

# The Chicago Health Care Access Puzzle



## Fitting the Pieces Together

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Mayor

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# EXECUTIVE SUMMARY

This report, "The Chicago Health Care Access Puzzle: Fitting the Pieces Together," documents a recent initiative to examine access to care for the most vulnerable residents of Chicago. It was undertaken by leaders in the health care system under the sponsorship of the Chicago Department of Public Health (CDPH) and the Chicago Board of Health (Board).

Regional meetings were convened by CDPH and Board between February and April, 2008. These meetings were well-attended by Chicago's safety net providers. Leaders from all three areas (South Side, West Side, and North Side) discussed prevalent issues problems they experience as service providers.

Four broad topical areas were found to have city-wide importance:

- 1. Policy**
- 2. Capital Financing**
- 3. Systems of Care**
- 4. Information Technology**

In June 2008, a meeting with all providers was held and participants convened in workgroups to consider issues from each of the topical areas. The task of each workgroup was to refine the issues and reach consensus on an immediately attainable, low-cost solution for at least one of the identified issues. Workgroups developed action plans for each solution proposed.

"The Chicago Health Care Access Puzzle: Fitting the Pieces Together" presents the findings, solutions, and action plans that are the products of this deliberative process.





# INTRODUCTION

Assuring access to health care services for the City's most vulnerable populations is a long-held focus of the Chicago Department of Public Health (CDPH) and is exemplified in its mission... "to make Chicago a safer and healthier city by working in partnership to promote health, prevent disease and injury, reduce environmental hazards, and assure access to care." Assurance is identified as one of the three core functions of public health, along with assessment and policy development, in the Institute of Medicine's 1988 landmark report, "The Future of Public Health." In addition, linking people to needed personal health services and assuring the provision of health care when otherwise unavailable is one of the ten essential public health services developed in 1994 by the Core Public Health Functions Steering Committee.

"The Chicago Health Care Access Puzzle: Fitting the Pieces Together" examines access to health care issues faced by Chicago's most vulnerable residents. In doing so, this report and the meetings from which the report is based, allowed and assisted CDPH to monitor, analyze, and publicize health disparities present in our communities, another one of the essential public health services. CDPH recognizes the necessity of addressing health disparities as well as improving access to care because these inter-related issues are primary to accomplishing CDPH's mission to make Chicago a healthier city.

This report is based on the discussions that occurred at the meetings CDPH convened between February and June 2008 with leaders in the health care system that serves the safety net population. It represents the understanding of the participating stakeholders and policymakers of the problems inherent in Chicago's safety net. This report proposes potential solutions to some of the issues identified and suggests, where appropriate, immediate, short-term actions to address those issues that CDPH has committed to undertake.

## PREVIOUS EFFORTS TO EXAMINE THE GAPS IN THE SAFETY NET

In the last 20 years, CDPH has provided leadership for several initiatives that have examined this issue. Two are highlighted here:

### *The Chicago and Cook County Health Care Summit*

In 1989, Mayor Richard M. Daley, former Cook County Board President George Dunne, and former Governor James Thompson launched the Chicago and Cook County Health Care Summit (Summit). Its charge was to develop a workable plan to improve the delivery of health care to those residents of Chicago and Cook County who depend on the City, County, or State to deliver or finance healthcare services. The Summit was a large-scale planning effort, which included public hearings held throughout the County. More than a hundred people participated on its committees and staff groups. CDPH staffed the Summit's System Design and Management Committee.

Recommendations were made in the areas of removing barriers between health care providers, increasing the number of community providers, promoting the use of appropriate levels of care, coordinating the roles and efforts of public and private providers and payers, and expanding capacity, especially at the community level.



While many recommendations were not implemented, most notably those that addressed governance of City and County health services, many improvements resulted from the Summit. Among the recommendations implemented were: the reopening of Provident Hospital and Mile Square Health Center; use of intergovernmental transfers (IGT) to increase Medicaid reimbursement; expansion of the Cook County referral program; expansion of primary care resources for the medically indigent, including a large expansion of Cook County-sponsored ambulatory care; and increasing state support of community health centers.

### *The Chicago Health and Health Systems Project*

In 2001, with the support of the Otho S.A. Sprague Memorial Institute, CDPH set out to create and institutionalize a process for monitoring Chicago's health care system. The primary goal of the Chicago Health and Health Systems Project (Project) was to enhance the understanding of the local system of care. More specifically, it was CDPH's intention to use this information to improve decision making by informing providers, policymakers, and public and private funders; informing its own internal planning efforts; and sharing the information for communities to use to increase their involvement with the system at the neighborhood level.

In addition to the creation and maintenance of web-based community and hospital profiles, the Project published several reports. One, "Casting Chicago's Health Care Safety Net," examined the availability of primary care services for the medically underserved in the 15 or so years since the Summit produced its findings. The other reports profile Chicago hospitals, the mental health system, and the availability of primary care services within regions of the City.

### **IMPETUS FOR THIS REPORT**

The increasing numbers of the uninsured; more frequent reports of uninsured patients not being able to receive needed care, in particular specialty care, mental health and oral health care; and the increasing vulnerability of several community hospitals, especially those on the South and West Sides of Chicago, compelled CDPH to engage in a process to understand the access issues that are now facing Chicago's most vulnerable and disadvantaged populations.

To build on the other reports prepared by CDPH that address access to care, it was determined that the first step would be to ask providers for their own perspectives on issues they face in serving Medicaid and uninsured patients, and then to let the process unfold from that point.

Joining CDPH in this effort was the Chicago Board of Health (Board), a nine-member, Mayoral-appointed board. Chaired by a physician, the Board's current membership includes leaders in medicine, public health, dentistry, business, law, social work, and nursing. Its membership also represents the diverse cultural composition of the City of Chicago. The Board's duties and powers include being well informed regarding all matters affecting the health of the residents of Chicago and to otherwise advise the Mayor of the City of Chicago and the Commissioner of Public Health on all health issues. The Board is charged with the specific role of promulgating regulations and formulating policies. With this general charge, the Board closely monitors changes in access to and quality of health care for the residents of the City of Chicago. The Board actively testifies on behalf of these issues at various levels of government, including the City Council and the Illinois Health Facilities Planning Board.

## PROCESS

The initial step was to meet with groups of safety net providers and other stakeholders to get their firsthand sense of the problems facing them in caring for Medicaid, uninsured, and underinsured populations, and to see where those conversations led. Because a major South Side safety net provider brought this area's particular issues to CDPH's attention, the first meeting, which took place in February, focused on the South Side. Senior leadership from area hospitals, both community hospitals and academic medical centers, community health centers, and local and state government were all invited to attend. North and West Side meetings followed in April 2008.

In an effort to maximize participants' participation and a successful outcome for this endeavor, prior to each meeting, an in-depth analysis of the area's health care status and health resources was completed by CDPH staff and sent to meeting participants for their review and background.

The specific goals for each of the meetings were to:

- Identify the particular problems providers recognize in adequately serving the insured, Medicaid and low-income uninsured populations
- Identify cooperative solutions to the recognized problems
- Determine methods to test collaborative approaches among area providers within each region
- Specify next steps

During the meetings, participants were provided the opportunity to provide their insight and comments on the issues they believe are the most urgent to improving Chicago's health care safety net. At the end of each of the meetings, participants were asked to join, or recruit expert staff, for one or more workgroups. Discussion at all of the meetings led to the identification of the following workgroups:

- Policy
- Capital Financing
- Systems of Care
- Information Technology

The three meetings provided the Board and CDPH with valuable insight with respect to the safety net issues existing in each of the respective areas. At the end of each meeting, a list of issues was identified. Because many of the identified areas of concern consistently occurred throughout Chicago, a list of city-wide common issues was identified and shared with participants from the three meetings.

For this reason, it was determined that an additional meeting would be convened with all the original meeting participants being invited to further explore and find solutions to the issue areas they identified as mutual areas of concern.

In early June 2008, meeting participants convened once again, along with expert staff from the participating agencies and institutions, to further explore and find solutions to the issues of mutual concern that had been identified. After a general introduction and charge for the day was provided, meeting participants moved into individual workgroups. To ensure the workgroups addressed key components, CDPH staff developed a single set of workgroup guidelines. Specifically, each workgroup was asked to prioritize their issues and then brainstorm to identify specific agreed-upon solutions. While completing this task, workgroup members were also asked to identify a distinctive process for implementing the solution, to name responsible organizations that would need to take part in the



process, to list the resources available and needed, and to create a reasonable timeline for delivering the solution. Each workgroup was asked to recommend at least one low-cost solution.

At the end of this brainstorming session, the individual workgroups reconvened as a group and each workgroup shared its recommendations and reasoning for the solutions they identified. An action plan was developed for each item.

### **ORGANIZATION OF THIS REPORT**

The report that follows contains three sections:

- **Findings** contains the problems identified by provider participants as well as some potential solutions posed by them. CDPH staff researched the issues identified to provide more of a foundation for the *Findings* section.
- **Action to Date** is an overview of actions, both completed and underway, to resolve access issues and support Chicago's safety net that were identified and developed by meeting participants.
- **Supporting Documentation** includes documents prepared by CDPH staff and provided to participants, as well as other background materials. These should be useful to the reader in acquiring a more comprehensive picture of the health status and health system challenges facing Chicago's uninsured, underinsured, and Medicaid populations.

# FINDINGS

The *Findings* delineated below were identified by meeting participants as the most pressing problems facing them in the delivery of health care to the medically underserved. The issues identified were further researched by CDPH staff. In some cases, potential solutions to the problems were identified as part of the meetings' discussions; they are also included.

The issues organized themselves into four overarching categories:

- Policy
- Capital Financing
- Systems of Care
- Information Technology

The *Findings* vary widely in their degree of development and specificity. This is an inevitable result of the process through which groups of participants identified issues: some were ideas just germinating, and others were already well-developed and lent themselves to the identification of possible solutions. As this process was and continues to be a fluid one, the *Findings* are reported as developed by participants and each finding is included, regardless of the level of development.



## POLICY

***The growing number of uninsured and underinsured people continues to be a serious issue in our city and throughout the country, resulting in many uninsured people not getting the care they need.***

This is the crucial underlying problem for much of what has been identified. Without a systems approach to ensuring that all people are covered, providers will need to continually search for piecemeal ways to provide care to the uninsured while staying viable.<sup>1</sup>

Lack of coverage has consequences. Nearly half of uninsured people postpone seeking care. Over one-third do not get the care they need. Uninsured children are 70% more likely than insured children to go without care. They are 30% less likely to receive care when they are injured. Uninsured children and adults are less likely to receive preventive care, are more likely to be hospitalized for untreated chronic conditions, and are more likely to be diagnosed at later stages. The Institute of Medicine estimates that nearly 18,000 people die prematurely in the U.S. each year simply because they are uninsured.

Over the past four years, the number and proportion of uninsured Hispanic Chicagoans have grown significantly. Hispanic Chicagoans accounted for 27% of the uninsured in 2004 but rose to 42% in 2007. More than 200,000 Hispanic Chicagoans were uninsured, an increase of nearly 50,000 in only four years. More than two-thirds of uninsured Hispanic Chicagoans are not citizens. The proportion of uninsured African American Chicagoans has remained stable at about 28% during the four-year period, but their total numbers have grown by nearly 14,000.

Uncompensated care in Illinois cost \$1.8 billion in 2005. Uninsured Chicagoans pay about one-third of the cost of their health care treatment. Twenty percent of the cost of paying for health care for uninsured people is paid through public programs. The remainder is paid primarily through increased premiums that add \$400 to the premium cost for each insured person in Illinois. These costs in Illinois added \$1,059 to the average family's premiums in 2005.

At the same time, bankruptcies due to medical bills are rising. A national study showed that in 2001, half of all bankruptcies, about 2 million, were attributable to unpaid medical bills. Among those filing for medical bill reasons, two-thirds were insured.<sup>2</sup>

Without reform, the cost of care that the uninsured cannot pay will exceed \$2.6 billion in 2010. This year each insured person will pay total costs of \$4,065 to cover the cost of treatment for the uninsured. By 2010, without reform, each family will pay total costs of \$17,273 to cover the cost of treatment for the uninsured.

Health care coverage is expensive for workers and employers. One-third of workers in Chicago have no health care coverage. Forty-two percent of self-employed adults in Chicago are uninsured. Many employees cannot afford to pay their share of the cost of health care coverage to which they are entitled. Fifty-five percent of Illinois firms provided coverage in 2003. Fewer employers are providing

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<sup>11</sup> The Policy section is based on information from *Kaiser State Health Facts*, retrieved on August 25, 2008, from [www.statehealthfacts.org](http://www.statehealthfacts.org).

<sup>2</sup> Himmelstein, D., Warren, E., Thorne, D., Woolhandler, S. "Illness and Injury as Contributors to Bankruptcy." February 2005. *Health Affairs*.

health care coverage for workers each year, and many small firms in Chicago cannot afford to provide health care coverage for their employees.

Workers in Chicago's small firms (2-500 employees) pay at least 30% of the cost of coverage for individuals and 50% for family coverage. Chicago workers paid \$1,707 out of pocket for health care costs in 2006. Monthly premiums for Chicago workers were \$142 or more than double the cost five years ago. Each employer paid \$922 in premiums for each family they insured in 2006 to cover the cost of treatment for the uninsured.



***Medicaid rates are inadequate in their reimbursement level and structure thereby creating incentives for inefficient care and incentives to not treat Medicaid patients.***

Twenty percent of Americans had health insurance coverage from Medicaid in 2005. As a state and federal partnership, Medicaid subsidizes essential health services for low income people and plays a vital role in funding our safety net system. Medicaid covered 19% of Illinoisans, nearly 2.4 million people, at a cost of nearly \$11.4 billion in 2006. More than half of Medicaid enrollees in Illinois are Chicago residents.

Medicaid spending nationally decreased 0.9% in 2006, the first decrease since the creation of Medicaid in 1965. The decrease is attributable to the replacement of Medicaid-funded prescription drug coverage for Medicare beneficiaries by Medicare Part D prescription drug coverage in 2006.

Even when the state makes no change to the program, the cost of Medicaid has the potential to increase because the overall cost of healthcare has been rising at a faster rate than the rest of the economy each year. The overall annual growth in health care expenditures between 1991 and 2004 was 6% in Illinois.

Illinois Medicaid spending rose 11% between 1990 and 2001 and 9% between 2001 and 2004. While the number of Medicaid recipients increased by 11% between 2004 and 2006, there was no change in Illinois Medicaid spending during that period.

### Possible Solutions

**Medicaid reimbursement rates must be increased.** Although Illinois is a relatively wealthy state<sup>3</sup>, ranked by census data among the top ten wealthiest states nationally, spending on health care is not commensurate. This inconsistency is graphically evident in Illinois' Medicaid fee for service rates. Illinois ranked 41<sup>st</sup> in the nation for all services in 2003, the last year for which data are publicly available, 42<sup>nd</sup> in primary care, and 29<sup>th</sup> in obstetric care.

For three decades Illinois Medicaid reimbursement rates have not kept pace with inflation, increasing about 11% between 1996 and 2006. Today the average dental reimbursement is 46% of the cost of providing services. Illinois specialists say that they are reimbursed 33% for services to Medicaid patients. According to the Illinois State Medical Society, Illinois Medicaid now reimburses physicians about 56% of what the federal Medicare program pays for the same care, or about 45% of the cost of providing the service.

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<sup>3</sup> The U. S. Census uses "Total income" defined as "the sum of the amounts reported separately for wages, salary, commissions, bonuses, or tips; self-employment income from own nonfarm or farm businesses, including proprietorships and partnerships; interest, dividends, net rental income, royalty income, or income from estates and trusts; Social Security or Railroad Retirement income; Supplemental Security Income (SSI); any public assistance or welfare payments from the state or local welfare office; retirement, survivor, or disability pensions; and any other sources of income received regularly such as Veterans' (VA) payments, unemployment compensation, child support, or alimony." American Factfinder. [www.americanfactfinder.gov](http://www.americanfactfinder.gov). Accessed October 3, 2008.

The following table (Figure 1), based on data from Kaiser Family Foundation, demonstrates how Illinois Medicaid reimbursement compared to other wealthy states in 2003, the latest year for which data are publicly available.<sup>4</sup>

**Figure 1: Medicaid Reimbursement in Selected "Wealthy" States, 2003**

State	All Services	Primary Care	Obstetric Care	Others
<b>Illinois</b>	<b>0.92</b>	<b>0.89</b>	<b>1.03</b>	<b>0.93</b>
Connecticut	1.30	1.33	1.53	0.96
New Jersey	0.56	0.61	0.41	0.65
Massachusetts	1.25	1.28	1.28	1.16
New York	0.70	0.71	0.88	0.46
Maryland	1.21	1.28	1.20	1.05
Delaware	1.49	1.64	1.09	1.41
Minnesota	1.09	1.00	0.94	1.47
New Hampshire	1.03	1.09	1.15	0.77
Colorado	1.06	1.08	1.03	1.04

*The Medicaid fee index measures each state's physician fees relative to national average Medicaid fees. The data are based on surveys sent by the Urban Institute to the forty-nine states and the District of Columbia that have a fee-for-service (FFS) component in their Medicaid programs (only Tennessee does not). These fees represent only those payments made under FFS Medicaid. The Medicaid fee index is a weighted sum of the ratios of each state's fee for a given service to the national average, using 2000 expenditure weights.*

New Jersey and New York raised Medicaid reimbursement rates in 2008 and are now among the highest in the nation. Illinois increased Medicaid rates in 2006 for 12 pediatric-related services in primary care in response to a court-ordered decision but is still one of the lower paying states.

Nationally, Medicaid reimburses at about 60% of Medicare reimbursement. Private coverage reimburses at 125% of Medicare. Medicare services are assumed to be reimbursed at an average of 80% of the cost of the service.

Additionally, the state conserves limited resources in down cycles by temporarily imposing longer payment cycles and effectively shifting the cost of care from the state to providers. A 2008 report by the Illinois Auditor General found that, on average, the state carried \$1.5 billion in unpaid medical claims into the next fiscal year in 2005, 2006, and 2007.<sup>5</sup> The reimbursement time has been improving in fiscal year 2008 as the state attempts to meet its goal of paying physicians' Medicaid claims for ambulatory care within 30 days for child patients and within 60 days for adult patients. By contrast, hospitals wait more than 90 days for reimbursement. Some nursing homes have payment cycles even longer. The state owed about \$1.7 million, half of the amount less than 30 days old, at the end of fiscal year 2008.

<sup>4</sup> Zuckerman, Stephen; McFeeters, Joshua; Cunningham, Peter; and Nichols, Len. "Medicaid Fee Indexes and Medicaid-To-Medicare Fee Indexes, 2003." June 2004. Health Affairs. Available at <http://content.healthaffairs.org/cgi/content/abstract/hltaff.w4.374v1>.

<sup>5</sup> "Financial Audit and Compliance Examination." (for the year ending June 30, 2007) Release Date: June 18, 2008. Illinois Department of Healthcare and Family Services.



Medicaid must be redesigned to support appropriate utilization patterns through addressing certain differentials in rates and ways to reimburse for services. Similar services provided by different types of providers, e.g., ambulatory care services provided in a Federally Qualified Health Center (FQHC) versus a hospital-based practice or a private practice setting, are reimbursed at widely different rates. Hospitals are reimbursed at differing rates that do not seem to be directly proportional to differences in the costs of providing the same services. Another example results from the inflexibility of Medicaid rules that results in FQHCs only being able to bill for one encounter of a similar service per day so that patients either need to return more frequently to obtain needed care or the FQHC provides the service without reimbursement.

Medicaid must expand its list of covered services. While the Illinois Medicaid program covers a substantial number of optional services, the state needs to do a better job in covering different types of health education, expanding existing oral health coverage, and providing parity for adults and mental health coverage.

Federal Medical Assistance Rate for Illinois Medicaid should be increased. Illinois is the only wealthy state severely disadvantaged by the Federal Medical Assistance Rate (FMAP) it receives. Commonly called the Medicaid match, FMAP has a statutory floor of 50% and a ceiling of 83% based on a state's Medicaid expenditures. The FMAP rate is determined by a state's per capita income with poorer states receiving a higher FMAP rate than wealthier states.

Illinois is among the wealthy states that currently have an FMAP of 50%. Illinois' true FMAP rate is 47% because Illinois, though wealthy, has a large number of low-income residents eligible for Medicaid. Because FMAP is based on per capita income, and does not take into account the numbers of low-income residents, Illinois receives less than its share of federal Medicaid funding. Illinois serves 4.5% of Medicaid enrollees nationally but receives only 3.6% of federal Medicaid funding. This represents a difference of \$1.167 billion annually.

The Illinois FMAP was temporarily increased to 52.95% in federal FY 2004 as a result of federal legislation to incentivize during an economic downturn. Illinois' FMAP rate returned to 50% thereafter.

The following table (Figure 2) from the Center for Tax and Budget Accountability's 2006 report, "Illinois' Medicaid Program: Financing Challenges in the Face of Federal Medicaid Cuts and a Flawed State Fiscal System<sup>6</sup>," demonstrates how disadvantaged Illinois is in comparison to other wealthy states and how the existing FMAP rate shortchanges Illinois.

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<sup>6</sup> O'Donnell, Heather and Martire, Ralph. "Illinois' Medicaid Program: Financing Challenges in the Face of Federal Medicaid Cuts and a Flawed State Fiscal System." 2006. Center for Tax and Budget Accountability.

**Figure 2: How the FMAP Formula Affects Illinois, 2006**

State	% of Medicaid Population	% of Federal Funding	(Cost) or Benefit
<b>Illinois</b>	<b>4.50%</b>	<b>3.61%</b>	<b>(\$1,167)</b>
Connecticut	1.00%	1.30%	\$ 391
New Jersey	2.12%	2.63%	\$ 670
Massachusetts	2.36%	2.69%	\$ 425
New York	9.27%	14.25%	\$ 6,498
Maryland	1.50%	1.48%	(\$ 24)
Delaware	.26%	.23%	(\$ 40)
Minnesota	1.73%	1.74%	\$ 11
New Hampshire	.24%	.40%	\$ 215
Colorado	.86%	.86%	\$ 6

In federal fiscal year 2009, which began October 1, 2008, the FMAP for Illinois will be increased to 50.32%. The increase is due to changes in population and income. Projecting based on Illinois' 2006 Medicaid spending, the latest year for which data are publicly available, the additional 0.32% will increase 2009 federal Medicaid matching funds to Illinois by at least \$64,759,202.

Advocate for the federal government to increase Medicaid funding during economically lean times, such as the current period. Medicaid programs are particularly vulnerable in times of economic downturn such as the one being currently experienced. State revenues that fund Medicaid typically decrease during a weak economy, while at the same time, the need for coverage increases as people lose employer-sponsored insurance.

A 1% rise in unemployment is projected to add 1.1 million to the nation's uninsured. Another one million people, 600,000 of them children, will enroll in Medicaid. This projected increase would in turn increase state Medicaid spending by \$1.4 billion at a time when state tax revenues would fall by 3 to 4%. Nonetheless, Medicaid provides a unique, counter-cyclical, positive stimulus during an economic downturn. Medicaid provides economic advantages, because of its federal matching funds, that are larger than that of state spending alone. Medicaid also has a greater economic impact than other state spending increases because it is not a transfer of funds but an infusion of new funds from federal match into the state economy. Each one million dollars in Medicaid spending results in \$2.4 million in business activity and \$850 thousand in salary and wages. These dollars move throughout the economy in successive waves of spending that economists call the "multiplier effect."

The Families USA "Bad Medicine" report documents how cuts in federal Medicaid funding due to the Deficit Reduction Act of 2005 (DRA) negatively affect states through lost business activity, jobs, and salary and wages. Illinois is projected to lose \$487.7 million in federal Medicaid dollars as a consequence of DRA cuts. The loss of those Medicaid dollars will result in losses of \$1.2 billion in business activity, 10,800 jobs, and \$418.8 million in salaries and wages in the first year of implementation. Cumulative losses over succeeding years will be in the billions.<sup>7</sup>

<sup>7</sup> "Bad Medicine: The President's Medicaid Regulations Will Weaken the Illinois Economy." April 2008. Families USA.



Illinois' IGT (intergovernmental transfer) and provider tax must be maintained. The hospital assessment program is a federal/state revenue matching program which permits states to leverage additional resources to attract additional federal matching funds into their state Medicaid programs. Hospitals are assessed a "tax" based on their level of inpatient and outpatient health services. Those monies are matched by federal dollars, bringing in additional revenue that is used to offset services to the uninsured.

The Bush Administration has been instituting regulatory changes over the past several years that have reduced states' ability to draw down federal match for services provided to uninsured, low-income patients through the use of IGTs and certified public expenditures. The regulations, as introduced, significantly reduce safety net revenue on which hospitals depend. Cook County alone would lose nearly \$100 million.

A moratorium on these federal regulations has been passed by Congress, and the President has signed the bill into law. The moratorium extends until April 1, 2009.

The current Illinois Hospital Assessment Program expired on June 30, 2008. (The hospital assessment program is a federally permissible method to leverage resources to attract additional federal matching funds into the state's health care systems.) The Illinois Department of Healthcare and Family Services (HFS) submitted to the U.S. Centers for Medicare and Medicaid Services (CMS) a new Medicaid state plan amendment to extend the hospital assessment program, effective July 1, 2008. To date CMS has not approved the plan amendment. Many of Chicago's safety net hospitals are likely to suffer a severe financial crisis if the revenue generated from this amendment is further delayed. Historically, approved plan amendments have been effective retroactively so that there is no break in the program.

Nearly three-quarters (74.3%) of the hospitals in the City of Chicago have negative patient margins (i.e., they lose money on their core service of providing patient care) and are struggling to survive. The Hospital Assessment Program would provide a net benefit to hospitals in Cook County of more than \$350 million a year. In addition, CDPH and other health care service providers (long term care, developmental disability services, and other Medicaid health care services) will also benefit from the Hospital Assessment Program, as a portion of the enhanced Medicaid match is used to increase reimbursement for all Medicaid providers.

This infusion of federal Medicaid funds from the Hospital Assessment Program will permit many of Chicago's hospitals to make needed facility improvements, many of which are required to maintain compliance with life safety codes, purchase needed equipment and technology improvements, and hire essential health care staff. This will likely prevent the reduction or elimination of services or even outright hospital closures.

***Concerns about the costs of malpractice insurance have contributed to restricted access to care, especially for specialty care.***

While there is no consensus as to the reasons behind the high cost of malpractice insurance, all would agree that the cost of malpractice insurance has increased dramatically, and that these increases have contributed to the reduction in access to some specialty care services, especially in particular geographical areas where there are large disadvantaged populations and for those without insurance.

There is some evidence that nationally the closure of hospital obstetrical (OB) units is in part due to high medical malpractice rates. For example, analysis of the reasons behind the closure of hospital maternity wards in Philadelphia in the past decade found that the high expenses for malpractice insurance and relatively low reimbursements from health insurers have been the major reasons. In a 2006 American College of Obstetricians and Gynecologists (ACOG) study, members nationwide were asked if they had made any changes in practices in the last three years due to the affordability or availability or both of professional liability insurance. Nearly 70% of ACOG members reported they had made one or more changes to their practice, including, ceasing the provision of OB services, decreasing the number of high-risk OB patients, and no longer performing major gynecological surgery.<sup>8</sup> Hospitals with smaller OB units are especially affected by high malpractice rates.

In Chicago, the impact of the high cost of malpractice insurance mostly affects facilities in low-income neighborhoods on the South and West Sides; however, this concern was brought up at all three area meetings. Meeting participants representing North Side hospitals also cited the cost of malpractice insurance as a barrier to expanding OB services for community health center patients.

Hospitals cited particular problems in identifying physicians in surgery specialties and subspecialties, such as neurosurgery, to provide services in their emergency departments and on a consultant basis, and FQHCs experienced similar problems in finding referral sources for their patients.

### Possible Solutions

**Expand FTCA so all providers treating FQHC patients are covered.** Employees of FQHCs are covered by the Federal Tort Claims Act (FTCA) and for purposes of liability coverage are considered to be federal employees. It would be very useful if all providers caring for FQHC patients would be covered by FTCA, not just those who are employed directly by the FQHC. This change would greatly enhance continuity and quality of care for FQHC patients.

Explore methods to increase coverage for patients who have an FQHC as their medical home, including expansion of scope of service FQHCs provide.

Publicize Illinois Good Samaritan Laws for those providers who provide care that is free of charge.

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<sup>8</sup> "Facts About the Obstetrical Crisis in Pennsylvania." The Hospital & Healthsystem Association of Pennsylvania. Fact Sheet, Last updated in April 2008.



***Academic medical centers should play a more active role in restructuring Chicago's health care system at the local level (also see Systems of Care section)***

Academic medical centers have a special role to play in training the workforce. Meeting participants recommended that medical schools:

- Improve their efforts in inculcating the psychological elements of illness and wellness into the training of residents and other health care providers, and
- Incorporate an anthropological approach to better understand and incorporate the ethnic and cultural mores of populations served so that providers can be more culturally and ethnically appropriate in their provision of care.

Meeting participants recognized these as outstanding opportunities for collaboration among all the academic medical centers. Academic medical centers receive federal funding to support graduate medical education (GME), such as internship and residency programs. The structure of GME has a significant influence on how medicine is taught and the types of services that are emphasized by teaching hospitals. Currently, GME funds are tied to inpatient, hospital-based care, while medical practice and education are shifting to the ambulatory care setting. The future practice of medicine, and therefore training, should focus on coordinated, interdisciplinary and patient-centered care, rather than maintaining the fragmentation now found among multiple unrelated providers and settings of care.

The need for education and training in team care, meeting the needs of special populations, chronic disease management, and overall principals of practice management and care delivery are recommended priorities by the Association of American Medical Colleges for training and education.

GME needs to be reformed not only to account for the growing number of residents shifting into specialty care over primary care, but also to account for the shift to the ambulatory care setting for both primary and specialty care services that medical education and practice are experiencing. Additionally, both the Medicare Payment Advisory Commission (MedPac) and the Council of Graduate Medical Education have recommended academic centers be held to greater accountability for the public monies they utilize for training new physicians. However, despite all the concerned calls for GME reform, "...it has not translated into broad support for changes that could save more money and provide better support for training physicians in innovative approaches to coordinate care, enhance care for the disadvantaged populations and develop better models of translational research. These are vital goals that need further development as soon as possible."<sup>9</sup>

### Possible Solutions

Reform GME in a way that provides incentives for academic medical centers to provide community-based care. It seems that extensive restructuring of the organization and reimbursement of care may be in the offing. Given the expertise at several of the universities in the Chicago region, Chicago could become a national leader. These are topics on which conconvocation of local academic and government leaders could develop new creative strategies to break the current impasse. In particular, the lack of faculty and mentors could be enhanced to increase the availability of nursing graduates. (See following section)

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<sup>9</sup> Iglehart, J.K. "Medicare, Graduate Medical Education, and New Policy Directions." *New England Journal of Medicine*, vol. 359, August 7, 2008: 643- 650.

*The health care workforce is inadequate in capacity and training.*

Greater attempts must be made to ready a workforce prepared to take care of Chicago's diverse populations and work in the increasingly complex and high-tech health care field. There is a growing need for bilingual staff, especially Spanish speakers and, in some areas, Polish, Chinese, and other Asian languages. All services should be provided in a culturally appropriate manner.

**Possible Solutions**

The Metropolitan Chicago Healthcare Council (MCHC); Mayor's Office of Workforce Development; and the City of Chicago initiative, Leading Economic Advancement, Development, and Sustainability Project (LEADS); are working to increase the number of direct care nurses in the metropolitan Chicago area.

In early 2008, MCHC first hosted a Healthcare Workforce Leadership Summit with the Governor's Subcabinet, followed by an advisory meeting of Chicago-based leaders to discuss the problem and solutions. Three main areas were identified as areas for potential development: improving health care workforce diversity, increasing registered nurse (RN) program capacity, and improving RN completion rates. The group continues to meet and three subcommittees are currently working on solutions in the areas of workforce diversity, education capacity, and student support services.

Other possibilities include:

- Increasing the use of community health workers, Americorps workers, and other programs; and
- Maximizing the use of non-physician providers in health care settings appropriate to their strengths and ability to provide services.

Specific fields, especially mental and oral health, require particular attention.



***The business and civic communities must be active partners in addressing access to health care issues in order to make significant, long-term, and wide-reaching changes in the system.***

Meeting participants expressed that, despite benefits to businesses, they did not sense a significant Chicago business presence involved in health system change.

With certainty, a strong health care system has positive impacts on business. Businesses rely on a healthy community as a source of quality employees and as consumers for their goods and services. Academic medical centers and community hospitals are major economic engines in the communities in which they are located. According to the MCHC, Chicago metropolitan area hospitals employ 142,347 FTEs, representing 8.1% of the areas total labor force.<sup>10</sup> Businesses also are concerned about the high cost of providing health insurance as well as the impact that serious and chronic illnesses have on their ability to run efficiently and effectively.

Statistics make a strong case that employers have a lot riding on a healthy health care system. Nationwide, 158 million employees are enrolled in employer-sponsored insurance. Premiums for employer-sponsored coverage increased at an average of 6.1% in 2007, less than the 7.7% increase reported in 2006, but still higher than the increase in workers' wages (3.7%) or the overall inflation rate (2.6%). Individual coverage cost \$4,479 in 2007 with employees paying 16% of premium costs. Family coverage in 2007 cost \$12,106 with employees paying \$ 3,281, 28%, of premium costs.

Employers and employees in Illinois shared premium costs at or below the national average in 2006. Employees contributed 22% of the average family premium, versus 25% nationally. Employees contributed the same as the national average, 19%, for individual coverage.

Even when employers offer so called "consumer directed" high deductible plans, the cost is significant. In 2007, 10% of employers offered employees a consumer-directed plan option. Coverage was equally divided between high-deductible plans that qualify for a health saving account (HAS) and plans with a health reimbursement arrangement (HRA). HSAs and HRAs are tax-preferred savings accounts that can be used to pay the costs of health care for those covered by the associated, high deductible plans. Employers pay an average of \$7,815, \$719 to the HSA, toward family coverage through an HSA-associated high deductible plan.

Eroding employer-sponsored health insurance costs U.S. taxpayers \$45 billion a year: \$33 billion to cover public insurance such as Medicaid or SCHIP for workers and their dependents, and \$12 billion for uncompensated health care that would otherwise covered by the workers' private insurance. This high cost for health insurance disadvantages American industry in the global market. Cost of coverage in manufacturing averages \$2.38 per hour per employee, whereas the comparable foreign cost is \$.96. Because of this, many large employers are pursuing public policy solutions nationally to reduce the cost of employee and retiree coverage.

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<sup>10</sup> "The Impact of Chicago Hospitals on the Metropolitan Chicago Area." January 2005. Metropolitan Chicago Healthcare Council.

## Possible Solutions

To address the rising cost of health care in Chicago, several larger businesses have implemented innovative wellness programs. These programs can serve as models for other employers that do not have comprehensive programs to address the health of their employees.

The Chicagoland Chamber of Commerce, representing the interests of large and small employers, provides leadership on health issues for members. In addition, the Midwest Business Group on Health engages in policy discussions, performs research in health care, and promotes solutions at the local and regional levels.

Additionally, meeting participants believe that the top echelon of the business and civic communities, e.g., the Civic Federation, the Metropolitan Planning Council, and the Civic Committee of the Commercial Club, need to be more involved and engaged.



## CAPITAL FINANCING

### *Safety net hospitals need access to capital.*

Lack of access has resulted in deferred maintenance for even the most basic physical plant needs, let alone for investment in information technology or other needs such as investing in primary care practices. Participants described an "arms race" between the "haves" and "have nots" in the hospital world, and noted how this gap disadvantages older facilities.

For safety net hospitals located within Chicago, a vicious cycle exists when it comes to accessing capital to improve their facilities. Unlike the more stable hospitals with positive balance sheets, safety net hospitals are unable to access capital to improve their operations because most of the patients they serve are low income, either covered by Medicaid or are uninsured. Their weak operating cash flows contribute to these hospitals not having the stable bottom lines to seek capital assistance from institutional lenders to improve their facilities through either the tax-exempt bond market or other capital financing. Without access to affordable financing, the hospitals are unable to make vital investments in their physical plant, equipment and technology. Yet, if they had the capital to make such investments, they would be able to attract insured patients, especially as physicians would be more likely to schedule procedures within a sound facility. This would improve the hospitals' overall bottom lines, subsequently improving their ability to strategically plan and finance future capital projects. Hospitals with healthy bottom lines do not experience these same problems. The volatile bond market and tightened credit requirements have disproportionately hurt safety net hospitals.

Another indicator of the safety net hospitals' need for capital is their amount "ready cash" available, which is considered liquid assets and used by lenders as a measure of worth. Some safety net hospitals report their ready cash in hours while the more affluent hospitals have more than a billion dollars in reserve. The present environment will likely exacerbate financial difficulties for these safety net hospitals.

The need for new facilities is influenced by aging plants, changing demographics, advances in high-tech medical procedures, and the growth of health informatics. Therefore, hospitals that have access to capital are undergoing these modernization and replacement efforts. This building boom is occurring throughout the country, as well as in Chicago, including the following hospitals: Northwestern Memorial Hospital's Feinberg and Galter Pavilion (1999) and Prentice Women's Hospital (2007), Comer Children's Hospital of the University of Chicago (2005), Children's Memorial Hospital new location (2012), and Rush University Medical Center's new inpatient and emergency room site (2012). These efforts are in contrast to other less affluent hospitals' difficulty accessing capital for improving technology and repairing aging buildings.

Another concern about this trend is that hospital construction is identified as one of the driving factors in the increase of medical costs, which is predicted to increase by 10% in both 2008 and 2009.<sup>11</sup>

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<sup>11</sup> "Medical Cost Trends for 2009." June 2008. PricewaterhouseCoopers' Health Research Institute.

*Community health centers need access to capital.*

Access to capital to build or expand their current infrastructure is a concern of many community health centers. As with hospitals, the current system of capital financing for health centers places them at a considerable disadvantage because they rely upon government funds, foundation grants, and capital campaigns; yet these resources are scarce and insufficient to produce the necessary amount of equity to allow health centers to move ahead with their capital projects. The National Association of Community Health Centers has developed a national plan to address this lack of critical capital resources for health centers. Their plan includes the following three components: (1) a federal credit enhancement source that can be used in conjunction with tax-exempt bonds; (2) a tax credit allocation specifically for health centers; and (3) a single national entity to provide streamlined access to the tax-exempt bond market and facilitate the use of tax credits.<sup>12</sup>

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<sup>12</sup> National Association of Community Health Centers and Capital Link. "Access Capital." March 2008.



## SYSTEMS OF CARE

*Although Chicago has a wealth of health care resources, the system is fragmented and services are unevenly distributed, making it difficult for patients, particularly those who are uninsured or covered by Medicaid, to receive appropriate and comprehensive care at a cost they can afford.*

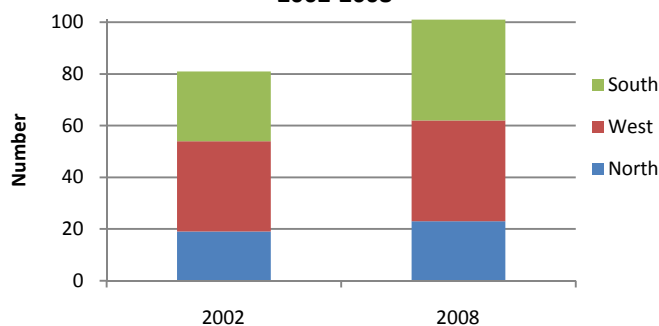
Chicago has a large health care system, ranging from world-class hospitals offering state-of-the-art treatment to highly-regarded community-based providers. Among these providers are four academic medical institutions within the City limits, one each on the South and North Sides, and two on the West Side. There are 31 general hospitals in Chicago that offer inpatient care, some outpatient care, and treatment through emergency departments. In addition, there are 101 community-based health centers (CHCs), both non-profit and publically-operated, and several free clinics. Twenty-six different organizations operate the community-based health centers and nearly two-thirds (62%) have more than one site, with the largest agency running 32 sites. And 24 school-based health centers provide easy access to primary health care for the student population.

Yet even with all the safety net providers and the significant numbers of private practice providers, accessing needed health care services can be difficult for many Chicagoans, especially the uninsured and patients covered by Medicaid. As the number of uninsured grows, providers are straining their resources and capacity to meet the need of these patients. In addition, these providers' ability to offer quality services will be affected by national trends in health care and the challenging economic environment.

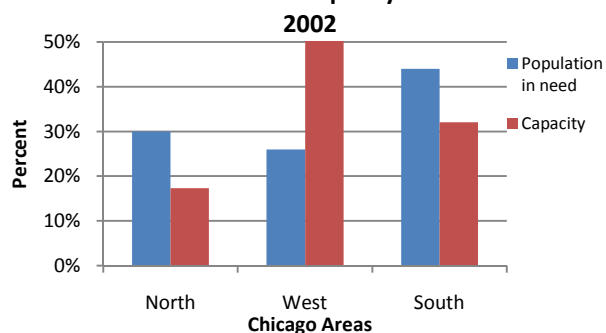
**Community-based Health Centers.** Since 2002, the number of Chicago CHCs grew by 25%, from 81 to 101. (Figure 3) The largest growth occurred in the South Side, from 27 sites to 39 sites. The number of sites expanded on the North Side, from 19 to 23, and on the West Side, from 35 to 39 sites. With this growth in the number of sites, it is expected that an increase in capacity also occurred, although the actual change in capacity is not yet able to be determined until a provider survey is administered in the fall of 2008.<sup>13</sup>

Analysis of the population-in-need (people under 200% of the federal poverty level and under 65 years of age) in 2002, compared to community-based health center capacity, indicates several areas of unmet need. (Figure 4) The South Side had the largest percentage of population in need, at 44%, but only had 32% of safety net capacity. The North Side also demonstrated a need for more capacity, with 30% of the population in need but only 17% of all

**Figure 3: Growth of Community-based Health Centers 2002-2008**



**Figure 4: Community-based Health Center Capacity 2002**



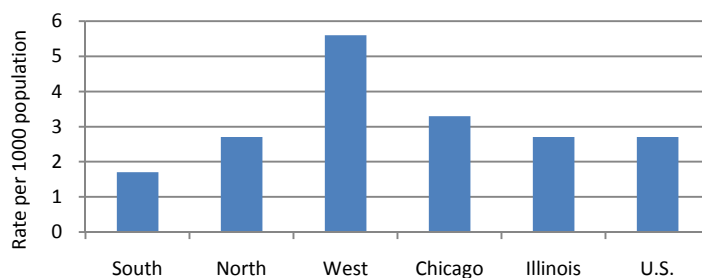
<sup>13</sup> Chicago Health and Health Systems Project, 2008. Chicago Department of Public Health, Office of Policy and Planning.

capacity. The West Side, however, had 26% of the population in need with 51% of health center capacity.<sup>14</sup>

**School-based Health Centers.** School-based health centers (SBHCs) represent an innovative component of the health care system to increase access to care for school-aged children and represent successful partnerships between Chicago Public Schools and safety net health care providers. Chicago has 24 SBHCs, 19 located in high schools, and are primarily operated by community health centers (15) and hospitals (8). The number of SBHCs grew between 2002 and 2008, from 19 sites to 24, an increase of 26%. Both the South and West Sides have nine SBHCs, while the North Side has six sites.<sup>15</sup>

**Hospitals.** The 31 hospitals providing general medical and surgical services are distributed relatively equally throughout Chicago, with 11 on the North Side, ten on the West Side, and ten on the South Side. Although the hospitals are divided among the regions, availability of hospital services is uneven. In 2006, the South Side's rate of peak set-up and staffed beds to 1,000 population is 1.7, while the North Side has 2.7 beds per population, and the West Side has 5.6 beds per 1,000 population. (Figure 5) The high rate of beds per population in the West Side is due to a concentration of several large medical complexes on the near West Side, including the Rush University Medical Center, University of Illinois at Chicago Medical Center, and John H. Stroger, Jr. Hospital.<sup>16</sup>

**Figure 5: Hospital Beds per 1000 population 2006**



Although a standard bed methodology is not currently being used in Illinois, a comparison is useful: Chicago's 2006 rate was 3.3 beds per 1,000 population, higher than the bed rate for Illinois and the United States, both at 2.7.

While hospital inpatient admissions showed only slight growth between 2000 and 2006, outpatient visits grew by 18%, from over 4.1 million visits to 4.8 million. Emergency department visits grew by 5.7%, from 1,116,000 visits to 1,180,000 visits in the same period. A few of the hospitals responded to this increase by creating emergency department diversion programs or by partnering with nearby community health centers to provide medical homes.

Some Chicago hospitals, especially those without large capital reserves, have been experiencing financial pressures. One-third of hospitals say they lost money on overall operations and two-thirds report not being able to cover costs for patient care services. This resulted in hospital closures and realignment or reductions in services. Three hospitals on the North Side closed since 2000 and Michael Reese Hospital

<sup>14</sup> Salem, E. and Ferguson, R. "Casting Chicago's Safety Net: A 12-Year Review of Chicago's Community-Based Primary Care System." Chicago: Chicago Department of Public Health, Planning and Development Division, 2005.

<sup>15</sup> Chicago Health and Health Systems Project. 2008. Chicago Department of Public Health, Office of Policy and Planning.

<sup>16</sup> All hospital data come from the *Annual Hospital Questionnaire*, 2000 and 2006. Illinois Department of Public Health.



and Medical Center is scheduled to close by the fall of 2008. These closures, plus other hospitals changes, resulted in a 22% decrease in set-up and staffed beds in the North Side, when comparing 2000 and 2006. In the South Side, after the closure of Michael Reese Hospital and Medical Center, the number of set-up and staffed beds will be down by 19%.

Advocate Bethany Hospital changed its scope of practice in 2007 from a community hospital to a long-term acute care facility. This change reduced the number of community hospitals beds by 4%, or 119 peak set-up beds (the maximum number of beds that were staffed), on the West Side. One hospital closed its OB unit in 2006, and another hospital has recently suspended these services. This represents a loss of 30 set up beds (16 in the North and 14 in the South Sides). Reasons identified for these closures include the rising cost of malpractice liability insurance, difficulty hiring and maintaining OB providers, and inadequate Medicaid reimbursement rates.

Although multi-hospital systems have been growing for the last two decades in many parts of the country, hospital systems within Chicago have declined slightly with only 12 of the 31 general hospitals in a multi-hospital system in 2008. Resurrection Health Care, with five locations in Chicago and four in the surrounding suburbs, is the largest. The other five systems in Chicago either have the majority of their system hospitals outside of Chicago or are part of a system that is composed of two locations. Competition from suburban multi-hospitals is occurring as hospitals aim to position themselves better in the regional market place.

Currently, Chicago has a low proportion of for-profit general hospitals, only 13% (10% when Michael Reese Hospital closes), while all specialty care hospitals in Chicago are for-profit hospitals and two out of the three psychiatric hospitals are for-profit. Financial difficulties of many safety net hospitals, especially those that are independently operated, place them at high risk in a marketplace where mergers and acquisitions that convert non-profit hospitals to for-profit hospitals run by corporations are increasing. St. Francis Hospital of Blue Island, for example, was recently purchased by MSMC Investors and its affiliate Transition Healthcare Co. and will now be operated as a for-profit entity. Other hospitals in Chicago report that they are at considerable risk as they weather these changes.

These changes raise concerns about access to care, especially for the uninsured or patients covered by Medicaid, as the changes in ownership and from a non-profit to a for-profit entity may alter the mission of these hospitals and could have a negative impact on patients.

Changes in hospital ownership and service array, as well as the outright closures of some hospitals, require that long-range planning take place to assure that the remaining hospitals critical to the health care needs of the City's residents and visitors remain viable and are organized in such a way to provide efficient and high-quality care.

### Possible Solutions

To improve access to quality care for all patients, meeting participants identified a need to create a comprehensive and structured approach by strengthening existing relationships and developing new collaborations among safety net providers.

Some Chicago safety net providers already are participating in collaborations among hospitals, CHCs, and specialty care providers. These collaborations have assisted many, especially uninsured and Medicaid patients, in accessing a continuum of care. Collaborative arrangements span from informal

agreements to legally binding contracts to provide services. Informal efforts may include hospitals referring patients to CHCs to obtain primary care services and CHCs and hospitals working together providing services at a health fair. Formal agreements may include CHCs contracting with hospitals for laboratory or radiology services at a significantly discounted price and contracts that provide admissions privileges for CHC providers to deliver babies in the hospital's labor and delivery unit.

Although collaborations are occurring in some areas and for some services, large gaps remain. To fully address continuity of care and access to needed services, a system-wide approach to collaboration is necessary. Development of overarching policies and procedures will help provide ongoing structure and move collaborative efforts beyond the necessity of personal relationships and individual will of collaborating organizations. Ultimately an organized primary care system with medical homes and a robust health information technology (IT) platform would solve many of these problems.



***Many Chicagoans, both insured and uninsured, do not have an appropriate and regular source of primary health care.***

Health care in Chicago, especially services available through the safety net system, is frequently fragmented, uncoordinated, and inefficient. Many individuals do not have a regular source of care, and therefore, do not receive preventive care or proper management of their chronic illness. When these individuals obtain treatment for an acute (but not emergency) health care issue, the care may not be as comprehensive or geared to their specific needs because this may be the first time this provider is treating them and is not familiar with their particular health history. For these and many other reasons, health care experts recommend patients having a medical home.

The American Academy of Pediatrics defines a medical home as "primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."<sup>17</sup> A medical home functions as the custodian for coordinating care around the patient's need and preferences. A medical home is also a clearinghouse for information about the patient's health status.

Many people who do not have a regular provider seek care at hospital emergency departments (EDs) for their health needs, including non-urgent services. This is due in part because EDs are always open and do not require appointments. Many people cannot afford to take time from work to go to a medical appointment during usual hours of operation. Many also delay obtaining care until the problem is too severe to wait a few weeks until the provider can see them. Not only has this pattern created a strain on hospital resources, but it also raises the cost of care because providing services in an ED is more costly than if the services were provided a medical home/primary care setting.

It is also important to recognize that sometimes patients with medical homes also use EDs for non-urgent care. This occurs because their provider may not have appointment times that fit the person's schedule, such as in the evenings or on weekends. Strengthening the relationship between patients and their medical homes may require more flexibility on the part of primary care providers.

From 2000 to 2005, the number of visits to U.S. hospitals' emergency departments increased by 20%.<sup>18,19</sup> This growth may be due to the increase in visits for non-urgent care (i.e., cases that needed to be seen within 2-24 hours), which grew from 10.7% in 2000 to 13.9% in 2005, an increase of 30%. In Chicago, visits to EDs increased by 5.7%, much lower than the national average. Information on the percentage of ED visits for non-urgent care locally is not available, but is expected to have increased with the rise of ED visits overall as well as the large and growing uninsured population and hospital closures and reduction in capacity. Although complete local data are not available, it is also expected that the last three years demonstrated an overall increase in Chicago's ED visits, due to the trends cited above. Some of the busiest EDs in Chicago report 10% annual increases.<sup>20</sup>

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<sup>17</sup> <http://www.medicalhomeinfo.org/> accessed October 1, 2008

<sup>18</sup> McCaig, Linda F., and Ly, Nghi. "National Hospital Ambulatory Medical Care Survey: 2000 Emergency Department Summary." April 22, 2002. U.S. Department of Health and Human Services, Division of Health Care Statistics.

<sup>19</sup> Nawar, Eric; Niska, Richard, and Xu, Jianmin. "National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary." June 29, 2007. U.S. Department of Health and Human Services, Division of Health Care Statistics.

<sup>20</sup> Based on personal communication from Dr. James Webster, Jr., MD, MS, MACP, Professor of Medicine at Northwestern University, August 2008.

In response to this problem, the Illinois Department of Healthcare and Family Services (HFS) mandated that nearly two million Medicaid enrollees choose a medical home. HFS instituted a special program to educate and coordinate care for those Medicaid enrollees that use emergency departments for non-urgent care six or more times annually. Such programs have been successful in other states.

### Possible Solutions

Meeting participants proposed development of ED Diversion programs to assist and encourage individuals to get connected to a medical home. Collaborative ED diversion programs, which refer non-emergent patients to a community-based primary care provider if they do not have a medical home, have been successful in hospitals locally and nationally. Several local hospitals, including the University of Chicago Medical Center (UCMC) and Resurrection Health Care System, initiated emergency room diversion programs utilizing federal grant funding. Patient advocates work with patients coming to the ED for non-urgent health care concerns and assist them with obtaining timely care at a nearby community health center. As part of the UCMC program, the South Side Health Collaborative promotes local community health centers where uninsured patients or patients covered by Medicaid can receive ongoing primary and preventive care. Resurrection Health Care System assists patients in obtaining health care and links them to community-based social services.

To grow these programs, the Illinois Department of Healthcare and Family Services is accepting proposals for its 2008 ER Diversion Program grant. Two proposals for new hospital-affiliated ambulatory care facilities will be funded with one in Chicago and one in a rural area. The grantees will improve services to Medicaid enrollees and the safety net population by collaborating among key providers, such as community health centers, hospitals, and behavioral health providers, to provide appropriate, comprehensive, and innovative care to these populations.

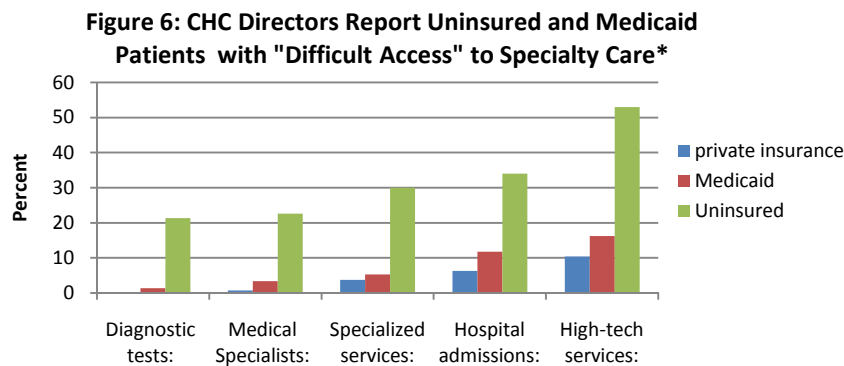


*It is increasingly difficult for the uninsured and Medicaid population to access specialty care.*

The difficulty in accessing specialty care was a major issue identified at each meeting. Patients who are uninsured or who receive Medicaid benefits are reportedly having a more difficult time receiving needed specialty care. There also seems to be a maldistribution of services geographically, which corresponds to the socioeconomic conditions found within certain communities.

A recent study documented the problems experienced by CHC patients. While CHCs provide comprehensive primary and preventive care to uninsured and patients covered by Medicaid, they do not have the expertise or equipment to provide much of the needed diagnostic or specialty care. Obtaining referrals for these off-site services, however, can be difficult, especially for patients who are uninsured or covered by Medicaid.<sup>21</sup> (Figure 6)

Patients covered by private insurance or Medicare were better able to access these services. In contrast, patients that had Medicaid or were uninsured had difficulties obtaining the same types of services. One promising finding, however, was that CHCs affiliated with medical schools or hospitals reported better access for the uninsured and patients covered by Medicaid.



\*"Difficult access" defined as patients that were "never" or "rarely" able to access services

Nonetheless, it is locally acknowledged that many Chicagoans, especially those uninsured, are experiencing difficulty in accessing specialty care. Locally, providers reported that despite new community health center collaboratives and collaborative relationships between some community health centers and hospitals, securing timely subspecialty care for patients remains difficult. Access problems also exist for diagnostic testing, including cardiovascular disease, colonoscopy, and other cancer screening. Even with expansion of the Illinois Breast and Cervical Cancer Program, which has greatly expanded eligibility for state-funded cervical and breast cancer screening and treatment, the community lacks access to mammograms and radiology services.

As would be expected, given the concentration of academic medical centers in Cook County and the typical concentration of specialists in metropolitan areas, Cook County overall is not a shortage area for specialty care. Lack of access is likely an artifact of medical, social, and economic conditions. Large numbers of uninsured Chicagoans; lack of primary care and medical homes even among the insured; the

<sup>21</sup> Nakela L. Cook, LeRoi S. Hicks, A. James O'Malley, Thomas Keegan, Edward Guadagnoli and Bruce E. Landon. "Access To Specialty Care And Medical Services In Community Health Centers." Health Affairs. 26, no. 5 (2007): 1459-1468.

prevalence of chronic diseases and high incidence in minority populations; low Medicaid reimbursement rates; long wait times at County facilities; clustering of specialty care providers in specific practices and institutions; and few collaborative arrangements among institutions all contribute to the difficulty of access to specialty care in the safety net.

While clearly these and many other issues help determine the availability of specialty care services for patients, especially those who are uninsured or are covered by Medicaid, it is useful to look at local access issues in a broader context.

*Nationally.* The adequacy of the present and future supply of physicians is continually being debated in the literature.

There is a consensus in the literature that the overall physician supply will slowly increase over the next fifteen years. Yet the supply of specialty physicians in clinical care is projected to grow at a slower rate, 10%, than that of primary care physicians, 18%, between 2005 and 2020. The total U. S. population is projected to grow 14% between 2005 and 2020. This is approximately the same anticipated growth rate as that of the combined primary and specialty FTE physician supply resulting in an expected and unvarying physician to patient ratio of 259 nationally.

Physician supply projections (Figure 7) from the Health Resources and Services Administration (HRSA) assume that current patterns of new graduates, specialty choice, and practice behavior continue.<sup>22</sup>

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<sup>22</sup> "Physician Supply and Demand: Projections to 2020." October 2006. USDHHS, HRSA, Bureau of Health Professions.



**Figure 7: FTE Supply of Physicians in Clinical Practice\*: 2000, Projected to 2020**

Specialty	Base Year	Projected				Percent Change from 2005- 2020
	2000	2005	2010	2015	2020	
<b>Total</b>	597,430	635,780	669,010	699,450	719,940	13%
<b>Primary Care</b>	214,810	228,660	244,370	259,910	271,440	19%
Gen. & Family Practice	89,710	94,380	99,850	105,460	109,980	17%
General Internal Med.	82,250	88,620	95,410	102,230	106,910	21%
General Pediatrics	42,850	45,670	49,110	52,230	54,560	19%
<b>Other Med. Specialties</b>	84,460	90,130	93,040	96,370	98,540	9%
Allergy	3,320	3,140	2,970	2,860	2,730	-13%
Cardiovascular Disease	18,690	19,450	19,940	20,370	20,420	5%
Dermatology	8,630	9,420	9,880	10,310	10,680	13%
Gastroenterology	9,660	10,220	10,430	10,630	10,650	4%
Internal Med Sub Spec	27,450	29,350	30,240	31,620	32,650	11%
Pediatric Cardiology	1,210	1,410	1,530	1,650	1,750	24%
Pediatrics Sub Spec	8,060	9,360	10,440	11,490	12,390	32%
Pulmonary Diseases	7,460	7,690	7,610	7,450	7,270	-5%
<b>Surgical Specialties</b>	134,470	138,990	141,750	143,140	143,090	3%
General Surg Sub Spec	5,780	6,410	6,900	7,180	7,310	14%
General Surgery	23,610	22,570	21,970	21,510	21,040	-7%
Neurological Surgery	4,220	4,380	4,490	4,520	4,490	3%
Obstetrics & Gynecology	35,990	38,790	41,280	43,240	44,630	15%
Ophthalmology	16,820	17,440	17,560	17,550	17,350	-1%
Orthopedic Surgery	20,170	21,210	21,740	21,870	21,710	2%
Otorhinolaryngology	8,440	8,820	8,980	9,050	9,030	2%
Plastic Surgery	5,760	5,890	5,820	5,690	5,510	-6%
Thoracic Surgery	4,480	4,270	4,070	3,850	3,620	-15%
Urology	9,200	9,200	8,950	8,680	8,400	-9%
<b>Other Specialties</b>	163,690	178,010	189,860	200,020	206,860	16%
Anesthesiology	33,560	37,680	41,080	43,690	45,250	20%
Child Psychiatry	5,550	6,440	7,240	8,070	8,800	37%
Diagnostic Radiology	18,130	20,570	22,100	23,120	23,640	15%
Emergency Medicine	21,890	25,450	28,490	30,770	32,490	28%
Gen. Prevent Medicine	2,160	1,850	1,680	1,620	1,560	-16%
Neurology	10,810	12,040	12,870	13,660	14,160	18%
Nuclear Medicine	1,230	1,280	1,300	1,320	1,330	4%
Occupational Medicine	2,320	2,520	2,690	2,880	3,020	20%
Other Specialties	3,280	3,200	3,290	3,400	3,450	8%
Pathology	14,240	14,730	14,880	14,970	14,940	1%
Physical Med. & Rehab	5,790	6,830	7,770	8,610	9,250	35%
Psychiatry	33,120	33,630	34,410	35,510	36,230	8%
Radiation Oncology	3,560	4,100	4,500	4,810	5,020	23%
Radiology	8,090	7,690	7,560	7,600	7,730	0%

\*Includes MD and DO office-based and hospital staff physicians. Excludes residents, and those in non-patient care. Physicians age 75 and older are excluded.

Note: Totals might not equal sum of subtotals due to rounding.

Estimated need for clinical care specialists nationally in 2000 was 33 for medical specialties, 55 for surgery, and 70 for other specialty care per 100,000. Between 2005 and 2020, the population under 65 is expected to grow by 9%. The population 65 and older is projected to grow by 50%. Although they vary by specialty type, these data reflect the impact of changing demographics on requirements and demonstrate that the aging population will contribute to foster growth for specialty services relative to the demand for primary care. According to HRSA, the projections likely overestimate projected shortages and surpluses in individual specialties because it is easier to adjust nationally to inadequacies in specialties than to inadequacies in overall physician supply. The length of time invested in training, eight to 15 years depending on specialty, guides educational policies that control admissions. At the conclusion of the training period, market forces affect individual choices by newly practicing physicians.

Projections by medical specialty are difficult to predict. While the number of medical school graduates is expected to increase over the next 20 years, while it has been stable over the past two decades, the specialties chosen will reflect the dynamics of market and other forces.

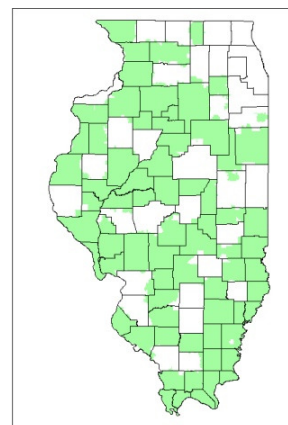
Career and lifestyle issues influence the selection of residency programs by new graduates. Future employment opportunities and reimbursement patterns for specialty care are particularly important. Knowing what specialties or subspecialties are being recruited by physician groups or healthcare providers will significantly influence the choices made by those entering residency programs.

Financial pressures, including the cost of malpractice coverage, rates of reimbursement, and loan repayment options, affect choices. One increasingly important factor is that the number of older Americans will increase dramatically by 2020 as will the need for geriatricians and other specialists that predominantly serve that population.

*Locally.* There is growing concern at the local level about whether the supply of physicians in Illinois, including specialists, will keep pace with anticipated future need. According to the Governor's Office, the number of potential physicians and other caregivers is projected to decrease 4.2% between 2000 and 2020<sup>23</sup>. At the same time, the number of Illinoisans needing care is projected to increase by 31% during that period.

In 2007, 59% of the 41,826 physicians in Illinois were specialists resulting in a ratio of 50 per 100,000.<sup>24</sup> There is an uneven distribution of specialists throughout the state with all or most of 70 counties designated as federal underserved areas for specialty care (Figure 8).<sup>25</sup>

**Figure 8: Specialty Care Physician Scarcity**



*Shaded areas represent zip codes that have been designated as specialty care physician scarcity areas by the U. S. Department of Health and Human Services Centers for Medicare and Medicaid Services.*

<sup>23</sup> Press Release: "Gov. Blagojevich introduces plan to address nursing shortage, ensure adequate level of frontline healthcare providers as baby-boomers age." February 7, 2006. Office of Governor Rod R. Blagojevich.

<sup>24</sup> Kaiser State Health Facts. [www.statehealthfacts.org](http://www.statehealthfacts.org). Retrieved August 25, 2008.

<sup>25</sup> "Specialty Care Shortage Areas in Illinois." Shortage Designations, Illinois Department of Public Health Center for Rural Health. <http://icahn.org/scarcityareas/SpecialtyCare/default.asp>. Accessed September 11, 2008.



In a dynamic health care environment, market forces that drive individual and institutional choice exacerbate specialty care shortages in the safety net. The Centers for Disease Control and Prevention (CDC) has documented how emergency department diversions reduce patient access to timely care. CDC estimates that the aging population will increase the demand for specialist care in emergency departments.

A recent article, for example, documented the absence of surgical subspecialty emergency care in community hospitals as a growing public health concern in Cook County. Fully 66% of neurosurgical transfers to academic medical facilities originated at hospitals without full-time neurosurgery coverage. The mean transfer time was five hours ten minutes. Delays led to deterioration in patient condition with 29 patients showing a decline in Glasgow Coma Scale score. A shortage of neurosurgical intensive care unit beds occurred on 55% of the days in the study. The authors believe that coordinated efforts among local governments, medical centers, and emergency medical services to efficiently coordinate subspecialty services will be necessary to manage this problem.<sup>26</sup>

Research on the relationship of provider type to health outcomes, measured by traditional population based disease related mortality rates and life expectancy, is beginning to show distinct patterns. States with more primary care physicians per capita have better health outcomes than states with fewer primary care physicians. Among the benefits of primary care medicine for patients is greater likelihood of receiving preventive care, better management of chronic diseases, and higher satisfaction with the care they receive.

Areas with more specialists or higher specialist to population ratios, by contrast, appear to have no advantages in meeting population health needs. A recent article in the *New England Journal of Medicine*,<sup>27</sup> for example, was critical of the growing emphasis on specialty care. The article asserts that areas with more specialist-oriented patterns are associated with higher spending but are not related to improved access to care, higher quality, better outcomes, or greater patient satisfaction.

### Possible Solutions

One possible local solution discussed was a system for specialty referrals similar to the Robert Wood Johnson medical school initiative, which places academic center-based specialists in community hospitals at no expense to the community hospitals.

Hospital provider staff as a resource for community-based specialty care remains an underutilized strategy; training programs should be encouraged to continually move more of their training opportunities into the community.

FQHC-hospital relationships should be fully utilized, as research has shown, in addition to other benefits, that patients of FQHCs with strong hospital affiliations have an easier time accessing specialty care; this finding was borne out anecdotally among meeting participants as well.

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<sup>26</sup> Byrne, Richard W. MD; Bagan, Bradley T. MD; Slavin, Konstantin V. MD; Curry, Daniel, MD; Kosti, Tyler R. MD. "Neurosurgical Emergency Transfers to Academic Centers in Cook County: A Prospective Multicenter Study." *Neurosurgery*. 62(3):709-716, March 2008.

<sup>27</sup> Iglehart, John K, "Medicare, Graduate Medical Education, and New Policy Directions." *New England Journal of Medicine*, Volume 359:643-650, August 7, 2008.

Another strategy to be explored is expanding the use of physician assistants (PAs), advance practice nurses, and other mid-level practitioners in specialty care practices. PAs, in particular, have been used to great success in several specialty areas, with the results being high quality and efficient care that permits the physician to see a greater number of patients.

Public policy, rather than market forces, must guide a national solution to specialist shortages. Reform in the current Graduate Medical Education (GME) system, incentives tied to safety net practice, increases in Medicaid reimbursement for specialty care, and other financial inducements require political will and the support of policymakers.



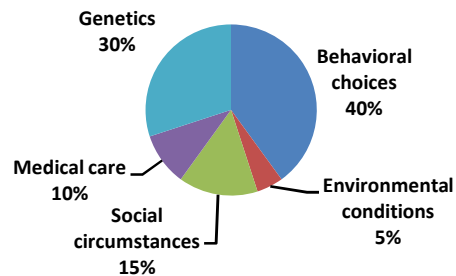
**Chronic diseases issues must be addressed earlier, before patients present at hospitals already sick.**

Meeting attendees discussed the high rates of chronic disease that they see in their practices, and the need for prevention.

Chronic diseases are described as today's epidemics. They are the leading causes of death nationwide, including in Chicago. The chronic diseases that are the leading causes of death in Chicago are heart disease, cancer, stroke, chronic lower respiratory disease, and diabetes.

Any analysis of the chronic disease trends in the U.S. today must address the complex factors that determine one's health. While good medical care is important for well-being, as shown in Figure 9, medical care only accounts for 10% of all health influences. The choices we make are the largest single component (40%). And although only 20% of what shapes our health is social circumstances and environmental conditions<sup>28</sup>, social factors and environmental conditions have a large impact on the choices available to us.

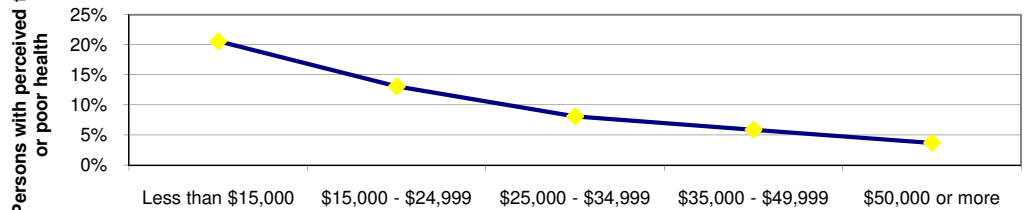
**Figure 9. Factors that Influence Health**



Social and environmental determinants of health are the conditions in which we live and work, including income, social inclusion, employment, working conditions, the social economy, early childhood care, education, and housing. Inequalities give rise to health disparities. Figure 10 depicts the relationship between income and reported health, as found by the National Health Interview Survey

(NHIS), 1995.<sup>29</sup> As incomes grow, smaller proportions of persons reported fair or poor health.

**Figure 10: Relationship Between Household Income and Fair or Poor Health Status**



Even when controlling for income, there is a direct relationship between education and health. An analysis using (NHIS) data looked at mortality rates of individuals age 25 and older. They found that persons with more education were less likely to die within five years of the NHIS interview. In addition,

<sup>28</sup> McGinnes JM, Williams-Russo P., Knickman JR. "The Case for More Active Policy Attention to Health Promotion." *Health Affairs*. 2002. 21(2), 78-93.

<sup>29</sup> Pleis JR, Lethbridge-Çejku M. "Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2005." *National Center for Health Statistics. Vital Health Stat 10(232)*. 2006.

those with more education were not as likely to report a past diagnosis of an acute or chronic disease, and were less likely to report anxiety or depression.<sup>30</sup>

Figure 11a on page 36 and Figure 11b on page 37 show the community area rankings of socioeconomic indices for Chicago in 2000<sup>31</sup>, illuminating the communities that may have the greatest risk of health problems. Areas such as Forest Glen, Edison Park, Norwood Park, Lincoln Park, Beverly, and Mt. Greenwood starkly contrast with the depressed socioeconomic conditions of Grand Boulevard, Oakland, Englewood, Riverdale, Washington Park, and Woodlawn.

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<sup>30</sup> David M. Cutler, Harvard University and Adriana Lleras-Muney. "Policy Brief #9" Education and Health National Policy Center. March 2007. Princeton University.

<sup>31</sup> Bocskay KA, Harper-Jemison DM, Gibbs KP, Weaver K, Thomas SD. "Community Area Health Inventory Part Two: Community Area Comparisons." Health Status Index Series Vol. XVI No. VI. Chicago, Illinois: Chicago Department of Public Health Office of Epidemiology, 2007.



Figure 11a: Community Area Rankings of Socioeconomic Indices, 2000

COMMUNITY AREA	MEDIAN HOUSEHOLD INCOME	BELOW POVERTY LEVEL	CHILDHOOD POVERTY	HOUSING VACANCIES	SAME RESIDENCE FOR 5 YEARS	HIGH SCHOOL GRADUATES	UNEMPLOYED
1 Rogers Park	55	28	30	37	70	32	38
2 West Ridge	29	43	44	54	57	17	52
3 Uptown	53	23	24	43	67	28	39
4 Lincoln Square	30	48	49	47	63	22	53
5 North Center	12	55	59	39	60	10	57
6 Lake View	8	54	57	52	74	4	63
7 Lincoln Park	1	55	64	48	72	3	58
8 Near North Side	5	42	14	18	68	5	50
9 Edison Park	7	68	74	65	19	9	61
10 Norwood Park	10	64	71	63	12	15	63
11 Jefferson Park	13	63	68	57	23	20	62
12 Forest Glen	2	67	73	64	7	8	64
13 North Park	15	52	55	54	48	16	41
14 Albany Park	31	35	38	50	61	54	43
15 Portage Park	22	57	60	55	44	30	56
16 Irving Park	28	49	50	47	46	38	51
17 Dunning	14	62	67	59	25	29	54
18 Montclare	17	61	66	54	43	33	48
19 Belmont Cragin	27	50	53	56	49	62	43
20 Hermosa	37	40	42	49	39	68	30
21 Avondale	38	37	39	41	42	63	34
22 Logan Square	41	31	34	28	55	60	39
23 Humboldt Park	58	16	17	21	35	67	15
24 WestTown	35	29	29	22	60	43	45
25 Austin	51	24	28	30	21	45	16
26 West Garfield Park	67	10	11	12	27	64	9
27 East Garfield Park	66	11	13	10	24	55	8
28 Near West Side	57	9	8	8	66	42	11
29 North Lawndale	71	5	5	7	18	56	4
30 South Lawndale	54	22	26	26	47	73	29
31 Lower West Side	61	21	22	17	38	72	33
32 Loop	4	46	72	11	71	2	58
33 Near South Side	49	14	9	6	62	21	33
34 Armour Square	68	16	19	25	36	65	49
35 Douglas	65	7	3	4	53	35	2
36 Oakland	76	2	4	3	37	57	3
37 Fuller Park	70	12	20	3	13	49	19
38 Grand Boulevard	74	4	6	1	47	54	7
39 Kenwood	39	25	23	20	56	12	24

<sup>†</sup>Ranking scale: 1 equals highest; Community Areas not ranked (--) if rate is suppressed. See Methods section for more information.

Figure 11b: Community Area Rankings of Socioeconomic Indices, 2000

COMMUNITY AREA	MEDIAN HOUSEHOLD INCOME	BELOW POVERTY LEVEL	CHILDHOOD POVERTY	HOUSING VACANCIES	SAME RESIDENCE FOR 5 YEARS	HIGH SCHOOL GRADUATES	UNEMPLOYED
40 Washington Park	73	3	2	2	58	58	5
41 Hyde Park	43	41	54	42	69	6	43
42 Woodlawn	72	8	10	9	51	44	10
43 South Shore	62	20	21	16	50	23	21
44 Chatham	52	35	37	32	32	24	25
45 Avalon Park	23	56	56	51	3	19	38
46 South Chicago	59	17	18	13	31	46	14
47 Bumside	47	18	16	23	26	40	13
48 Calumet Heights	18	46	43	53	1	14	32
49 Roseland	36	36	35	36	14	26	16
50 Pullman	56	26	25	29	17	37	17
51 South Deering	48	32	33	40	2	41	28
52 East Side	33	45	48	44	22	55	27
53 West Pullman	32	27	27	26	8	43	23
54 Riverdale	75	1	1	18	10	52	1
55 Hegewisch	24	51	51	34	15	34	40
56 Garfield Ridge	20	53	47	62	11	39	47
57 Archer Heights	34	60	65	51	54	59	46
58 Brighton Park	41	38	40	35	52	69	30
59 McKinley Park	42	44	45	33	33	66	36
60 Bridgeport	46	34	32	24	35	50	42
61 New City	64	13	12	14	45	70	22
62 West Elston	21	59	63	54	34	53	44
63 Gage Park	40	33	38	45	40	71	31
64 Clearing	19	59	61	58	28	25	55
65 West Lawn	16	58	61	57	41	47	43
66 Chicago Lawn	44	31	36	31	40	48	20
67 West Englewood	63	15	14	15	20	51	6
68 Englewood	69	6	7	5	30	61	4
69 Greater Grand Crossing	60	19	15	19	29	31	12
70 Ashburn	9	59	62	61	30	18	35
71 Auburn Gresham	50	30	31	27	16	36	18
72 Beverly	3	65	69	64	5	1	51
73 Washington Heights	26	45	46	46	4	27	26
74 Mount Greenwood	6	66	70	60	6	7	59
75 Morgan Park	11	47	52	44	9	11	37
76 O'Hare	25	57	58	38	64	15	60
77 Edgewater	45	39	41	43	65	13	46

<sup>†</sup>Ranking scale: 1 equals highest; Community Areas not ranked (–) if rate is suppressed. See Methods section for more information.



Psychosocial factors influence behavior, which in turn, has health consequences. Psychosocial factors also have biological effects that impact health, though the biological pathways by which these occur are not completely understood. Exposure to stressors, both on an individual basis as well as community level, is associated with poor health outcomes, while social support is beneficial to health. Adverse childhood experiences are associated with future health behavior as well as particular health problems.<sup>32</sup>

A population's health status is also linked to the physical conditions within the community. This was documented through research that studied the association between gonorrhea rates in New Orleans and the degree of physical deterioration in community.<sup>33</sup> It was found that the state of community disorder explained more about the variance in gonorrhea rates than did poverty level, unemployment, and low education. This theory, "Broken Windows," described by James Q. Wilson<sup>34</sup>, found that the appearance of the physical environment provides direct messages that regulate individual behavior.

Another set of lifestyle "choices" pertains to a community's access to good quality food. In the report, "Examining the Impact of Food Deserts on Public Health in Chicago," researchers analyzed the connection between Chicago food deserts (areas with no or limited access to grocery stores) and quality of life, length of life, and cause of death. They found that community residents that have limited or no accessible grocery stores and access to fast food (those with out-of-balance food choices) have an increased risk of chronic disease and early death.<sup>35</sup> The analysis showed that the communities in Chicago with food deserts are predominately in the South and West Sides of Chicago. African Americans/Blacks have the most unbalanced food availability, and travel the longest distances from their homes to grocery stores. Generally, the closest grocery store was about two times as far as the closest fast food restaurant in these communities.

Racism influences health. Even for persons with equal levels of education, housing, and income, African Americans/Blacks generally have poorer health than Whites. Social exclusion, prejudice, decreased levels of optimism, and lack of access to the health care system are some of the ways by which this occurs.

The 2002 Institute of Medicine report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," found that even among those of comparable insurance status, income levels, age, and medical conditions, racial and ethnic minorities are less likely to receive routine medical procedures, are more likely to suffer a lower quality of health care service, and obtain significantly different rates of medical procedures than do non-minorities.<sup>36</sup>

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<sup>32</sup> Fellitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. "The Relationship of Adult Health Status to Childhood Abuse and Household Dysfunction." *American Journal of Preventive Medicine*, 1998;14:245-258.

<sup>33</sup> Cohen, D., Spear, S., Scribner, R., Kissinger, P., Mason, K., and Wildgen, J. "Broken Windows and the Risk of Gonorrhea." *Am J Public Health*. 2000; 90:230-236.

<sup>34</sup> Wilson, J.Q., Kelling, G. Broken windows. In: Durham, R., Alpert, G., eds. "Critical Issues in Policing: Contemporary Readings." Prospect Heights, IL: Waveland Press, Inc. 1989.

<sup>35</sup> "Examining the Impact of Food Deserts on Public Health in Chicago." Mari Gallagher Research & Consulting Group, 2006.

<sup>36</sup> Brian D. Smedley, Adrienne Y. Stith and Alan Nelson, editors. "Unequal Treatment: confronting racial and ethnic disparities in health care." Committee on Understanding & Eliminating Racial and Ethnic Disparities in Health Care. Board of Health Sciences Policy, Institute of Medicine, 2002.

The findings were echoed in a recent study analyzing Medicare claims, which found that race and area of residence can have a profound effect on health by influencing the course and quality of medical care. In this study, African Americans/Blacks were generally less likely than Whites to receive recommended medical care in a given region, and there were differences in the types of medical procedures received by racial group. Researchers said that education and poverty levels explained some, by not all, of the differences.<sup>37</sup>

The following table (Figure 12) shows some of the numbers and rates of selected chronic diseases in Chicago. Though chronic diseases are the leading causes of death, the rates of these chronic diseases have actually fallen in the last 10 years, with the exception of Alzheimer's disease.<sup>38</sup>

**Figure 12: Chronic Disease Deaths, 2004**

Chronic Disease Type	Number	Rate (per 100,000)	10-Year-Relative % Change
All-Cancers	4,916	204.6	-15.5
Breast	423	17.4	-21.3
Colon	558	23.4	-9.9
Lung	1,297	54.1	-15.6
Prostate	278	11.9	-27.2
Heart Disease	6,117	257.6	-30.9
Stroke	1,154	48.9	-32.9
Lower Respiratory Disease	642	26.6	-25.7
Diabetes Mellitus	680	28.5	-10.3
Liver Disease and Cirrhosis	261	10.5	-97.7
Alzheimer's Disease	344	15	+107.1

Disparities in chronic disease mortality are evident when comparing Chicago community areas, shown in Figure 13a on page 40 and Figure 13b on page 41.<sup>39</sup> Community areas with the highest rates of chronic disease are located on the South and West Sides of Chicago, whose populations are predominantly people of color.

Racial and ethnic health disparities remain a major problem. Improving the quality of care for African-Americans and Hispanic populations must be a priority if morbidity and mortality are to be lowered and overall quality of life is to be raised.

<sup>37</sup> Sack, Kevin. "Research Finds Wide Disparities in Health Care by Race and Region." The New York Times. June 5, 2008.

<sup>38</sup> Bocskay, KA, Harper-Jemison DM, Gibbs KP, Weaver K, Thomas SD. "Community Area Health Inventory Part One: Demographic and Health Profiles." Health Status Index Series Vol. XVI No V. Chicago, Illinois. Chicago Department of Public Health Office of Epidemiology, 2007.

<sup>39</sup> Bocskay, KA, Harper-Jemison DM, Gibbs KP, Weaver K, Thomas SD. "Community Area Health Inventory Part Two: Community Area Comparisons." Health Status Index Series Vol. XVI No V. Chicago, Illinois. Chicago Department of Public Health Office of Epidemiology, 2007.



**Figure 13a: Community Area Rankings of Mortality: Chronic Disease**

COMMUNITY AREA	HEART DISEASE	STROKE*	LOWER RESPIRATORY DISEASE*	DIABETES MELLITUS*	LIVER DISEASE & CIRRHOSIS*	ALZHEIMER'S DISEASE*
1 Rogers Park	16	18	10	16	11	10
2 West Ridge	52	15	12	15	10	8
3 Uptown	14	17	12	10	5	15
4 Lincoln Square	55	16	6	15	--	16
5 North Center	41	16	13	17	--	--
6 LakeView	68	18	15	15	11	13
7 Lincoln Park	42	15	9	16	14	9
8 Near North Side	69	16	15	17	10	14
9 Edison Park	48	16	14	13	--	--
10 Norwood Park	38	11	9	11	13	16
11 Jefferson Park	66	13	11	12	--	15
12 Forest Glen	45	18	17	13	--	--
13 North Park	54	16	9	14	--	--
14 Albany Park	43	16	13	9	14	17
15 Portage Park	51	13	17	13	6	16
16 Irving Park	60	15	7	10	13	14
17 Dunning	61	15	12	16	8	15
18 Montclare	44	13	--	--	--	--
19 Belmont Cragin	39	16	14	15	5	16
20 Hemosa	36	17	--	--	--	--
21 Avondale	64	14	10	15	--	--
22 Logan Square	59	13	9	8	2	14
23 Humboldt Park	47	16	8	3	10	--
24 West Town	37	14	15	7	4	13
25 Austin	21	10	8	4	12	13
26 West Garfield Park	4	5	--	13	--	--
27 East Garfield Park	7	14	1	12	--	--
28 Near West Side	31	10	17	18	--	--
29 North Lawndale	11	8	8	4	--	--
30 South Lawndale	53	12	16	9	9	--
31 Lower West Side	46	16	16	16	--	--
32 Loop	--	13	--	--	--	--
33 Near South Side	34	--	--	2	1	--
34 Armour Square	58	12	--	--	--	--
35 Douglas	8	6	9	8	--	11
36 Oakland	--	--	2	--	--	--
37 Fuller Park	--	--	--	--	--	--
38 Grand Boulevard	33	15	15	10	--	13
39 Kenwood	23	9	7	16	--	--

†Ranking scale: 1 equals highest; Community Areas not ranked (--) if rate is suppressed. See Methods section for more information.

\*Ranking based on standardized mortality ratios. See Methods section for more information.

Figure 13b: Community Area Rankings of Mortality: Chronic Disease

COMMUNITY AREA	HEART DISEASE	STROKE*	LOWER RESPIRATORY DISEASE*	DIABETES MELLITUS*	LIVER DISEASE & CIRRHOSIS*	ALZHEIMER'S DISEASE*
40 Washington Park	12	6	--	--	--	--
41 Hyde Park	70	19	18	17	--	--
42 Woodlawn	5	14	14	15	--	--
43 South Shore	6	10	7	4	7	1
44 Chatham	18	12	13	9	--	6
45 Avalon Park	26	2	--	--	--	--
46 South Chicago	63	7	9	4	2	--
47 Burnside	--	1	--	1	--	--
48 Calumet Heights	27	3	12	4	--	1
49 Roseland	1	4	9	6	10	4
50 Pullman	--	--	--	--	--	--
51 South Deering	--	10	--	--	--	--
52 East Side	57	12	4	11	--	--
53 West Pullman	10	5	8	9	--	--
54 Riverdale	--	--	--	--	--	2
55 Hegewisch	15	16	--	--	--	--
56 Garfield Ridge	40	13	12	11	--	7
57 Archer Heights	28	10	--	--	--	--
58 Brighton Park	50	18	17	12	--	--
59 McKinley Park	19	8	--	--	--	--
60 Bridgeport	49	17	13	10	--	--
61 New City	9	14	7	5	3	3
62 West Elston	65	16	14	6	--	--
63 Gage Park	62	16	5	13	2	--
64 Clearing	30	15	7	14	--	--
65 West Lawn	32	17	11	15	--	--
66 Chicago Lawn	20	14	16	9	--	12
67 West Englewood	2	6	9	10	--	--
68 Englewood	17	9	3	6	--	12
69 Greater Grand Crossing	25	12	12	9	--	10
70 Ashburn	22	9	6	14	--	5
71 Auburn Gresham	13	7	11	4	5	4
72 Beverly	24	12	19	16	--	--
73 Washington Heights	3	9	13	5	--	--
74 Mount Greenwood	29	18	14	14	--	--
75 Morgan Park	56	16	13	6	--	15
76 O'Hare	67	17	--	--	--	--
77 Edgewater	35	16	16	14	7	16

†Ranking scale: 1 equals highest; Community Areas not ranked (–) if rate is suppressed. See Methods section for more information.

\*Ranking based on standardized mortality ratios. See Methods section for more information.



Disparities for three of the leading chronic diseases are evident in Figure 14, below.<sup>40</sup> Rates of heart disease and cancer mortality are higher for non-Hispanic Blacks than for the Hispanic and non-Hispanic White groups. Rates of diabetes are higher for non-Hispanic Whites than for non-Hispanic Black and Hispanic groups.

**Figure 14: Disease Rates by Race and Ethnicity for Heart Disease, Cancer, and Diabetes, Chicago, 2004\***

Health Indicators	Non-Hispanic White Alone- Rate/%	Non-Hispanic White Alone or In Combination- Rate/%	Non-Hispanic Black Alone- Rate/%	Non-Hispanic Black Alone or In Combination- Rate/%	Hispanic- Rate/%
Heart Disease Mortality	238.5	233.6	333.3	330.1	154.4
Cancer Mortality	188.0	183.6	270.4	267.9	133.7
Diabetes	20.1	19.7	41.1	40.8	37.4

\*Mortality rates are age-adjusted using year 2000 as the standard per 100,000 population, based on U.S. Census Bureau 2000 figures. For the non-Hispanic group specified above, alone represents the population indicated only by that race; Alone/Combination represents the population that indicated being only of that race or being of that race in combination with one or more races.

There are also prominent differences in rates of asthma. In Chicago, where the asthma hospitalization rate is nearly double the national average<sup>41</sup>, non-Hispanic Blacks have age-adjusted rates of asthma that are five times higher than non-Hispanic Whites.<sup>42</sup>

Disparities in rates of obesity, a risk factor for chronic disease, have been well-documented. Community health studies by Sinai Urban Health Institute found an 11.8% prevalence of childhood obesity in a non-Hispanic white community on the North side of Chicago, 34.0% for a Mexican-American community on the West side, and 56.4% for a non-Hispanic Black community on the South Side.<sup>43</sup>

### Possible Solutions

At the community health center level, recommendations to address chronic disease included health center providers promoting the use of "Your Health Care Plus," the state's Medicaid disease management program for certain chronic conditions, and building upon the Health Disparities Collaborative model already being implemented at many of Chicago's community health centers.

Another community-based recommendation was to utilize more health educators in the community or to expand the use of indigenous community health outreach workers, such as the Promotoras de Salud program currently operating in many Latino communities. Alivio Medical Center highlighted its

<sup>40</sup> "Big Cities Health Inventory: The Health of Urban America, 2007." National Association of County and City Health Officials, Benbow, N., editor. Washington, D.C. 2007.

<sup>41</sup> Respiratory Health Association of Metropolitan Chicago, Fact Sheet, Retrieved August 25, 2008.

<sup>42</sup> Thomas, S.D., Whitman, S. "Asthma Hospitalizations and Mortality in Chicago, An Epidemiologic Overview," 1999. *CHEST*, 116, 4.

<sup>43</sup> Margellos-Anast, H., Shah, A.M., Whitman, S. "Prevalence of Obesity Among Children in Six Chicago Communities: Findings from a Health Survey." 2008. Public Health Reports, Vol. 123.

promotoras program, which has been very successful in reaching Latino community members, but is limited in its growth due to lack of resources. It was suggested that the Mayor's Office of Workforce Development might be able to assist with these types of projects.

In the area of breast cancer, providers can look for opportunities to build upon existing infrastructure and efforts. The Metropolitan Chicago Breast Cancer Task Force formed to address the widening disparity breast cancer mortality in Chicago. The Task Force, composed of a group of community leaders, advocates, and professionals, received funding to carry out the recommendations made at its March 2007 "Breast Cancer Summit: A Call to Action." It is in the process of funding community-based organizations to implement breast cancer outreach and education in vulnerable Black populations.

Adolescence is a critical period for the development of persistent overweight and obesity, based on the strong evidence for tracking of adolescent adiposity into adulthood. Adolescent obesity is associated with all the long term risks of adult obesity and may carry additional risks for metabolic disorders and poor body image associated with the earlier onset. In an effort to reach adolescents for obesity-related illnesses and other health risks, expansion of school-based health centers programs was proposed.

In addition, the City of Chicago's Inter-Departmental Task Force on Childhood Obesity (IDTF), whose members include CDPH, Children and Youth Services, Chicago Public Schools (CPS), the Chicago Park District, and the Consortium to Lower Obesity in Chicago Children (CLOCC), is in the development stage of expanding after-school programs for both students and their family members through proposed wellness centers. These centers are needed because most CPS student curricula do not include physical activity and many neighborhoods are unsafe for unsupervised play. The wellness centers will be located in six Chicago communities and will provide opportunities for fun physical activity and nutritional education to children. Programming will also include nutrition basics for parents and guardians.

IDTF has taken on policy initiatives as well, as it is clear that policy shapes the ability of individuals to take personal responsibility for their lifestyles and choices. Policies that IDTF is exploring include:

- Limiting the hours of screen time, increasing physical activity and strengthening nutritional standards for children in day care
- Increasing healthier choices in school cafeterias
- Restricting access to soft drinks in schools
- Requiring daily physical activity in schools (organized recess, physical education classes, etc.)

Other potential policy changes to pursue by CDPH and other stakeholders are:

- Restricting sodium level in commercially sold foods
- Restricting trans fats in commercially sold foods
- Labeling food calories at fast food restaurants menu boards
- Expanding access to nutritious food in underserved communities (food deserts) through various incentive options
- Increasing the parameters of the USDA Food Stamp program to allow participants to purchase more nutrient rich foods
- Earmarking funds from the City of Chicago's Soda Tax for obesity prevention programming
- Enhancing the built environment of the City of Chicago through increased maintenance and better lighting of side walk environment, especially near the walkways of schools



*Chicago's mental health system does not meet the needs of the population.*

Meeting participants uniformly reported the need for a quicker response from the state mental health facilities when patients in crisis present in hospital emergency departments, reporting a pattern in which patients needing to be transferred to a psychiatric hospital were forced to wait for long periods of time. The care required for these patients to become stabilized may divert attention from other patients. Hospitals need to ensure that emergency room clinical and support staff is trained to provide quality care for patients who need psychiatric emergency services.

Moreover, the overall need for increased capacity, ideally using a community-based model, was also discussed. People being served by safety net systems need better access to mental health services. The state's mental health system is chronically underfunded, and a larger safety net mental health workforce and more services in many areas of Chicago are needed.

In particular, reports from area stakeholders, including CDPH, have documented a need for an improved system and greater capacity for children's mental health services, a need for more psychiatry services, and a need for more outpatient mental health services in general on the South Side of Chicago.

Statewide, National Alliance on Mental Illness's "Grading the States" report has given Illinois an "F" for its health care system for those with serious mental illness, reporting problems with access, an imbalance of hospital and community service capacity, and a lack of implementation of evidence-based practices, among other problems.<sup>44</sup>

Nationally, there is movement toward the integration of primary care and mental health services to provide greater access to mental health services and improved coordination of care.

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<sup>44</sup> "Grading the States: A Report on America's Health Care System for Serious Mental Illness, 2006." National Alliance on Mental Illness.

***There is a substantial shortage of oral health care providers willing to serve the uninsured and Medicaid recipients.***

Lack of access to preventive and restorative services is a particular problem. With nearly half of Illinois counties being recently identified by the Agency for Healthcare Research and Quality as having an insufficient supply of dentists to meet the needs of local residents, it is not surprising that residents are experiencing such difficulty in accessing dental services. Yet, of the private dental offices currently located within Chicago, a majority of these providers do not accept Medicaid nor maintain a sliding fee scale for patients. Dental providers say that they do not participate in the state's Medicaid program because the reimbursement rates have been historically low.

Although Chicago has some dental safety net sites, many neighborhoods do not have any facilities to serve low income uninsured or underinsured patients. Currently, there are less than twenty dental clinics, staffed by the City and County health departments, FQHCs, and charitable clinics, serving low-income Chicagoans. In some Chicago community areas, as many as 34% of the residents did not obtain necessary dental care because it was too costly.<sup>45</sup> High demand for dental services has flooded the existing clinics with more patients than they are able to treat. As one example, Cook County patients waited up to nine months to see a dentist at County-funded facilities in 2007.<sup>46</sup>

There is currently only one School of Dentistry in Chicago (University of Illinois at Chicago) and its clinic is overwhelmed on a daily basis.

**Possible Solution**

CDPH and the Board have begun discussions with the Chicago Dental Society regarding the problem of access to uninsured people and those on Medicaid.

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<sup>45</sup> Whitman Steven, Williams Cynthia, Shah Ami M. "Sinai Health System's Community Health Survey: Report 1." Chicago, Illinois: Sinai Health System, 2004.

<sup>46</sup> "Bridge to Healthy Smiles' Three Point Plan for Improved Access to Dental Care." Illinois State Dental Society, 2008.



## INFORMATION TECHNOLOGY

The lack of resources for health information technology (HIT) was identified by most providers as a serious detriment to developing state-of-the-art electronic health record (EHR) and other enterprise systems.

HIT and EHR systems ensure better patient care; reduce medical errors, save lives, increase efficiencies, and lower overall health care costs. HIT permits health care providers and supporting health services to safely share patient information. Providers in different settings have improved access to information and are better able to provide coordinated care and reduce duplicative tests and other services. HIT connects providers and hospitals with vital health information during emergencies or when the patient is incapacitated. A fully developed HIT system gives patients access to all their health records through a single portal.

A recent Congressional Budget Office report suggests that HIT adoption, by itself, cannot significantly reduce health care costs but does contribute to savings when combined with other incentives. Savings may accrue to the health care system overall but may not be realized by individual providers and hospitals. Large, integrated health systems are more likely to realize savings from HIT while other providers and hospitals may not capture enough savings from HIT to pay its cost.<sup>47</sup>

While providers recognize the importance of HIT in controlling overall health care costs and improving efficiency and quality of care, adoption of HIT has been slow. Only 28% of primary care physicians in the country used EHR in 2006 while 98% of physicians from other leading countries do so.<sup>48</sup> High cost, cited as high as \$44,000 in Washington hearings on HIT funding, prevents many providers from installing the technology. Even when providers embrace HIT, it can be difficult for specialists like pediatricians, psychiatrists, and neurosurgeons to find software to meet their needs as many products focus on general practice or hospitals.

It is worth noting that an informal survey of selected Chicago providers documented that there is a great deal of variation between the types of EHR, patient registration, financial, and PACS (radiology) systems used by providers. More information can be found in the *Supporting Documentation* section.

### Possible Solutions

Most HIT proponents support financial incentives to encourage adoption of EHR.

States, which have a large stake in reducing health care costs because of their commitment to Medicaid, can support adoption of EHR in multiple ways. Illinois is one of several states working on a Health Information Exchange (HIE). HIEs permit interoperability or sharing of health information across institutions using different software. Consumers will also have access to their health information through the HIE. Directly contributing financing of the cost of adopting EHR, the Commonwealth of Massachusetts passed a law this year that allocates \$25 million dollars to pay for EHR in provider practices.

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<sup>47</sup> "Evidence on the Costs and Benefits of Health Information Technology." Congressional Budget Office, May 2008, [www.cbo.gov/ftpdocs/91xx/doc9168/05-20-HealthIT.pdf](http://www.cbo.gov/ftpdocs/91xx/doc9168/05-20-HealthIT.pdf), accessed April 11, 2008.

<sup>48</sup> "Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008." The Commonwealth Fund, July 2008.

At present, several federal programs provide limited funding for HIT expansion. Federally-financed pilot programs will finance implementation of EHR in several communities beginning next federal fiscal year. Funding is through Medicare. Additional federal incentive initiatives will begin next year with bonuses paid to providers e-prescribing. Beginning in 2012, penalties will be imposed on those not e-prescribing.

President Bush vetoed both SCHIP reauthorizations that included \$200 million in funding through the State Children's Health Program (SCHIP). Such funding was not included in SCHIP law extending funding to 2009. Funding IT expansion through SCHIP or Medicaid, in addition to Medicare, is important because those programs cover so many of the nation's low-income children.

Establishing national standards for health IT is essential to widespread adoption. Patient confidentiality and privacy must be protected. Different programs used by different providers, hospitals, pharmacies, and labs must be interoperable and compatible.

The Nationwide Health Information Network (NHIN), sponsored by the U.S. Health and Human Services, is a federal initiative to develop a foundation for an interoperable, standards-based network for secure exchange of health information. This "network of networks" will link state and regional HIEs nationwide. Cooperative agreements and trials began in 2007. Once operable, the NHIN will connect providers, consumers, and others involved in supporting health and healthcare. Health information will follow the consumer, be available for clinical decision making, and support appropriate use of healthcare information beyond direct patient care to improve health.





# ACTION TO DATE

## POLICY

### *Action Item #1: Initiate a single voice to speak for health care issues*

**Rationale:** This will be the one local entity providing a unified voice for health care. The entity will have a political advocacy function and help facilitate collaborative arrangements among providers. This will result in a common message on each important health care issue that will be delivered to legislators and other policymakers on behalf of Chicago. The group felt that we need someone to say, “Here is the problem, and here is the solution. “

**Background:** There was discussion around who should provide this leadership and be this single voice. Some participants determined that it was a role for Chicago, while others believe that it should be a broader, regional, local leader.

Some discussion related to the former Chicago-Cook County Community Health Council occurred at the meeting. Participants wanted to know why the Council, which had a similar function, was not ultimately successful.

Another point that may illuminate the issue and needs clarifying is understanding the unique role of public providers and the City. Also important to consider is how public functions relate to the private sector, complementing each other and what this means for the potential for collaboration.

Other issues discussed to be addressed by “single voice” entity:

- Medicaid reimbursement for specialist care with an emphasis on pediatric care
- Fraudulent activities of certain providers, e.g., home health agencies
- Health care coverage for undocumented/illegal immigrants

### **Process:**

- Look to other cities or regions for models that speak with one voice for advocacy around health care issues of common concern.
- Form a group that provides advocacy and leadership on health care issues for Chicago.

#### Possible Members:

- Mayor
- Commissioner, Chicago Department of Public Health
- Health care community (including hospitals, FQHCs, city and county clinics, academic medical centers, VA
- Trade Organizations, MCHC, IHA, IPHCA, business community are secondary
- Form a new ad hoc entity under the auspices of the Commissioner

#### Duties:

Develop consensus on functions of health care players and communicate to all potential participants



- Identify core issues (including those identified such as provider tax, OB malpractice, Amicus Curiae Brief, Medicaid reimbursement rate, specialty care, gun violence, and work force development)
- Facilitate provider collaboration
- Give voice to important health care issues and needs.

Primary Organizations/Roles:

- To Be Determined

**Status:** CDPH Policy and Planning staff are researching other models.

***Action Item #2: The City will support the Provider Assessment and Disproportionate Share Hospital (DSH) payments at the federal level***

**Rationale:** Maintaining the provider assessment and DSH payments is critical to the financial stability of Chicago’s safety net providers, especially those serving larger numbers of Medicaid and uninsured and underinsured patients. Chicago needs a strong and viable safety net that receives funding commensurate with the quality of services provided.

**Background:** The Illinois General Assembly passed continuing enabling legislation for the provider assessment last session. The Illinois Department of Healthcare and Family Services (HFS), the state’s Medicaid agency, completed the accompanying Medicaid State Plan Amendment and submitted it to the Center for Medicare and Medicaid Services (CMS) for approval. HFS does not anticipate any problems with the approval process. Once approved, the state may collect the provider assessment and utilize those monies to draw down federal Medicaid matching funds to cover the cost of indigent care. Disproportionate Share Hospital payments are federal funds disbursed according to a formula based on a hospital’s amount of care provided to indigent patients. Many Chicago hospitals receive DSH payments each year. Safety net hospitals, especially those with a high Medicaid population, rely on DSH funds to supplement reimbursement from Medicaid.

**Process:**

- MCHC drafted letter to Mayor signed by all Chicago hospital CEOs asking him to contact Center for Medicare and Medicaid Services and federal officials in support of provider assessment and DSH state plan amendments
- Letter sent to the Mayor
- CDPH followed up with Mayor’s Office of Intergovernmental Affairs

**Status:** A letter was sent to the Center for Medicare and Medicaid Services from Mayor Daley on August 12, 2008.

## CAPITAL FINANCING

**Action Item #3: Advocate for more capital to support safety net hospitals at various levels: (a) Illinois General Assembly Capital proposals and (b) Certificate of Need (CON) Task Force Review.**

**Rationale:** As the revenue for most safety net hospitals is generated from government sponsored programs, Medicaid and Medicare reimbursements, advocating for resources through the Illinois General Assembly is a necessary part of any capital financing review process.

**Background:** The Illinois General Assembly is contemplating a Capital Budget plan for the State of Illinois in 2009. The current Capital Budget proposal does not include any capital for hospital infrastructure projects. However, as safety net hospitals play a critical role in caring for the underserved, and because they depend upon federal and state reimbursements for covering their daily expenses, they do not have the resources to improve, expand, or maintain their facilities to the best quality standards. The group felt it was necessary to review the possibility of not only having safety net hospital infrastructure projects added to the capital bill, but to also explore any other legislative opportunities, such as the General Assembly's current review of the Illinois Health Facility Planning Board through its Task Force on Health Planning Reform.

**Process:** CDPH convened a meeting of the Capital Financing Group in August 2008 and made the following decisions:

- Members were uncertain if the Capital Budget would move forward in Springfield and, therefore, determined that it might be too late to pursue any safety net hospital financing initiatives through the current Capital Budget proposal.
- Members wanted to be involved in advancing discussions on advocating for more capital for safety net hospitals if opportunities evolve through the Capital bill negotiation process or through the Attorney General's (AG) charity care proposal.
- Members recognized that the CON Task Force is winding down its meetings and, therefore, it is unlikely that directly appealing to the CON Task Force is feasible at this point.

**Status:** CDPH will monitor the opportunities and convene another meeting as appropriate.

**Action Item #4: Develop an insurance-type program to support the capital needs of safety net hospitals.**

**Rationale:** Due to their unreliable and weak balance sheets, safety net hospitals are unable to access capital to improve or expand their facilities.

**Background:** Safety net hospitals typically are located in the poorer communities within the City of Chicago and, therefore, they often care for the most underserved of the City of Chicago. Patients of these hospitals are either uninsured or underinsured. Due to these facts, these hospitals have very low operating budgets because they mostly rely upon state and federal reimbursements. These reimbursements are rarely paid at 100% of cost and the hospitals are forced to cover the remaining balance, which places them in an untenable situation of not having the additional resources for facility infrastructure improvements.



**Process:** CDPH convened a meeting of the Capital Financing Group in August 2008. The members recognized that to increase capital for the safety net hospitals, they need to demonstrate to the financial markets already involved with hospital financing that providing capital to safety net hospitals is a value proposition for them.

- CDPH, with assistance of a UIC professor and the group members, will conduct background work to research this proposal.
- A high-level meeting of hospital financing stakeholders will be convened to discuss their role in assisting safety net hospitals.

**Status:** CDPH is currently conducting research on how an insurance-type program for safety net hospitals will benefit the healthcare industry and financial markets.

## SYSTEMS OF CARE

### ***Action Item #5: Increase access to specialty care by developing a regional center at an academic medical center.***

**Rationale:** A common and pervasive problem in the safety net is the lack of accessibility to specialty care for Medicaid and uninsured patients.

**Background:** Although Chicago is not designated by the federal Health Resources and Services Administration as an underserved area for specialty care, low Medicaid reimbursement rates and other issues reduce the numbers of specialists that treat Medicaid and uninsured patients. Other areas of the country also experience this artificial shortage and several have tried new and collaborative approaches to leverage necessary services from providers. Innovations include leveraging community hospitals, expanding existing hospital relationships, and agreements between academic medical centers and community health centers.

#### **Process:**

- Research other models of increasing access to specialty care, including subspecialty care and some diagnostic care, acknowledging that models are a response to local demographics and environment
- Perform a city-wide needs assessment
- Address financing and HIT interoperability issues
- Create a vision statement of what we are trying to do
- CDPH convenes a group to develop service hubs to cover large parts of Chicago
- Develop a process to funnel resources to the center
- Participants will include representatives from:
  - Insurance
  - Business leaders
  - Academic medical centers
  - FQHCs and other safety net primary care providers
  - Explore relationship with County
  - Examine capacity issues

**Status:** Northwestern Memorial Hospital has had internal discussions and will be meeting with CDPH and the Board in early November 2008 to discuss progress and next steps.

### ***Action Item #6: Increase capacity for uninsured patients at quality medical homes by creating Emergency Department (ED) Diversion Programs at all hospitals.***

**Rationale:** Many uninsured patients and patients covered by Medicaid lack medical homes and often use hospitals EDs when they need health care. However, many of these patients do not require the specialized and expensive care provided at hospital EDs. In addition, if patients only receive care at an ED, they do not develop an ongoing relationship with a medical provider who could assist them in preventing illness and treating ongoing health issues.

**Background:** ED Diversion Programs are collaborations among a hospital, a CHC, and a community mental health provider to provide the patient with primary health care and mental health services when



ED services are not warranted. Patients benefit by these programs because they are connected to a medical home and can receive comprehensive health treatment by a provider who knows their health history. CHCs benefit from these programs because as they serve more Medicaid patients and improve their payer mix to cover expenses, they can serve more uninsured patients. Hospitals benefit by making the EDs more accessible to patients requiring emergency care. And the whole health care system benefits by patients receiving appropriate care in the most cost-efficient setting.

**Process:**

- Form a citywide ED Diversion Working Group to share information, best practices, legal fees, templates, models, etc.
- Suggested organizations to be involved in this group include:
  - Safety Net Meeting Medical Home Group
  - MCHC
  - IPHCA
  - Gilead
  - CDPH

**Status:** The ED Diversion Working Group is forming.

**Action Item #7: Create a Resource Inventory**

**Rationale:** The enthusiasm engendered by the safety net meetings convened by CDPH indicated need for a resource inventory.

**Background:** National studies show that many consumers are not aware of health services available in their areas. A dynamic local resource inventory, in a variety of formats, would assist Chicagoans in finding and accessing the services they need. There is a need to establish the feasibility of a resource inventory and whether it is possible to keep it dynamic and current as to actual capacity for particular services.

**Process:** CDPH will convene a group that includes workgroup participants and other potential collaborators. The group will learn about one another's services, educate hospitals about FQHCs, and inform private practice providers of existing referral sources, including:

- MCHC
- Illinois Primary Health Care Association
- The Gilead Outreach & Referral Center
- IDPH
- Breast Cancer Task Force
- Health & Medicine Policy Research Group Safety Net Project
- Other identified resources

**Status:** CDPH is researching feasibility of using non-emergency 311 as a resource inventory of health care sites.

***Action Item #8: Improve and increase collaborative efforts among hospitals and community health centers to better serve the safety net population.***

**Rationale:** Providers have difficulty obtaining all levels of health care services for patients who are uninsured and covered by Medicaid.

**Background:** Many hospitals and health centers have collaborative efforts to provide some services to the safety net population; however, these efforts may not cover all types of needed services or include all safety net providers. Meeting participants were interested in setting up a venue to encourage more collaboration among providers.

**Process:**

- The South Side Health Collaborative (SSHC), convened by the University of Chicago and an already-existing group, will lead this effort on the South Side
- CDPH will convene groups for the West and the North sides

**Status:**

- The South Side Health Collaborative (SSHC) has held two meetings since the South Side Safety Net Meeting and decided to expand their membership to include more community health centers and local hospitals. To focus their work, SSHC is developing the following groups: (1) specialty care, (2) research, (3) quality, and (4) marketing.
- CDPH convened the West and North side groups in October 2008 and discussed strategies on how to address these issues.





# SUPPORTING DOCUMENTATION

- **Safety Net Meeting Attendees**
- **Health Care Issues**
  - *Health Care System Trends*
  - *Financial Health Care Programs*
  - *Studies Demonstrating Negative Impacts from Service Closures*
- **Information Technology Systems**
- **Materials Prepared for Meetings: Overview of Demographic, Health, and Safety Net Services**
  - *South Side*
  - *West Side*
  - *North Side*



# SAFETY NET MEETING ATTENDEES

Access Community Health Network	Tariq Butt, M.D., Deputy Medical Officer Joe McLaurin, Manager, Comm. Affairs & Business Dev. Jim Murphy, Director, Health System Affiliations Linda Shapiro, V P Strategic Planning & External Affairs
Advocate Illinois Masonic Medical Center	Delois Brown-Daniels, Vice President Mission & Spiritual Care Susan Nordstrom Lopez, President Michael Swarzman, Regional VP, Advocate Health Care Chgo Region
Advocate Trinity Hospital	Brenda Aranda, Director, Communications & Government Relations
Alivio Medical Center	Carmen Velasquez, Executive Director
Alliance of Chicago Community Health Services, LLC	Fred Rachman, M.D., Chief Executive Officer
American Indian Health Service of Chicago	Murry Bass, M.D., Medical Director Kenneth Scott, Executive Director
Asian Family Health Centers	Muhammad Paracha, Clinic Director Somboon Sriaroon, M.D., Clinical Medical Director
Beloved Community Family Wellness Center	Margie Johnson, Chief Executive Officer Laura Lucero, Medical Director
Centro de Salud Esperanza	Daniel Fulwiler, Chief Executive Officer
Chicago Family Health Center	Wendy Cox, CPA, MBA, Chief Executive Officer Dwayne Mitchell, Chief Operating Officer
Children's Memorial Hospital	Susan Hayes Gordon, Chief, Government and Community Relations
Christian Community Health Center	Virgil Tolbert, Executive Director Kenya Garrett-Burnett, Esq., Director of Legal Affairs
Circle Family Care	Reuben Pettiford, Chief Executive Officer
CommunityHealth	Judy Haasis, Executive Director
Cook County Bureau of Health Services	Randall Mark, Director of Policy Analysis
Erie Family Health Centers, Inc.	Lee Francis, M.D., MPH, Chief Executive Officer/President Iliana Mora, Vice President, Development and Community Relations
Friend Family Health Center	Wayne Moyer, Chief Executive Officer
Heartland Health Outreach, Inc.	Heidi Nelson, Vice President and Executive Director
Heartland International Health Center	Bechara Choucair, MD, Executive Director Tony Beltran, Chief Operating Officer
Holy Cross Hospital	Wayne Lerner, DPH, Chief Executive Officer
Howard Brown Health Center	Anna Carvalho, Director of Strategic Planning
Illinois Department of Public Health	Michael Cook, President and Chief Executive Officer Damon Arnold, M.D., MPH, Director Rory Slater, Regional Health Officer David Carvalho, Deputy Director Mary Driscoll, RN, MPH, Division Chief, Patient Safety Quality John Wilhelm, M.D., MPH, Executive Director
Infant Welfare Society of Chicago	Randall Smith, Executive Vice President
Jackson Park Hospital and Medical Center	Misty Drake, Director of Health Support Services
Lawndale Christian Health Center	Kevin Rehder, Vice President Clinical Services
Little Company of Mary Hospital	Steve Drucker, Chief Executive and President
Loretto Hospital	Sheila Lyne, RSM, President and Chief Executive Officer
Mercy Hospital	Barbara Townsend, VP Business Development & Community Affairs
Michael Reese Hospital & Medical Center	Enrique Beckmann, M.D., Chairman and Chief Executive Officer
Mile Square Health Center	Henry Taylor, Executive Director
Near North Health Services Corporation	Berneice Mills-Thomas, RN, MSM, MPH, MBA, Executive Director Wahabi Tijani, Director of Finance and Accounting
Northwestern Memorial Hospital	Posh Charles, Director Community Service
Northwestern Memorial Physicians Group	Daniel Derman, MD, Vice President, Operations
Norwegian American Hospital	Michael O'Grady, Jr., Chief Executive Officer and President
Our Lady of the Resurrection Medical Center	Maryanne Bajgrowicz, Director of Emergency and Critical Care
PCC - Salud Family Health Center	Robert Urso, Chief Executive Officer and President Lynn Hopkins, Chief Operating Officer
PrimeCare Community Health, Inc.	Joan Sheforgen, Chief Executive Officer
Provident Hospital of Cook County	Jasim Din, MBA, FCMA, CPA, Chief Financial Officer Sidney Thomas, Chief Operating Officer

Resurrection Medical Center  
Rush University Medical Center

Sacred Heart Hospital

Saint Anthony Hospital  
Saint Bernard Hospital and Health Care Center  
Saints Mary and Elizabeth Medical Center  
Sinai Health System  
South Shore Hospital

Swedish Covenant Hospital

University of Chicago Hospitals

University of Illinois Medical Center at Chicago  
Weiss Memorial Hospital  
West Suburban Hospital

Larry Narum, Vice President of Community Affairs  
Larry J. Goodman, M.D., President and Chief Executive Officer  
Avery Miller, Senior Vice President Corporate & External Affairs  
Gena Faas, Governmental Affairs Specialist  
Laura Bach, Intern  
Michael Applegate, Director of Marketing & Community Relations  
Clarence Nagelvoort, Senior Vice President of Administration  
Jim Sifuentes, Vice President, Mission & Community Development  
Charles Holland, Vice President of Planning & Development  
Margaret McDermott, Executive Vice President and CEO  
Roberta Rakove, Senior Vice President, Government Affairs  
Jesus Ong, President  
Tim Caveney, Chief Finance Officer  
Craig Cathcart, Director of Legislative Affairs & Advocacy  
Gary Krugel, Senior VP of Operations/Chief Financial Officer  
Mark Newton, President and Chief Executive Officer  
Laura Derks, Director, External Affairs, Office of Community Affairs  
Quin Golden, Assoc. VP Strategic Affiliates, Urban Health Initiative  
Eric Whitaker, M.D., Executive Vice President  
John J. DeNardo, Chief Executive Officer  
Frank Molinaro, Chief Executive Officer  
Jay Kreuzer, Chief Executive Officer



## HEALTH CARE SYSTEM TRENDS

### Hospitals

*Closures/Change in Scope:* As a result of financial pressures, three hospitals in the North Side closed since 2000. This loss reduced the number of set-up and staffed beds in the North by 695, (17% of beds in 2000 or 22% of beds in 2006). Michael Reese Hospital and Medical Center is scheduled to close in the fall of 2008 due to significant and long-standing financial problems. The closure of this site will reduce the number of peak beds by 240 in the South Side, a 12% loss. In addition, many other hospitals in Chicago are at risk of closure, with one-third of hospitals stating that they lost money on overall operations and two-thirds reporting not being able to cover costs for patient care services.<sup>49</sup>

Community hospital beds were also lost in 2007 in the West Side when Advocate Bethany Hospital changed its scope of practice from a community hospital to a long-term acute care facility, which reduced the number of community hospitals beds by 119 peak set-up beds, a 4% decrease.<sup>50</sup>

Another trend occurring throughout the country is the closure of obstetric (OB) units at community hospitals. Reasons identified for these closures include the rising cost of malpractice liability insurance, difficulty hiring and maintaining OB providers, and the inadequate Medicaid reimbursement rates. In Chicago, one hospital closed its OB unit in 2006 and another hospital has recently suspended these services. This represents a loss of 30 set up beds (16 in the North and 14 in the South Sides).<sup>51</sup>

*Hospital Market: Independent stand-alone institutions and multi-hospital systems:* The rise of multi-hospital systems has been occurring for the last two decades, with 103 separate arrangements announced or completed throughout the U.S. in 2007.<sup>52</sup> These numbers have shown a similar trend for the past three years, indicating activity in hospital deal making throughout the country. Reasons given for these changes are primarily financial; aiming to reduce costs through operational efficiencies and to improve their contracts with health insurance companies.

Although the growth in aggregation and multi-hospitals systems has been occurring in other parts of the country, hospital systems within Chicago have remained stable. In 2008, 12 of the 31 general hospitals in Chicago were part of a multi-hospital system. This number is slightly less than in 2004, when 15 Chicago hospitals were part of multi-hospital systems. Growth of multi-hospital systems in the suburban areas, however, is occurring as hospitals aim to position themselves better in the regional market place.

The largest health care system in Chicago is Resurrection Health Care. Resurrection is a Catholic-owned, non-profit health care system, with five locations in Chicago and four in the surrounding suburbs. The other five systems in Chicago either have the majority of their system hospitals outside of Chicago or are part of a system that is composed of two locations.

*Non-Profit and For-Profit Hospitals:* Many of the mergers and acquisitions occurring throughout the country involve conversions from non-profit hospitals to for profit hospitals, run by corporations. Although for-profit hospitals comprise only 13% of the community hospital market (10% when Michael

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<sup>49</sup> *Annual Hospital Questionnaire*, 2000 and 2006. Illinois Department of Public Health.

<sup>50</sup> *Ibid.*

<sup>51</sup> *Ibid.*

<sup>52</sup> Contact: Brenda Stewart. "More Than 200 Hospitals Changed Hands in 2007." Jan. 21, 2008. Modern Healthcare.

Reese Hospital closes), for-profit hospitals represent the majority of specialty care hospitals (four of four sites) and psychiatric hospitals (2 out of 3 sites).<sup>53</sup>

Financial difficulties of many safety net hospitals, especially those that are independently operated, may result in conversion of more of these types of facilities. If these changes occur, there may be concerns about access to care, especially for the uninsured or patients covered by Medicaid. One example of a non-profit hospital converting to a for-profit corporation is St. Francis Hospital of Blue Island. St. Francis Hospital is a Catholic-owned, non-profit hospital and was scheduled to close earlier in 2008. Just prior to this closure, however, St. Francis Hospital was purchased by MSMC Investors and its affiliate Transition Healthcare Co. and will now be operated as a for-profit entity. Although outside of Chicago, St. Francis serves a sizeable Chicago population and this closure would have reduced the number of beds available to the residents of the South Side by 410. Although the purchase of St. Francis keeps the hospital open, the change in ownership to a for-profit hospital may alter its mission and could have a negative impact on access for residents of the south side who are uninsured or on Medicaid.

*New hospital models:* The Illinois General Assembly (GAO) is currently reviewing the overall health planning system within Illinois; including reform of the Illinois Health Facility Planning Board and its certificate of need program (CON). However, based upon the experiences of other states where the CON process does not exist, one could argue that allowing the market to alone manage the state's hospital system could be detrimental to the overall health care delivery system, especially to the Chicago market. States without a CON process have seen a flurry of specialty care hospital expansions. According to the GAO, states without a CON process account for half of the US population and 55% of US general hospitals, but 83% of all specialty hospitals.<sup>54</sup> Unlike full-service hospitals, specialty care hospitals are designed to serve a distinct health practice area, e.g., heart, cancer and bone are the most prevalent. Although specialty care hospitals would argue that they are more efficient and bring more competition to the marketplace to the overall benefit of the consumer, there actually is confounding evidence that negates this premise.

### ***Ambulatory Care***

*In-store Clinics:* Another growing trend for ambulatory care is health clinics in local retail stores, such as Wal-Mart, Walgreens, CVS, Brooks, Rite-Aid, and Target. These "in-store clinics" provide a narrow range of low-complexity services, including colds, flu, minor infections for the relatively well populations that want to see a provider without the complexity of going to a medical office. Most in-store clinics do not accept third party payment, and there are issues around Medicaid, Medicare, and other third-party reimbursement.

Retail chains benefit by bringing people into the store to receive care and offering to fill prescriptions at the same time. Medical experts identify concerns with the care provided at some of these sites due to the lack of physical equipment to provide comprehensive care, as well as some clinics using a computer system to initiate patient diagnosis. In addition, continuity of care is an issue for those using in-store clinics.

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<sup>53</sup> Chicago Health and Health Systems Project, 2008. Chicago Department of Public Health, Office of Policy and Planning.

<sup>54</sup> "Specialty Hospitals: Geographic Location, Services Provided and Financial Performance." GAO. Pub. no. GAO-04-167. 2003.



Currently, there are about 2,000 in-store clinics. Wal-Mart alone has 76 in-store clinics and expects to host 2,000 in-store clinics by 2014. To compete with the retail chains, Mayo Clinic recently announced that they will open an Express Care site in a shopping center, and other hospitals and providers are expected to do the same. Insurers in Massachusetts recently agreed to cover care provided to plan enrollees in some in-store clinics.<sup>55</sup>

### **MANDATORY MEDICAID MANAGED CARE**

**Illinois Health Connect:** Illinois Health Connect, the state's mandatory managed care program, is altering the safety net landscape. Neighborhood health centers and other safety net ambulatory care providers that accept Illinois Health Connect patients will focus on maintaining and expanding their Medicaid base.

Of the state's 1.9 million Medicaid enrollees, 1.7 million (89%) are in mandatory Illinois Health Connect, the state's PCCM program, and another 180,000 (9%) are in voluntary HMO plans. The remaining enrollees are in protected classes that are prohibited by federal law from participation in mandatory managed care.

Participating in Illinois Health Connect earns primary care providers (PCPs) a small monthly payment per patient: \$2 for children, \$3 for parents and \$4 for seniors and people with disabilities. Pay for performance (P4P) is expected to be initiated in 2008. Participation also locks PCPs into the state's low fee-for-service reimbursement rates and sometimes lengthy payment cycle.

**Medicaid HMOs:** Another 180,000 (9%) Medicaid enrollees are in voluntary HMO plans. The remaining enrollees are in protected classes that are prohibited by federal law from participation in mandatory managed care.

### **CHARITY CARE AND HOSPITAL DISCOUNT PROGRAMS**

Nearly 26% of Chicagoans, 539,750 people, are uninsured.<sup>56</sup> When uninsured patients present to the hospital for health care services, they typically are charged significantly more in fees simply because they do not have insurance and an employer or group that has negotiated a lower rate for hospital services for them. Charity care and hospital discounts assist uninsured Chicagoans in paying more reasonable charges for the hospital services they receive.

**Charity Care:** Charity care is health care services provided free or at a discounted rate by a hospital. All not-for-profit hospitals in Chicago, and Illinois overall, are required by the *Hospital Fair Patient Billing Act* to provide some form of charity care in order to maintain not-for-profit status.

Each hospital has its own charity care policy. Eligibility requirements are specific to each hospital, and programs at different hospitals vary in who qualifies for benefits and which services are covered.

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<sup>55</sup> Kaiser Daily Health Policy Report, Friday, July 25, 2008, [www.kaisernetwork.org](http://www.kaisernetwork.org), accessed July 25, 2008.

<sup>56</sup> "In Their Own Words- The Voice of the Uninsured: A Detailed Description of Illinois' Uninsured", Gilead Outreach and Referral Center, April 2008, [www.gileadcenter.org](http://www.gileadcenter.org), accessed September 15, 2008.

Emergency care mandated by the federal *Emergency Medical Treatment and Active Labor Act* may also be covered by charity care.

**Hospital Discounts:** The Illinois General Assembly passed the *Hospital Uninsured Patient Discount Act* in the 2008 session. This Act creates mandatory hospital discounts for uninsured patients who qualify. In order to qualify for the discount, patients must apply with the hospital. Hospitals are required to inform uninsured patients about this program through prominent placement of information in the hospital or directly on a statement, bill, invoice, or other summary of charges to an uninsured patient. Patients have sixty days from the date of their discharge or date of service to apply for the discount program.

The discount may be applied to all hospital charges over \$300 incurred by a qualifying patient in one inpatient admission or outpatient encounter. The discount will be based on the hospital’s Medicare Cost Report and the cost-to-charge ratio reported therein multiplied by the uninsured discount factor. The uninsured discount factor is a formula which is: 1.0 less the product of a given hospital’s reported cost-to-charge ratio multiplied by 1.35.

The eligibility period begins on the date that a patient receives services that are determined eligible for the discount and continues for 12 months thereafter as long as the patient remains eligible for the hospital’s discount program.

For Illinois residents residing in metropolitan statistical areas (MSA) such as Chicago, patients must have family income of no more than 600% of the federal poverty income guidelines. An individual would be eligible for the discount with an annual income of no more than \$62,400. Annual family income of \$127,200 would be the limit for a family of four. For those living outside an MSA, or seeking treatment at a rural critical access hospital, patients must have family income of no more than 300% of the federal poverty income guidelines.

**Table of Maximum Collectible Amounts for an Individual**

Federal Poverty Income Guidelines	200 %	300%	400%	500%	600%
Individual Income	\$20,800	\$31,200	\$41,600	\$52,000	\$62,400
Maximum Collectible	\$ 5,200	\$ 7,800	\$10,400	\$13,000	\$15,600

**Table of Maximum Collectible Amounts for a Family of Four**

Federal Poverty Income Guidelines	200 %	300%	400%	500%	600%
Family Income	\$42,400	\$63,600	\$84,800	\$106,000	\$127,200
Maximum Collectible	\$10,600	\$15,900	\$21,200	\$26,500	\$ 31,800



Hospitals in an MSA may create policies to consider patient family assets over 600% of the federal poverty income guidelines when screening for eligibility. Assets do not include the primary home, some personal property, or assets in a pension or retirement plan. Income distributions from pensions or retirement plans may be included as income by the hospital. For those outside an MSA, or seeking treatment at a critical access hospital, the asset limit would be 300% of the federal poverty income guidelines.

In addition to the income and asset verification tests, a patient must prove Illinois residency. Patients may verify residency in a variety of ways that will not be difficult. Patients do not have to meet federal immigration status requirements.

Uninsured patients requesting the discount must also apply for publicly funded health programs when they appear eligible. Hospital obligations will cease for patients who refuse to apply for publicly funded health programs. According to the Office of the Illinois Attorney General, hospital discounts will augment hospital charity care programs not replace them.

### *STUDIES DEMONSTRATING NEGATIVE IMPACTS FROM SERVICE CLOSURES*

A growing body of literature demonstrates what is thought intuitively, which is that the closing of services has a negative impact on access and also on health status:

- Researchers found that the closure of hospitals causes a "significant negative impact on the community" that both decreases economic stability (lost jobs and tax base) and widens health disparities. The study examined 85 hospitals that closed between 1998 and 2000, a period "where there were a historically unprecedented high number of closures." It found that hospitals in lower-income communities serving minority patients were more likely to close. In addition, on average, the hospitals that closed were different from other urban hospitals, in that the hospitals that closed had fewer beds, lower occupancy rates, and lower annual net income. There was a statistically significant difference pre and post closure in perceived health status, emergency room utilization, and overall mortality.<sup>57</sup>
- A 1990 study compared access to care and health status of patients who were treated at two public hospitals in California: Shasta General Hospital that closed, and San Luis Obispo that stayed open. The study found that the closing of a public hospital had a significant effect on health status and access to care. The percentage of Shasta patients without a regular provider rose from 14% to 27%. The percentage of Shasta patients reporting that they were denied care increased from 10.8% to 16.9% (San Luis Obispo patients did not change). Further, Shasta County patients had significant decreases in health perception, social and role function, and increases in pain as compared with San Luis Obispo patients.<sup>58</sup>

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<sup>57</sup> Munroe, A.E. "Health System Reconfiguration: Urban Hospital Closures Impact on Health Disparities and Access." Teachers College, Columbia University. 2007. (Doctoral Dissertation).

<sup>58</sup> Bindman, A. B., Keane, D., and Lurie, N. "A Public Hospital Closes. Impact on Patients Access to Care and Health Status." The Journal of American Medical Association. Vol. 464, No. 22, December 12, 1990.

- Another examined Los Angeles County, an area that has had many hospital closures in the past 10 years. The study found that when care is appropriately shifted to doctor's offices; urban hospital closures can improve the efficiency of a system. However, this study found evidence that proximity of a hospital influences perceived access to care for vulnerable residents, such as seniors. There was also evidence that increased distance to the closest hospital is correlated with higher mortality counts for emergent conditions, "such as heart attacks and possibly from unintentional injuries."<sup>59</sup>
- One study assessed the monthly diversion times for 80 hospitals because of emergency department saturation during a period in which nine hospitals closed. Through multivariate modeling, the study showed that hospital closure increased ambulance monthly diversion hours for 4 months by an average of 56 hours at the nearest hospital. County-operated hospitals had 150 hours and trauma centers had 48 hours more diversion than other hospitals. Diversion hours for a given facility were positively correlated with diversion hours of the nearest ED.<sup>60</sup>

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<sup>59</sup> Buchmueller, T. C., Jacobson, M., Wold, C. "How Far to the Hospital? The Effect of Hospital Closures on Access to Care." *Journal of Health Economics*. 25(2006). 740-761.

<sup>60</sup> Sun, B. C. MD, MPP et al. "Effects of Hospital Closures and Hospital Characteristics on Emergency Department Ambulance Diversion." Los Angeles County, 1998-2004.



# INFORMATION TECHNOLOGY SYSTEMS

## Safety Net IT Systems Survey

At the June 2008 meeting of safety net stakeholders, employees at eight (8) Chicago hospitals and 17 Chicago community health centers were asked to indicate the types of information technology systems in use at their facilities. Overall, there is a lot of variation in system types.

## Electronic Health Record Systems

Forty percent (40%) of the facilities reporting did not have an electronic health record system. Facility staff reported five (5) different electronic health systems. The largest single type of system used was Centricity, which was used by almost one-quarter (24%) of all facilities (all were community health centers). For 8% of facilities, the type of electronic health system was unknown.

Of the 8 hospitals reporting, three-quarters (75%) reported that they had an electronic health record system, compared to 53% of the 17 community health centers.

### Electronic Health Record Systems at Selected Chicago Hospitals and CHCs

System	Hospitals	CHCs	Total #	Total %
None	2	8	10	<b>40.0%</b>
Centricity	0	6	6	<b>24.0%</b>
Unknown	2	0	2	<b>8.0%</b>
Cerner	2	1	3	<b>12.0%</b>
Epic	1	1	2	<b>8.0%</b>
Meditech	1	0	1	<b>4.0%</b>
Visionary	0	1	1	<b>4.0%</b>
<b>Total</b>	<b>8</b>	<b>17</b>	<b>25</b>	<b>100.0%</b>

## Patient Registration Systems

All 25 facilities have a patient registration system. Thirteen (13) different systems were named, and for one facility, the name of the system was unknown. Megawest was the largest single type, with 20% of facilities using that system for patient registration, followed by Centricity and Meditech at 16% each.

At hospitals, Meditech was used most frequently (by one-half of hospitals). At community health centers, Megawest was the most commonly named, followed by Centricity.

### Patient Registration Systems at Selected Chicago Hospitals and CHCs

System	Hospitals	CHCs	Total #	Total %
Megawest	0	5	5	<b>20.0%</b>
Meditech	4	0	4	<b>16.0%</b>
Centricity	0	4	4	<b>16.0%</b>
Cerner	1	1	2	<b>8.0%</b>
Advantix	0	1	1	<b>4.0%</b>
Cadence	1	0	1	<b>4.0%</b>
Access	0	1	1	<b>4.0%</b>
Indian Health Service RDMS	0	1	1	<b>4.0%</b>
McKesson	1	0	1	<b>4.0%</b>
MD Serve	0	1	1	<b>4.0%</b>
Medical Manager	0	1	1	<b>4.0%</b>
OACIS	1	0	1	<b>4.0%</b>
Visionary	0	1	1	<b>4.0%</b>
Unknown	0	1	1	<b>4.0%</b>
<b>Total</b>	<b>8</b>	<b>17</b>	<b>25</b>	<b>100.0%</b>

### Financial Systems

Overall, just over one-half (52%) of hospital and CHC representatives at the Safety Net meeting did not know what financial system was in use at their facility. Seven different systems were identified overall.

Meditech was the most commonly reported system at hospitals, and MIPS and Peachtree were most commonly reported at community health centers.

### Financial Systems at Selected Chicago Hospitals and CHCs

System	Hospitals	CHCs	Total #	Total %
Unknown	4	9	13	<b>52.0%</b>
Meditech	3	0	3	<b>12.0%</b>
MIPS	0	2	2	<b>8.0%</b>
Peachtree	0	2	2	<b>8.0%</b>
Cerner	1	1	2	<b>8.0%</b>
Centricity	0	1	1	<b>4.0%</b>
Great Plains	0	1	1	<b>4.0%</b>
Quickbooks	0	1	1	<b>4.0%</b>
<b>Total</b>	<b>8</b>	<b>17</b>	<b>25</b>	<b>100.0%</b>



### Picture Archiving and Communication Systems/PACS (Radiology)

Of the 25 facilities reporting, just over one-half (52%) did not use PACS at their facility and close to one-third (32%) of staff said that they didn't know what radiology system was used. The remaining four that reported the use of PACS were all hospitals.

#### PACS (Radiology) Systems at Selected Chicago Hospitals and CHCs

System	Hospitals	CHCs	Total #	Total %
None	0	13	13	52.0%
Unknown	4	4	8	32.0%
Cerner	1	0	1	4.0%
Fuji	1	0	1	4.0%
Fuji and Prosolve	1	0	1	4.0%
GE	1	0	1	4.0%
<b>Total</b>	<b>8</b>	<b>17</b>	<b>25</b>	<b>100.0%</b>

# MATERIALS PREPARED FOR MEETINGS

## OVERVIEW OF DEMOGRAPHIC, HEALTH, AND SAFETY NET SERVICES

### CHICAGO'S SOUTH REGIONS

#### (SOUTH, FAR SOUTH, AND SOUTHWEST)

*\*Updated on 4/1/08*

#### Demographic Information<sup>61</sup>

- From 1990 to 2000, the population in Chicago increased by 4% while the populations in the Far South and South regions decreased up to 6%. During the same time, however, the population in the Southwest increased by 9%, due primarily to the 117% increase in their Hispanic population, which comprises over one-third of its population. Forty two percent of the population in the Southwest speaks a language other than English at home, an increase of 67% from 1990.
- The South region had the highest percentage of people living below the poverty level (29%) and below twice the poverty level (49%) compared to the other south regions and Chicago. However, the percentages of people in poverty in the South region decreased since 1990.

#### Calculation of Medically Needy<sup>62</sup>

- Methodology: The number of medically needy is calculated from the population under age 65 years old who also have family incomes less than 200% of poverty. (It is presumed that the majority of persons over 64 years of age have some coverage through Medicare.) Subtracting from this figure the number of Chicagoans enrolled in the State's Medicaid program provides a reasonable estimate of the low-income uninsured or under-insured population. The number of persons "in care" and "out of care" was determined through CDPH's Chicago Health and Health Systems Project survey.
- While Chicago's medically needy population decreased by 1% between 1990 and 2002, this population increased in the combined south regions by 4%. Wide variations were seen in the regions, with a 34% decrease in Far South, a 4% decrease in the South, and a 32% increase in medically needy in the Southwest. Southwest also has the largest population of medically needy in these regions.
- The combined south regions comprised approximately 1/3 of all medically needy in Chicago in both 1990 and 2002.
- The percentage of medically needy that was out of care was higher in the combined three south regions than for Chicago: 71% compared to 65%. The Southwest region had the largest population of medically needy out of care, at 84%. Those without care comprised 60% and 53% of the South and Far South's medically needy population.

#### Safety Net Sites<sup>63</sup>

- There are ten general hospitals in the three south regions, seven of which are in the South region.
- These regions currently house 36 community health centers (federally funded sites, CDPH, and Cook County) and 7 school-based health centers.

<sup>61</sup> US Census 2000, <http://factfinder.census.gov>

<sup>62</sup> Salem, E. and Ferguson, R. "Casting Chicago's Safety Net: A 12-Year Review of Chicago's Community-Based Primary Care System." Chicago: Chicago Department of Public Health, Planning and Development Division, 2005.

<sup>63</sup> Chicago Health and Health Systems Project, 2008. Chicago Department of Public Health, Office of Policy and Planning.



### Safety Net System Capacity<sup>\*64</sup>

- Safety net clinics (not including school-based health centers) in Chicago grew almost 125% from 1990 to 2008, for a total of 93 sites. Clinics in the three south regions grew from 21 in 1990 to 35 in 2008, representing a 67% increase and 38% of all Chicago safety net clinics.
- In 2002, the number of clinics in these regions had only increased by 4, from 21 to 25. The number of visits provided decreased during this time period by 9% even though capacity increased by 15%. In 1990, clinics operated over capacity, at 106% while in 2002, 85% of safety net capacity was being used.

*\*Does not include Mercy Family Health Center*

### Hospital Data<sup>65</sup>

- In 2006, the three south regions had ten general hospitals with 3,404 authorized beds and 2,365 set-up and staffed beds. The number of set-up and staffed beds represents a 10% decrease from 2000. The South region has the most hospitals, seven facilities, and the highest number and percentage of set-up and staffed beds, at 1,798, or 76% of the set-up and staffed beds in the three south regions.
- Throughout the three regions, the number of hospital admissions increased by 1% and the number of visits to the emergency room increased by 3%. Live births decreased by 16%.

### Hospitalizations and Ambulatory Care Sensitive Conditions<sup>66</sup>

- The rates of hospitalization in 2001 were higher in the South (1,730 per 10,000 population) and the Far South (1,588) regions than for Chicago (1,488) or for the Southwest region (1,423) for all hospitalizations and most individual causes.
- Hospitalizations for ambulatory care sensitive conditions show hospitalizations for conditions that most likely could have been prevented if treated appropriately in an ambulatory care setting. Rates of these hospitalizations tend to be higher in the South and Far South regions.

### Maternal and Child Health<sup>67</sup>

- From 1993 to 2004, Chicago's infant mortality rates decreased by 37%, from 13.7 infant deaths per 1,000 live births to 8.7. Infant mortality rates also decreased in the three south regions; however, two regions continue to have higher rates than Chicago: South region decreased from 19.1 deaths per 1,000 live births in 1993 to 14.7 in 2004 (-23%), and Southwest decreased from 15.2 in 1993 to 10.9 deaths in 2004 (-28%). The Far South region showed the largest infant mortality rate decrease during this time period, from 16.9 in 1993 to 8.5 in 2004, a decrease of 50%, which was lower than for all Chicago.
- In both 1993 and 2005, the South region had the highest rates of teen births, babies born to women who did not receive prenatal care of all the south regions, followed closely by the Far South region. Although the Southwest had the lowest rates of the three south regions for these indicators, these rates were higher than Chicago's (excluding low birth weight babies).

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<sup>64</sup> Ibid

<sup>65</sup> All hospital data come from the *Annual Hospital Questionnaire*, 2000 and 2006. Illinois Department of Public Health.

<sup>66</sup> Illinois Health Care Cost Containment Council, Uniform Data Set, 2001

<sup>67</sup> Chicago Department of Public Health, Office of Epidemiology

### Leading Causes of Mortality<sup>68</sup>

- Comparing 1990 to 2005, mortality rates decreased in Chicago, as well as in all the three south regions. In 1990, mortality rates were higher in the three south regions than for Chicago, at 1109 deaths per 100,000 population and 1097, respectively. However, in 2005, Chicago's rates were slightly higher: 866 in Chicago and 859 in the south regions.
- The South region had the highest mortality rate of the three south regions in 1990; however, it experienced the largest decrease in mortality rates, at 23%. Far South only had a 7% decrease in its rate from 1990 to 2005. As a result, Far South had the highest mortality rate of all the south regions in 2005, at 1048. The Southwest had the lowest mortality rate of these regions, at 891 in 2005.

### Cancer<sup>69</sup>

While the 2005 age-adjusted cancer rates in the South and Southwest regions mirrored the overall Chicago rates, the Far South region had consistently higher rates of breast, lung, prostate, and colorectal cancer.

### Tuberculosis (TB)<sup>70</sup>

- From 1996 to 2007, TB cases decreased in Chicago by 62%. Two of the three south regions experienced larger decreases than Chicago: 74% in South and 68% in Far South. The Southwest had a 51% decrease in the number of TB cases, less than the other regions.
- The percentage of all Chicago's TB cases found in the south regions decreased during this time period, from 43% of all TB cases in 1996 to 40% in 2007.

### HIV/AIDS Incidence<sup>71</sup>

- From 1996 to 2006, the number of AIDS cases being diagnosed each year decreased in the three south regions by 49%, in line with the 50% decrease in all Chicago cases. The south regions continue to comprise 36% of all Chicago AIDS cases. The South region housed 49% of all AIDS cases in the south regions.
- From 2000 to 2006, the number of HIV cases being diagnosed each year in the three south regions increased by 6% while HIV cases in Chicago stayed the same. This increase was due to the 50% growth in cases in the South region. In comparison, the number of HIV cases decreased in the Southwest and Far South regions, by 28% and 11%, respectively. The South region now represents 54% of all HIV cases in the three south regions, up from 38% in 2000. The south regions continue to account for approximately 30% of all HIV cases in Chicago.

### Sexually Transmitted Diseases<sup>72</sup>

- Rates of Chlamydia increased in Chicago between 1996 and 2006 by 63%, from 499 cases per 100,000 population to 813. Rates increased even more in the south regions, from 511 to 1053, or 106%. The South region continued to have the highest rates of Chlamydia, at 637 in 1996 and 1317 in 2006. In 2006, the Far South region had 1084 cases per 100,000 population and Southwest had 847.

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<sup>68</sup> Ibid

<sup>69</sup> Ibid

<sup>70</sup> Chicago Department of Public Health, Office of Tuberculosis Control

<sup>71</sup> Chicago Department of Public Health, Office of HIV/AIDS Surveillance

<sup>72</sup> Chicago Department of Public Health, Office of STD/HIV/AIDS



- From 1996 to 2006, gonorrhea cases decreased by 23% in all of Chicago, but only decreased by 5% in the south regions. The South region had the highest rate, at 661 cases per 100,000 population in 2006. Far South had a rate of 534 and Southwest had 352. Chicago's rate was lower than all of the south regions, at 340.
- As with the other STDs, the South region had higher rates of people with primary and secondary syphilis, at 12 cases per 100,000 population in 2006, down from a rate of 19 in 1998. The rates of syphilis in the other south regions also decreased: from 12 to 6 in the Far South and from 10 to 5 in the Southwest. Chicago's rate decreased from 11 to 8 in this same time period.

### Lead Poisoning<sup>73</sup>

- In 2006, 37% of the children under 6 years old in the three south regions were tested for lead poisoning. The percentage of tested children increased from 30% in 1997 and is larger than the percentage of all Chicago children being tested, which was 34% in 2006.
- The percentage of children tested for lead poisoning increased in both the Southwest and Far South regions from 1997 to 2006. The Southwest region had a large increase, from 27% to 44%, while the percentage of tested children in Far South increased only from 26% to 28%. The percentage of children tested for lead in the South region, however, decreased, from 39% in 1997 to 33% in 2006.
- The percentage of tested children whose blood lead levels were elevated decreased by 89% in both the three south regions and for Chicago as a whole. The south regions' percentage decreased from 27% in 1997 to 2.9% in 2006 and Chicago's percentage decreased from 24% to 2.7%. The percentage of tested children with elevated blood lead levels was slightly higher in the Far South region, at 3.1%, compared to 2.9% of the tested children in the South and Southwest regions.

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<sup>73</sup> Chicago Department of Public Health, Lead Prevention Program

## OVERVIEW OF DEMOGRAPHIC, HEALTH, AND SAFETY NET SERVICES CHICAGO'S WEST REGION

### Demographic Information<sup>74</sup>

- From 1990 to 2000, the population in Chicago increased by 4%, while the population in the West Region remained relatively unchanged.
- The West Region has larger percentages of people aged 0-14 and 15-44 than Chicago, which has a larger percentage of older residents.
- The percentage of people living below poverty and twice below poverty decreased in both Chicago and the West Region between 1990 and 2000. However, in 2000 the West Region continued to have a higher percentage of people living below the poverty level (29% in the West compared to 20% in Chicago) and below twice the poverty level (54% in the West and 40% in Chicago).

### Calculation of Medically Needy<sup>75</sup>

- Methodology: The number of medically needy is calculated from the population under age 65 years old who also have family incomes less than 200% of poverty. (It is presumed that the majority of persons over 64 years of age have some coverage through Medicare.) Subtracting from this figure the number of Chicagoans enrolled in the State's Medicaid program provides a reasonable estimate of the low-income uninsured or under-insured population. The number of persons "in care" and "out of care" was determined through CDPH's Chicago Health and Health Systems Project survey.
- The Cook County Bureau of Health Services' Fantus clinic serves patients from all over the Chicago Region, not just the West Region, where it is located. Therefore, its clinic data were not included in the data analysis.
- In both 1990 and 2000, the West Region comprised nearly twenty percent of Chicago's overall population. However, the West Region comprised 26% of Chicago medically needy in 2000, which is marginally down from 28% in 1996.
- The majority of the West Region's medically needy (70%) were able to access care in 2002. In contrast, only 36% of all Chicago's medically needy were in care.

### Safety Net Sites<sup>76</sup>

- In 2008, there are ten general hospitals in the West Region, three of which are major teaching hospitals. Advocate Bethany Hospital operated as a general hospital until December 2006, when it changed its hospital type to a Long Term Acute Care hospital.
- The Region currently houses 37 community health centers (federally funded sites, CDPH, Cook County and one Free Clinic) and 8 school-based health centers.

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<sup>74</sup> US Census 2000, <http://factfinder.census.gov>

<sup>75</sup> Salem, E. and Ferguson, R. "Casting Chicago's Safety Net: A 12-Year Review of Chicago's Community-Based Primary Care System." Chicago: Chicago Department of Public Health, Planning and Development Division, 2005.

<sup>76</sup> Chicago Health and Health Systems Project, 2008. Chicago Department of Public Health, Office of Policy and Planning.



### Safety Net System Capacity<sup>77</sup>

- Safety net clinics (not including school-based health centers) in Chicago grew just over 125% from 1990 to 2008, for a total of 93 sites. Clinics in the West Region increased at a higher rate, from 14 in 1990 to 37 in 2008, or a 164% change.
- The increase in clinical capacity was commensurate with the increase in capacity.
- Both the West Region and Chicago's safety net clinic operated at over 90% of available capacity in 1990 and 2000.

### Hospital Data<sup>78</sup>

- In 2006, the West Region had ten hospitals with 12,662 authorized beds and 9,450 set-up and staffed beds. In the West Region as well as Chicago, there was a 14% decrease in the number of set-up and staffed beds compared to 2000.
- Since 2006, Advocate Bethany Hospital converted from a general hospital to a Long Term Acute Care Hospital, which contributed to the decrease in bed capacity.
- Some hospital trends were similar in Chicago and the West Region, with an increase in admissions and emergency room visits. However, the West Region had a 28% increase in the number of outpatient visits delivered, while Chicago's number decreased by 2 percent. In addition, live births in the West decreased by 12%, but only by 5% in Chicago.

### Hospitalizations and Ambulatory Care Sensitive Conditions<sup>79</sup>

- The rates of hospitalization in 2001 were higher in the West Region (1,827 per 10,000 population) than for Chicago (1,488) for all hospitalizations and most individual causes.
- Hospitalizations for ambulatory care sensitive conditions show hospitalizations for conditions that most likely could have been prevented if treated appropriately in an ambulatory care setting. Rates of these hospitalizations tend to be slightly higher in the West Region.

### Maternal and Child Health<sup>80</sup>

- From 1996 to 2004, Chicago's infant mortality rates decreased by 8%, from 9.5 infant deaths per 1,000 live births to 8.7. Yet, in the West Region, infant mortality rates remained relatively unchanged, from 5.7 deaths per 1,000 births in 1996 to 5.4 in 2004.
- From 1996 to 2005 the rate of teen births, babies born to women who did not receive prenatal care, and low birth weight babies decreased in both Chicago and the West Region. However, the West Region rates were much higher than Chicago's for teen births (17.9 compared to 13.3) and low birthweight babies (22.8 compared to 10.2).

### Mortality<sup>81</sup>

Mortality rates decreased in Chicago, as well as the West Region from 1996 to 2005 by 18% and 14%, respectively. West Region consistently has higher mortality rates than Chicago, with 2005 rates in the West at 975 deaths per 100,000 population compared to Chicago's rate of 866.

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<sup>77</sup> Ibid.

<sup>78</sup> *Annual Hospital Questionnaire*, 2000 and 2006. Illinois Department of Public Health.

<sup>79</sup> Illinois Health Care Cost Containment Council, Uniform Data Set, 2001.

<sup>80</sup> Chicago Department of Public Health, Office of Epidemiology.

<sup>81</sup> Ibid.

## Cancer<sup>82</sup>

The age adjusted cancer rates in the West Region and in Chicago decreased between 1996 and 2005. However, as in 1996, the rates for the West Region remained higher than Chicago: 218 deaths per 100,000 population to 199, respectively. The West Region also had much higher rates for prostate cancer and colorectal cancer.

## Tuberculosis (TB)<sup>83</sup>

- From 1996 to 2007, TB cases decreased in Chicago by 62%. The West Region experienced an even larger decrease than Chicago: 68%.
- In 1996, the percentage of TB cases in the West Region represented 26% of all TB cases in Chicago and in 2007 this percentage decreased further to 22% of all Chicago cases.

## HIV/AIDS Incidence<sup>84</sup>

- From 1996 to 2006, the number of AIDS cases being diagnosed decreased in the West Region by 55%, in line with the 50% decrease in all Chicago cases. 2006 AIDS rates also decreased, but remain higher in the West, at 28 per 100,000 population compared to Chicago's rate of 25.
- From 2000 to 2006, the number of HIV cases diagnosed in the West Region decreased by 29% while the number of HIV cases in Chicago stayed the same. As a result, the current West Region HIV rate, which was 56 per 100,000 population in 2000, is very similar to Chicago's rate, at 40 and 39 per 100,000 population, respectively.

## Sexually Transmitted Diseases<sup>85</sup>

- Rates of Chlamydia increased in Chicago between 1996 and 2006 by 63%, from 499 cases per 100,000 population to 813. For the same time period, the West Region's Chlamydia rate increased at a higher rate by 104%, as rates went from 588 in 2000 to 1201 in 2006.
- From 1996 to 2006, gonorrhea rates for both Chicago and the West Region decreased by 23%. However, the West Region 2006 rates were higher than Chicago: 447 to 340, respectively.
- Unlike Chlamydia and gonorrhea, the West Region had a lower rate of cases of primary and secondary syphilis, at 4 cases per 100,000 population in 2006, down from a rate of 6 in 1999. Chicago's rate increased from 5 to 8 in this same time period.

## Lead Poisoning<sup>86</sup>

In both the West Region and Chicago, the percentages of tested children whose blood lead levels were elevated decreased by 89%. However, the percentage of children with elevated levels remains higher in the West Region, at 3.4%, compared to Chicago, at 2.7%.

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<sup>82</sup> Ibid.

<sup>83</sup> Chicago Department of Public Health, Office of Tuberculosis Control.

<sup>84</sup> Chicago Department of Public Health, Office of HIV/AIDS Surveillance.

<sup>85</sup> Chicago Department of Public Health, Office of STD/HIV/AIDS.

<sup>86</sup> Chicago Department of Public Health, Lead Prevention Program.



**OVERVIEW OF DEMOGRAPHIC, HEALTH, AND SAFETY NET SERVICES  
CHICAGO'S NORTH REGIONS  
(NORTH, NORTHWEST, NEAR NORTH)**

**Demographic Information<sup>87</sup>**

- From 1990 to 2000, the population in combined northern regions increased more than for Chicago: 10% compared to 4%. This increase was due to large population increases in the Northwest Region (14%) and the Near North region (19%), while the North Region's percentage population growth was similar to Chicago's (4%).
- The Hispanic population represented 28% of the population in the northern regions in 2000, an increase of 48% from 1990. This increase is primarily due to the Northwest Region, where number of Hispanics increased by 51%, from 27% of the population in 1990 to 41% of the population in 2000. In Chicago, Hispanics comprised 26% of all Chicagoans, an increase of 33% from 1990.
- The northern regions have a higher percentage of people who report speaking another language than English at home than for all of Chicago: 43% compared to 36% in 2000. The Northwest Region has the largest percentage of non-English speakers in the area; 47% in 1990 and 59% in 2000.
- The percentages of people living below poverty level and twice below poverty level were lower in the northern regions than in Chicago. In 2000, 13% of the northern region population and 20% of Chicago lived below poverty, and 30% of the northern region population and 40% of Chicago lived at twice below poverty level. These rates were lower than 1990 poverty levels in the North Region, Near North Region, and Chicago. In contrast, the percentage of people living below poverty and twice below poverty increased in the Northwest Region, by 1% and 6%, respectively.

**Calculation of Medically Needy<sup>88</sup>**

- Methodology: The number of medically needy is calculated from the population under age 65 years old who also have family incomes less than 200% of poverty. (It is presumed that the majority of persons over 64 years of age have some coverage through Medicare.) Subtracting from this figure the number of Chicagoans enrolled in the State's Medicaid program provides a reasonable estimate of the low-income uninsured or under-insured population. The number of persons "in care" and "out of care" was determined through CDPH's Chicago Health and Health Systems Project survey.
- In the northern regions, the general population and the medically needy population increased by 10% (between 1990 and 2000) and 1% (between 1990 and 2002), respectively. Chicago's population increased by 4%, but the medically needy population decreased 1%.
- Between 1990 and 2002, the trends of the medically needy varied widely among the regions, with an 8% decrease of medically needy in North, a 9% increase in Northwest, and a 30% increase in Near North. Northwest has the largest number of medically needy in this area.
- The percentage of medically needy that was out of care in 2002 was higher in the combined three northern regions than for Chicago: 80% compared to 64%. The Northwest region had the highest percentage of medically needy out of care, at 94%. The North region had 71% of its medically needy out of care and 29% of the medically needy living in the Near North Region were out of care.

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<sup>87</sup> US Census 2000, <http://factfinder.census.gov>.

<sup>88</sup> Salem, E. and Ferguson, R. "Casting Chicago's Safety Net: A 12-Year Review of Chicago's Community-Based Primary Care System." Chicago: Chicago Department of Public Health, Planning and Development Division, 2005.

### Safety Net Sites<sup>89</sup>

- There are 11 general hospitals in the three northern regions, eight of which are in the North region.
- These regions currently house 21 community health centers (including 1 CDPH and 1 Cook County site) and 6 school-based health centers. Two-thirds of these clinics are located in the North Region.

### Safety Net System Capacity<sup>90</sup>

- Safety net clinics (not including school-based health centers) in the three northern regions grew from 6 in 1990 to 21 in 2008, representing a 250% increase and 23% of all Chicago safety net clinics. Safety net clinics in Chicago grew by over 125% from 1990 to 2008, for a total of 93 sites.
- In 2002, 18 clinics were located in the northern regions, providing 179,000 patient visits. This represents a tripling in the number of clinics and an almost 60% increase in the number of visits and capacity in 1990.
- The majority of the visits and capacity are in the North Region; however, the Northwest Region experienced an almost 700% increase in patient visits and a 460% increase in capacity from 1990 to 2002.
- The safety net clinics in the combined northern regions and Chicago used approximately 90% of their capacity in 2002. Both the Northwest and Near North regions operated at over 100% of capacity and the North region was at 76% of capacity.

### Hospital Data<sup>91</sup>

- In 2006, the three northern regions had 11 general hospitals with 4,616 authorized beds and 3,167 peak set-up and staffed beds. This represents a 19% decrease in authorized beds and a 22% decrease in set-up and staffed beds since 2000, due to the closure of three hospitals in the North region. Chicago lost over 9% authorized beds and 14% staffed beds between 2000 and 2006.
- In 2006, the North Region was home to eight of the 11 area hospitals, or 73%, but had 57% of all area staffed beds, 53% of all area admissions, 57% of all area emergency room visits, and 60% of all area outpatient visits. In contrast, the Near North Region houses only one hospital, Northwestern Memorial Hospital, (9% of area's hospitals), but had 23% of all staffed beds, 28% of all area admissions, 21% of all area ER visits, and 25% of all outpatient visits.
- Between 2000 and 2006, the number of live births decreased at hospitals in the North, Northwest, and for all Chicago by 5%, 11%, and 5%, respectively. However, births at Northwestern Memorial Hospital, the one hospital in the Near North, increased by 43%.

### Hospitalizations and Ambulatory Care Sensitive Conditions<sup>92</sup>

- The age-adjusted rates of all hospitalizations in 2001 were lower in the North (1,380 per 10,000 population) and the Northwest (1,270) regions compared to Chicago (1,488). Many of the hospitalization rates by diagnoses were also lower in the North and Northwest Regions, including diabetes, heart disease, and asthma. (Rates are not currently available for the Near North Region.)

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<sup>89</sup> Chicago Health and Health Systems Project, 2008. Chicago Department of Public Health, Office of Policy and Planning.

<sup>90</sup> Ibid.

<sup>91</sup> *Annual Hospital Questionnaire*, 2000 and 2006. Illinois Department of Public Health.

<sup>92</sup> Illinois Health Care Cost Containment Council, Uniform Data Set, 2001.



- Hospitalizations for ambulatory care sensitive conditions (ACSCs) show hospitalizations for conditions that most likely could have been prevented if treated appropriately in an ambulatory care setting. The rates of these hospitalizations, as well as the percentages of hospitalizations due to ACSCs, are slightly lower in the North and Northwest Regions compared to Chicago. (Rates not currently available for the Near North Region.)

### Maternal and Child Health<sup>93</sup>

- The northern regions had many variations in infant mortality between 1996 and 2004. The North Region experienced a 28% decrease, to a rate of 3.6 deaths per 1,000 live births, the lowest of all Chicago. Northwest Region's rate decreased by 3% however, continues to have a much higher rate than all of Chicago: from 12.4 deaths per 100,000 in 1996 to 12.0 in 2004. In the Near North Region, the number of infant deaths increased from 4 to 8. (Rates for the Near North Region are not calculated due to the limited number of cases.) Chicago's infant mortality rates decreased by 8.4%, from 9.5 infant deaths per 1,000 live births to 8.7.
- The rates for teen births and babies born to women who did not receive prenatal care from 1996 to 2005 decreased in the northern regions and in Chicago. The northern regions continue to have lower rates than Chicago for these indicators.
- For 1996 and 2005, rates of babies born at a low birth weight (<2500 grams) show an increase in the northern regions: North by 12%, Northwest by 25%, and Near North by 6%. Northwest had the highest rate, of 16.1 per 1,000 live births. In contrast, Chicago's rate went down 4%, to 10.2 per 1,000 live births.
- Comparing the three northern regions, Northwest had the highest rates of most maternal and child health indicators, including teen births, low birthweight babies, and infant mortality.

### Mortality<sup>94</sup>

- Age-adjusted mortality rates decreased in all the three northern regions and Chicago between 1996 and 2005, although the rates of the northern regions were lower than for Chicago. For 2005, North's mortality rate was 706 per 100,000 population, Northwest's rate was 729, Near North's rate was 94, and Chicago's rate was 866.
- In 1996, North Region had the highest mortality rate of the northern regions. In 2005, however, Northwest Region had the highest mortality rate due to the 30% rate decrease in North compared to a 17% decrease in Northwest.

### Cancer<sup>95</sup>

- Age-adjusted cancer rates decreased in the northern regions and Chicago between 1996 and 2005. The rates in the northern regions continue to be lower in comparison to Chicago, especially for lung cancer and prostate cancer.
- Northwest Region had the highest total age-adjusted cancer rate (165 per 100,000 population) compared to North (151) and Near North (142), as well as the highest rates for many specific cancers, such as breast, lung, and prostate.

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<sup>93</sup> Chicago Department of Public Health, Office of Epidemiology.

<sup>94</sup> Ibid.

<sup>95</sup> Ibid.

## Tuberculosis (TB)<sup>96</sup>

- From 1996 to 2007, TB rates decreased in all three northern regions and in Chicago, by 55% and 62%, respectively. The decrease was largest in the Near North Region, where rates decreased by 67%. However, Near North continues to have the highest rate of TB (10.1 per 100,000) compared to the North (8.6), Northwest (8.0) and all of Chicago (8.9).
- The percentage of all Chicago's TB cases found in the northern regions increased during this time period, from 30% of all TB cases in 1996 to 38% in 2007.

## HIV/AIDS Incidence<sup>97</sup>

### AIDS:

- From 1996 to 2006, the number of AIDS cases being diagnosed each year decreased in the three northern regions by 57%, in line with the 50% decrease in all Chicago cases. AIDS rates also decreased by 61% and 50%, respectively.
- AIDS cases in the northern regions made up 33% of all Chicago cases in 2006. This percentage represents a decrease from 1996, when 39% of all AIDS cases lived in the northern regions.
- The North Region has the highest rate of AIDS, at 35 per 100,000 population in 2006. In comparison, Near North had a rate of 14, Northwest had a rate of 10, and Chicago's rate was 21.

### HIV:

- From 2000 to 2006, HIV cases in the northern regions decreased from 438 per 100,000 population to 417, or 5%. The northern regions currently represent 37% of all Chicago's HIV cases, primarily due to HIV cases in the North Region, which make up 76% of HIV cases in these three regions. The number of HIV cases being diagnosed each year in Chicago stayed the same.
- HIV cases in the North Region increased by 2% from 2000 to 2006, from 310 to 316, with a rate increase of 62 per 100,000 to 63. In comparison, Chicago's HIV rate stayed at 39 in both years, Near North Region's rate decreased from 44 to 38, and Northwest Region's rate fell from 15 to 11.

## Sexually Transmitted Diseases<sup>98</sup>

### Chlamydia:

- Rates of Chlamydia between 1996 and 2006 increased in the three northern regions and Chicago, both by 63%. However, the rate in the northern regions was much lower than Chicago's rates, at 270 per 100,000 population in 2006 compared to 813, respectively.
- Of the northern regions, Northwest had the highest percentage rate increase, 97%, while Near North had the highest rate of Chlamydia, at 340 in 2006.

### Gonorrhea:

- From 1996 to 2006, the rate of gonorrhea decreased by 13% in the northern regions, from 101 per 100,000 population to 88. Chicago's rate decreased by 23%, from 442 to 340.
- The Near North Region had the largest decrease (47%), but also had the highest gonorrhea rate in the northern regions (300 in 1996 and 159 in 2006). The rate in the North Region decreased by 5%, from 134 to 127. Northwest Region's rate was the lowest of all the northern regions; however, it increased by 9% between 1996 and 2006, from 41 per 100,000 population to 45.

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<sup>96</sup> Chicago Department of Public Health, Office of Tuberculosis Control.

<sup>97</sup> Chicago Department of Public Health, Office of HIV/AIDS Surveillance.

<sup>98</sup> Chicago Department of Public Health, Office of STD/HIV/AIDS.



#### *Primary and Secondary Syphilis:*

- Rates of syphilis increased by almost 300% in the northern regions between 1999 and 2006, primarily due to a 650% rate increase in the North Region, from 3.1 per 100,000 in 1999 to 22.5 in 2006. This increase was seen in the population of men who have sex with men.
- The Northwest Region and Chicago also had increases in syphilis rates, at 100% and 59%, respectively. Syphilis cases in the Near North Region, however, decreased by 50%.

#### **Lead Poisoning<sup>99</sup>**

- In 2006, 28% of the children under 6 years old in the three northern regions were tested for lead poisoning. The percentage of tested children increased from 25% in 1997, however is less than the percentage of all Chicago children being tested, which was 34% in 2006. These percentages are influenced by the available testing programs, which focus efforts in areas with old housing stock.
- The percentage of tested children whose blood lead levels were elevated decreased in both the northern regions as well as Chicago, by 87% and 89%, respectively.
- The percent of tested children with elevated blood lead levels was at 1.6% in the North Region, 1.5% in the Northwest, and 1.0% in Near North, compared to 2.7% in Chicago.

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<sup>99</sup> Chicago Department of Public Health, Lead Prevention Program.