IHA COMMITTEE ON HEALTH DISPARITIES
REPORT TO THE IHA BOARD OF TRUSTEES
March 26, 2021

In June 2020, A.J. Wilhelmi, President & CEO, and Phillip M. Kambic[1], Board of Trustees Chair of the Illinois Health and Hospital Association, issued a Statement entitled, "Addressing Health Disparities", which stated in part:

> The senseless and tragic killing of George Floyd in Minneapolis has sparked outrage, grief and frustration among people from all backgrounds, and exposed once again the systemic racism, injustice, and inequality that unfortunately still exist within the fabric of our society. Simultaneously, the disproportionate impact of the COVID-19 pandemic on people and communities of color has highlighted the fact that dramatic health disparities continue to exist in Illinois. The combination of these two events has heightened everyone's awareness to these issues and has set the stage for the possibility of true change.
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> If we are to achieve IHA's vision for Illinois healthcare – that all individuals and communities have access to high-quality healthcare at the right time, in the right setting, in order to support each person's quest for optimum health – then redoubling our efforts to address health disparities is imperative.
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> To further enhance our voice and our efforts on these important issues, the IHA Board is establishing a permanent standing committee on health disparities.

This first Report of the IHA Committee on Health Disparities ("**COHD**") to the IHA Board of Trustees describes the charge to the COHD, a scan of the environment, new activities undertaken during 2020, and the recommended plan and strategies for IHA to pursue in 2021 to reduce health disparities and advance health equity.

I. IHA Committee on Health Disparities – Charge

The IHA Board of Trustees established the permanent Committee on Health Disparities in July 2020. The Committee's charge is to provide information, options and recommended actions to IHA and the hospital community to reduce health disparities in Illinois, taking into consideration the mission and leadership role of hospitals and health systems in the community. Subjects to be considered include, but are not limited to, the following:

- To identify the nature and causes of health disparities that exist in Illinois.
- To identify, recommend and help implement, short term and long term local, state and federal policies and advocacy strategies to reduce health disparities in Illinois.

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[1] Phillip M. Kambic is President & CEO of Riverside Healthcare in Kankakee.

- To identify, recommend and help implement best practices for hospitals to employ, collectively and individually, to reduce health disparities.
- To identify, recommend and pursue opportunities for IHA and hospitals to partner with government and other stakeholders to reduce health disparities.

II. Environmental Scan

Residents in one Chicago neighborhood have a 30-year lower life expectancy than those in a nearby neighborhood. In several Illinois counties, Black residents have a five to eight year shorter life expectancy than White residents. Individuals living in rural areas have higher incidences of chronic conditions, including diabetes, some cancers and obesity. People and communities of color have faced health inequities driven by systemic racism for generations–a wrong that has been profoundly laid bare during the COVID-19 pandemic. And in recent years, maternal mortality rates for Black and Brown women have reached a crisis level.

While health disparities exist across many groups, COVID-19 has shined a spotlight on the racial health disparities that have long existed in our communities. For decades, communities of color have suffered higher rates of chronic conditions and have been more likely to die from such conditions.

- COVID-19 death rates per 100,000 people in **Illinois** are 184 for Black, 134 for Latinx, and 143 for White (IDPH, January 26, 2021). COVID-19 death rates per 100,000 people in **Chicago** are 220 for Black, 199 for Latinx, and 110 for White (City of Chicago, January 26, 2021).

- According to a 2017 report published by the CDC, "Disparities in the leading causes of deaths for blacks compared with Whites remain large and persistent across the life span. Blacks had higher death rates than Whites for all-cause mortality in all age groups under age 65. To continue to reduce the gap in health disparities, these findings suggest an ongoing need for universal and targeted interventions that address the leading causes of deaths among blacks (especially cardiovascular disease and cancer and their risk factors) across the life span and create equal opportunities for health."[2]

- The Latinx community has different degrees of illness and health risks than Whites, such as:
  - 35% less heart disease and 49% less cancer;
  - A lower death rate overall, but about a 50% higher death rate from diabetes;
  - 24% more poorly controlled high blood pressure;
  - 23% more obesity;
  - 28% less colorectal screening. [3]

[2] Cunningham TJ, Croft JB, Liu Y, Lu H, Eke PI, Giles WH. Vital Signs: Racial Disparities in Age-Specific Mortality Among Blacks or African Americans — United States, 1999–2015. MMWR Morb Mortal Wkly Rep 2017;66:444–456. DOI: http://dx.doi.org/10.15585/mmwr.mm6617e1External

[3] CDC, Vital Signs, May 2015, https://www.cdc.gov/vitalsigns/hispanic-health/index.html

- Past research indicates that minorities suffer more medical errors, leading to greater clinical consequences; have longer lengths of stay for the same condition; experience higher rates of avoidable hospitalizations and 30-day readmission rates; and experience more test orders for similar conditions.[4]

- In Illinois, non-Hispanic Black women are six times as likely to die of a pregnancy-related condition as non-Hispanic White women.[5]

- In Chicago, there is an 8.8 year gap between Black and White life expectancy. Black and Latinx life expectancy has declined while White life expectancy has increased. There is a 30-year life expectancy gap between certain Chicago neighborhoods. Life expectancy gaps between Black and White residents exist in several Illinois counties.

- 20% of health outcomes (life expectancy and quality of life) is determined by clinical care, while physical environment (10%), social and economic factors (40%) and health behaviors (30%) drive 80% of health outcomes.

- Chicago income inequality has grown from 1970 to 2010, with 53% of census tracts having income decline by more than 20%, compared to the region average. The percentage of Chicago census tracts considered very low-income increased from 17% in 1970 to 46% in 2010.

- Poverty is a challenge statewide with numerous downstate counties having poverty rates above the state average.

III. IHA Health Disparities Activities in 2020

New activities to reduce health disparities undertaken by IHA in 2020 include:

- Issued IHA Statement on Health Disparities, June 2020.

- Established the COHD in July 2020. At its three meetings in 2020, the COHD identified and discussed key challenges to addressing health disparities; engaged in a facilitated discussion on diversity, equity and inclusion, facilitated by an outside consultant; and evaluated and recommended that IHA distribute the “Advancing Health Equity Guide” developed by the Michigan Health and Hospital Association.

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[4] “Ushering In The New Era Of Health Equity, " Health Affairs Blog, October 31, 2016.DOI: 10.1377/hblog20161031.057296

[5] Illinois Maternal Morbidity and Mortality Report – 2018 - http://dph.illinois.gov/sites/default/files/publications/publicationsowhmaternalmorbiditymortalityreport112018.pdf

- Established the Health Equity Leaders' Workgroup ("**HELW**"), consisting of the health equity leaders of the organizations on the COHD. At its first meeting (which several COHD members joined), the HELW evaluated and recommended that IHA consider adopting the "Racial Equity in Healthcare Progress Report" for adoption on a statewide basis. The "Progress Report" is a tool for hospitals and health care organizations to use to assess their implementation of key strategies aimed at reducing disparities to achieve equity and improve quality. IHA is assuming responsibility for this project in 2021.

- Conducted a panel discussion at the IHA Leadership Summit on health equity and implicit bias, joined by Brenda Battle, Chief Equity, Diversity and Inclusion Officer, UChicago Medicine, and Darlene Oliver Hightower, JD, Vice President, Community Health Equity, Rush University Medical Center.

- Conducted diversity, equity and inclusion education sessions, facilitated by an outside consultant, for the IHA Board of Trustees, the COHD, the IHA Senior Leadership Team, and the entire IHA staff.

- Successfully advocated for legislation that was passed by the Illinois General Assembly in early 2021 to authorize the Hospital and Healthcare Transformation program. The transformation program provides the opportunity for vulnerable communities to receive state funds to implement strategies to reduce health disparities, advance health equity and improve the health and healthcare of their community.

- Successfully advocated for and resolved issues raised by legislation initiated by the Legislative Black Caucus on Health and Human Services Reform. While this legislation was not enacted, this work positions IHA well for further negotiations on this legislation in 2021.

- The COHD held three meetings in 2020 and one joint meeting with the HELW.

IV. Hospital Tools to Address Health Disparities – IHA Projects in 2021

To support hospitals and health systems as they strive to reduce health disparities to improve health equity, IHA will focus on the following projects in 2021.

A. Advancing Health Equity Guide.

In 2021, IHA will distribute to its members the Advancing Health Equity Guide created by the Michigan Health and Hospital Association (MHA) or a similar guide that aligns with the Racial Equity in Healthcare Progress Report. This guide describes key terms, the critical role that equity plays in assuring that every person receives high quality, safe patient care, and an organizational framework for advancing health equity. The timing

of the distribution of the guide is intended to align with the distribution of the Racial Equity in Healthcare Progress Report.

B. Racial Equity in Healthcare Progress Report.

Recognizing that progress and improvement require measurement and accountability, the COHD determined that hospitals and other providers will need a tool to assess their performance in addressing racial disparities in their provision of health care. The ***Racial Equity in Healthcare Progress Report*** ("**Progress Report**") is a tool for hospitals and health care organizations to use to assess their implementation of key strategies aimed at reducing disparities to achieve equity and improve quality. Those strategies include increasing racial and ethnic understanding of governance, leadership and staff, analyzing outcomes by racial and ethnic groups, and partnering to address the social determinants of health such as food and housing insecurity. The Progress Report guides organizations to prioritize and act on identified gaps so that deliberate and purposeful action is taken to ensure outcomes across all patient populations are equitable.

In 2021, IHA will assume ownership of the "Progress Report" and take responsibility for its further development, management and dissemination to hospitals and other health care providers statewide. In 2021, IHA has the goal of having at least 70% of member hospitals participate in the Progress Report. IHA will implement this project under the guidance and direction of the Health Equity Leaders' Workgroup ("**HELW**") with oversight from the COHD.

C. Chicago Hospital Engagement, Action and Leadership ("**HEAL**") Initiative.

Chicago HEAL— Hospital Engagement, Action and Leadership—is a bold, three-year initiative (2019 – 2021) to reduce violence and improve health through neighborhood engagement. In October 2018, U.S. Senator Richard J. Durbin (D-IL) challenged ten leading Illinois health systems to join forces and use their organization's economic and community footprint to redouble their efforts to curb violence and improve health in 18 vulnerable Chicago neighborhoods.

The Chicago HEAL hospitals have come together to share best practices and identify ways to collaborate to make progress on 16 metrics that are organized around three pillars:

- Increase local workforce commitment to reduce economic hardship;
- Support community partnerships to improve health and safety of public environments; and
- Prioritize key in-hospital practices to address unmet needs.

In 2021, IHA will continue to coordinate the HEAL Initiative and collaborate with the HEAL hospitals to issue a report of the progress being made on the HEAL metrics.

D. Supplier Diversity Task Force.

With the guidance from IHA's Supplier Diversity Task Force, IHA will continue to provide information, resources and support to hospitals as they strive to increase diversity in their suppliers and expand opportunities for female-owned, minority- owned, veteran-owned and small business enterprises. To date the Task Force has met with several key stakeholders (legislative champions, supplier groups, and community groups) incorporating their key construction contractors to develop further relationships, discuss challenges and opportunities, as well as steps to move forward to increase the use of diverse vendors in the hospital construction space and beyond. Additionally, the Task Force's input allowed IHA to successfully advocate for changes to the Annual Hospital Questionnaire (administered by IDPH) that provided greater clarity for hospitals and systems regarding the data they were inputting which will provide reports that better reflect a hospital's progress in this space.

V. IHA Health Equity Advocacy Agenda for 2021

IHA's vision for Illinois healthcare is that all individuals and communities have access to high quality healthcare at the right time, in the right setting, in order to support each person's quest for optimum health. To achieve this vision Illinois hospitals and health systems are committed to eliminating health disparities to achieve health equity.

To this end, IHA will work with partners to enact policies that ensure essential, high- quality health care services are available to all individuals and communities, and are not impacted by socioeconomic conditions, background or ZIP code. IHA will support federal, state and local policies to invest resources in underserved communities, to enhance access to primary and specialty care, address social determinants of health, and reduce maternal mortality.

Key issues anticipated to be considered by policymakers in 2021 are described below. IHA's priorities in 2021 are: 1) Hospital and Healthcare Transformation; 2) Expanding Telehealth; and 3) Expanding Health Coverage.

A. Hospital and Healthcare Transformation.

On January 13, 2021, the General Assembly overwhelmingly passed IHA supported legislation – *Public Act 101-655* *(Senate Bill 1510)* – to authorize the Hospital and Healthcare Transformation program. The Department of Healthcare and Family Services (HFS) will administer the program which is supported by an annual transformation funding pool of $150 million. This legislation closely aligns with IHA's principles for meaningful and systemic healthcare transformation. In short, this program provides the opportunity for vulnerable communities to receive state funds to implement strategies to reduce health disparities, advance health equity and improve the health and healthcare of their community.

HFS intends to invest these vital dollars into the creation of innovative partnerships in Illinois' most distressed communities. The Department envisions new partnerships that will connect clinical healthcare organizations with community-based organizations to have the greatest impact on health outcomes by filling the gaps in health care delivery and tackling the social and structural determinants of health. Additionally, partnerships are intended to improve access to care, particularly for distressed communities. For example, one category identified for funding is for collaborations between safety net hospitals and a larger hospital partner that increases access to specialty care in a distressed community.

In 2021, IHA will work to assure that the Transformation program is implemented effectively and to provide information to hospitals that wish to participate in the program.

B. Expanding Telehealth.

Expanding access to telehealth is an additional tool to help address health disparities, for both urban and rural communities, as vulnerable patients often face transportation and other barriers in being able to visit their physicians.

In 2021, IHA will advocate for the extension of state telehealth coverage mandates during the pandemic. Additionally, permanent telehealth coverage and reimbursement parity with in-person services is a priority for patient care access and equity, targeting Medicaid fee-for-service and managed care organizations regulated by HFS and commercial health insurers regulated by the Department of Insurance (DOI). IHA will work with the Coalition to Protect Telehealth, legislators, HFS, and DOI to advocate for full coverage and payment parity.

C. Expanding Health Coverage.

Access to and the affordability of adequate health insurance is likely the greatest barrier to high quality healthcare, particularly for racial minorities and those with low-incomes. In 2019, there were approximately 906,000 uninsured in Illinois[6], or 7.3% of the total population and of that number approximately 40% were White, 37% were Latinx, and 17% were Black. It is estimated that in Illinois the percentage of each population that is uninsured is as follows: White – 6%; Black – 10%; and Latinx – 16%.

Under the Health Care Affordability Act, the Illinois Departments of Health Care and Family Services (HFS) and Insurance (DOI) are to develop a feasibility study to explore options to make health insurance more affordable for low-income and middle-income individuals. Their report is due by February 28, 2021 and needs to include cost estimates and impact on affordability including break-out data by race, ethnicity and

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[6] Kaiser Health Facts. https://www.kff.org/other/state-indicator/total-population/?dataView=1¤tTimeframe=0&selectedRows=%7B%22states%22:%7B%22illinois%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

income. Early indications are that options for a Medicaid buy-in plan as well as a public option will be explored.

IHA has always advocated for health coverage for all. However, **IHA has strong concerns regarding a potential state public option or Medicaid buy-in plan, including:**

- The potential unintended consequence of individuals switching from commercial insurance to the new option;
- The need to ensure adequate provider rates necessary to incentivize participation and encourage network adequacy and high-quality healthcare;
- Ensuring the continued stability of the individual and small group market; and
- The significant financial pressure that will be placed on many struggling providers due to a shift from commercial payment rates to much lower Medicaid rates that will result from a Medicaid buy-in option.

IHA believes that the financial cost of expanding health coverage is outweighed by the broader economic cost to society and the human suffering experienced by persons who are uninsured. Therefore, IHA supports a number of strategies to improve access to affordable coverage:

- Implement a plan to enroll in Medicaid or the Marketplace coverage those uninsured individuals who already qualify for coverage or subsidies under those programs.
- Allow presumptive eligibility for Medicaid enrollees, particularly for residents in high areas of poverty.
- Expanding coverage under the Illinois Medical Assistance program, including coverage for post-acute care, to undocumented individuals, provided it is financed through broad based state general revenues and not through provider taxes.
- Address the high deductibles of many marketplace plans resulting in both delayed and uncompensated care.
- Expand Medicaid program coverage for prenatal through 12 months postpartum care, including mental health services, which would have the added benefit of improving maternal health.

D. Improving Maternal Health.

Addressing the high rate of maternal mortality and morbidity rates, particularly among women of color continues to be a focus of policymakers and interest groups at both the state and federal levels. In Illinois, non-Hispanic Black women are six times as likely to die of a pregnancy-related condition as non-Hispanic White women.[7] Officials have also expressed their strong concerns to IHA regarding the significant number of hospitals

[7] Illinois Maternal Morbidity and Mortality Report – 2018 - http://dph.illinois.gov/sites/default/files/publications/publicationsowhmaternalmorbiditymortalityreport112018.pdf

closing their OB units, or suspending services at the height of the pandemic, and what that means for access to care, especially in rural parts of the state, as well as underserved communities like the south and west sides of Chicago.

Maternal health continues to be a high priority for IHA and its member hospitals and health systems. Addressing the complex challenges and advancing maternal health requires ongoing partnerships and innovation in the quality, cost, and delivery of care, and in addressing the social determinants of health such as food and housing insecurity. **IHA will continue to support current efforts to improve maternal health, including**:

- Home visiting programs sponsored through state and federal grant dollars;
- Various quality programs being operated by the Illinois Perinatal Quality Collaborative (ILPQC), which includes most Illinois birthing hospitals;
- IHA's participation on the Maternal Health Task Force, which is part of the Innovations to Improve Maternal Outcomes in Illinois (I PROMOTE-IL);
- IHA's participation on the Home Birth Maternity Care Crisis Study Committee.

In considering new proposals to improve maternal health, it is important to recognize that addressing this complex challenge will require a multifaceted, long-term effort. Consequently, it may be appropriate to implement new strategies on a pilot or limited basis to evaluate their effectiveness. At the same time, assuring access to quality health care must remain of paramount importance and the services furnished by all providers caring for women must be coordinated and aligned with the broader health system.

For example, expanding coverage for certified doulas or home visiting programs should require them to coordinate with the treating health professional and hospital and should first be evaluated on a pilot basis. Similarly, expanding the current number of birthing centers is unlikely to substantially reduce maternal mortality and morbidity. Consequently, expansion of birthing centers should be limited and should only be done in compliance with the certificate of need law in order to help assure sufficient volume at existing hospitals to maintain professional competency and quality of care.

E. Moratorium on Hospital and Service Closures.

In response to the proposed closure of hospitals and the discontinuation of certain services in vulnerable communities, some legislators have suggested that a moratorium should be imposed on the closure of a hospital or category of service.

IHA is opposed to broad moratoriums on such closures because they are unworkable and unreasonable and would jeopardize patient safety. Hospitals need financial resources, appropriate staffing, and patient volume to maintain service lines and clinical competencies as well as the hospital as a whole. **If any limitations are to be considered on the ability to close a hospital or service, such measures must be narrowly crafted and limited to the current emergency situation created by the COVID-19 pandemic.**

F. Community Health Workers.

Community health workers are increasingly used to assist individuals in accessing health care, social services and other community based services. Legislation has been proposed to certify community health workers and require their services to be reimbursed by Medicaid.

IHA is generally supportive of efforts to expand the use of community health workers to expand access to and coordination of services to address chronic conditions.

G. Diversity, Equity and Inclusion.

In considering strategies to improve diversity, equity and inclusion in health care, it is important to recognize that this is a long term endeavor that will require sustained and consistent engagement by the senior leadership of organizations. Compliance with laws and regulations is only a starting point for building an organizational culture that truly values and rewards diversity, equity and inclusion.

Legislative proposals may be considered that are aimed at increasing transparency with respect to the racial and ethnic diversity of the governance, management and physicians at hospitals. In evaluating such proposals, **it will be important to assure that any diversity reporting is structured in a way that recognizes the diversity of communities throughout Illinois.**

Additionally, proposals aimed at addressing implicit bias and improving the cultural competency of health care organizations and professionals will also likely be considered. **IHA supports efforts to address implicit bias and recognizes that new requirements may require time and resources to develop effective and meaningful education and training programs.**

VI. Health Equity Information, Resources and Education for Members

In 2021, IHA will also continue to provide information, resources and educational opportunities in order to raise the awareness and understanding of its members on health disparities and health equity.

A. IHA Health Disparities Resource Hub.

IHA will continue to provide information and resources to members through the health disparities resource hub on the IHA web site, as well as through other direct communications to members. The purpose of such communications is to raise awareness and visibility of members to key health equity issues and to provide them with easy access to key resources.

In particular, IHA will focus on providing resources from key partners, such as the American Hospital Association, as well as to share strategies and interventions applied by Illinois hospitals.

B. Webinars and other education opportunities.

As appropriate, IHA will also seek to provide members with access to webinars and other educational opportunities, whether sponsored by IHA or other leading organizations, such as AHA. In particular, a session on health equity will likely be included at the IHA Leadership Summit.

VII. Conclusion

As with the efforts made over the past ten years to improve quality and patient safety, the work to eliminate health disparities and improve health equity will not be quick or easy. We are running a marathon, not a sprint. However, IHA's Committee on Health Disparities believes that the overall plan and strategies outlined in this report put the Illinois hospital community on the right track. Moreover, Illinois hospitals have the dedication and commitment to finish the race.

Illinois Health and Hospital Association

Committee on Health Disparities
Roster

Name	Title	Hospital
George Miller, Co-Chair	President & CEO	The Loretto Hospital
José Sánchez, Co-Chair	President & CEO	Humboldt Park Health
Michael Cruz, MD	Chief Operating Officer	OSF HealthCare
Gabrielle Cummings	President	NorthShore University HealthSystem Highland Park Hospital
Sheri DeShazo, FACHE	President	Advocate Sherman Hospital
William Dorsey, MD	Chairman of the Board and CEO	Jackson Park Hospital & Medical Center
Phillip Kambic	President & CEO	Riverside Medical Center
Omar Lateef, DO	Chief Executive Officer	Rush University Medical Center
James Leonard, MD	President & CEO	Carle Health
Mary Lou Mastro, FACHE	System President & CEO	Edward-Elmhurst Health
Larry McCulley	President & CEO	Touchette Regional Hospital
Kumar Nathan, MD	President	Northwestern Medicine Huntley Hospital
Kenneth Polonsky, MD	Dean & EVP of Medical Affairs	UChicago Medicine
Israel Rocha, Jr.	Chief Executive Officer	Cook County Health
Ted Rogalski, FACHE	Administrator	Genesis Medical Center Aledo
Thomas Shanley, MD	President & CEO	Ann & Robert H. Lurie Children's Hospital of Chicago
Allan Spooner	Chief Executive Officer	Franciscan Health Olympia Fields
Mary Starmann-Harrison	President & CEO	Hospital Sisters Health System
Airica Steed, FACHE	System Chief Operating Officer/Executive Vice President	Sinai Chicago
Yolande Wilson-Stubbs	President	AMITA Health Holy Family Medical Center