I. Attendance/Call to Order

Chairman Batts called the meeting to order.

Present: Chairman Warren L. Batts and Directors David A. Ansell, MD, MPH; Hon. Jerry Butler; David Carvalho; Benn Greenspan, PhD, MPH, FACHE; Luis Muñoz, MD, MPH; Heather E. O'Donnell, JD, LLM and Andrea Zopp (8)

Present
Telephonically: Directors Quin R. Golden and Sister Sheila Lyne, RSM (2)

Absent: Vice Chairman Jorge Ramirez (1)

Chairman Batts stated that Directors Golden and Lyne were unable to be physically present, but would like to participate in the meeting telephonically.

Director Greenspan, seconded by Director Ansell, moved to allow Directors Golden and Lyne to participate as voting members for this meeting telephonically. THE MOTION CARRIED UNANIMOUSLY.

Director Golden indicated her presence telephonically at the start of the meeting. At approximately 9:20 A.M., Director Lyne indicated her presence telephonically.

Additional attendees and/or presenters were:

John Abendshien
Michael Ayres
Richard Boykin
Robert Cohen, MD
Patrick T. Driscoll, Jr.
Harold Emahiser
William T. Foley
Commissioner Bridget Gainer
Lucio Guerrero
Helen Haynes
Daniel Howard
Randolph Johnston
Maurice Lemon, MD
Terry Mason, MD
Elizabeth Reidy
Deborah Santana
Anthony J. Tedeschi, MD, MPH, MBA
Robert Wright

II. Public Speakers

Chairman Batts asked the Secretary to call upon the registered speakers.

The Secretary called upon the following registered public speakers:

1. George Blakemore Concerned Citizen
2. Christine Boardman President, SEIU Local 73
3. Richard David, MD Physician, John H. Stroger, Jr. Hospital of Cook County
4. Rochelle Lowe Registered Nurse, John H. Stroger, Jr. Hospital of Cook County
5. Sheila Agnew Nurse, John H. Stroger, Jr. Hospital of Cook County
6. Alma Jaromahum Registered Nurse, John H. Stroger, Jr. Hospital of Cook County
7. Carletha Hughes, MD Physician, John H. Stroger, Jr. Hospital of Cook County
8. Daisy Sewell Machine Operator, Angelica Health Service

Robert Wright and Richard Boykin, representing MedAssets Net Revenue Systems LLC, also signed up to provide public testimony; however, they chose to defer their comments until the Board discussed and considered Item VII(D) Contracts and Procurement Items.
II. Public Speakers (continued)

After public testimony was provided regarding the CareLink policy, Chairman Batts commented on the subject. He stated that the purpose of co-pays is not to raise revenue or drive away patients; rather, it is to have patients bring in their documentation to prove that they are residents of Cook County. He added that when the policy was being considered, information was provided on other health system co-pay policies; the co-pay chosen was on the low end of the scale for public safety net hospitals across the United States.

Chairman Batts stated that he and William T. Foley, Chief Executive Officer of the Cook County Health and Hospitals System, visited the Denver Health system in the previous week. Denver Health is the number one-rated public safety net hospital in the country. Chairman Batts noted that their co-pays are quite high; he believed they were in the range of $38. With regard to the System’s co-pay policy, he stated that the Board has decided to revisit the subject; however, he noted that there should be some co-pay if people are treated.

III. Report from Chairman of the Board

Update on proposed UCMC/CCHHS joint venture regarding Provident Hospital of Cook County

Chairman Batts provided an update on the proposed University of Chicago Medical Center (UCMC)/CCHHS joint venture regarding Provident Hospital of Cook County. He reviewed the activity on the subject to date. The System Board previously approved a request to jointly fund an assessment and exploration of the feasibility of a possible collaboration/academic and clinical relationship with UCMC and Provident Hospital of Cook County. The assessment was completed and was presented at the System Board Meeting in March. The Board deferred action at that time, so that additional review by both parties could take place.

Chairman Batts noted that UCMC’s consultant is still working on presenting all options available to UCMC, not only those options relating to the System; he added that a meeting has been requested to further explore options for a joint venture between UCMC and the System. He has asked Vice Chairman Ramirez and Director Carvalho to participate in these discussions.

Update on recent legislative activity regarding CCHHS

Chairman Batts noted that on June 1st, legislation created and sponsored by Commissioner Gregg Goslin to make the System Board permanent is expected to be considered by the Cook County Board’s Committee on Health and Hospitals; a resolution in support of passage of such legislation will be considered by the System Board later at this meeting.

Update on recent visits to public safety net hospitals

As referenced earlier in the meeting, Chairman Batts stated that he and Mr. Foley recently visited the Denver Health system. They are trying to visit those public safety net hospitals that have been successful in taking care of their poor, uninsured, underinsured and undocumented patients.

Denver County and the City are one and the same; they have a unified government. Chairman Batts estimated their population at approximately two and one-half to three million people. He stated that their hospital is one of the dominant hospitals in the area, and added that there are no federally qualified health centers in Denver that do not belong to them. For taking care of a volume that amounts to approximately 60% of the Cook County Health and Hospitals System’s patient volume, Denver Health charges the city $28 million per year.
III. **Report from Chairman of the Board (continued)**

Chairman Batts provided information on Denver Health’s patient population. He stated that Denver Health attracts Medicare, Medicaid and privately insured patients; forty-six percent (46%) of their patient population is self-pay. They have a health maintenance organization (HMO) for all county and hospital employees; these employees receive their care at Denver Health facilities.

Chairman Batts provided additional information on Denver Health. They have the number one trauma center in the mountain states. With regard to corporate governance, he stated that the hospitals are independent of the county government. At Denver Health, the hospital nominates the individual(s) they would like to see appointed, however the Mayor may select whomever he or she chooses.

Chairman Batts noted that there was also a visit to Parkland in Dallas, Texas, for the same purposes; he was unable to attend, however he indicated that Mr. Foley would provide an update on that visit during his report to the Board. He added that he would like to visit the public safety net hospital in Philadelphia. Additionally, although their structure is quite different from other public safety net hospital systems, he noted that he was interested in visiting and learning more about Washington, DC’s public health safety net structure.

IV. **Report from Chief Executive Officer**

*Update on recent visits to public safety net hospitals*

Mr. Foley provided information on the recent visit to Parkland. He stated that Dr. Terry Mason, System Chief Medical Officer, and Randall Mark, System Director of Intergovernmental Affairs and Policy, joined him on the Parkland site visit. He noted that Parkland is building a replacement hospital over the next few years, so in their strategic plan, much like the System, they are also looking at a regional outpatient expansion (including primary and specialty care) throughout the Dallas market.

Some issues discussed during the site visit included those relating to co-pays, executive and staff compensation philosophies, and staffing needs. With regard to co-pays, Mr. Foley noted that Parkland shared their co-pay policy during the visit; he stated that on these site visits, he noticed that having a co-pay is very consistent with other public hospitals’ policies.

Chairman Batts provided additional information relating to the visit to Denver Health. He stated that it is a teaching hospital, and is affiliated with the University of Colorado Medical School. With regard to staffing, they are currently staffed at approximately five full-time equivalent employees (FTEs) per adjusted occupied bed (AOB); their goal is to decrease that to three and one-half FTEs per AOB. Additionally, Chairman Batts stated that all clinics are staffed with permanent physicians; they assign each physician a panel of patients, and the physician builds a relationship with those patients over time.

Chairman Batts provided information on several factors that have helped Denver Health become so successful. He stated that an advisory board was created, that includes representatives from Ritz-Carlton, Toyota and other leading companies in Colorado, to provide advice on how to run the health system better. Denver Health has a stable management group; its Chief Executive Officer has been in the position for over twenty years. Additionally, their foundation is delivering approximately $15-20 million per year for healthcare.
IV. Report from Chief Executive Officer (continued)

Miscellaneous

Mr. Foley responded to comments made during the public testimony portion of the meeting which relate to quality and staffing issues. Staffing continues to be a challenge, as there are many vacant nursing positions. The System must continue efforts to recruit for these positions; he added that a recent job fair held by the System netted approximately three hundred potential nursing applicants with a diverse range of skills and experience.

Update on Public Relations activities

Lucio Guerrero, Director of Public Relations and Community Affairs, provided an update on public relations activities. He noted that next month, the System’s annual report will be completed; there has not been an annual report for the System in several years. They are also planning on convening focus groups within the next few weeks to gauge the public’s perception of the System.

Additionally, Mr. Guerrero stated that for the past month, a production crew has been filming in Stroger Hospital’s Trauma Department; they have been trailing the physicians to get a “feel” for the Department. This activity has the attention of a national cable company that is interested in doing a series based upon Stroger Hospital’s Trauma Department’s physicians. He presented a three-minute video trailer relating to this subject.

A. CCHHS 2010 System Leadership Goals

Mr. Foley presented the CCHHS 2010 System Leadership Goals (Attachment #1).

B. FY2010 System Operational Plan Update

Dr. Anthony Tedeschi, System Interim Chief Operating Officer, presented the FY2010 System Operational Plan Update (Attachment #2), and provided a brief overview.

Dr. Maurice Lemon, Chief Medical Officer of John H. Stroger, Jr. Hospital of Cook County, provided additional information on one of the operational initiatives, relating to the development and implementation of a collaborative “innovation initiative” (Attachment #3).

Dr. Robert Cohen, System Director of Pulmonary, Critical Care, and Sleep Medicine, provided information relating to core measures for pneumonia and congestive heart failure (Attachment #4). Discussion took place on the information presented. Following the presentation, Chairman Batts stated that the Board should have presentations such as this on a regular basis. Director Ansell suggested that a quarterly quality dashboard be prepared and presented for the Board’s information.

Dr. Mason added that Dr. Cohen has recently been appointed to the position of System Medical Director for all of the System’s Critical Care Units.
V. **Update from ad hoc Strategic Planning Committee**

A. Strategic plan update

Mr. Foley provided a brief overview of the plans with regard to finalizing and presenting the strategic plan. He stated that, following the April 30th retreat, there were some additional information items and clarifications needed. They have re-focused the presentation on the action items based upon the System Board’s prior discussions. He stated that the plan is to return to the System Board in June with a recommendation for action on the strategic plan. There is some additional financial information that will be shared at today’s meeting that will put the plan in the framework of major action items, so focus can be given to the key elements.

John Abendshien, of Integrated Clinical Solutions, Inc. (ICS) began the presentation (Attachment #5). He introduced Harold Emahiser, of ICS, who would be assisting him.

Director O’Donnell inquired whether there is a priority list for projects. Mr. Abendshien responded affirmatively, stating that a tentative timetable has been developed.

Director Carvalho noted that the last time the subject of location/epicenter was discussed, it was stated that Oak Forest and Provident Hospitals would serve on an interim basis as regional outpatient centers (ROCs) until the System achieved that end state, which he recalled was in the Blue Island area. He inquired whether the information presented at today’s meeting is a different marketing of that same idea, or whether it is a different idea. Mr. Abendshien responded that it is a little of both. He stated that, as the subject was further reviewed, it is believed that retrofitting a building at Oak Forest Hospital would be the best and quickest launch pad to the development of a ROC. He added that there are other options available for consideration; in the interim, it was decided that the Oak Forest Hospital option would be presented.

The discussion on the subject continued. Director Carvalho stated that his recollection from previous discussions was that a location would be found that would be the end-stage goal, while recognizing interim efforts would be required between now and then. He stated that the proposal for an interim Oak Forest Hospital ROC appears to be an end-stage action; if dollars are spent on bricks and mortar for building in an interim location, he felt that it is unlikely that a move towards end-stage goals will take place. Director Ansell stated that further review, discussion and agreement by the System Board on the concept of ROCs should take place, perhaps prior to the discussion of locations; however, he indicated that he is in favor of the idea of using existing campuses for this purpose.

Mr. Foley provided information on the subject of the development of the concept of ROCs and potential locations. He stated that they are recommending that a ROC be developed in the South; in terms of implementation, there are many options to consider. He noted that the “E” Building on the Oak Forest Hospital campus has been identified as a possible short-term solution. With regard to Provident Hospital, he noted that previous discussions have been held on the subject of developing a major outpatient presence on the campus. He added that later in the meeting the subject of a potential collaboration with the University of Chicago Medical Center (UCMC) would be addressed.
V. **Update from ad hoc Strategic Planning Committee**

A. Strategic plan update (continued)

The System Board discussed the preliminary estimates relating to an expansion of outpatient services, which indicate that under certain scenarios, the System’s outpatient services could increase to one million patient visits. Director Golden noted that prior to the budget cuts in fiscal year 2007, the System had nearly 800,000 outpatient visits; she asked if there has been any review of the correlation between fluctuation in outpatient services and its effect on inpatient admissions. She noted that this question needs further review. Mr. Abendshien responded that Denver Health might provide a good example in response to this question. He stated that they have a much higher ratio of outpatient visits to inpatient admissions; this could be as a result of patients getting into the system in a more timely way at the appropriate stage of care, which seems to lessen the need for hospitalization. Director O’Donnell commented that there are many studies that indicate that when patients are reached in the primary care setting, it lessens the need for inpatient admissions. However, she noted that this does not occur over a short period of time; she suggested that in order to avoid unintended consequences, the estimate for inpatient admissions may need to be more conservatively adjusted.

The subject of federally-qualified health centers (FQHCs) was discussed. Chairman Batts inquired whether the effects that will likely result with the increased funding for FQHCs, as a result of passage of the health care bill, have been factored into the scenarios presented; one such effect may be an increased aggressiveness by FQHCs to recruit primary care patients. Mr. Abendshien responded affirmatively, stating that they anticipate that will occur. He stated that the plan’s intent is not to necessarily expand so much in primary care; rather, it is specialty care and outpatient services in which the plan expects to expand. Director Greenspan commented that the backbone of health care reform is primary care; the System should consider carefully any proposals to reduce or eliminate primary care services, because if primary care services are reduced or eliminated, it may be challenging to resurrect those services in the future.

Mr. Foley added that in the discussions held with FQHCs, there is interest in partnering or co-managing some of the proposed outpatient sites. As they are looking at developing ROCs, if the space belongs to the System, a portion of it could be leased to an FQHC for the provision of primary care, while the System focuses on specialty care. Or, as mentioned recently in a meeting with representatives from an FQHC, it could be the reverse; the space could belong to the FQHC and the System could lease space from them and provide specialty services at that site. Mr. Foley added that the System also needs to review and consider whether it should get FQHC designation for its own clinics.

Director Ansell noted that as a result of health care reform, in order to succeed, the System will need to be the Medicaid specialty provider of choice in the County. It is his experience that it is very difficult for hospital systems to successfully run big ambulatory systems at the same time. Director O’Donnell stated that the subject of the System’s Medicaid population decline continues to be discussed in the Finance Committee; the Medicaid patient day volume has dropped significantly over the last five months. She noted that an aggressive strategy to attract this population needs to be developed.

Chairman Batts noted that the System Board needed to move on to the items requiring action, as there would soon be quorum issues. He added that a very important factor in the overall discussion relates to funding issues. He stated that the idea that the System will have the funds to keep the very high-cost operations open for a very small number of patients is not realistic.
V. Update from ad hoc Strategic Planning Committee

A. Strategic plan update (continued)

Discussion returned to the subject of the development of a ROC on the Oak Forest Hospital Campus. Director O’Donnell referenced Director Carvalho’s earlier comments regarding investing capital for a short-term facility. She noted the proposed capital outlay of $20 million for this short-term or interim option; she asked why, five years down the road, the System would abandon that short-term facility in which $20 million was invested, for a long-term goal. Chairman Batts stated that the question remains whether the System would receive the capital funding for this type of project; he noted that the System’s capital budget was reduced by $26 million this year. Director Zopp stated that her concern is that funding may not be available for this purpose in five years. Chairman Batts stated that the optimal option would be to lease space further east for this purpose.

During the discussion of capital needs, Chairman Batts inquired whether information technology needs are included in the capital costs associated with the strategic plan. Mr. Emahiser responded in the negative. Director Greenspan noted that the information technology expansion to match the patient care expansion is related to the strategic plan. Mr. Foley stated that all of this needs to be incorporated into the five-year financial plan.

Director Greenspan requested that the System Board be provided with information on the impact of capital expenditures on future operating budgets, before the plan is finalized. He noted that in the information provided, operating expenses and savings are a wash; however, capital is a cost that needs to be amortized and contemplated in terms of its impact on future operating budgets, particularly with regard to those investments, such as Fantus Clinic, that will have no net change in volume.

Mr. Foley stated that consolidation timelines with priorities and the five-year financial plan are needed to address the issues raised. He stated that the plan, recommendations, and five-year financial plan are expected to be presented to the System Board at the June 25th Meeting, and presented to the County Board for their meeting in July. Meetings have been held with various constituency groups to get their input on some of the options in the plan; these activities will continue.

B. UCMC/CCHHS Joint Consulting Project regarding Provident Hospital of Cook County

Mr. Foley provided additional information on the subject of the exploration of a possible relationship with the University of Chicago Medical Center (UCMC) and Provident. Discussions with UCMC continue; UCMC has had their consultant look at the Provident option for them, as well as some other strategic options. Mr. Foley stated that the work group consisting of Chairman Batts, Vice Chairman Ramirez and Director Carvalho would like to meet with representatives of UCMC’s Board. He stated that the strategic plan should be constructed so that this possible relationship remains an option.

VI. Board and Committee Reports

A. Minutes of the Board of Directors Meeting, April 30, 2010

Director Greenspan, seconded by Director Butler, moved the approval of the minutes of the Board of Directors Meeting of April 30, 2010. THE MOTION CARRIED UNANIMOUSLY.
VI. Board and Committee Reports (continued)

B. Minutes of the Board of Directors Special Meeting, April 30, 2010

Director Butler, seconded by Director Greenspan, moved the approval of the minutes of the Board of Directors Special Meeting of April 30, 2010. THE MOTION CARRIED UNANIMOUSLY.

C. Minutes of the Finance Committee Meeting, May 14, 2010

During the presentation of the minutes of the meeting, the Board discussed the update on the CareLink Policy. Director Carvalho noted that at the next Finance Committee Meeting, information is expected to be provided on the subject of co-pays; this will include a review of information previously presented, and will include additional information that provides detail on what is standard for public safety net hospitals on this subject. Additionally, he stated that discussion is expected on the subject of the systems that will need to be in place to implement this Policy, along with discussion of the communications plan.

Director Carvalho restated his abstention on request numbers 3 and 4 under the Contracts and Procurement Items contained within the minutes.

Director Carvalho, seconded by Director Greenspan, moved the approval of the minutes of the Finance Committee Meeting of May 14, 2010. THE MOTION CARRIED UNANIMOUSLY.

D. **Minutes of the Human Resources Committee Special Meeting, May 18, 2010

This item was deferred to the meeting of the Board of Directors scheduled for Friday, June 25, 2010.

E. **Minutes of the Quality and Patient Safety Committee Meeting, May 18, 2010

This item was deferred to the meeting of the Board of Directors scheduled for Friday, June 25, 2010.

VII. Action Items

A. Proposed Resolution urging the Cook County Board of Commissioners to amend the Ordinance establishing the Health System including an amendment to delete the sunset provision terminating the Health System and the Ordinance.

Elizabeth Reidy, System General Counsel, provided an overview of the item presented for consideration. On June 1st, Commissioner Gregg Goslin’s proposed legislation to delete the sunset provision terminating the Health System and the Ordinance is expected to be considered by the County Board, through its Health and Hospitals Committee. A resolution (Attachment #6) has been drafted for the System Board’s consideration and approval, which urges passage of the Ordinance Amendment.

Director Ansell stated that there is a correction to a date that is needed to be made to the supporting documents relating to the proposed resolution. Ms. Reidy noted the correction, and stated that the final document submitted to the members of the County’s Health and Hospitals Committee will reflect that correction.
VII. Action Items

A. Proposed Resolution (continued)

Director Ansell, seconded by Director Muñoz, moved the approval of the proposed Resolution urging the Cook County Board of Commissioners to amend the Ordinance establishing the Health System including an amendment to delete the sunset provision terminating the Health System and the Ordinance.

Director Butler clarified that the System Board’s resolution will be presented to the County Board’s Health and Hospitals Committee; he stated that the motion ought to reflect this detail. Ms. Reidy agreed, and stated that the motion should be amended to reflect this.

On the motion, as amended, to approve the proposed Resolution urging the Cook County Board’s Committee on Health and Hospitals to amend the Ordinance establishing the Health System including an amendment to delete the sunset provision terminating the Health System and the Ordinance, a voice vote was taken and THE MOTION CARRIED UNANIMOUSLY.

B. Ratify CCHHS Grade 24 position salary adjustments for the period of December 2, 2009 through May 4, 2010; and approve new CCHHS Grade 24 position salary adjustments.

Mr. Foley provided a brief summary relating to the item presented (Attachment #7). Last year, when the County Board passed the FY2010 budget, an amendment was approved that requires the departments of the County to seek County Board approval for any changes to Grade 24 positions, such as those changes relating to new hires or adjustments.

Director Ansell, seconded by Director Muñoz, moved to ratify the CCHHS Grade 24 position salary adjustments for the period of December 2, 2009 through May 4, 2010, and to approve the new CCHHS Grade 24 position salary adjustments. THE MOTION CARRIED.

Directors Butler and Carvalho voted NO.

C. Proposed Academic Affiliation Agreements - see attached (Agreements with no fiscal impact)

This item was reviewed by the Quality and Patient Safety Committee on May 18, 2010.

This item was deferred to the meeting of the Board of Directors scheduled for Friday, June 25, 2010.

D. Contracts and Procurement Items (Attachment #8)

Note: This item was considered out of order.

Seeking authority to:

i. Enter into and execute contract with PricewaterhouseCoopers, for performance improvement implementation services, including revenue cycle

ii. Terminate contract with MedAssets Net Revenue Systems LLC, for revenue cycle services (Contract No. 08-41-245)
VII. **Action Items**

D. **Contracts and Procurement Items (continued)**

Michael Ayres, System Chief Financial Officer, provided an overview of the two contractual requests presented.

In November of 2009, a request for proposals (RFP) was issued, seeking assistance to improve operational efficiencies in revenue enhancement. Responses were received; however, the benefit was not high enough and the cost was too high. Mr. Ayres noted that there was hesitancy on the part of the third parties to engage in discussions, because the RFP was limited to the operational component of the System, and did not take into consideration the revenue cycle component, which was already under contract.

The RFP was amended, and two major issues were included. One issue included was that fees had to be at-risk; the second issue was that the System reserved the right to include the revenue cycle component. Responses were received from Navigant Consulting Group, PricewaterhouseCoopers (PwC) and Quorum Health Resources (QHR). Navigant and QHR were in the lower end of the benefit range over a three year period; however, neither of these two proposers had a full 100% risk component. PwC’s proposal suggested that they would do the non-revenue cycle work and create $164 million in benefit; if the revenue cycle work was included, the total benefit created would be $313 million. With regard to payment options, PwC offered the following: a full-risk arrangement in which they would earn $1 for each $4 that was collected; or a shared risk arrangement in which they would earn $1 for each $6 that was collected.

There are four primary initiatives in the non-revenue cycle component: labor and productivity; supply chain; physician funding plan; and the Ambulatory and Community Health Network of Cook County (ACHN) operations components. Mr. Ayres noted that virtually everything done in each of these areas is impacted by the revenue cycle component; questions and conflict arose regarding how to balance two separate firms who are incentivized in two separate ways - yet they are co-dependent on their output. As a result, the discussion evolved to how the System could maximize its benefit.

Mr. Ayres summarized the proposed contract with PwC. He stated that the fees are all-inclusive; there is a cap of $50 million. There is a ratio calculation of $6 in benefit to $1 in fee that becomes the controlling element as of the end of the first year. The fee-sharing arrangement occurs in the first year, where, in order to get the 6:1 ratio, the System had to agree to a payment on a monthly basis regardless of how much is collected, with certain criteria. The criteria included the following: PwC would never be paid more, under any circumstances, than $2.5 million per month; they could not be paid more than the System collected for that month; there is a methodology that is self-correcting each month (cumulative benefit versus cumulative earnings); and they won’t get paid anything until the first $10 million of benefit is achieved. There is a commitment from PwC and acceptance from the County’s Office of Contract Compliance that they will have a 35% minority and women-owned business involvement. There is a thirty day cancellation clause; if there is a cancellation, the maximum fees for which PwC is eligible is tied to the ratio calculation of 6:1 of what was collected. He added that there is a commitment from PwC to offset the cost of the contract cancellation that will likely be necessary with MedAssets.

In each of the five initiatives, there are Statements of Work that very specifically articulate the details, such as what will happen /who will do it /how it will be measured /timeframe involved /responsibilities of the parties. Mr. Ayres noted that the Statements of Work become sort of a “mini-contract” under the master services agreement.
VII. **Action Items**

D. **Contracts and Procurement Items (continued)**

Director Muñoz inquired whether the goal at the end of the contract period is to transition these functions in-house. Mr. Ayres responded affirmatively; at the end of two years, the program is to hand-off the changes to the System staff. He added that at the conclusion of each Statement of Work, which will occur prior to two years, one of the conditions or criteria within a Statement of Work is to ensure that System staff is positioned or trained to assume that responsibility.

Director Carvalho noted that the goal is for an overall performance improvement contract. The consequence of making this an overall contract is the displacement of the existing revenue cycle vendor. He stated that the request relating to MedAssets’ contract is very clearly stated as a cancellation for convenience. Director Carvalho noted that he stated the point at the meeting of the Finance Committee, and re-stated it at this meeting, that the System is in no way casting aspersions on performance; this is not a cancellation for any other reason than convenience.

Director Golden asked how much the System has paid MedAssets to date. Mr. Ayres responded that MedAssets has been paid $12.5 million to date; they are due a bonus of $2.5 million, so at this point, total compensation will be $15 million.

Director Ansell presented several questions relating to the scope and governance of the contract with PwC. Mr. Foley stated that progress reports will be provided regularly to the Board through the Finance Committee.

With regard to the request to terminate the contract with MedAssets for convenience, Mr. Ayres provided additional information. Assuming that the Board approves the request to terminate the contract for convenience, discussions will be immediately held with MedAssets to determine next steps. He stated that there is a six-month notification period; duties and responsibilities, as well as payment for such services during that time period, are yet to be determined.

Robert Wright and Richard Boykin, representing MedAssets, addressed the Board on the matter. They spoke on behalf of MedAssets, and voiced their opposition to the proposed termination of the contract.

Director Zopp requested additional information relating to any impact and cost for the System to change vendors for revenue cycle services. Mr. Ayres stated that this is going to be the subject of discussions with MedAssets, assuming the Board moves ahead with the proposed termination of contract for convenience. He added that this will require a great deal more focus from management to make sure that disruption is minimal and transition from one vendor to the other goes smoothly. Director Zopp noted that she would like to see a quantification of costs (direct and indirect) associated with this transaction.

Director Carvalho, seconded by Director Butler, moved that the Board grant authority to the Chief Executive Officer to issue a notice of termination for convenience in his discretion, with respect to Contract No. 08-41-245, which is the contract between the Health System and MedAssets for revenue cycle; in addition, in anticipation of the issuance of this notice, Director Carvalho, seconded by Director Butler, moved to grant authority to the Chief Executive Officer to negotiate the details of services to be provided by MedAssets during the final period of services provided by MedAssets.
VII. **Action Items**

D. **Contracts and Procurement Items (continued)**

Further discussion took place on the two requests presented for consideration. Chairman Batts indicated that it is too large an issue to resolve with the time pressure of the impending loss of a quorum. He stated that he would like to table the motion regarding the revenue cycle portion of the PricewaterhouseCoopers (PwC) contract, and the termination of the MedAssets contract; furthermore, he suggested that the revenue cycle portion and contract termination be remanded to the Finance Committee, and brought back to the Board. He requested a motion on the PwC – non-revenue cycle portion of the contract.

Helen Haynes, System Associate General Counsel, provided additional information relating to Chairman Batts’ suggestion for a motion on the PwC contract. She stated that what is before the Board is the Master Contract; the revenue cycle portion is one of several components, or Statements of Work, that the System, under the Master Contract, would engage PwC. The Board could move to approve the PwC contract, and defer action relating to entering into a Statement of Work relating to revenue cycle at this time.

Director Carvalho withdrew his motions, and Director Butler withdrew his second.

Director Carvalho, seconded by Director O’Donnell, moved to approve the request to enter into and execute a contract with PricewaterhouseCoopers, and to direct the administration to defer entering into the component of that contract relating to revenue cycle activities until further action by the Board. THE MOTION CARRIED.

Director Ansell voted NO, and Directors Lyne and Golden voted PRESENT.

Chairman Batts stated that the proposed termination of the contract with MedAssets and the deferred revenue cycle component of the PricewaterhouseCoopers contract should come back to the Finance Committee for their next meeting in June.

E. **Any items listed under Sections V, VI, VII and VIII**

VIII. **Closed Session Discussion/Information Items**

A. **Minutes of the Human Resources Committee Special Meeting, May 18, 2010**

B. **Minutes of the Quality and Patient Safety Committee Meeting, May 18, 2010**

These items were deferred to the meeting of the Board of Directors scheduled for Friday, June 25, 2010.

IX. **Adjourn**

As there was no longer a quorum present, Chairman Batts declared the MEETING ADJOURNED.
Respectfully submitted,
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXXXXX
Warren L. Batts, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary
## COOK COUNTY HEALTH AND HOSPITALS SYSTEM

### FY 2010 CCHHS SYSTEM LEADERSHIP GOALS

<table>
<thead>
<tr>
<th>Goal #</th>
<th>Task</th>
<th>Staff</th>
<th>Completion Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Approve strategic plan including 5-year financial plan.</td>
<td>CEO</td>
<td>6/30/10</td>
<td>Analytic design has been completed; database determined. Progress Report scheduled for 5/27/10 Board Meeting.</td>
</tr>
<tr>
<td></td>
<td>UCMC/CCHHS joint feasibility study exploring a clinical collaboration at Provident Hospital.</td>
<td>CEO</td>
<td></td>
<td>Phase I complete. Discussion regarding go/no go decision to proceed with Phase II scheduled for 5/27/10 Board Meeting.</td>
</tr>
<tr>
<td></td>
<td>• Phase I – Situation assessment and feasibility study.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Phase II – Operational and organizational planning issues.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Complete Enterprise Resource Planning (ERP) system implementation including general ledger, payroll, materials management and human resources.</td>
<td>CFO and CIO</td>
<td>11/30/10</td>
<td>General ledger complete. Ongoing discussions with County regarding human resources, materials management and accounting.</td>
</tr>
<tr>
<td>3</td>
<td>Design and implement a management restructuring and development plan.</td>
<td>System Leadership</td>
<td>6/30/10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete management assessment.</td>
<td></td>
<td>3/31/10</td>
<td>Assessment complete.</td>
</tr>
<tr>
<td></td>
<td>Restructure system-wide management.</td>
<td></td>
<td>4/30/10</td>
<td>Restructuring in process.</td>
</tr>
<tr>
<td></td>
<td>Establish a leadership development program.</td>
<td></td>
<td>11/30/10</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Achieve the CCHHS FY10 operating budget including.</td>
<td>System Leadership</td>
<td>11/30/10</td>
<td>Developing process for implementing $106 million reductions.</td>
</tr>
<tr>
<td></td>
<td>Incorporating $80M budgeted savings and $26M reduction related to tax roll back.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Complete workforce rebalancing plan.</td>
<td>System Leadership</td>
<td>8/31/10</td>
<td>Phase I reductions have eliminated approximately 1,000 FTE positions (vacant and filled). Phase II has identified 350 positions for elimination and is in planning stages.</td>
</tr>
<tr>
<td></td>
<td>Achieve budgeted savings.</td>
<td></td>
<td>11/30/10</td>
<td></td>
</tr>
<tr>
<td>Goal #</td>
<td>Task</td>
<td>Staff</td>
<td>Completion Date</td>
<td>Status</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>-----------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>6</td>
<td>Implement system-wide quality, patient safety and risk management structure.</td>
<td>CEO, CCO, CMO, General Counsel and Director of Quality and Patient Safety.</td>
<td></td>
<td>Structure has been developed.</td>
</tr>
<tr>
<td></td>
<td>Recruit System Director of Quality &amp; Patient Safety and appropriately staff department.</td>
<td></td>
<td>6/30/10</td>
<td>Candidate has been selected.</td>
</tr>
<tr>
<td></td>
<td>Recruit System Director of Risk Management and appropriately staff department.</td>
<td></td>
<td>3/31/10</td>
<td>Melinda Malecki assumed position of Director of Risk Management on 3/15/10.</td>
</tr>
<tr>
<td></td>
<td>Complete and implement quality reorganization plan.</td>
<td></td>
<td>9/30/10</td>
<td>CMO presented plan to the Quality &amp; Patient Safety Committee on 3/16/10 and approved by Board of Directors on 3/26/10.</td>
</tr>
<tr>
<td></td>
<td>Implement complete online Physician documentation (Power Note) across the System.</td>
<td></td>
<td>11/30/10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Achieve HIMSS Level 6 for the Emergency Department across the System.</td>
<td></td>
<td>11/30/10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintain accreditation status at all member organizations.</td>
<td></td>
<td></td>
<td>Successful Stroger Hospital Joint Commission survey completed 2/26/10.</td>
</tr>
<tr>
<td></td>
<td>Achieve Best in Class Performance in SCIP, CHF, CAP and AMI.</td>
<td></td>
<td>11/30/10</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Develop and implement a service excellence plan with focus on: employee satisfaction, patient satisfaction and cultural diversity.</td>
<td>System Leadership</td>
<td>11/30/10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recruit System Director of Diversity &amp; Multi-Cultural Affairs.</td>
<td></td>
<td></td>
<td>Candidate has been selected.</td>
</tr>
<tr>
<td></td>
<td>Measurable improvement in system-wide Press-Gainey patient satisfaction survey scores.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conduct baseline employee satisfaction survey.</td>
<td></td>
<td>11/30/10</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Develop and implement comprehensive Internal Audit and Corporate Compliance functions within CCHHS.</td>
<td>Director of Internal Audit and Director of Corporate Compliance</td>
<td>6/30/10</td>
<td>Organizational plans approved by Audit and Compliance Committee.</td>
</tr>
<tr>
<td>9</td>
<td>Complete assessment of Graduate Medical Education (GME) Program.</td>
<td>CEO, CFO, CMO, Stroger Hospital CMO</td>
<td>11/30/10</td>
<td>GME Program cost/benefit analysis included in Performance Improvement RFP.</td>
</tr>
</tbody>
</table>
ATTACHMENT #2
The color in the far right column denotes the progress of the operational initiative.

**Significant Issue (SI) Red = 1%**

**Outstanding Issue/On Track (OI/OT) Yellow = 89%**

**Complete (C) Green = 10%**

The color in the far left column denotes the category of the operational initiative as defined below.

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Financial Performance</th>
<th>Efficiency</th>
<th>Quality</th>
<th>Service &amp; Satisfaction</th>
<th>Workforce Excellence</th>
<th>Market Share</th>
<th>Physician Partnership</th>
<th>Strategic Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ops Number</td>
<td>Description</td>
<td>Assignee</td>
<td>Co-Assignee</td>
<td>Due Date</td>
<td>Revised Due Date</td>
<td>Comments</td>
<td>Status</td>
<td></td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td>7 (Stroger)</td>
<td>Develop and implement a collaborative “Innovation Initiative” that achieves: hospital wide learning around innovation strategies successfully improves a system or process impacting patient care provides a forum for spreading learning</td>
<td>Stroger CMO</td>
<td>Stroger COO and Stroger CNO</td>
<td>9/30/2010</td>
<td></td>
<td>Initiative plan is in progress and is being implemented</td>
<td>OI/OT</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Develop and implement a comprehensive Internal Audit function within CCHHS</td>
<td>Director of Internal Audit</td>
<td>Audit Committee of Board</td>
<td>6/30/2010</td>
<td></td>
<td>Audit department is functioning and has a comprehensive plan</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Develop and implement a comprehensive Corporate Compliance function within CCHHS</td>
<td>Chief Compliance Officer</td>
<td>Compliance Committee of Board</td>
<td>6/30/2010</td>
<td></td>
<td>Director has presented an overview of process to build and implement function.</td>
<td>C</td>
<td></td>
</tr>
</tbody>
</table>
| 44         | Achieve and maintain “best-in-class” performance in CHF care as measured by the Core Measures at all CCHHS sites                                                                                                                                                                                                                          | System Chair Critical Care System Chair Cardiology | System CMO and System CCO | 11/30/2010 |                 | CHF Core Measures: February 2010 Data  
Discharge Instructions for Heart Failure – 88%  
Measure LV Function – 100%  
ACEI or ARB for LV systolic dysfunction – 91%  
Adult Smoking Cessation – 100%                                                                                             | OI/OT  |
<table>
<thead>
<tr>
<th>Ops Number</th>
<th>Description</th>
<th>Assignee</th>
<th>Co-Assigne</th>
<th>Due Date</th>
<th>Revised Due Date</th>
<th>Comments</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>Achieve and maintain “best-in-class” performance in Pneumonia care as measured by the Core Measures at all CCHHS sites</td>
<td>System Chairs of Critical Care &amp; Pulmonary Care</td>
<td>System CMO and System CCO</td>
<td>11/30/2010</td>
<td>7 Core Measures</td>
<td>Oxygenation – we are at 100% compliance – all patients get at least Oximetry performed and this is done throughout the hospital admission</td>
<td>OI/OT</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Pneumococcal Vaccination – 33% The numbers for Stroger are low – will gather data for all 3</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Timeliness of blood cultures – We are 100% on transfers, and 75% on ED admits</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adult Smoking Cessation Advice 100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Antibiotic Timing – 58% within 6 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Antibiotic Selection – There is controversy over this as we have different antibiograms based on our organisms compared to TJC reccs. Ranges from 63 to 100% depending on category</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Influenza Vaccination: Numbers are low</td>
<td></td>
</tr>
</tbody>
</table>
ATTACHMENT #3
CCHHS Operational Initiative # 7

*Develop and implement a collaborative “innovation initiative” that achieves hospital wide learning around innovation strategies, successfully improves a system or process impacting patient care and provides a forum for spreading learning.*

**Goals:**
- Transform Stroger Hospital care to be more patient-centered
- Involve greater employee participation in improvements in care delivery

**Methodology:**
- Create multidisciplinary groups of employees at front lines of patient care that work to improve efficiency and focus of patient care.
- Groups will develop, track and review Performance Improvement initiatives using the PDSA methods helped by facilitators from our institution.
- Long term strategy developed from the Dartmouth Microsystem Improvement Curriculum (DMIC) group and Institute for Healthcare Improvement (IHI) – both of whom are assisting in this effort.
- Areas selected for initial improvement efforts are (1) Labor and Delivery and (2) Inpatient Pediatrics – aligned with CCHHS Strategic plan drafts and considers need for urgent improvements in patient care experience.

**Steps to date/plan:**
- Began in winter 2009-10 with hospital participation in an eight week IHI “expedition” on improving patient centered care and Press Ganey scores. This effort involved the participation of physicians, nurses, pharmacists, social workers, administrators from Maternal and Child health areas, both inpatient and outpatient. The effort sparked discussion about improving care by reviewing initiatives presented by other institutions.
- Met with and gained support of institutional and departmental leadership. A consultant worked with us to create an administrative structure and implementation plan.
- Worked with DMIC leaders directly to develop implementation plan – the effort starts with small groups in patient care areas and builds over time to broader hospital participation.
- Selected four well-regarded internal leaders to train to serve as facilitators for improvement efforts.
- Met with interested physicians, nurses and others from Ob-Gyn and Pediatrics areas to get feedback and encourage interest in participating in improvement groups.
• With the help of a former IHI Governing Board member, arranged for the four coaches to participate/observe a current DMIC training program with VA outpatient clinics in New England.
• Forming frontline improvement groups from Labor and Delivery and Pediatric inpatient wards to begin meeting next month. Two facilitators will be assigned to each improvement group.
• Plan to enroll coaches in scheduled DMIC facilitator course in fall 2010, with additional on-site facilitation to be provided by DMIC faculty.
• Plan will be to expand to other hospital areas in 2011, including critical care units and other areas.
• Developing a plan to link this effort to and integrate with other patient-centered care initiatives being developed in institution/system.

Critical concerns:

• Little past experience at Stroger with PI methods (such as six sigma, etc...).
• Few past efforts to establish multidisciplinary working groups within the hospital.
• Improvements in patient care delivery should parallel improvements in employee satisfaction.
• Difficulties in data collection and analysis in order to assess current state and progress to goals.
• Need for a realistic time table that steadily builds on early successes and ultimately reaches all staff.
• Must obtain continuing leadership support, both moral and financial.
• Ensure this program is echoing and amplifying other efforts to improve the patient experience.

5/27/10
ATTACHMENT #4
Core Measures for Pneumonia and CHF

Robert Cohen, M.D.
System Director Pulmonary, Critical Care, and Sleep Medicine

CORE Measures – TJC and CMS

- Core Measures for Hospitals Developed by TJC in 2001
- Pneumonia, AMI, Pregnancy, Heart Failure
- TJC and CMS Joined together in 2003
- Completely aligned in 2004
- Works with ATS, IDSA, ASEP, and CDC for pneumonia guidelines
- Last updated 4/2008

CORE Measures – Pneumonia

- Initial set were 5 CORE Measures (2001)
  - Oxygenation assessment
  - Pneumococcal Vaccination
  - Blood Cultures
  - Smoking Cessation
  - Antibiotic timing
- Added 2 more in 2004
  - Antibiotic Selection and Influenza Vaccination
Working Group Pneumonia

- Mary Wisniewski – Quality Stroger
- David Schwartz – ID Stroger
- Lesley Charles – ID Provident
- Homer Abiad – ID OFH
- Helen Straus – ED Stroger
- Lula Roberson – Quality Provident
- Subir Sinharoy – Internal Medicine Provident

Pneumonia Outcomes Data

- Oxygenation
  - 100% compliance – all patients get Oximetry performed at the time of hospital admission
- Pneumococcal Vaccination
  - 33% The numbers for Stroger are low
- Data being gathered from OFH and PHCC
- Timeliness of blood cultures (within 24 hours)
  - SHCC - 100% on transfers, and 75% on ED admits

Pneumonia Outcomes Data

- Adult Smoking Cessation Advice 100%
  - Smoke Free Lung Health – Lung Health Educators
  - Discharge Summary
- Antibiotic Timing (First dose within 6 hours)
  - SHCC - 58% within 6 hours
  - Gathering data from PHCC and OFH
Pneumonia Outcomes Data

- Antibiotic Selection – There is controversy over this as we have different antibiograms based on our organisms compared to TJC reccs.
  - ICU vs. non-ICU pt. – TJC
  - No distinction - CMS
  - Ranges from 63% to 100% depending on category
- Influenza Vaccination: Numbers are low – plans to enhance this with automatic triggers in electronic medical record.

Working Group CHF

- Mary Wisniewski – Quality Stroger
- Russ Kelly – Cardiology Stroger
- Lesley Charles – ID Provident (Also Quality and Outcomes Point Person)
- Lorraine Bangayan – Cardiology OFH
- Janice Benson – Family Medicine Provident Hospital

Outcome Measures for CHF

- Discharge Instructions for Heart Failure – 88%
  - Incorporated into Discharge Summaries
  - Quality of teaching not monitored
- Measure LV Systolic Function
  - This has been measured at 100%
  - Patients all get ECHO before discharge
- ACEI or ARB for LV systolic dysfunction – 91%
- Adult Smoking Cessation – 100%
ATTACHMENT #5
VISION 2015:
An Overview of Strategic Direction
Board Progress Meeting

May 27, 2010
Key Questions

- WHY are changes to the Cook County Health and Hospitals System necessary?

- WHAT will the System look like?

- HOW will we get there?
Key Questions

- WHY are changes to the Cook County Health and Hospitals System necessary?

- WHAT will the System look like?

- HOW will we get there?
Key Issue #1: THERE ARE SIGNIFICANT UNMET HEALTH CARE NEEDS IN COOK COUNTY.

- Cook County has a low overall health status ranking based on composite health indicators.

- Key areas of the County—e.g. South Cook—have especially poor health indicators.

### Health Outcomes Snapshot: Cook County

<table>
<thead>
<tr>
<th>Health Outcomes</th>
<th>Cook County</th>
<th>Target Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premature death</td>
<td>7,701</td>
<td>5,694</td>
</tr>
<tr>
<td>Morbidity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor or fair health</td>
<td>18%</td>
<td>9%</td>
</tr>
<tr>
<td>Poor physical health days</td>
<td>3.3</td>
<td>2.4</td>
</tr>
<tr>
<td>Poor mental health days</td>
<td>3.2</td>
<td>2.0</td>
</tr>
<tr>
<td>Low birthweight</td>
<td>9%</td>
<td>6%</td>
</tr>
</tbody>
</table>

* Reflects 90th percentile
Source: www.countyhealthrankings.org
Key Issue #2: SYSTEM ACCESS POINTS NEED TO BE BETTER ALIGNED GEOGRAPHICALLY WITH VULNERABLE PATIENT POPULATIONS.

- There has been a significant geographic redistribution of the vulnerable population to South/South Cook, Downtown/West, and North Cook regions.

- The community areas with the lowest health rankings have the least health resource coverage.

FQHC/CHC Locations and Median Household Income (2007) by ZIP Code

Sources: CCHHS; Illinois Primary Health Care Association; Microsoft MapPoint data
Key Issue #3: CCHHS RESOURCES ARE MOVING TOWARD EXPANDED OUTPATIENT CARE, BUT ARE STILL SOMEWHAT ORIENTED TO MORE COSTLY INPATIENT SERVICES.

- Compared with other major public health systems, CCHHS is highly focused on the provision of acute inpatient services.

- Evolving healthcare models are placing increased emphasis on primary care/prevention and comprehensive case management/care coordination.

![Graph of Ratio of OP Visits to IP Discharges, 2008](image)

Source: National Association of Public Hospitals

* Includes 600,000 visits paid by LACDHS to private community clinics for uninsured low-income patients.
Key Issue #4: OUTPATIENT SERVICES NEED TO BE GREATLY EXPANDED TO DEAL WITH THE BACKLOG FOR MANY BASIC PROCEDURAL SERVICES.

- There is a significant backlog of patients, particularly for outpatient procedural services.
- Having ready access to needed outpatient services can reduce complications and the need for more cost-intensive care in other settings.

IRIS Referrals Greater Than 21 Days Old, Specialties and Associated Clinics, Feb. 2010

Source: IRIS, CCHHS
Key Issue #5: CCHHS’ CURRENT STRUCTURE IS NOT SUSTAINABLE.

- CCHHS has a high cost per inpatient day.

Calculated IP Cost per Patient Day, 2007

Operating losses are projected to increase substantially over the 5-year forecast period.

Forecasted Pro Forma– Status Quo*

Source: CCHHS; ICS Analysis

NOTE: *Does not factor in potential impact of performance improvement initiatives.
Health reform...how will it impact CCHHS?

<table>
<thead>
<tr>
<th>Market Impacts</th>
<th>CCHHS Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Fewer un-/underinsured</td>
<td>✓ Substantial #'s remain uncovered</td>
</tr>
<tr>
<td>✓ Medicaid expansion</td>
<td>✓ DSH cuts + state freezes</td>
</tr>
<tr>
<td>✓ More healthcare $$</td>
<td>✓ Declining special payments &amp; subsidy revenues</td>
</tr>
<tr>
<td>✓ Increased demand for healthcare</td>
<td>✓ Growing volumes, esp. OP care</td>
</tr>
<tr>
<td>✓ More “choice-enabled” patients</td>
<td>✓ Higher consumer expectations</td>
</tr>
</tbody>
</table>
The future-state evolution of health care will place increased emphasis on the full spectrum of care…

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

- WHY are changes to the Cook County Health and Hospitals System necessary?

- WHAT will the System look like?

- HOW will we get there?
### Core Goals

#### I. Access to Healthcare Services
- Eliminate System access barriers at all delivery sites.
- Designate and develop strategically-located sites for development of comprehensive outpatient services.
- Evaluate optimal long-term development of Provident, Oak Forest, and ACHN sites.

#### II. Quality, Service Excellence & Cultural Competence
- Develop an integrated, System-wide approach and supportive infrastructure for patient-centered care coordination.
- Implement a program of continuous process improvement: patient care quality, safety, and outcomes.
- Develop a comprehensive program to instill cultural competency.

#### III. Service Line Strength
- Develop/strengthen clinical service lines in key disciplines based on patient population needs.
- Pursue mutually beneficial partnerships with community providers.
- Assure the provision of the Ten Essentials of Public Health.

#### IV. Staff Development
- Implement a full range of initiatives to improve caregiver/employee satisfaction.
- Focus on effective recruiting and retention processes.
- Develop a robust program for in-service education and professional skill building.

#### V. Leadership & Stewardship
- Foster leadership development and succession planning.
- Develop long-term financial plans and sustaining funding.
- Hold Board and management leadership accountable to agreed-upon performance targets.

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### Mission

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

### Vision 2015

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

1) Deliver the *best possible health care* for the vulnerable population of Cook County within the constraints of dollar resources available to the System.

2) Provide healthcare that is *population-centered vs. hospital-centered*.

3) Ensure that services are *accessible*.

4) Provide health services that are focused on the needs of the vulnerable population, with a *major emphasis on the provision of specialty care* and extension of primary care through partnerships with other healthcare providers.
Guiding Principles for System Development

5) Make CCHHS the System of choice for patient populations, with best practices and high patient/caregiver satisfaction on a System-wide basis.

6) Provide cost-effective care.

7) Strengthen role as leading-edge institution in clinical services, education, and research.

8) Develop and support caregiver training and leadership development at all levels of the organization.
## System Design—Old vs. New

<table>
<thead>
<tr>
<th><strong>Current State</strong></th>
<th><strong>Future State</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOSPITAL-CENTERED MODEL</strong></td>
<td><strong>POPULATION-CENTERED MODEL</strong></td>
</tr>
<tr>
<td>Resources are focused largely on inpatient care services.</td>
<td>Resources are reallocated to emphasize broad spectrum of health care delivery.</td>
</tr>
<tr>
<td>Existing hospital campuses are principal delivery sites.</td>
<td>Resources are located in geographic settings accessible to population segments having the greatest needs.</td>
</tr>
</tbody>
</table>
System Design Overview

System-Wide Care Accountability

- Primary Care
- Specialty Care
- Emergency Care
- Inpatient Care
- Rehab/LTC

Partnerships:
- FQHC’s
- Medical Education
- Public Health
- Other Health Systems
Primary Care:
- Maintain ACHN clinics as local Primary Care Centers (PCC’S) in selected community areas: Austin, Englewood, Logan Square, Near South, Vista, Woodlawn.
- Evaluate consolidation of low-volume clinics.
- Develop partnerships with FQHC’s for overall extension of primary care coverage and for possible clinic staffing and operations at selected sites.
Comprehensive Community Health Centers (CCHC’s):

- Develop CCHC’s as expanded outpatient clinic models to include primary care, rotating specialists, and basic diagnostic & treatment services.
- Target CCHC development for West (Cicero), Northwest (new site, circa Arlington Heights/Des Plaines), and South (Cottage Grove).
Regional Outpatient Centers:
- Develop Regional Outpatient Centers (ROC’s) with comprehensive primary and specialty outpatient services, urgent care, and ancillary services.
- Redevelop Fantus as ROC serving Downtown/West/North communities.
- Redevelop Oak Forest Hospital as ROC serving S. Cook market, with evaluation of best-case options re: development on current campus vs. new site located east of existing campus.
- Expand Provident Hospital outpatient services to become ROC serving S. Side market.
Proposed CCHHS Outpatient Locations

- ACHN Sites
- CCHC’s
- ROC’s

Map Showing CCHHS OP Origin, 2008
**Acute Care:**

- Continue and strengthen role of John H. Stroger, Jr. Hospital as acute care/tertiary hub of System; develop key service lines.
- Restructure Provident Hospital with expanded outpatient services as ROC and with retention of urgent/emergency care and focused inpatient support; discontinue OB services; continue to explore collaboration with UCMC.
- Redevelop Oak Forest Hospital as ROC; discontinue inpatient care operations, including acute care and rehab/long-term care.
Rehabilitation/Aftercare:

- Develop defined service agreements with one or more community providers for the provision of rehabilitation and long-term care services.
- Fully implement care pathways and discharge planning protocols at JHSJH, with the goal of reducing length of stay and improving utilization of available bed capacity.

Partnerships:
- FQHC’s
- Medical Education
- Public Health
- Other Health Systems
VISION 2015: “What CCHHS will Look Like”

- ACHN Clinics as Primary Care Centers:
- Partnerships with FQHC’s, CHC’s, and other agencies

Primary Care Office

Comprehensive Community Health Center
- Primary Care/Urgent Care
- Rotating Specialists
- Basic Diagnostic & Treatment Services

Regional OP Center
- Primary Care
- Multi-specialty Care
- Urgent Care
- OP Surgery (Fantus & Provident)
- Imaging
- Pharmacy
- Public Health
- Behavioral Health
- Oral Health
- Heath Educ./Community Rooms

Acute Care
- JHSJH ongoing role as emergency/trauma/acute inpatient care hub
- JHSJH strengthened through development of key service lines
- Ongoing performance, quality improvements

Rehab & Aftercare
- Post-acute care provided through partnerships with other provider organizations
THROUGH THE REALLOCATION OF INPATIENT RESOURCES TO OUTPATIENT SETTINGS, THE SYSTEM CAN MEET MORE OF THE NEEDS OF THE VULNERABLE POPULATION.

- There is a significant opportunity to increase the overall service value of the System by reallocating dollars from currently being spent on inefficient hospital operations.

- Through reallocation, primary care and specialty care outpatient volume can be increased by 65+% over current levels.

- Patients can receive more timely care in a geographically accessible setting.

Trended and Forecasted Primary Care and Specialty Visits, CCHHS

Source: CCHHS, ICS Analysis
Key Questions

- WHY are changes to the Cook County Health and Hospitals System necessary?

- WHAT will the System look like?

- HOW will we get there?
Major System Action Items

- Rebuild Fantus Clinic as a Regional Outpatient Center.
- Redevelop Oak Forest Hospital as a Regional Outpatient Center.
- Restructure Provident Hospital as a focused inpatient facility and Regional Outpatient Center.
- Strengthen John H. Stroger, Jr. Hospital’s clinical services and operations.
- Fully develop the primary care/CCHC network.
- Implement System-wide performance improvement initiatives.
I. Rebuild Fantus Clinic as a Regional Outpatient Center

**Impact**

<table>
<thead>
<tr>
<th>Clinic Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
</tr>
<tr>
<td>2015</td>
</tr>
</tbody>
</table>

**Description**

Replace existing facilities: new construction + expanded parking.

**Proposed Changes – Service & Staffing**

- Addition of OP surgical capability (4 rooms) and 2 procedure rooms to existing service complement
- Maintain existing primary care and specialty complement
- Relocate OB/Peds to distributed clinics

**Implementation**

- Program design
- Site evaluation
- Budget evaluation/schedule/approvals
- Regulatory approval

- Detailed planning and design
- Begin construction

- Complete Construction
- Transition services to new building

**Capital Requirements**

$90 million for 180,000 square foot building

**2010-11**

- 2012-13
- 2014-16

**Clinic Visits**

![Bar Chart showing Clinic Visits](chart.png)
II. Redevelop Oak Forest Hospital as a Regional Outpatient Center

**Description**
- Discontinue all inpatient services—acute care & rehab./LTC; develop service and transfer agreements for patients requiring hospital admission or rehab/LTC.
- Identify best-case site options for short- and longer-term development of ROC: Oak Forest campus; new “greenfield” site; co-location with existing S. Cook health care provider.
- Urgent Care (~13 MD FTEs)
- Advanced Imaging
- Pharmacy
- Heath Educ./ Community Rooms

**Proposed Changes – Service & Staffing**
- Consolidate services in “E” bldg.
- Primary Care/ Prevention/ Screening Services (~7 MD FTEs)
- Multi-specialty Care (~18 MD FTEs)
- ROC renovation/ construction Staffing
- ROC renovation/ construction Regulatory approvals—IP closure
- Open new ROC
- Continue to evaluate long-term options re: location

**Impact**
- Clinic Visit Growth
  - 2009: [chart showing initial visit numbers]
  - 2015: [chart showing significant increase, marked with +80,000]

**Capital Requirements**
- $19 million for retrofit of 55,000 square feet

*ICS Consulting, Inc.*
**Action Items**

**III. Restructure Provident Hospital as a focused inpatient facility + ROC**

**Impact**

<table>
<thead>
<tr>
<th>Clinic Visit Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
</tr>
<tr>
<td>![Bar Chart]</td>
</tr>
</tbody>
</table>

**Capital Requirements**

$12 million for retrofit of 60,000 square feet

**Description**

- Expand outpatient services
- Retain emergency services + short-stay (low acuity) beds; discontinue OB, ICU, and general M/S inpatient services
- Utilize JHSJH for OB inpatient services + M/S transfers
- Continue to explore collaborative options with UCMC

**Proposed Changes – Service & Staffing**

- Full service ED
- Short-stay unit (36 beds + overflow unit)
- Primary Care/ Prevention/ Screening Services (~8 MD FTEs)
- Multi-specialty Care (~23 MD FTEs)
- OP Surgery
- Advanced Imaging
- Pharmacy
- Heath Educ./ Community Rooms
- OP Surgery
- Advanced Imaging
- Pharmacy
- Heath Educ./ Community Rooms
- OP Surgery
- Advanced Imaging
- Pharmacy
- Heath Educ./ Community Rooms

**Implementation**

<table>
<thead>
<tr>
<th>2010-11</th>
<th>2012-13</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing UCMC discussions</td>
<td>ROC renovation/construction</td>
<td></td>
</tr>
<tr>
<td>Plan &amp; Implement.: ED/ Short-stay; IP Transfers</td>
<td>Staffing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ROC opening</td>
<td></td>
</tr>
</tbody>
</table>
**Action Items**

### IV. Strengthen John H. Stroger, Jr. Hospital clinical and operating profile

<table>
<thead>
<tr>
<th>Impact</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Projected Growth** | • Strengthen clinical service lines overall  
• Strengthen/expand Women + Child Health; increase IP/OP volumes  
• Continue performance improvement, quality, and service excellence initiatives |

| Capital Requirements | Investment in key service lines, capital equipment upgrades, and performance improvement initiatives |

<table>
<thead>
<tr>
<th>Proposed Changes – Service &amp; Staffing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased IP bed utilization through facility and operational initiatives</td>
<td></td>
</tr>
<tr>
<td>• Expanded OR access</td>
<td></td>
</tr>
<tr>
<td>• Capital equipment upgrades</td>
<td></td>
</tr>
<tr>
<td>• Service/quality improvements and multicultural initiatives</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implementation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-11</td>
<td>2012-13</td>
</tr>
<tr>
<td>• IP capacity optimization</td>
<td></td>
</tr>
<tr>
<td>• On-going service line planning</td>
<td></td>
</tr>
<tr>
<td>• Capital equipment upgrades</td>
<td></td>
</tr>
<tr>
<td>• On-going performance improvement</td>
<td></td>
</tr>
</tbody>
</table>
Action Items

V. Fully develop primary care services and Comprehensive Community Health Centers

**Impact**

<table>
<thead>
<tr>
<th>Clinic Visit Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
</tr>
<tr>
<td>+74,000</td>
</tr>
</tbody>
</table>

**Capital Requirements**

- **$9 million** for investment in 6 primary care locations to update clinic facilities and expand services
- **$13 million** for expansion/remodel of two existing CCHC locations and development of new NW facility

**Description**

- Increase efficiency/volumes through <'s in staffing/support
- Evaluate consolidation of low-volume clinics
- Define partnerships with FQHC's/CHC’s
- Develop targeted sites: Northwest, West, and South CCHC's

**Proposed Changes – Service & Staffing**

- Increased support staff to provider ratio from 2.8 to ~4.0
- Expanded primary care (~8 MD FTEs) and specialty care (~17 MD FTEs)
- New Northwest CCHC location
- Service/quality improvements and multicultural initiatives

**Implementation**

- CCHC site selection
- Detailed planning & design
- Evaluation of clinic consolidation
- Partnerships with FQHCs
- Support staffing increases

- Facility expansion/construction
- On-going performance improvement

2010-11 2012-13 2014-15

**2010-11**

- Facility expansion/construction
- On-going performance improvement

ICS Consulting, Inc.
VI. Implement System-wide performance improvement initiatives

<table>
<thead>
<tr>
<th>Impact</th>
<th>Description</th>
</tr>
</thead>
</table>
| Performance Improvement | • Aggressively pursue System-wide operations improvement + quality, service, and cultural competence initiatives.  
                               • Formalize and pursue staff + leadership development initiatives |
|                         | Proposed Changes – Service & Staffing                            |
|                         | • Service/quality improvements and multicultural initiatives       |
|                         | • See Goal IV                                                     |
| Capital Requirements    | Implementation                                                    |
|                         | • Implement service line initiatives                              |
|                         | • Performance improvement initiatives                              |
|                         | • Service excellence/cultural competency initiatives              |
|                         | • Staff training and development                                  |

- System-wide caregiver/patient satisfaction improvement
- Top quartile ranking

See Goal IV for detail
<table>
<thead>
<tr>
<th>STRATEGIC INITIATIVE</th>
<th>Cash Source</th>
<th>Cash Use</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restructure Oak Forest Hospital Clinical Services</td>
<td>$55M</td>
<td>$(13M)</td>
<td>Discontinue inpatient care—both acute and rehabilitation care—and ER services; significantly expand outpatient services (see below).</td>
</tr>
<tr>
<td>Expand OFH Outpatient Services; develop as Regional Outpatient Center</td>
<td></td>
<td>$(13M)</td>
<td>Consolidate OP services in renovated or new facility on OFH campus; significantly expand scope of specialty services and ancillary support; grow services from 25K to ~105K annual visit volume.</td>
</tr>
<tr>
<td>Make Provisions for Displaced OFH Acute Care Inpatient Volume</td>
<td>$(5M)</td>
<td></td>
<td>Reserve funds to reimburse community hospitals for displaced uninsured inpatient cases. (Long-term need for funding will be reduced by impact of HC reform.)</td>
</tr>
<tr>
<td>Make Provisions for Displaced OFH Rehabilitation Inpatient Volume</td>
<td>$(4M)</td>
<td></td>
<td>Through agreement, relocate rehabilitation inpatients to an outside healthcare system; reserve funds for the provision of such services. (Assume ADC of 20 or less.)</td>
</tr>
<tr>
<td>Restructure Provident Hospital Clinical Services</td>
<td>$17M</td>
<td>$(14M)</td>
<td>Discontinue inpatient OB/maternal health and ICU, resize IP unit to short stay beds/general acute of 36 beds plus overflow unit.</td>
</tr>
<tr>
<td>Expand Provident Hospital Outpatient Services; develop as Regional Outpatient Center</td>
<td></td>
<td>$(14M)</td>
<td>Consolidate OP services in new or renovated facility; significantly expand scope of specialty services; grow OP from 35K annual visits to 150K visits, grow OP surgeries from 1,650 to 4,000 cases annually.</td>
</tr>
<tr>
<td>Develop CCHC’s: Cicero/Jorge Prieto, Cottage Grove, NW market (new)</td>
<td>$(9M)</td>
<td></td>
<td>Expand/build to include primary care, specialty care, pharmacy and basic imaging. Budget to include expansion of bi-lingual staff/patient advocacy skills. New clinic in northwest market.</td>
</tr>
<tr>
<td>Support Expansion of Primary Care</td>
<td>$(4M)</td>
<td></td>
<td>Invest in support staff to improve productivity and patient care.</td>
</tr>
<tr>
<td>Enhance service lines, ancillary services at John H. Stroger, Jr. Hospital</td>
<td>$(23M)</td>
<td></td>
<td>Make investment in key service lines. In addition, provide for upgraded capital equipment, service/quality improvements, and multicultural initiatives.</td>
</tr>
</tbody>
</table>

**TOTAL** | **$72M** | **$(72M)** |
## Capital Requirements—Strategic Direction

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>ESTIMATED COSTS</th>
<th>SQUARE FOOTAGE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROC – Oak Forest Hospital Campus</td>
<td>$19M</td>
<td>55,000</td>
<td>Assumes $250 per square foot to retrofit existing building (e.g., Building E) into clinic space, $5M estimated for new equipment.</td>
</tr>
<tr>
<td>ROC – Replacement Fantus Facility</td>
<td>$90M</td>
<td>180,000</td>
<td>Assumes $500 per square foot, based on current footprint and square footage.</td>
</tr>
<tr>
<td>ROC – Provident Hospital Campus</td>
<td>$12M</td>
<td>60,000</td>
<td>Assumes $200 per square foot to retrofit hospital floor into clinic space.</td>
</tr>
<tr>
<td>CCHC – Cicero/Jorge Prieto/Cottage Grove + New Northwest site</td>
<td>$13M</td>
<td>17,000</td>
<td>Assumes a $3M investment in each of the two existing CCHC locations to update clinic, expand services and space; assumes new clinic (northwest site) is 17K feet at $400 per square foot.</td>
</tr>
<tr>
<td>Primary Care Expansion</td>
<td>$9M</td>
<td>N/A</td>
<td>Assumes a $1.5M investment in each of the six primary care locations to update clinic, expand services and space.</td>
</tr>
<tr>
<td>Capital Avoidance: Oak Forest &amp; Provident Hospitals</td>
<td>?</td>
<td>?</td>
<td>Assumes that future capital requirements at both facilities will be substantially less if inpatient facilities are eliminated or downsized.</td>
</tr>
<tr>
<td><strong>TOTAL, ROUNDED</strong></td>
<td><strong>$143M</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Operating Impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2011</td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>Oak Forest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discontinue inpatient, ED</td>
<td>$24.5</td>
<td>$50.6</td>
<td>$52.1</td>
</tr>
<tr>
<td>Lease 24 med/surg beds</td>
<td>(13.5)</td>
<td>(13.9)</td>
<td>(14.4)</td>
</tr>
<tr>
<td>Expand ambulatory services</td>
<td>(4.0)</td>
<td>(7.5)</td>
<td>(11.5)</td>
</tr>
<tr>
<td>Relocate Rehab Unit</td>
<td>(3.7)</td>
<td>(3.8)</td>
<td>(4.0)</td>
</tr>
<tr>
<td>Provident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discontinue inpatient OB and ICU</td>
<td>7.7</td>
<td>15.9</td>
<td>16.4</td>
</tr>
<tr>
<td>Expand ambulatory services</td>
<td>(7.6)</td>
<td>(10.3)</td>
<td>(12.7)</td>
</tr>
<tr>
<td>PC expansion</td>
<td>(1.7)</td>
<td>(2.7)</td>
<td>(3.7)</td>
</tr>
<tr>
<td>CCHC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expand Cicero and Cottage Grove</td>
<td>(1.3)</td>
<td>(3.5)</td>
<td>(5.0)</td>
</tr>
<tr>
<td>New Northwest Clinic</td>
<td>-</td>
<td>-</td>
<td>(2.1)</td>
</tr>
<tr>
<td>Strategic Investment, Stroger Hospital</td>
<td>(0.3)</td>
<td>(24.7)</td>
<td>(15.1)</td>
</tr>
<tr>
<td>Forecasted Change in Operating Cash</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>Capital Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fantus rebuild</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PC clinic expansion/update</td>
<td>(3.0)</td>
<td>(3.0)</td>
<td>(3.0)</td>
</tr>
<tr>
<td>CCHHC clinic expansion/update</td>
<td>(3.0)</td>
<td>(3.0)</td>
<td>(7.0)</td>
</tr>
<tr>
<td>Provident reconfigure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oak Forest reconfigure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forecasted Strategic Capital Requirement</td>
<td>$ (25.0)</td>
<td>$ (18.0)</td>
<td>$ (10.0)</td>
</tr>
</tbody>
</table>
ATTACHMENT #6
RESOLUTION

RESOLUTION OF THE COOK COUNTY HEALTH & HOSPITALS SYSTEM BOARD URGING THE COOK COUNTY BOARD OF COMMISSIONERS TO AMEND THE ORDINANCE ESTABLISHING THE HEALTH SYSTEM INCLUDING AN AMENDMENT TO DELETE PROVISIONS TERMINATING THE HEALTH SYSTEM AND THE ORDINANCE

WHEREAS, On February 29, 2008, the Cook County Board of Commissioners approved an Ordinance Establishing the Cook County Health and Hospitals System ("Enabling Ordinance") and, on May 20, 2008, approved amendments to the Enabling Ordinance; and

WHEREAS, the Enabling Ordinance provided for the nomination of the initial members of the Board of Directors of the Cook County Health and Hospitals System ("System Board") by a number of groups representative of various government, civic, and healthcare organizations concerned with the success of the mission of the Health System; and

WHEREAS, the System Board currently consists of members with expertise and experience in healthcare governance and management, clinical medicine, employee relations, labor relations, and public administration appointed by the President of the County Board, which appointments were approved by the County Board; and

WHEREAS, since the System Board’s first meeting on June 18, 2008, its volunteer members have demonstrated their commitment to success of the mission of the Health System, and have already accomplished a number of important objectives including overseeing the reorganization and centralization of operations within the Health System and the initiation of a two-phase reduction in force; and

WHEREAS, as mandated by the Enabling Ordinance, the System Board is currently fully engaged in the development of a strategic plan for the future of the Health System which plan is designed to utilize finite resources to maximize access to quality care for our patient population; and

WHEREAS, Section 38-93 of the Enabling Ordinance provides that the Cook County Health and Hospital System and the Enabling Ordinance shall terminate after three (3) years from the effective date of the Enabling Ordinance, unless the Cook County Board of Commissioners acts to renew its powers and responsibilities; and
WHEREAS, the System Board respectfully submits to the County Board that termination provisions inhibit the System Board’s ability effectively to operate the Health System, and that the Health System and its patients are best served by a governing body that has no pre-determined termination date.

NOW, THEREFORE, BE IT RESOLVED, that the System Board urges the Cook County Board of Commissioners to approve proposed amendments to the Enabling Ordinance, including the deletion of the termination provision and the revision of the nominating procedures and terms for Directors, in order that the System Board may continue to exercise the powers granted to it by the County Board and continue to provide the expertise in healthcare governance required to manage the Health System effectively.

Effective date: This Resolution shall be in full force and effect immediately upon passage.

Approved by the Board of Directors of the Cook County Health and Hospitals System on May 27, 2010.
ATTACHMENT #7
<table>
<thead>
<tr>
<th>Request #</th>
<th>Title/Job Code</th>
<th>Current Salary</th>
<th>Previous Salary</th>
<th>Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cermak Director of Human Resources/1043</td>
<td>$115,000.00</td>
<td>$100,000.00</td>
<td>$15,000.00</td>
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<tr>
<td>2</td>
<td>System Director of Human Resources/5229</td>
<td>$205,000.00</td>
<td>$180,000.00</td>
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<tr>
<td>3</td>
<td>Associate General Counsel/5237</td>
<td>$160,000.00</td>
<td>$123,989.00</td>
<td>$36,011.00</td>
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<tr>
<td>4</td>
<td>CCDPH Program Manager/0028</td>
<td>$98,820.00</td>
<td>$86,825.00</td>
<td>$11,995.00</td>
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<tr>
<td>5</td>
<td>Stroger Hospital Director of Human Resources</td>
<td>$140,000.00</td>
<td>$129,538.24</td>
<td>$10,461.76</td>
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<table>
<thead>
<tr>
<th>Request #</th>
<th>Title/Job Code</th>
<th>Salary</th>
<th>PID Budgeted Amount</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Pharmacist Manager/2103</td>
<td>$129,538.24</td>
<td>$129,538.00</td>
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<td>7</td>
<td>Provident/Oak Forest Hospitals Chief Financial Officer/2184</td>
<td>$125,000.00</td>
<td>$76,880.00</td>
<td>$48,120.00</td>
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<tr>
<td>8</td>
<td>CCDPH Emergency Preparedness Lead Attorney</td>
<td>$85,000.00</td>
<td>$70,158.08</td>
<td>$14,849.92</td>
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<tr>
<td>9</td>
<td>System Director of Risk Management/0082</td>
<td>$140,000.00</td>
<td>$57,924.00</td>
<td>$82,076.00</td>
</tr>
<tr>
<td>10</td>
<td>Provident Hospital Director of Human Resources/1043</td>
<td>$127,000.00</td>
<td>$129,538.00</td>
<td>($2,538.00)</td>
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<tr>
<td>11</td>
<td>System Director of Labor Relations/5284</td>
<td>$145,000.00</td>
<td>$57,514.00</td>
<td>$87,486.00</td>
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<td>12</td>
<td>System Chief Medical Officer</td>
<td>$350,000.00</td>
<td>$118,744.00</td>
<td>$231,256.00</td>
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<td>13</td>
<td>Director of Hospital Purchasing and System Support/4882</td>
<td>$97,305.00</td>
<td>$96,892.00</td>
<td>$413.00</td>
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<tr>
<td>14</td>
<td>System Director of Nursing Professional Development and Education/5340</td>
<td>$145,000.00</td>
<td>$43,809.00</td>
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<table>
<thead>
<tr>
<th>Request #</th>
<th>Title/Job Code</th>
<th>Salary</th>
<th>PID Budgeted Amount</th>
<th>Difference</th>
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<tbody>
<tr>
<td>15</td>
<td>System Director of Quality and Patient Safety</td>
<td>$150,000.00</td>
<td>$66,606.00</td>
<td>$83,394.00</td>
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<td>16</td>
<td>Director of Plant Operations</td>
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<td>Associate Internal Auditor</td>
<td>$100,000.00</td>
<td>$57,924.00</td>
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<td>18</td>
<td>Director of System Operations</td>
<td>$100,000.00</td>
<td>$52,687.00</td>
<td>$47,313.00</td>
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<table>
<thead>
<tr>
<th>Grade 24 Open Positions</th>
</tr>
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<tbody>
<tr>
<td>19</td>
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BOARD APPROVAL REQUEST

DATE: May 21, 2010

TERMS OF REQUEST: Enter into and Execute Contract

TYPE OF REQUEST: Performance Improvement Implementation Services

SELECTION METHODOLOGY: RFP

ACCOUNT#: 890-260/520-8230 Professional and Managerial Services

FISCAL IMPACT: $50 million

GRANT FUNDED AMOUNT: None

CONTRACT PERIOD: June 1, 2010 through May 31, 2012

REQUESTING DEPT./AFFILIATE: CCHHS

SPONSOR: William T. Foley, Chief Executive Officer

IS THIS REQUEST THE LOWEST BIDDER/SUPPLIER?: Yes

IS THIS CONTRACT SOLE SOURCE?: No

JUSTIFICATION: The Health System has committed itself to a significant transformation designed to reduce overall operating expenses, increase revenues, realign service delivery and implement strategic initiatives designed to improve overall quality and access to care and reduce the system’s dependence on funding from Cook County. CCHHS has engaged consultants to identify and quantify areas of improvement throughout the System. This work has been the basis for the development of an all-encompassing multiyear RFP designed to aid management in the implementation of process improvements throughout the System. The project design impacts virtually all areas of operation and will significantly alter where and how work is performed. CCHHS does not have and cannot employ the number of technical experts required to implement these changes. This contract will bring the requisite skills to focus on each area of improvement and will include staff training, allocation, enhancement or replacement as necessary to maintain change. This contract will include revenue cycle services.

TERMS OF REQUEST: This is a full risk all-inclusive contract. Compensation to the vendor is dependent upon identified and realized cash improvement — fees collected or expense avoided. The anticipated benefit is $313.8 million; fees will be paid on an hourly basis after the first $10 million of realized benefit at a ratio of 6:1 for the first $200 million of realized benefit and at a ratio of 7:1 if the amount of realized benefit exceeds $200 million; maximum fees are set at a $50 million; no fee will be paid for the first $10 million of realized benefit. Contract consists of a Master Services Agreement that will be supplemented with individual Statements of Work identifying and controlling specific project activity.

HAS THIS BEEN REVIEWED BY CONTRACT COMPLIANCE?: Pending WHAT PERCENTAGE OF THIS CONTRACT IS W/MBE?: 10/25%

ATTACHMENTS

BID TABULATIONS: N/A

CONTRACT COMPLIANCE MEMO: Pending

CEO: William T. Foley, Chief Executive Officer  CCHHS

COO: Anthony Tedeschi, Chief Operating Officer  CCHHS

CFO: Michael D. Ayres, Chief Financial Officer  CCHHS

The request to enter into and execute the contract, but to defer the component relating to revenue cycle activities until further action by the Board, was approved on May 27, 2010 by the Board of Directors of the Cook County Health and Hospitals System.

Request # 1

*Approved May 27, 2010

BY BOARD OF
DIRECTORS OF THE COOK COUNTY
HEALTH AND HOSPITAL SYSTEM
May 24, 2010

The Honorable Warren Batts,
Chairman, Board of Directors
The Honorable David Carvalho
Chairman, Finance Committee
Cook County Health and Hospitals System
1900 W. Polk Street
Chicago, IL 60612

Re: Request to Terminate Contract #08-41-245, MedAssets

Dear Chairman Batts and Chairman Carvalho:

A three year contract between the Health System and MedAssets was approved by the Cook County Board of Commissioners on May 20, 2008. The contract requires MedAssets to provide Revenue Cycle Re-Engineering and Operational Improvement Consulting Services and Accounts Receivable Improvement Services.

After a review of our progress in the revenue cycle area, coupled with the identification of numerous other areas in which the performance of the Health System requires focused and integrated effort, the Health System issued a Request for Proposals for Performance Improvement Implementation Services. In the RFP, the Health System sought to identify prospective vendors to provide implementation services with regard to a full range of performance improvement initiatives, and reserved the right to include revenue cycle services as part of any contract that was pursued. After careful consideration, we believe that optimal improvements will be achieved through use of a single vendor for both performance improvement and revenue cycle efforts. Our goal in doing so is to improve the quality of services, reduce duplication of activities and standardize practices throughout the Health System.

On May 14, 2010, we presented a recommendation to the Finance Committee that the Health System enter into a contract with PricewaterhouseCoopers for performance improvement implementation services, including revenue cycle services. In order to move forward with this contract, it will be necessary to transition away from our current revenue cycle vendor, MedAssets. The contract with MedAssets may be terminated upon six months advance written notice to MedAssets. Authorization is requested to issue a notice terminating the MedAssets contract. I am further requesting authorization to negotiate and approve an agreement with MedAssets regarding the amounts payable for the services to be provided during the period prior to the termination date.

Thank you for your consideration.

Sincerely,

William T. Foley
Chief Executive Officer
Cook County Health & Hospitals System

Request #2