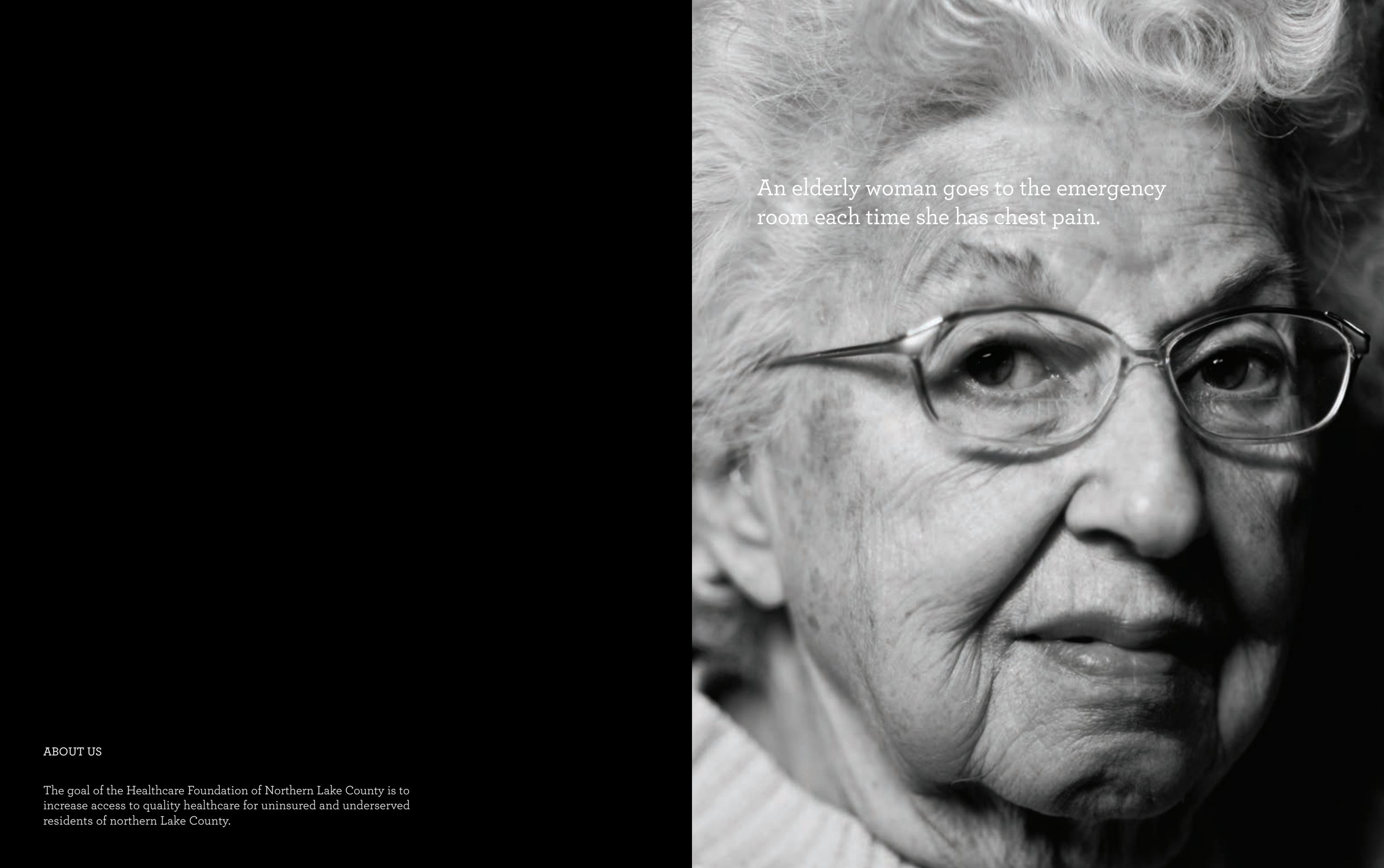


2010-12 REPORT

# HEALTHCARE FOUNDATION OF NORTHERN LAKE COUNTY



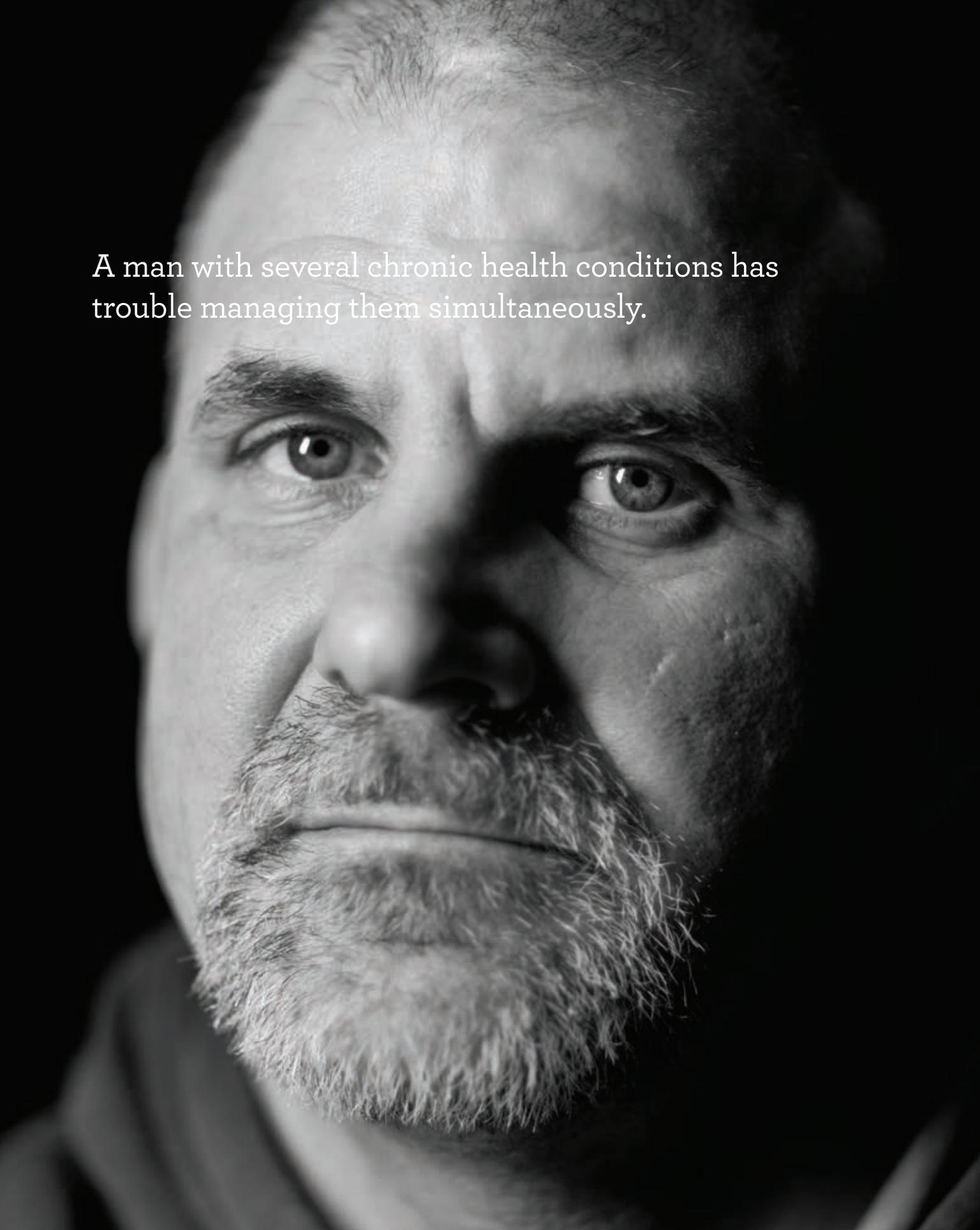
An elderly woman goes to the emergency room each time she has chest pain.

#### ABOUT US

The goal of the Healthcare Foundation of Northern Lake County is to increase access to quality healthcare for uninsured and underserved residents of northern Lake County.



A mother has no way to get her sick child to the nearest clinic.



A man with several chronic health conditions has trouble managing them simultaneously.



A man with diabetes has Medicaid,  
but can't find a doctor who accepts it.

Something's wrong.  
But what, exactly?  
And how do you fix it?

# We do that in three ways.

## We increase the number and variety of entry points to healthcare.

We support an array of programs that provide comprehensive and ongoing health services to prevent disease and delay the progression of disease. These programs provide primary care services (including direct medical, dental, vision, and mental healthcare), medical supplies, pharmaceuticals, and healthcare equipment.

## We increase residents' ability to gain control over the social and personal conditions that affect their health.

We support community health education that is paired with screenings, referrals, and follow-up, recognizing that many of the chronic diseases that disproportionately affect low-income populations—conditions such as heart disease, hypertension, diabetes, obesity, and arthritis—respond favorably to preventive treatment as well as changes in diet, exercise, and other behavioral factors.

## We increase the number of health care practitioners in Lake County.

We support postsecondary education scholarship programs that prepare county residents to pursue health-related careers and to work in underserved Lake County communities.

STRATEGY 1

## Eliminate waste and bottlenecks

For healthcare providers—and for those who pay the bills—the ideal system would provide care at the right time, at the right place, and at the exact level the patient needs.

“We’re all in agreement conceptually about what needs to be done,” says Julie Mayer, director of community and government relations at Advocate Good Shepherd Hospital. “The question is how to operationalize it.”

Bringing public and private healthcare providers together to answer that question was the goal of a 2011 proposal from Lake County Health Department/Community Health Center (LCHD/CHC). Specifically, the department wanted to explore two initiatives: setting up a web-based, HIPAA-compliant connection to link primary care providers with specialists for referrals and devising a plan to divert patients away from emergency rooms.

Project consultant Health Management Associates met with hospital leaders and physicians to assess

their interest, needs, and potential commitment. While the electronic referral platform was judged a good idea, the ER diversion plan sparked more immediate interest.

“The word ‘diversion’ is kind of a misnomer,” says LCHD/CHC primary care services director Jeanne Ang, who with executive director Irene Pierce has been overseeing the process. “The idea isn’t so much to divert patients from the emergency department as it is to make sure they’re getting the primary care they need. A patient might go to the ER for a non-emergency issue, one better taken care of, and at a much lower cost, in a primary care environment. Or she might go to the ER for a legitimate emergency, say chest pain, and not have a relationship with a primary care provider who could have given her the medication that might have prevented the chest pain in the first place.

“At this point, the alert system is probably priority number one. When an uninsured patient or one with Medicaid hits the emergency room, LCHD/CHC and HealthReach would get an email; we

would then have the responsibility within 24 hours to follow up with those patients to get them into ongoing care.”

Learning why and when patients choose to go to the hospital instead of a health center may suggest a second strategy: longer or alternate clinic hours. “If people are going to the hospital because it’s 2 a.m. and we’re not open, we’re not going to be able to solve that problem. But if it’s because it’s a Sunday afternoon and we’re not open, we may be able to solve that one,” Ang says.

Progress will depend on hospitals’ willingness to work together, and Ang is confident they will. “The hospitals see themselves as part of the solution, and they’re willing to say ‘We’ll do as much as we can.’ Sometimes that’s enough.”

“We’re all in agreement conceptually about what needs to be done....The question is how to operationalize it.”





## STRATEGY 2

# Find the resources you have and build visible pathways to them

Antioch's ambitious plan to improve access to healthcare began as a simple conversation at an HFNLC community forum. Among the neighbors who turned out that night were representatives from the local rescue squad, food pantry, state and local government, churches, and schools.

"Everyone had something to contribute, a story to tell about what wasn't working," says Pastor Ellen Arthur of St. Stephen Lutheran Church. "As we listened, we started thinking, 'Is there a way to coordinate our efforts and our resources to better connect people to the health-related services they need?'"

At evening's end, village trustee Mary Dominiak, a board member at HFNLC, asked if participants were interested in continuing the conversation. It would be the beginning of the Antioch Area Healthcare Accessibility Alliance (AAHAA), launched to identify and coordinate existing service providers and then plan and communicate a comprehensive quality healthcare access strategy for Antioch residents. Two related issues came quickly to the forefront: the

lack of transportation options and the shortage of local doctors, particularly specialists, to serve the area's elderly, disabled, and uninsured.

With HFNLC funding, the group began work on transportation and network nurse pilots and a strategic plan. Millennia Consulting, hired to help develop that plan, is currently mining existing data sources, including census and school data and reports from HFNLC and Lake County Health Department. Interviews and surveys, plus two community focus groups, will ensure that residents' views inform the plan.

In the meantime, the pilot projects are addressing the area's current and pressing problems. Community network nurse Gloria Stevens started part-time at the end of April; by June, she'd already referred, talked to, or worked with about 30 residents.

"She's out there, she's seen, people know who she is," says Arthur. That visibility is important. Stevens' job is not to provide medical care, per se, but to act as a health system navigator, answering questions,

providing health education, and linking individuals and resources.

"Navigation—knowing what's out there and how to get it—is a big problem for the people we see," says alliance member Marytherese Ambacher, executive director of Open Arms Mission, which operates a local community pantry.

Arthur agrees. "If we're totally wrong about what we're hearing, we will still have accomplished something with the nurse pilot. We will still have that referral network, and a community that looks out for each other and knows who to call when something's wrong."

"Everyone had something to contribute, a story to tell about what wasn't working."



### STRATEGY 3

## Remove the obstacles between people and treatment

If you are homeless, chances are you won't be getting regular medical care. To schedule or get to an appointment, fill a prescription, and comply with prescribed treatments depend on regular access to a phone, a predictable schedule, transportation, a place to store medicine, and food to take it with.

Without regular care, manageable illnesses become emergencies. "We used to have ambulances pulling into the PADS parking lot nearly every day," says Cathy Curran, executive director of PADS Lake County.

Two years ago, the Lake County Coalition for the Homeless, a consortium of 32 community organizations, approached HFNLC for funding to pilot a medical advocates program to assist clients with the logistics of both accessing primary care and following through with treatment.

The program was an immediate hit. "You have clients waiting for you in the parking lot, requesting services for medical issues," says advocate Ron Bowles, one of two based at PADS' Assessment Center in North Chicago. "From then on, you are basically just run-

ning, going from client to client and trying to answer as many questions as you possibly can within the time that you have."

During the "slow" months of summer, advocate case loads typically include 30 to 35 people. When colder weather hits, that number jumps to more than 100. The coalition estimates that this year, Bowles and coworker Geri Romero will serve approximately 1,200 individuals, giving priority to those with acute and chronic health conditions, chief among them hypertension, psychiatric disorders, and diabetes.

Working from referrals, Bowles and Romero spend the bulk of their time scheduling and rescheduling medical, psychiatric, and dental appointments; following up with clients to make sure they understand and complete their treatments; dropping off and picking up prescriptions; and assisting with transportation to and from appointments. To ensure coordination with other organizations, advocates track each client, referral, and record of service in a centralized information and case management system hosted by the county.

"We used to have ambulances pulling into the PADS parking lot nearly every day."

Providing follow-up to a fluid population is a constant challenge. "People come and go," says Curran. "We try to track them, to make sure they're taking their medications and making it to their appointments. Still, it's hard to stay on top of things."

In spite of the difficulties, using medical advocates to remove the barriers to primary care seems to be improving healthcare outcomes for the homeless and lowering healthcare costs overall. Comparing current data to baseline figures kept by PADS before program launch, the coalition estimates the advocates' work has reduced hospital emergency room visits by 34 percent; hospitalizations by 24 percent, and the need for ambulance services by 41 percent.

#### STRATEGY 4

## Fill in the cracks that people slip through

When distinct but related disorders such as mental illness and substance abuse are treated separately, patients bouncing between service providers can get confused, and even lost. In May 2011, four Lake County nonprofit organizations—Arden Shore Child and Family Services, NICASA, YWCA Lake County, and the Lake County Health Department (LCHD)—formed the Lake County Mental Health Coalition to close the gaps between them.

Backed by funding from HFNLC, in February 2012 the collaborative began piloting a coordinated care approach. Clients coming to Arden Shore or NICASA for treatment of mental illness or substance abuse are first screened for co-occurrence of these disorders. Clients who are dually diagnosed are referred to the project director, Peter Mazzeratti, for assessment. If the client agrees, he or she is randomly assigned to either an experimental or control group.

Control group participants receive services from both agencies under the “parallel services” model, the traditional approach to treatment. Mental illness and substance abuse are treated independently.

Communication between respective clinicians is minimal or nonexistent. Follow through on referrals is the client’s responsibility.

Experimental group participants, on the other hand, enter into a four-agency treatment alliance marked by collaboration, coordination, and communication. Clients receive substance abuse treatment at NICASA and mental health treatment at Arden Shore. LCHD provides supportive ongoing and acute psychiatric services, while the YWCA’s employment and leadership and development services help clients acquire the life skills and supports they need for recovery. Integrated care plans, referrals, and other case information are shared among the collaborative’s partners.

Mazzeratti follows clients across agencies; Arden Shore and NICASA staff jointly follow up on referrals and monitor client compliance across treatments. Ongoing training in the new approach and monthly staffings bring the teams together.

“We discuss what’s going on in treatment, how clients are responding, and what their perceptions are,” says

“We decide together what we have to do to meet clients’ needs and better engage them.”

Mazzeratti. “We decide together what we have to do to meet clients’ needs and better engage them.”

A researcher from Northwestern University’s Feinberg School of Medicine is examining project data on both client-side and interagency variables. “We are not just evaluating client progress, we are evaluating how our agencies are working together and whether that is having an impact on how we provide client services,” says Dora Maya, president and CEO of Arden Shore.

Bruce Johnson, CEO of NICASA, believes the integrated approach is already paying dividends. “Some agencies fear they make themselves vulnerable by divulging program information and data,” he says. “But in the end, it’s the collaboration, the relationship, the ability to pick up the phone and talk to each other, that’s going to provide for a much better handoff between the partner agencies for services.”



## 2010–12 GRANTEES

At the core of all our grant making are a few simple tenets. We encourage program designs based on best practices—models that not only provide healthcare but that gather data to measure program effectiveness and point the way to improvement. We believe in collaboration and promote strategic partnerships with public and private organizations, including public health departments, community organizations, and educational and healthcare institutions. We value linguistically and culturally appropriate models of service. We seek sound knowledge and information to improve access to health services.

We support programs that target uninsured or underinsured individuals and families, and underserved neighborhoods and communities of Antioch, Fox Lake, Grayslake—Third Lake, Great Lakes, Gurnee, Lake Villa—Lindenhurst, North Chicago, Round Lake, Wadsworth, Waukegan, and Zion.

Details regarding these and other grants can be found on our web site, [www.hfnlc.org](http://www.hfnlc.org).

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Illinois Coalition for Immigrant & Refugee Rights

Illinois Maternal and Child Health Coalition

Illinois State Dental Society Foundation

The Josselyn Center

Lake County Coalition for the Homeless

Lake County Community Foundation

Lake County Crisis Center (known as A Safe Place)

Lake County Health Department Behavioral Health Services

Lake County Health Department/Community Health Center

Lake County Mental Health Coalition

Mano a Mano Family Resource Center

Mobile C.A.R.E Foundation

Most Blessed Trinity

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YouthBuild Lake County

YWCA Lake County

Zacharias Sexual Abuse Center

Zion Benton Children's Services

Our thanks to the following residents of northern Lake County and to the staff of the organizations profiled whose photos appear in this report: Dolores R. Faltynek, Yamel Azcoitia and Omar Gomez, James Richardt, Douglas Alexander, Jeanne Ang, Ellen I. Arthur, Ronald Bowles, and Peter Mazzeratti.

Healthcare Foundation of Northern Lake County  
114 South Genesee Street, Suite 505  
Waukegan, Illinois 60085  
[www.hfnlc.org](http://www.hfnlc.org)