November 26, 2019

Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

Dear Chairman Neal and Ranking Member Brady:

On behalf of the University of Illinois Hospital and Health Sciences System (UI Health), thank you for the opportunity to respond to the request for information (RFI) on priority topics that affect health status and outcomes in rural and underserved areas. We appreciate all of the Committee’s and Task Force’s work to address inequalities in these communities.

UI Health includes a 465-bed acute care hospital, 45 primary and specialty care clinics, Mile Square Health Center (six federally qualified health center locations and five school based clinics across Chicago) and seven health sciences colleges (medicine, nursing, pharmacy, dentistry, applied health sciences, social work and public health). As an academic medical center, we care for the needs of the most vulnerable patients in our state and provide specialty care for all populations. The majority of our patients are either Medicare or Medicaid recipients and our 30 primary care and specialty care clinic sites reach some of Illinois’ most underserved populations.

As one of the leading providers of care to underserved populations on the Westside of Chicago, we are on the forefront of tackling the complex social issues impacting our patients every day. And our patients’ health outcomes are startling. On Chicago’s West Side, where the majority of our patients live, the average lifespan is only 69 years. If you travel just seven miles east to Chicago’s downtown Loop neighborhood, the life expectancy jumps to 85 years. We recognize that while individuals may be dying from heart disease and cancer, health outcomes are dependent on other social determinants including access to healthy food, a stable job, reliable transportation, or neighborhood violence. It is now widely believed that 70% of what impacts health happens outside of the healthcare system.

We understand the detrimental impacts of the conditions our patients face, such as having to choose between getting a prescription filled or finding a place to sleep for the night; having the financial means to obtain prescriptions or treatment; the ability to take time off from a job to receive follow-up care; waiting at the hospital after discharge because of limited transportation options; unsafe home environments; and severely limited access to healthy food. We are grateful for this opportunity to comment because we have piloted successful programs that can be scaled to other urban or rural areas to help address social determinants of health. We hope our response can be helpful to you as you consider future policy options.

Before addressing the specific questions in this RFI, allow us to provide an overview of two successful models we have implemented at UI Health that focus on improving health care outcomes for our underserved communities and patients, and addressing the health inequalities our patients face. First, UI Health launched the Better Health Through Housing (BHH) program which provides stable housing...
for chronically homeless individuals in our emergency department. UI Health launched this initiative after recognizing that a large number of our most expensive emergency department patients dealt with housing instability as well. Chronically homeless patients often face numerous chronic health issues and mental health issues. The data underlying the need for this program was clear. Homeless patients spend an average of four extra days in an inpatient stay, have readmission rates that are 50.7% (vs 18.3% for all other conditions) and their costs are $2,500 more per stay. 1 At UI Health, these patients’ healthcare costs ranged from 7 times to 76 times the average patient. 2

UI Health committed $539,000 to fund this initiative and plans to invest another $250,000 over the course of the next year. It was the first Chicago-area hospital to work on this type of healthcare-and-housing enterprise. Under this program, UI Health identifies individuals who are frequent patients in our emergency department and partners with the Center for Health and Housing in Chicago to place these individuals in stable housing environments with a case manager to help with their healthcare needs. This collaborative interdisciplinary model includes hospital social workers, supportive housing case managers, and street outreach workers. The health benefits of this program for a homeless patient that may have one or more chronic conditions cannot be understated: the program affords patients a safe place to sleep, store medicine, escape the elements, cook warm meals, bathe, and access a support team to help manage his or her health. Not only is this intervention meaningful to patients, but it has reduced costs for UI Health by between 21% and reduced hospital utilization by 67% per patient. 3

Our second successful model is UI Health’s PROgram for Non-emergency TranspOrtation (PRONTO), which was developed in response to an assessment that identified transportation as a major barrier to care for our patients. Through this program, UI Health front-line clinicians evaluate the transportation needs of recently discharged patients and supply transportation through a partnership with Lyft. In some cases, a patient experience visit also follows once the patient is returned home. The ability to safely and easily get to and from appointments or go home after being discharged post-surgery should not be taken for granted; not having transportation can be a barrier to care and greatly impact a patient’s recovery. Furthermore, reliable transportation can speed up the discharge process for our patients, which then increases the number of inpatient beds available. Most importantly, reliable transportation expedites the process of getting the recovering patient out of the hospital setting and back into their home.

The success of the PRONTO program has ushered in the launch of Phase II, called PRONTO Plus. A recent study has found that many patients who have negative experiences with other social factors impacting health, including inadequate family supports, limited access to transportation, and poor access to healthy food options have increased rates of re-hospitalizations. To combat this, the new PRONTO Plus program would combine population health sciences, logistics, and data analytics to bring destination services (such as home care and follow-up care) to the home, while at the same time strengthening connections to the hospital and post-hospital services like providing food, prescriptions, and transportation to follow up appointments.

We believe that these models can be scaled in both rural and urban settings to meet the needs of underserved individuals. With the details of these models in mind, we are pleased to respond to the following questions:

1 http://resources.smartpolicyworks.com/health/social-determinants-housing-pilot.pdf
2 Id.
3 https://housingforhealth.org/bhh/
**Question 1:** What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

At UI Health, we see three main factors influencing patient outcomes in our underserved, urban area: 1) addressing social and structural determinants of health; 2) improving access to care, community resources and system improvements and 3) primary and secondary prevention of chronic diseases.

As we have already discussed our programs aimed at addressing a few of the social determinants of health, we would like to focus on access to care. For patients, having access to care in their communities is critical. Federally Qualified Health Centers, like our Mile Square Health Center, ensure that patients can get care in both their rural and urban communities, regardless of a patient’s ability to pay. In addition to primary care, FQHCs can also provide dental, mental and behavioral health care. We have had great success placing dental services in two of the Mile Square locations and are pleased to offer both wraparound and medication assisted treatment at our main Mile Square site. The ability to provide these services comes from federal funding of FQHCs and several HRSA grants we have received.

Preventative care and screenings play an essential role in addressing chronic diseases. Addressing health care in communities should also involve reaching into communities and homes through programs like health fairs and screening events. Our cancer care delivery model at UI Health was redesigned to serve this model and bring not only health and preventative care into the communities but also to exemplify a “bench to community model” and bring access to cancer clinical trials into underserved communities.

**Question 2.** What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

As aforementioned, we have implemented two models focused on addressing social determinants of health that have demonstrated improved healthcare outcomes and cost savings for our underserved communities. Through the BHH program, UI Health supports patients moving from the emergency room to stable housing. This provides a home base for essential health activities and recovery, such as storing medication, sleeping, eating, and staying warm. If you are homeless, recovery and/or managing health is extremely difficult. This program is often the difference between the path to recovery or ending up back to the emergency room. It provides better healthcare options for patients and has reduces costs at UI Health for these patients by 21 percent.

UI Health’s PRONTO program addresses the transportation needs of patients, which has resulted in a reduction in re-hospitalizations. Under this program, front-line clinicians evaluate transportation needs of recently discharged patients and supply rides via Lyft. Several federal policies that could help expand and support these types of innovative models in a variety of communities would include:

- Provide flexibility in the Medicaid program to support these types of services, either through waivers or demonstrations.
• Provide incentives for public-private partnerships to innovate and scale up programs such as BHH and PRONTO that address social determinants of health, or encourage partnerships with local organizations and safety-net hospitals.

• Provide grant funding either directly to programs addressing social determinants of health or through partnerships with state and local governments.

• Provide funding for innovative and flexible programs at the CMS Innovation center.

Question 5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?

As mentioned above, BHH is a partnership with the Center for Housing and Health, which UI Health helped launch. This network is called the Flexible Housing Pool, a collaborative alliance of 28 supportive housing agencies across Chicago and Cook County focused on addressing the gaps between the housing and health care sectors. It includes other hospitals, state and local entities, and public and private funders. The City of Chicago recently announced a $5 million investment in the Flexible Housing Pool. Through its partnerships, the network helps provide permanent supportive housing across Chicago and offers support and wrap-around health services to its clients. This type of model could serve as an example for other healthcare providers in urban and rural settings to address some of the most pressing social factors that can contribute to poor health outcomes.

As with many programs aimed at addressing social determinants of health, the main challenge is funding, both the lack of investment from the private sector and the rigidity of federal funding to support this type of activity. If incentives were given to drive initial private seed funding in this type of program or if Medicaid had more flexibility to pay for this type of activity—specifically housing—this type of model could be scaled up and/or replicated. Because we have seen a decrease in costs as a result of BHH, we believe that after initial investments there would be motivation for further funding based on the demonstration of reduced costs.

Question 6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

In addition to experiencing provider workforce shortages (which can be addressed by lifting the federal cap on Medicare GME slots) we also face a shortage of professionals that are trained to work in underserved areas, further exacerbating health inequities. Exposing future health professionals to underserved settings is an important part of the student experience and critical to addressing health inequity. At UI Health, we are exposing students to these types of experiences through programs like the Urban Medicine program; this four-year curriculum integrates core principles of public and population health with direct participation in local, underserved community interventions. Among its attributes, it engages course participants with community organizations to develop and evaluate health promotion and disease prevention projects and prepares students for roles that will be able to impact healthcare in underserved communities.
At our Rockford campus, we have implemented the Rural Medical Education Program, which seeks to recruit, admit, and prepare medical students from Illinois who will locate and practice in rural Illinois after finishing their residency. The Rural Student Physician Program (RSPP) provides clerkships in which students spend 28 weeks in a rural community learning with physician mentors.

Congress could examine opportunities to build on the current GME structure to expand the workforce to be more diverse and prepared to address the needs of underserved patients. We would suggest increasing federal funding for resources like scholarships for students from underrepresented backgrounds, and funding innovative GME demonstrations through the CMS Innovation Center.

**Question 9:** There are known, longstanding issues with availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved area, but are unavailable or lack uniformity?

The escalation of public sector service utilization (criminal justice, first responders, human services, mental health and substance use treatment, individualized education plans) often predates the increase in downstream healthcare cost & utilization. Data about individuals who frequently utilize public sector systems remain locked away in isolated silos. This limits the ability for identification and intervention earlier in a person’s life, when trauma, injury or mental illness first occur.

These silos of remote, locked-up data impedes the development of evidence-based policy that could lead to right-sizing the provisioning of mental health, substance use, healthcare and criminal justice diversion. Earlier lifespan identification will interrupt the cycle of generational poverty and may result in the reduction of excessive public sector costs.

The Office of the National Coordinator (ONC) should play the role of developing data interoperability standards and ontologies that will standardize vocabularies, much like it has done for Electronic Health Records, so that disparate systems and the resulting data can be combined across public sector systems.

The most vulnerable persons in underserved or rural communities often require an array of services across several agencies that are uncoordinated. The ONCs work would have the effect of creating inter-system communication protocols that would facilitate coordination of care among disparate healthcare EHRs, human service case management, homeless management information systems (HMIS), and public benefit systems.

**Question 10:** Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

To answer this question, we would like to sum up some of the policy recommendations that we have made in this document because they can have a significant impact on care quality in health systems that provide care to underserved areas.
Congress should provide the flexibility for health systems to support innovative pilots, demonstrations and programs aimed at addressing social determinants of health to help improve care and health outcomes. This can be done by allowing Medicaid dollars to pay for services like housing. Congress should consider promoting the use of 1115 waivers for this type of activity.

Congress should also consider supporting demonstrations that allow for innovative approaches to address social determinants of health through the CMS Innovation Center. A program similar to the Healthcare Innovation Awards (once funded though the Innovation Center) could spur real, scalable solutions to the health equity and social determinants of health challenges facing the United States.

Congress should provide incentives for public-private partnerships to innovate and scale-up programs (like the UI Health PRONTO or Better Health Through Housing models) that address social determinants of health. Congress could also encourage partnerships with local organizations and safety-net hospitals.

Thank you again for this opportunity to comment, and your efforts to address health inequalities in the United States. If you have any questions please do not hesitate to reach out to Emily Gibellina, Assistant Vice Chancellor for Health Affairs Advocacy and Government Relations at emilyg@uic.edu.

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1 [https://housingforhealth.org/who-we-are/](https://housingforhealth.org/who-we-are/)