medicaid has become a major provider of coverage; it expanded rapidly during the economic boom of the early 90s, and in the past several years, it launched several large-scale coverage initiatives. For reference, the largest American employers are indicated at the bottom of figure 2 and demonstrate how the American economy fundamentally changed in a short period of time. Figure 3 (from Crain's) identifies Chicago's largest employers for the same time period.

Figure 2

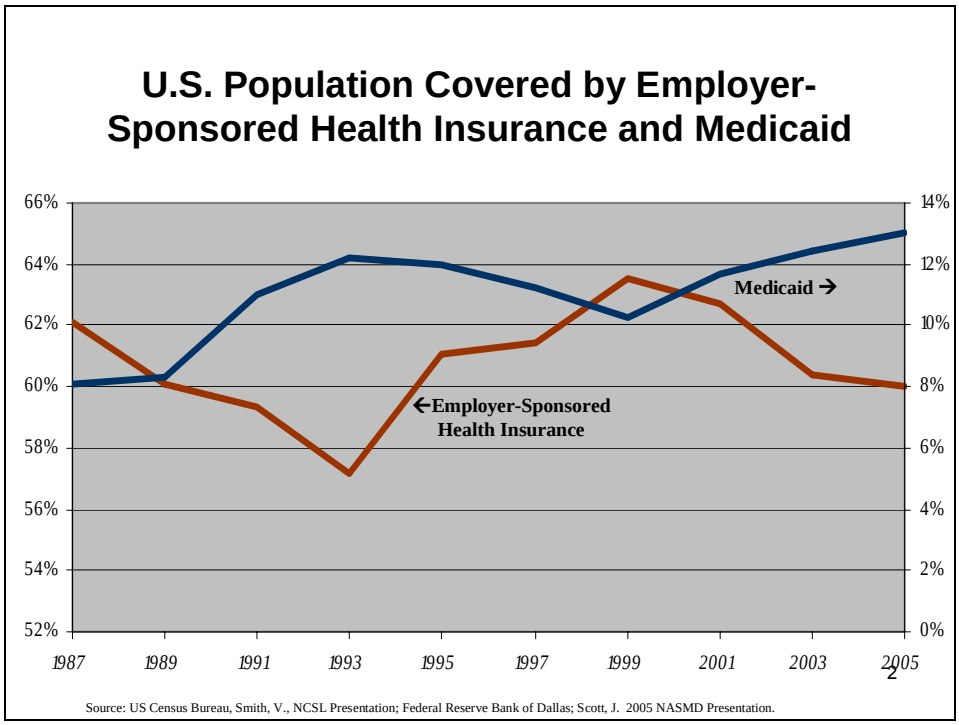


Figure 3

Chicago's Largest Employers

*1987**		*1995*	
1. Sears, Roebuck and Co.	37,416	1. Chicago Public Schools	43,404
2. Jewel	28,500	2. City of Chicago	41,328
3. AT&T	24,000	3. US Government	34,456
4. Illinois Bell	18,731	4. Cook County	27,849
5. Dominick's	18,000	5. US Postal Service	25,083

*No government information provided.

2001		*2005*	
1. US Government	75,000	1. US Government	78,000
2. Chicago Public Schools	46,179	2. Chicago Public Schools	43,783
3. City of Chicago	40,324	3. City of Chicago	39,675
4. Jewel-Osco	39,201	4. Jewel-Osco	34,037
5. Cook County	27,042	5. Cook County	25,482
6. SBC Ameritech	22,400	6. Advocate Health Care	25,279
7. Advocate Health Care	20,573	7. United Parcel Service	19,346
8. United Parcel Service	19,373	8. State of Illinois	17,056
9. State of Illinois	18,915	9. SBC Communications	16,500
10. United Airlines	18,276	10. Wal-Mart	16,350

A recent survey of businesses provided insight into the employer point of view of how health care has become the most important policy issue on the business agenda for policy makers. Business leaders rated health care reform first (32%), followed by tax reduction (29%) and budget deficit reduction (19%), as the most preferred U.S. legislative issues that they wanted addressed this year.[39]

Economics of Unfettered Growth and the Likely Fallout

Health care continues to take up a larger portion of Americans' personal spending. To what extent and at what level Americans should be concerned have been topics of debate for decades. Spending patterns have been cyclical; some extended periods of growth and extended periods of stability have occurred over the past several decades. Some key variables in the conversation include the following:

- The current climate indicates that the employer-based system continues to experience a downward trend, with many employers openly discussing the possibility of increasing cost sharing and dropping health care coverage.
- More public dollars are being applied to health care.
- Other questions include the extent of people's tolerance for access restrictions, or whether any model (e.g., managed care in the 1990s) will introduce a reprieve in the increases in health care costs.

The potential fallout from unfettered increases in costs includes several scenarios. Perhaps the worst scenario is a larger and larger population of uninsured persons, with greater health status disparities than those that currently exist. America becoming less competitive in the global marketplace is certainly a possibility with lasting implications. Perhaps the more realistic scenario for likely consequences involves the continued incremental deterioration of the health care system as we have known it. With this point in mind, it is crucial to pay close attention to the policy debates at hand (e.g., Massachusetts health care reform, IGTs, and funding the health care safety net), to

[39] http://www.prnewsire.com/cgi-bin/stories.pl?ACCT=104&STORY=/www/story/90-31-2

popular innovations in the health care market (e.g., health savings accounts), and to the ways in which innovation and technology are integrated with the public system.

Figure 4 from the U.S. Bureau of Economic Analysis shows how the face of the U.S. economy has changed since 1970. As the chart shows, the proportion U.S. personal consumption taken up by health care has increased significantly, with a meaningful spike in the 1990's. Figure 5 is more widely referenced and shows how the proportion of the U.S. GDP that is health expenditures represents a greater portion as of the U.S. economy.

Figure 4

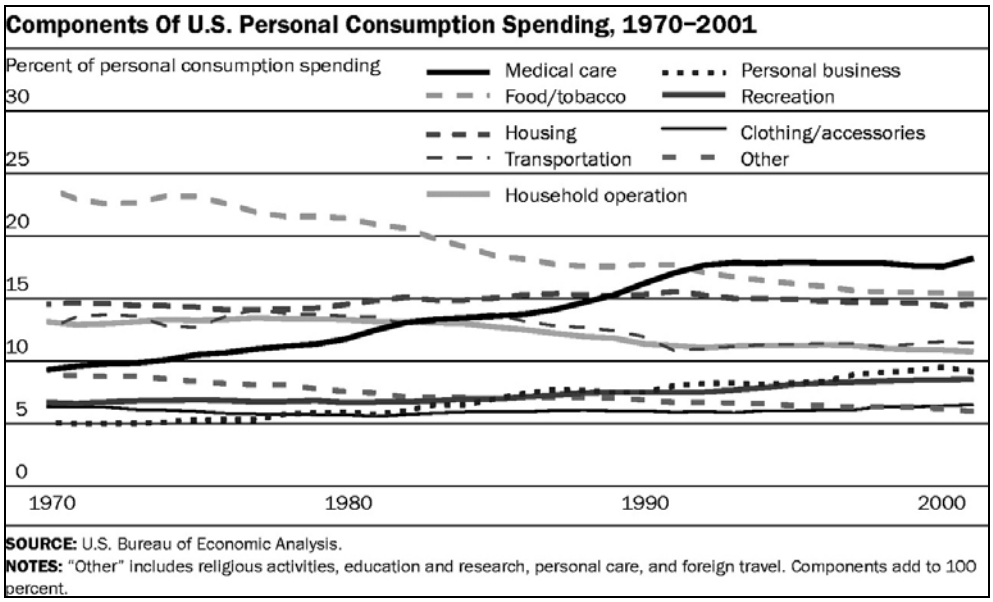


Figure 5

Health Care Expenditures, % of GDP

	1990	2000	2001	2002	*Projected*		
					2003	2004	2005
National Health Expenditures (billions)	$696.00	$1,309.40	$1,420.70	$1,553.00	$1,673.60	$1,793.60	$1,920.80
National Health Expenditures as a Percent of Gross Domestic Product	12	13.3	14.1	14.9	15.3	15.5	15.7

The State Climate

Medicaid is the largest health care program in the nation. Nationally, Medicaid expenditures comprise approximately 13% of all state-funded spending; in Illinois, they comprise 18% of all state-funded spending.[40] Most long-range estimates of Medicaid project a growth rate of 8%–9%, whereas most state revenue estimates realistically project a rate of 4% over time.

AllKids Program and the Introduction of a Primary Care Case Management Model

In the fall of 2005, Governor Blagojevich and the Illinois General Assembly launched the AllKids initiative. The initiative will provide and subsidize health insurance for approximately 250,000 uninsured children. The program will provide funding for a significant number of children who use Cook County services.

To help fund the program, most Medicaid recipients will be enrolled in a primary care case managed model (PCCM) and many will be enrolled in disease management programs. A PCCM program is defined by CMS as a program in which a provider "contracts to locate, coordinate, and monitor covered primary care (and sometimes additional services)" for Medicaid-dependent patients who are enrolled with a primary care provider. Primary care providers typically provide or coordinate primary and specialty care, including inpatient and outpatient hospital care. More than 30 states have been granted a federal waiver to administer a PCCM program.

Similarly, many state Medicaid programs have initiated disease management programs. Whereas in 2002 there were only 11 state Medicaid disease management programs, there were 25 disease management programs in October 2005, and at least 9 other states have some type of disease management program that was not established through legislation.[41]

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[40] Congressional Research Service June 2005 "Medicaid in State Budgets" memorandum.

[41] Smith, V and Wachino, V. "Medicaid Spending Growth: Results from a 2002 Survey." Kaiser Commission on Medicaid and the Uninsured, September 2002.

The structures of the PCCM and of disease management programs will be imperative, with respect to care coordination and finances. The Medicaid-dependent population and the payment base are essential to the Cook County Bureau of Health Services (CCBHS). Rollout for Medicaid-dependent patients who select clinics as their medical home will begin in the summer, whereas the remainder of the population will enroll in December 2006. Variables associated with the changes could include the following:

- **Network and Patient Choice**: PCCM, in its goal of providing a medical home for patients, and the Disease Management contractor's care coordination initiative have the potential to become positive forces in the coordination of care and the promotion of cost-effectiveness. The creation of the PCCM network and patient choice will have a less-than-certain effect on patient use. In many cases, patients who do not make an active choice for a medical home will be assigned to one by the state's contractor. The implications of the managed care program are factors as well, because the voluntary managed care program will remain an option as the program unfolds.

- **Effect on IGT**: How the care coordination models will unfold will have a direct effect on IGTs. Use of Medicaid is a significant, positive financial benefit for CCBHS.

Memisovski

The Memisovski consent decree was issued in response to the court's finding that Illinois violated federal Medicaid law by failing to provide Medicaid-enrolled children in Cook County (Chicago) with access to medical care, including EPSDT (early periodic screening, diagnosis, and treatment) services, equal to those of the general population. The decree requires the Department to provide plaintiffs with equal access to pediatric and EPSDT services. The decree is 45 pages and includes 48 provisions, most of which require the Department of Healthcare and Family Services to perform certain tasks, as follows:

- Distribute several informational mailings regarding Medicaid-enrolled children that encourage the use of well childcare, including EPSDT services, immunizations, dental care, and transportation services.

- Launch annual EPSDT informational campaigns that have coordinated efforts with schools, child care centers, providers, and other institutions.
- Contract with a third party to conduct dental outreach.
- Contract with a third party to perform provider information, recruitment, and referral duties for Medicaid.
- Hire a third party to prepare a report on the access to specialty care services among Medicaid-enrolled children.
- Beginning in the second quarter of 2007, pay eligible physicians and Federally Qualified Health Centers (FQHCs) a $30 bonus for each child for whom documentation of certain types of EPSDT visits is provided.
- Beginning 1 January 2006, increase certain dental care rates.
- Beginning 1 January 2006, increase reimbursement rates for certain primary care visits.
- Track eligibility, service, and provider data by type of service provided to Cook County children, child age, and child zip code, and prepare a quarterly report for plaintiffs.
- Prepare an annual report on EPSDT participation and immunization coverage levels for all Illinois and Cook County children.

The consent decree, as well as the resulting changes to rates and communication with Medicaid recipients, will substantially change how Medicaid conducts business in Cook County. The department's cost projection for implementation of the consent decree is $45 million per year. The extensive reporting requirements are likely to require a substantial amount of information system programming, which may also be costly. Outreach campaigns, enrollee mailings, and third party contracts will also affect costs.

Other Illinois Initiatives

The challenges of the public system and the health care safety net have been described by Attorney General Lisa Madigan in her discussion of the Tax-Exempt Hospital Responsibility Act. In addition to Madigan, many Illinois hospitals have debated the tax-exempt status and the percentage of free services (i.e., the community benefit) required to maintain it. Madigan has maintained that, on average, Illinois hospitals spend <1% of revenue generated by hospital charges on services for uninsured persons. Although such statistics and assumptions based on them are debatable, at a minimum, the topic provides valuable insight into and promotes discussion of issues related to providing care for uninsured persons.

Certainly, the work of the Adequate Health Care Task Force, which was created by the Health Care Justice Act, is essential to the future of uninsured persons in Illinois. Currently, the Task Force is crafting a detailed plan to address issues related to uninsured persons in Illinois. The Task Force is charged with developing a health care access plan that will provide Illinois residents with access to a full range of preventative, acute, and long-term health care services by 1 July 2007.

Trends in Other States

Trends in other states reflect philosophical shifts that occur as they try to control the unabated increases in health care spending. Although employers experience the same fundamental pressures regarding health care coverage, problems in state government health care systems are often more visible, given the scope of the Medicaid program and Medicaid's strong relationship with the health care safety net. Most of the recent trends have been driven by the federal government's cooperation with states to increase the predictability of the federal-state relationship. States that have particularly visible initiatives include the following:

- Massachusetts: Massachusetts has a hybrid model that includes a universal heath care program. A combination "pay or play" funding from taxes and

protection from special financing provisions in Medicaid help finance a massive expansion of commercial options and Medicaid coverage. Individuals who do not sign up for health care are subject to financial penalties and disincentives.

- Florida: Governor Jeb Bush's Florida Medicaid Modernization Proposal has been described as being the template for Republican health care reform, and it seeks to provide recipients with more control of resources and benefits, implement rate cuts and rate freezes for most providers, and develop a consumer-rated system to encourage quality. How the model will translate into a high-acuity population may pressure the current view of the medical entitlement. Financial predictability is a key element of the proposal.

- Iowa: Governor Tom Vilsack won approval from the CMS that has many states looking at the details. What was originally a CMS directive for Iowa to cease using certain IGT resources has turned into a waiver that deinstitutionalizes nursing homes, is aimed at expanding managed care, and protects "special financing" in Iowa.

- Tennessee: Governor Phil Bresden is seeking major changes to the TennCare program, including eliminating coverage to ~300,000 residents, with an estimated annual savings to the state of $1.7 billion.

- South Carolina: South Carolina's current Medicaid program operates primarily on a fee-for-service basis, with only limited participation by managed care organizations. Under the 1115 waiver proposal, the state would restructure its Medicaid program to give most beneficiaries a Personal Health Account (PHA), modeled on a health savings account, to pay for part of their health care expenses. Accounts would be funded with an actuarially determined amount generally based on current fee-for-service average expenses and would be risk-adjusted for eligibility categories, health status, age, and sex. Beneficiaries would be required to use the account to purchase a coverage plan from an array of options approved by the state Medicaid agency. Coverage options would range from a safety net of limited benefits to full service plans.

- California and Kentucky: California's waiver protects special financing and permits managed care expansion. Kentucky's waiver is more philosophically based, with an emphasis on quality of care.

Common themes among state trends include the protection of "special financing" (IGTs), increased beneficiary cost sharing, adding financial predictability into the system, and an increased emphasis on quality of care and/or care coordination initiatives including managed care. Such trends are also partly guided by desires to do "more with less" and to improve accountability. Whereas deliberate coverage initiatives were common in the middle to late 1990s (e.g., SCHIP/Illinois KidCare) and benefited the large public health care systems, such initiatives lost their popularity to more philosophically-driven initiatives.

Lessons for Cook County from the National and State Climates

As we have discussed, at the national level, most health care resources for low-income and underserved persons have been used to improve financial predictability and accountability. System-wide topics of interest have included Medicare Part D drug implementation, technology, health savings accounts, and portability. It is fair to say that there is little expectation that the federal government will initiate comprehensive health care reform near future and that the federal government prefers working with states to craft and coordinate state-specific programs. Initiatives that are advancing in Massachusetts, Florida, and Illinois are certainly large-scale and have significant implications.

Many recent federal initiatives present challenges for Cook County. Medicare Part D may make accessing health care at Cook County less appealing for Medicare-dependent patients, a population that is critical to the success of the Cook County system. Clearly, the federal government's concern regarding special Medicaid financing arrangements, including the arrangement between Cook County and the State of Illinois, has financial implications. Although the special financing has been approved many times through state plan amendments and other administrative actions, it remains

intense scrutiny. Changes to immigration policy are also worthy of Cook County's attention.

Major state-level changes regarding coordinating care will occur in the future. Although coverage will increase with the Governor's AllKids program, coordination of care and use of services could fluctuate significantly as Primary Care Case Management (which affects 1.2 million Illinois Medicaid beneficiaries) and Disease Management initiatives advance in Illinois. How those initiatives affect Cook County has not been determined. Predicting their effects and seeking options with the state and the successful vendors is imperative for the Cook County health care system. Although Illinois has been able to limit problems associated with uninsured persons through progressive and aggressive coverage initiatives, uninsured persons continue to have a significant presence in Illinois.

Appendix 2: Other Components of the Health Care Safety Net

Disproportionate Share Hospitals

Under the Medicaid Disproportionate Share Hospital (DSH) program, hospitals that care for a large number of Medicaid-dependent and uninsured patients are eligible for additional Medicaid payments. Twenty-nine hospitals in Cook County meet the minimum federal requirements for DSH.[42] Because the majority of DSH payments in Illinois go to the Cook County Bureau of Health Services hospitals as part of an Intergovernmental Transfer agreement, the State of Illinois has created a its own program, modeled after DSH, to support other safety net hospitals. As a result, many safety net hospitals in Cook County—including all 29 DSH hospitals and 9 non-DSH hospitals—receive a majority of their funding through this Medicaid Percentage Adjustment (MPA) program.

MPA and DSH are often used interchangeably to refer to Illinois health care safety net hospitals. Collectively, these hospitals care for a significant number of Medicaid and uninsured patients.

Medicaid Hospital Admissions as Percentage of Total Admissions (2003)

Hospitals in Cook County	Total Admissions	Medicaid Admissions	Medicaid %
DSH/MPA Hospitals	1,415,882	553,575	39%
Other Hospitals	2,950,978	468,496	16%

Source: AHA 2003 Hospital Survey

[42] Federal law specifies that hospitals meeting one of the following conditions must qualify for Medicaid DSH payments: (1) have a Medicaid inpatient utilization rate of at least one standard deviation above the mean in the state or (2) have a low income utilization rate of at least 25%. In addition, states may designate other criteria to allow additional hospitals to qualify for DSH.

Academic Medical Centers

Academic Medical Centers also play a critical role in the Cook County health care safety net by providing primary, specialty, and tertiary care to Medicaid-dependent and uninsured patients, in addition to fulfilling their pedagogical and research missions. Cook County Academic Medical Centers include Rush University Medical Center, University of Illinois Medical Center, the Loyola University Health System, Northwestern Memorial Hospital, and the University of Chicago Hospitals.

Along with Stroger Cook County Hospital, academic Medical Centers also provide much of the trauma care in the County. Northwestern, Loyola, and the University of Chicago Hospitals all operate Level-1 trauma centers.

Veterans Administration (VA) Hospitals and Clinics

The VA operates 2 hospitals (Edward Hines, Jr., and Jesse Brown) and 6 clinics in Cook County by means of its Veterans Integrated Services Network. Edward Hines, Jr., VA Hospital is located 12 miles west of downtown Chicago and offers primary, extended, and specialty care, and it serves as a tertiary care referral center for the network. Hines Hospital also operates several community-based outpatient clinics, including clinics in Oak Park and Oak Lawn. Hines had nearly 512,000 patient visits in its network of outpatient clinics during the 2004 fiscal year.

The Jesse Brown VA Medical Center consists of a 205-bed acute care facility and several community-based outpatient clinics, including locations in Beverly, downtown Chicago, and Chicago Heights. Jesse Brown VAMC provides care to ~62,000 veterans. In the 2004 fiscal year, the medical center had ~7600 inpatient hospital admissions and 531,000 outpatient hospital visits.

Chicago Department of Public Health Clinics

In the 1970s, the Chicago Board of Health received funding from Model Cities, a federal urban aid program that enabled the number of City clinics to increase to more than twenty. During this time, the Chicago Department of Public Health served as the foundation of the primary health care safety net in the City of Chicago. Beginning with the Omnibus Budget Reconciliation Act (OBRA) of 1989, Federally Qualified Health Centers (FQHCs) became a covered benefit under Medicare and Medicaid, entitling

federally funded community health centers and similar facilities to receive cost-based reimbursement from both programs. Shortly thereafter, the City and other safety net clinics sought status as FQHCs or FQHC Look-Alikes.

During the 1990s, there was tremendous growth in the number of FQHCs in Chicago and a dramatic increase in the number of clinics developed by the Cook County Bureau of Health Services' Ambulatory and Community Health Network. This growth was further enhanced in the first part of this decade by initiatives to support new FQHC expansion.

As the primary care safety net infrastructure expanded, the Chicago Department of Public Health reduced the number of public health clinics that they operated to refocus their concentration on public health services. Some of the City clinics were closed, whereas others entered into partnerships with private community hospitals. In 2003, three of these clinics partnered with other hospitals to improve the comprehensiveness of their services and improve continuity between inpatient and outpatient services. For these clinics, the City of Chicago contracts private hospitals to provide primary care doctors who attend these patients when they are hospitalized. All seven City of Chicago health centers work with the Cook County Bureau of Health Services to provide specialty care. The City of Chicago clinics also facilitate access to behavioral health services, through one of the city's 13 behavioral health clinics. The City of Chicago's seven health centers include five primary health care centers: Englewood, Uptown, Lower West Side, West Town, and Roseland; and two maternal/child health centers: South Lawndale and South Chicago.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are characterized by five essential elements that differentiate them from other providers:

- They must be located in or serve a high-need community (i.e., medically underserved areas or medically underserved populations).
- They must provide comprehensive primary care services as well as supportive services, such as translation and transportation services, that promote access to health care.

- Their services must be available to all, with fees adjusted on the basis of patients' ability to pay.
- They must be governed by a community board, with a majority of members being health center patients.
- They must meet other performance and accountability requirements regarding administrative, clinical, and financial operations.

Federal designation as an FQHC or as a Look-Alike allows the health center to receive cost-based reimbursement for Medicare- and Medicaid-dependent patients. FQHCs also receive federal grant funds to offset the cost of caring for uninsured persons, as well as other benefits not given to Look-Alikes.

According to the federal Health Resources and Services Administration, there are 21 FQHCs and Look-Alikes in Cook County providing services at 78 separate sites. These sites include the seven Chicago Department of Public Health primary care clinics, which are designated as Look-Alikes. FQHCs and Look-Alikes in Cook County annually serve >475,000 patients, the vast majority of whom are below 200% of the federal poverty level (FPL). Approximately 40% of FQHC patients were uninsured in 2004, 41% were covered by Medicaid, and the remaining 19% had other public or private coverage.

No. of Cook County FQHC Patients by Insurance Source (2004)

Uninsured	Medicaid	Medicare	Other Public	Private	Total
192,604	193,876	19,556	340	68,777	475,152
40%	41%	4%	<1%	14%	100%

Source: Illinois Primary Health Care Association. Includes grant-funded FQHCs and Look-Alikes

There are several FQHCs in Cook County, many of which are quite large, have multiple sites, and have significant geographic coverage. FQHCs are designed to be independent and governed by a community board; however, the FQHCs in Cook County demonstrate sophistication in their efforts to communicate and coordinate. For example,

the Alliance of Community Health Centers pools the resources of six large FQHCs to improve quality of care while lowering the cost for its patient population by sharing best practices and achieving cost efficiencies with shared functions. Although the FQHCs provide primary health care services, they do not provide a comprehensive system of care and often need lab and pharmacy support, as well as a partner to provide specialty care for their patients.

Free and non-FQHC Clinics

There are eight free clinics in Cook County: six in Chicago (Community Health, Pacific Garden Mission Clinic, Pilsen Homeless Health Services, St. Basil's Free People's Clinic, Chinese Community Center, and the Free Health Clinic operated by the New Life Volunteering Society); one in LaGrange (LaGrange Community Nurse Health Association), and one in Rolling Meadows (Neighborhood Health Resource Center). Free clinics typically do not accept government funds and are operated by volunteers. In 2005, these clinics provided a total of >34,000 patient visits for primary care and dental services.

In addition, the Infant Welfare Society (IWS) is a maternal and child community health center that provides a comprehensive program of medical, dental, educational, and mental health services for underserved children and persons less than 19 year old. The IWS also provides prenatal care, gynecological care, general health services, and parenting information to underserved mothers. The IWS provides affordable, accessible health care to low income Chicagoans, with the primary patient population being recent immigrants. In 2005, IWS provided a total of 33,000 patient visits.

Access to Care

The Suburban Primary Health Care Council operates the Access to Care program, which is funded significantly by a line-item in the Cook County Bureau of Health Services budget, is a unique public-private partnership that makes primary health care, pharmacy, laboratory, and radiology services available to low income, uninsured persons in suburban Cook County and northwest Chicago. Although the Access to Care program relies on Cook County specialty and inpatient services, it organizes the provision of charitable primary health care services by contracting local physicians and

compensating them at a discounted rate ($68 per patient per year). A modest enrollment fee and a small co-payment is requested of program enrollees. Eligibility requirements include the following: having a family income less than twice the federal poverty level and no health insurance (or a deductible of ≥$500 per person), being ineligible for Medicare or Medicaid, and having a residence in suburban Cook County or northwest Chicago (defined as being located west of Pulaski Road and north of North Avenue).

In 2004, nearly 12,000 individuals were served by the Access to Care program, with a total of 44,925 prescriptions that were dispensed and 9917 laboratory and 919 radiology procedures that were performed. Single adults (38% of enrollees) were the largest group of individuals served by the Access to Care program in 2004, because they are categorically ineligible to receive Medicaid unless they are pregnant or permanently disabled. The Access to Care program experienced a continued decrease in the number of eligible children (11.8% of enrollees) as a result of increasing enrollment in KidCare. The majority of enrollees (>61%) live in a household in which someone was working but did not have health insurance; however, in 2004, the program experienced the largest increase in the percentage of unemployed enrollees (30.6%) that have been served since the program's inception in 1988.

Resources in Neighboring Counties

Lake County

The Lake County Health Department operates four community health centers, two of which are near the border of Cook County. In the 2005 fiscal year, there were 1445 patient visits to these clinics from residents of counties other than Lake County. According to the Health Department's Director of Primary Care, the vast majority of these visits (~1400) were residents of Cook County.

DuPage County

DuPage County applies strict residency criteria for individuals seeking care in the County's mental health or community health clinics. As a result, the County sees very few residents from other counties, including Cook County.

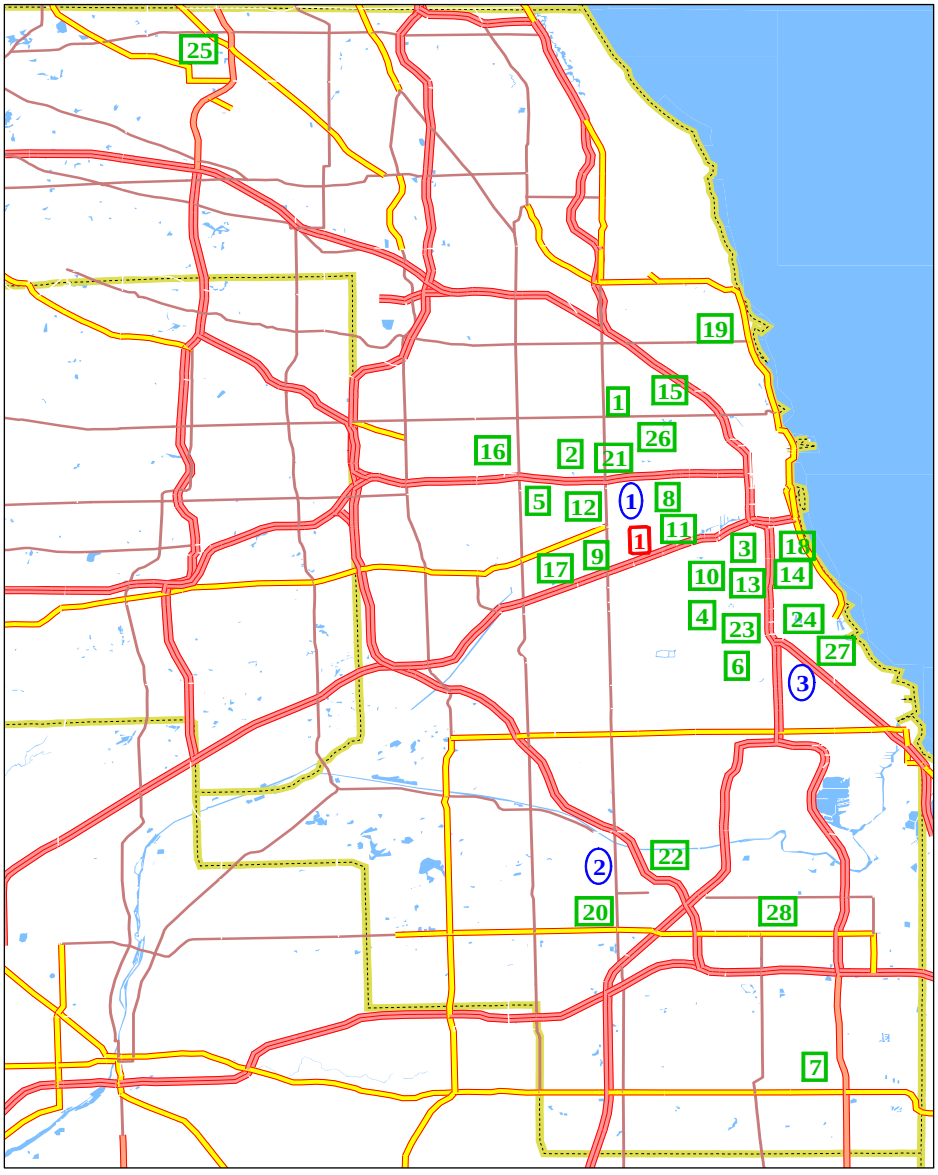
Since 2002, DuPage County has operated the Access DuPage program, a collaborative effort whose mission is to provide access to medical services to people in DuPage County who lack access because of economic reasons.

Access DuPage is not an insurance program, but it provides access to primary care services, lab services, x-ray services, and pharmaceuticals to uninsured county residents who qualify for a network of participating physicians. Participants pay a small fee for services.

Since its inception, Access DuPage has served over 10,000 DuPage county residents. To be eligible, individuals satisfy the following criteria:

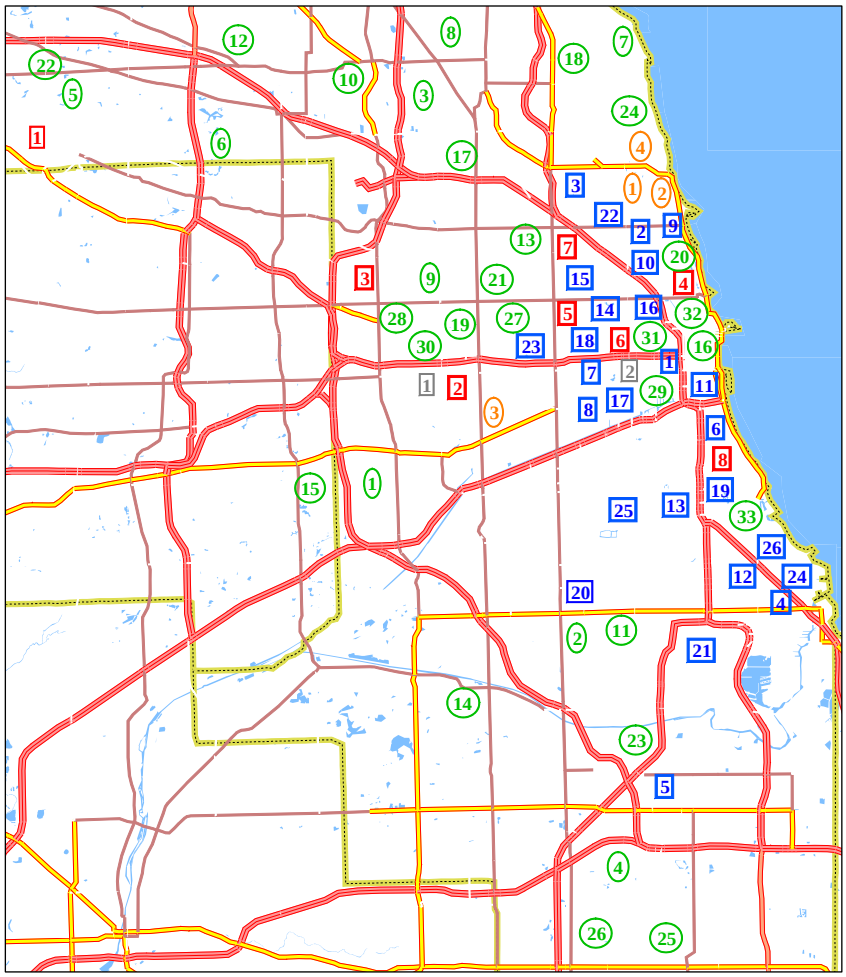
- Reside in DuPage County for at least 90 days.
- Be less than 65 years old.
- Have a household income at or below 200% of the federal poverty level.
- Not be eligible for other health insurance programs (e.g., Medicaid, Medicare, KidCare, employer-sponsored insurance, Cobra, and SSI).

Cook County Map 1: County-Operated Hospitals, Clinics, and Jail Health Services



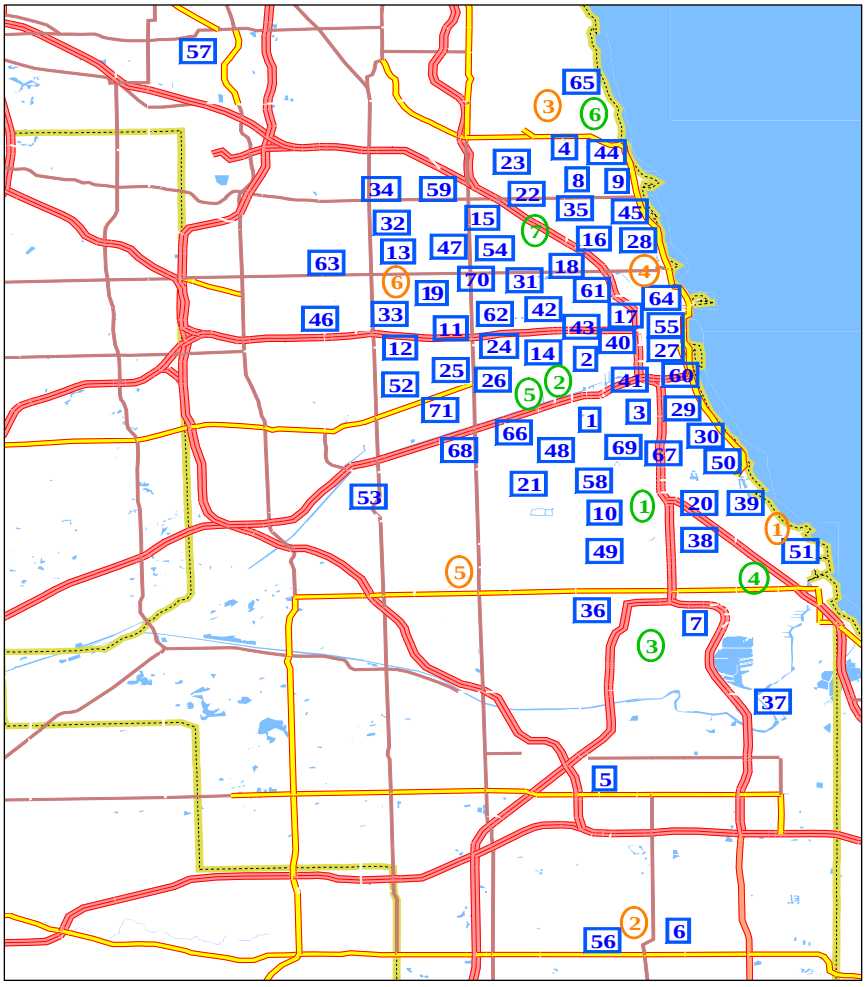
County Hospitals:	1 Stroger	2 Oak Forest	3 Provident	
County Clinics:	1 Austin	2 Austin/PATH Adolescent	3 Beethoven Child	4 Bond Child
	5 Cicero	6 Cook County/Englewood	7 Cottage Grove	8 Crane Adolescent
	9 Dr. Jorge Prieto	10 DuSable Adolescent	11 Fantus	12 Stroger - Specialty
	13 Hayes	14 John Sengstacke	15 Logan Square	16 Maywood
	17 Morton East Adolescent	18 Near South	19 Northside	20 Oak Forest Specialty
	21 Orr Adolescent	22 Robbins	23 Southside Chidlren's	24 Southside OB/Gyne
	25 Vista	26 Westside	27 Woodlawn	28 Woody Winston
County-Operated Jail Health Services:	1 Cermak Health Services			

Cook County Map 2 – Non-County Operated Hospitals by Type



Not-For-Profit Safety Net Hospitals:	1 Rush Children's	2 Northside Health System IL Masonic	3 Swedish Covenant	4 Advocate Trinity	5 Ingalls
	6 Mount Sinai	7 Schwab	8 Sinai Children's	9 Thorek	10 Children's Memorial
	11 Mercy	12 South Shore	13 Saint Bernard	14 Norwegian-American	15 Saint Elizabeth's
	16 Saint Mary of Nazareth	17 Saint Anthony	18 Bethany	19 Univ. of Chicago - Comer Children's	20 Hope Children's
	21 Roseland	22 Methodist	23 Loretto	24 Jackson Park	25 Holy Cross
	26 La Rabida				
Not-For-Profit Non-Safety Net Hospitals:	1 La Grange Memorial Hospital	2 Advocate Christ Medical Center	3 Advocate Lutheran Hospital	4 Advocate South Suburban Hosp	5 Alexian Brothers Behav.
	6 Alexian Brothers MC	7 Evanston Hospital	8 Glenbrook Hospital	9 Gottlieb Memorial Hospital	10 Holy Family Medical Center
	11 Little Company of Mary	12 Northwest Community Hospital	13 Our Lady Resurrection MC	14 Palos Community Hospital	15 RML Specialty Hospital
	16 Rehab Institute of Chicago	17 Resurrection Medical Center	18 Rush North Shore MC	19 Rush Oak Park Hospital	20 Saint Joseph Hospital
	21 Shriners Hospitals - Chicago	22 St. Alexius Medical Center	23 St. Francis Hospital & HC	24 St. Francis Hospital	25 St. James - Chicago Hgts.
	26 St. James - Cty. Fields Campus	27 West Suburban Medical Center	28 Westlake Hospital	29 University of Illinois	30 Loyola University
	31 Rush University	32 Northwestern University	33 University of Chicago		
For-Profit Safety Net Hospitals:	1 Streamwood Behavioral H.C.	2 Riveredge Hospital	3 Kindred Hospital - Northlake	4 Lincoln Park Hospital	5 Sacred Heart Hospital
	6 Hartgrove Hospital	7 Kindred - Chicago Central	8 Michael Reese Hospital & MC		
For-Profit Non-Safety Net Hospitals:	1 Chicago Lakeshore Hospital	2 Louis A Weiss Memorial Hospital	3 MacNeal Hospital	4 Neurologic & Ortho Inst. of Chicago	
Veterans Hospitals	1 Hines Hospital	2 Jesse Brown VA Medical Center			

Cook County Map 3 – FQHCs, CDPH and Veterans Clinics



FQHCs:	1 Alivio - Western Ave.	2 Alivio-Gladstone School	3 Alivio - 21st and Morgan	4 Asian Human Services	5 Aunt Martha's-Harvey
	6 Aunt Martha's-Vincennes	7 Chicago Family - Roseland	8 Chicago Health Outreach	9 CHO - Spang Center North	10 CHO - Spang Center South
	11 Circle Family - W. Jackson	12 Circle Family - N. Parkside	13 Circle Family - Main	14 Centro de Salud Esperanza	15 Erie Humboldt Park
	16 Erie Family Health Center	17 Erie Seniors	18 Erie Teen	19 Erie Westside	20 Friend-Family Health Center
	21 Friend Family - West	22 Howard Brown-Triad	23 Howard Brown Health Center	24 Lawndale Christian - Homan Square	25 Lawndale Christian - Main
	26 Lawndale Christian-Farragut	27 Mercy Diagnostic	28 Near North-Health Service Corp.	29 Near North-CottageView	30 Near North Konred/Holman
	31 Near North-Landau	32 PCC-Com Wellness Center	33 PCC-Austin	34 PCC-Salud	35 Prime Care
	36 Roseland Christian	37 Altgeld-Carver School	38 Altgeld-MCH	39 Altgeld-South Shore	40 UIC-Better Care for You
	41 UIC-James Jordan	42 UIC-Mile Square	43 UIC-Near West	44 Uptown	45 ACHN - Anixter
	46 ACHN - Alma	47 ACHN - Armitage	48 ACHN - Ashland	49 ACHN - Auburn-Gresham	50 ACHN - Booker
	51 ACHN - Brandon	52 ACHN - Cicero	53 ACHN - Des Plaines	54 ACHN - Division	55 ACHN - Dr. James West
	56 ACHN - Family Health	57 ACHN - Genesis	58 ACHN - Grand Boulevard	59 ACHN - Humboldt Park	60 ACHN - Ideal
	61 ACHN - Jackson	62 ACHN - Madison Park	63 ACHN - Melrose Park	64 ACHN - Near North	65 ACHN - Rogers Park
	66 ACHN - La Villita	67 ACHN - South State	68 ACHN - Southwest	69 ACHN - Taylor	70 ACHN - Warren
	71 ACHN - Westside				
Chicago Dept. of Public Health (CDPH) Clinics:	1 Englewood	2 Lower West Side	3 Roseland	4 South Chicago	5 South Lawndale
	6 Uptown	7 West Town			
Veterans Clinics	1 Beverly Clinic	2 Chicago Heights Clinic	3 Evanston Clinic	4 Lakeside Clinic	5 Oak Lawn Clinic
	6 Oak Park Clinic				

Appendix 3: Interviews and Focus Groups

As part of the information gathering and review process, a large number of individuals were interviewed either individually or in focus groups. As part of this process, we pledged that there would be no attribution of specific ideas or comments to any specific individual. Therefore we would like to acknowledge all of those individuals who took time to provide their insights about the County government and the Bureau. In recognizing their contribution, we also want to note that mention of any individual name does not imply endorsement of this report. In addition to those named, we would also like to thank those individuals who participated yet asked to remain anonymous.

Whitney W. Addington, MD: *President, Otho S. A. Sprague Memorial Institute*
James N. Alexander: *Executive Director, Otho S. A. Sprague Memorial Institute*
Ron Anderson, MD**:** *President and CEO, Parkland Health and Hospital System*
Dennis Andrulis, PhD: *Research Dean*, *Drexel University, Center for Health Equality*
Victoria Bigelow: *Executive Director, Access to Care*
John Bouman: *Advocacy Director, National Poverty Law Center*
Hon. Jerry Butler: *Commissioner, Cook County Board*
Alan Channing: *President and CEO, Sinai Health System*
Hon. Forrest Claypool: *Commissioner, Cook County Board*
Hon. Earlene Collins: *Commissioner, Cook County Board*
Lester Crown*: Civic Committee Chair, Commercial Club*
Kathy DeVine: *President and CEO, St. Anthony Hospital*
Brian Fabes: *Executive Director, Civic Consulting Alliance*
Lee Francis, MD: *Medical Director, Erie Family Health Center*
Larry Goodman, MD: *President and CEO, Rush University Medical Center*
Hon. Gregg Goslin, *Commissioner, Cook County Board*
Larry Haspel, MD: *Vice President, Metropolitan Chicago Healthcare Council*
Andrew Hedberg, MD: *President, American College of Physicians*
Art Jones, MD: *President, Lawndale Christian Health Center*
John Kretzmann, PhD: *Co-Director, The Asset-Based Community Development Institute, Northwestern University*
Joan Kurtenbach: *System Director of Business Development, Resurrection Health Care*
Stuart Levin, MD: *Chairman of Medicine, Rush University Medical Center*
Peggy Luce: *Vice President, Chicago Chamber of Commerce*
R. Eden Martin: *Executive Director, Civic Committee, Commercial Club*
Terry Mason, MD: *Commissioner, Chicago Department of Public Health*
Laurence Msall: *President, Civic Federation*
Heidi Nelson: *Executive Director, Heartland Health Alliance*
Michelle Obama: *VP for Community/External Affairs, University of Chicago Hospitals*
Ann Patla: *Assistant to the Vice-Chancellor for Health Affairs, University of Illinois at Chicago*
Hon. Anthony Peraica: *Commissioner, Cook County Board*
Hon. Mike Quigley: *Commissioner, Cook County Board*
Ken Robbins: *President, Illinois Hospital Association*
Erica Salem: *Assistant Commissioner, Chicago Department of Public Health*
Kevin Scanlan: *President Elect, Metropolitan Chicago Healthcare Council*

Margie Schaps: *Director, Health and Medicine Policy Research Group*
Henry Scheff: *Policy Director, AFSME Illinois*
Laura Schneider: *Policy Analyst for Lake County, Lake County Health Dept.*
Hon. Debra Simms: *Commissioner, Cook County Board*
Hon. Bobbi Steele: *Commissioner, Cook County Board*
Hon. Larry Sufferdin*: Commissioner, Cook County Board*
Jim Tarrant: *Executive Director, Chicago Medical Society*
Donna Thompson: *President, Community Health Network*
James Webster, Jr., MD: *President, The Institute of Medicine Chicago*
Arnie Widen, MD: *Illinois Attorney General's Office*
John Wilhelm, MD: *President, Infant Welfare Society*
Xichel Woods: *Executive Director, Erie Family Health Center*
Quentin Young, MD: *Chairman of the Board, Health and Medicine Policy Research Group*

Also, we thank those Bureau physicians who participated in focus groups at the Stroger Cook County Hospital.