Healthcare Transformation Collaboratives Cover Sheet

1. Collaboration Name:

South Side Health Equity Collaborative (SSHEC)

2. Name of Lead Entity:

Insight Hospital & Medical Center

3. List All Collaboration Members:

Alivio Medical Center
Chinese American Service League
Friend Health
HRDI, Inc.
Insight Hospital & Medical Center
Inner-City Muslim Action Network
Malcolm X College
Sylvester Broome Empowerment Village

4. Proposed Coverage Area:

The service area for this initiative includes a broad swath of the South Side of Chicago, essentially from the lakefront west to the city limit, from the Stevenson Expressway on the north to the city limits on the south. (zip codes 60609, 60615, 60616, 60617, 60619, 60620, 60621, 60628, 60629, 60631, 60632, 60633, 60636, 60637, 60638, 60643, 60649, 60652, 60653, 60655).

5. Area of Focus:

The 5 core strategies are

- Maternal Health
- Youth Empowerment
- Addressing chronic conditions in adults
- Behavioral Health
- Workforce Development

6. Total Budget Requested:

$56,178,585.00

0. Start Here - Eligibility Screen

Does your collaboration include multiple, external, entities?

☒Yes
☐No

Can any of the entities in your collaboration bill Medicaid?

☒Yes
☐No

1. Participating Entities

Contact Information for Collaborating Entities

1. What is the name of the lead entity of your collaborative?

Insight Hospital & Medical Center

2. Please provide primary contact information, secondary contact information, and the Tax ID # of each entity in your collaborative. Please list the lead entity in the top row.

Entity Name	Primary Contact	Position	Email	Secondary Contact	Secondary Contact Position	Secondary Contact Email
Insight Hospital & Medical Center	Atif Bawahab	CEO	Atif.bawahab@iinn.com	Dr. Dillon Bannis	Chief Medical Informatics Officer	dillon.bannis@iinn.com
Alivio Medical Center	Esther Corpuz	CEO	ecorpuz@aliviomedicalcenter.org,	Pankaj Nagpal	CFO	pnagpal@aliviomedicalcenter.org
Chinese American Service League	Jered Pruitt	COO	jered_pruitt@caslservice.org	Jamie Ewing	DPS	jamie_ewing@caslservice.org
Friend Health	Dr. Verneda Bachus	CEO	vbachus@friendhealth.org	Wendy Thompson	COO	wthompson@friendhealth.org
HRDI, Inc.	Deborah Parnell-Washington	Director of Clinical Strategies	DParnell@hrdi.org	Dr. Verneda Bachus	CEO	vbachus@friendhealth.org
Inner-City Muslim Action Network	Maysoon Haleem	Senior Revenue Manager	Maysoon@imancentral.org	Patricia Washington	Grants Manager	patricia@imancentral.org
MXC	Dr. Elizabeth Gmitter	Executive Director-College Initiatives and Projects	egmitter@ccc.edu	David Sanders	President	dsanders67@ccc.edu
Sylvester Broome Empowerment Village	Maryum Rasool	Executive Director	maryum@sbev.org	Nadir Ijaz	Chief Operating Officer	nadir.ijaz@iinn.com

1. Are there any primary or preventative care providers in your collaborative?

☒Yes
☐No

1A. Please enter the that names of provide primary or preventative care in your collaborative.

Alivio Medical Center
Friend Health
HRDI, Inc.
Insight Hospital & Medical Center
Inner-City Muslim Action Network

2. Are there any specialty care providers in your collaborative?

☒Yes
☐No

2A. Please enter the names of entities that provide specialty care in your collaborative.

Alivio Medical Center
Friend Health
HRDI, Inc.
Insight Hospital & Medical Center

3. Are there any hospital services providers in your collaborative?

☒Yes
☐No

3A. Please enter the name of the first entity that provides hospital services in your collaborative.

Insight Hospital & Medical Center

3B. Which MCO networks does this hospital participate in?

☒YouthCare
☒Blue Cross Blue Shield Community Health Plan
☒CountyCare Health Plan (Cook County only)
☒IlliniCare Health
☒Meridian Health Plan (Former Youth in Care Only)
☒Molina Healthcare

4. Are there any mental health providers in your collaborative?

☒Yes
☐No

4A. Please enter the names of entities that provide mental health services in your collaborative.

Alivio Medical Center
Chinese American Service League
Friend Health
HRDI, Inc.
Insight Hospital & Medical Center
Inner-City Muslim Action Network

5. Are there any substance use disorder services providers in your collaborative?

☒Yes
☐No

5A. Please enter the names of entities that provide substance abuse disorder services in your collaborative.

Alivio Medical Center
Friend Health
HRDI, Inc.
Insight Hospital & Medical Center
Inner-City Muslim Action Network

6. Are there any social determinants of health services providers in your collaborative?

☒Yes
☐No

6A. Please enter the names of entities that provide social determinants of health services in your collaborative.

Chinese American Service League
HRDI, Inc.

7. Are there any safety net or critical access hospitals in your collaborative?

☒Yes
☐No

7A. Please list the names of the safety net and/or critical access hospitals in your collaborative.

Insight Hospital & Medical Center

8. Are there any entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that that are majorly controlled and managed by minorities?

☒Yes
☐No

8A. Please list the names of the entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that that are majorly controlled and managed by minorities.

Alivio Medical Center
Chinese American Service League
Friend Health
HRDI, Inc.
Insight Hospital & Medical Center
Inner-City Muslim Action Network
Sylvester Broome Empowerment Village

9. Please list the Medicaid-eligible billers (firms that can bill Medicaid for services) in your collaborative, and the Medicaid ID for each.

Alivio Medical Center:

- Berwyn Clinic
- Morgan Clinic
- Western Clinic
- Alivio Walk-In Wellness at Berwyn
- Alivio Medical Center at Benito Juarez Community Academy
- Alivio Medical Center at Little Village
- Jose Clement Orozco Academy of Fine Arts & Sciences

Chinese American Service League

Friend Health

HRDI, Inc.

Insight Hospital & Medical Center:

- Hospital
- Medical Group

Inner-City Muslim Action Network:

- IMAN Youth and Family Health Center
- IMAN

10. Below are high-level descriptions of project types that appeared in the Transformation funding statute. Check any that apply to your project; if none apply, please provide a brief description of what kind of entities comprise your collaboration. (This question is informational only and will not affect your eligibility).

☒Safety Net Hospital Partnerships to Address Health Disparities
☐Safety Net plus Larger Hospital Partnerships to Increase Specialty Care
☒Hospital plus Other Provider Partnerships in Distressed Areas to Address Health Disparities (led By Critical Area Hospitals, Safety Net Hospitals or other hospitals in distressed communities)
☐Critical Access Hospital Partnerships (anchored by Critical Area Hospitals, or with Critical Area Hospitals as significant partners)
☒Cross-Provider Care Partnerships Led By Minority Providers, Vendors, or Not-For-Profit Organizations
☒Workforce Development and Diversity Inclusion Collaborations
☐Other

2. Project Description

Brief Project Description

1. Provide an official name for your collaboration.

South Side Health Equity Collaborative (SSHEC)

2. Provide a one to two sentence summary of your collaboration's overall goals.

The South Side Health Equity Collaborative seeks to improve the health status of individuals and communities on the South Side of Chicago in a manner that is community-informed, data-driven, and deployed with a "racial equity first" disposition. It focuses innovative strategies on healthcare access and social conditions that are directly contributing to shortened life spans and poorer quality of life in highly vulnerable communities of color that have been historically disinvested and disproportionately harmed by structural racism.

Detailed Project Description

Introduction. The South Side Health Equity Collaborative seeks to improve the health status of individuals and communities on the South Side of Chicago in a manner that is community-informed, data-driven, and deployed with a "racial equity first" disposition. It focuses innovative strategies on healthcare access and social conditions that are directly contributing to shortened life spans and poorer quality of life in highly vulnerable communities of color that have been historically disinvested and disproportionately harmed by structural racism.

The service area for this initiative includes a broad swath of the South Side of Chicago, essentially from the lakefront west to the city limit, from the Stevenson Expressway on the north to the city limits on the south. (zip codes 60609, 60615, 60616, 60617, 60619, 60620, 60621, 60628, 60629, 60631, 60632, 60633, 60636, 60637, 60638, 60643, 60649, 60652, 60653, 60655). This area constitutes the major service area of the Insight Hospital and Medical Center (the former Mercy Hospital) and the other partners have a strong historical presence of service in this area. The area is almost entirely composed of neighborhoods of high social vulnerability as designated by the Centers for Disease Control and Prevention (See Figures 1 and 2).

Figure 1

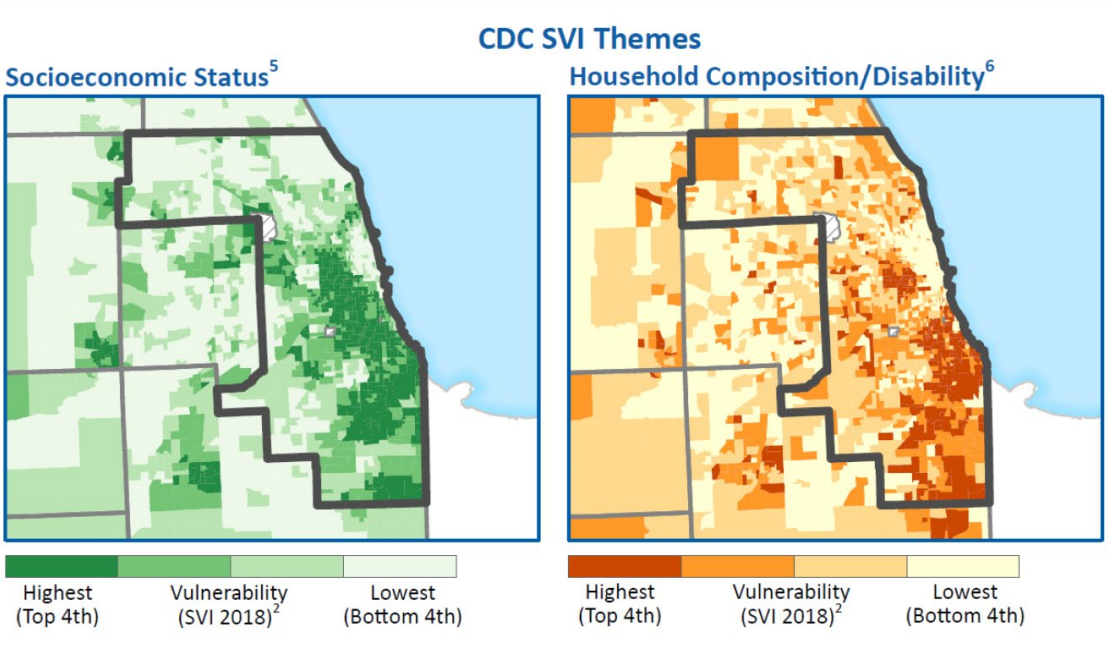
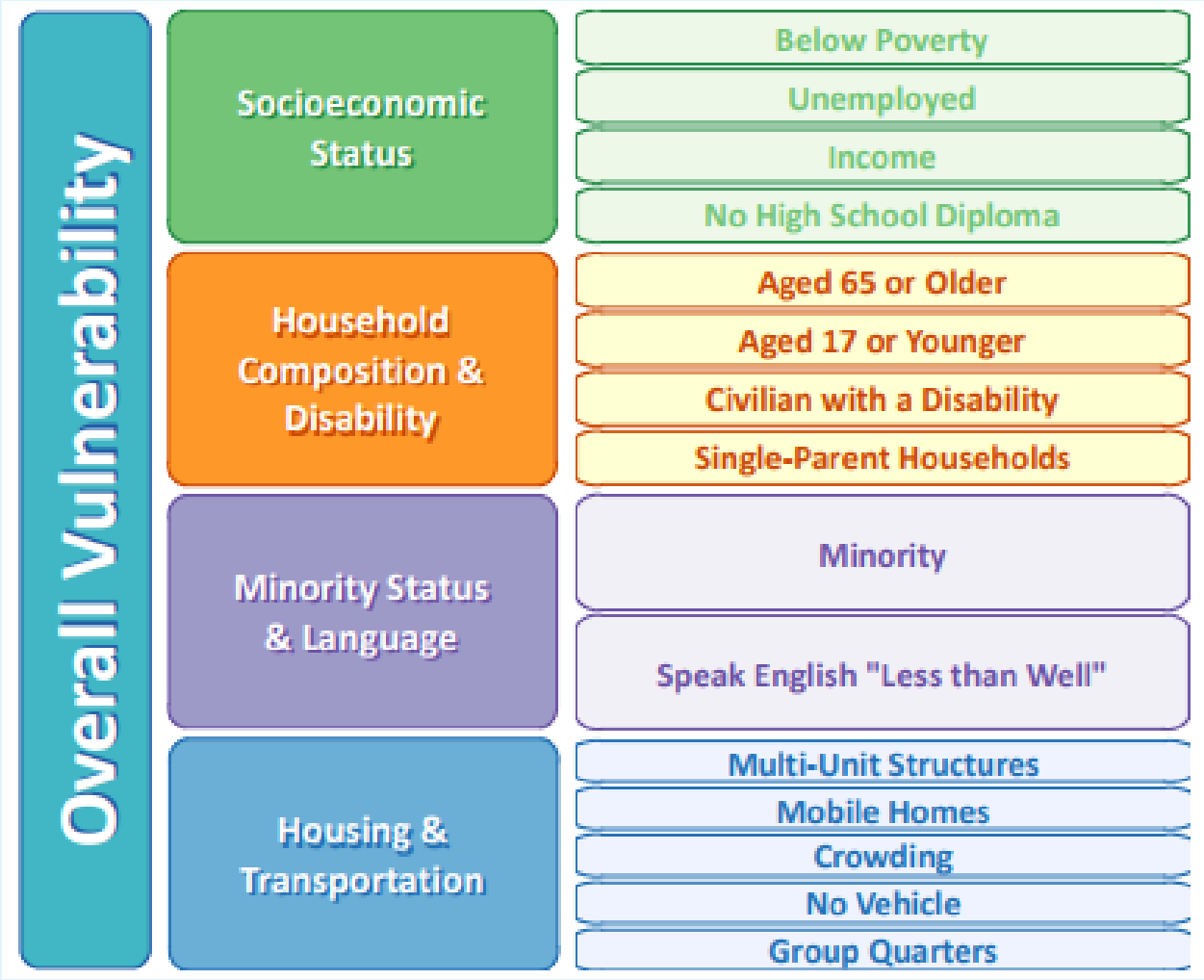
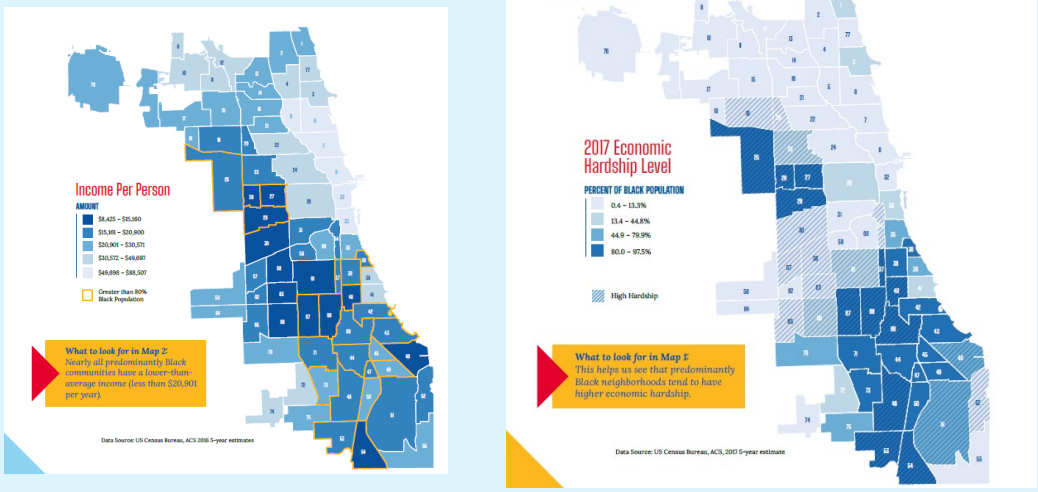


Figure 2



Challenges. This area has suffered significant social disruption over the past 100 years. As a result of the Great Migration of African Americans from the southern part of the United States, seeking a better quality of life and opportunity, the area has seen a significant change in racial and ethnic makeup. More recently, partly in a response to community-level violence, poor educational opportunities, and the disappearance of good-paying jobs, there has been an exodus of African Americans again, this time to suburbs of Cook County and to other destinations in the United States. Nonetheless, the South Side continues to be home mainly to black and brown residents, with lower household incomes and poor health status[1] (see Figure 3).

Figure 3



[1] Chicago Department of Public Health. *2021 Data Brief: The State of Health for Blacks in Chicago*

These challenges have been accompanied by a significant loss of healthcare assets on the South Side. The last 35 years have seen the closing of several hospitals on the South Side, including Provident (later reopened by Cook County Health), Doctor's Hospital of Hyde Park, Chicago Osteopathic, Michael Reese, the Hospital of Englewood, Mercy, and MetroSouth Medical Center in Blue Island. The area was a so-called "Trauma Desert" until the re-opening of the University of Chicago Medical Center service in 2018, and in the past five years several South Side hospitals closed their doors to delivering babies, including St. Bernard, Jackson Park, South Shore and Holy Cross. Likewise, with overall secular trends in decreasing hospitalization for children, the only general acute care hospital with inpatient pediatric services on the South Side of Chicago is the University of Chicago Comer Children's Hospital. Not only are there fewer hospitals serving these historically red-lined communities, but the hospitals that predominantly serve people of color are often subject to cash and capital shortages that limits the types and quality of care they provide[7].

In addition to these reduced physical and "operational" assets, the area has barriers to care (it is particularly underserved by medical specialists, maternal/delivery sites and specialists, behavioral health specialists, i.e., a medically underserved population, see Figure 4) and unequal representation of social drivers of health, resulting in healthcare disparities and lower life expectancy birth (see Figure 5).

Figure 4

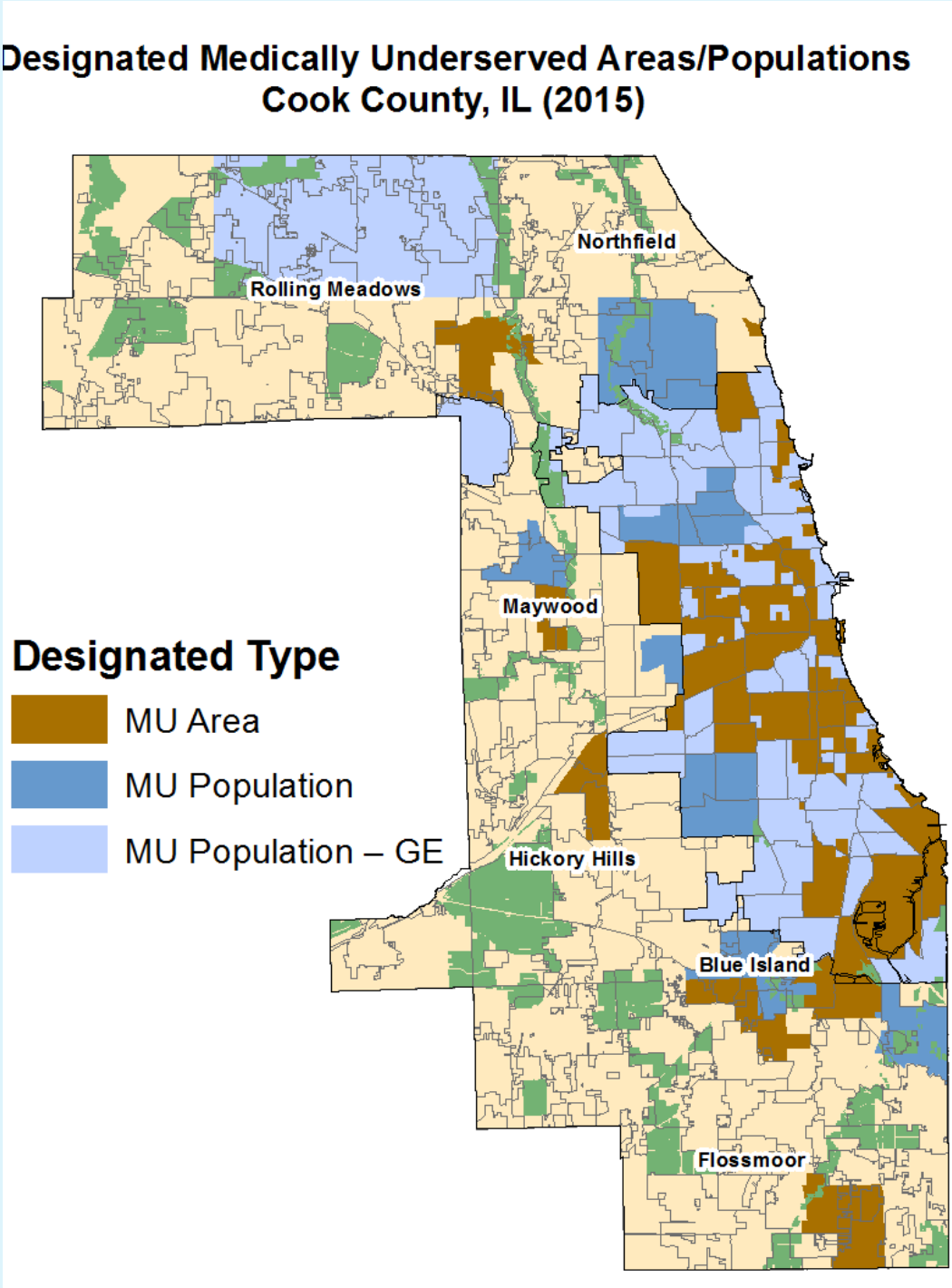
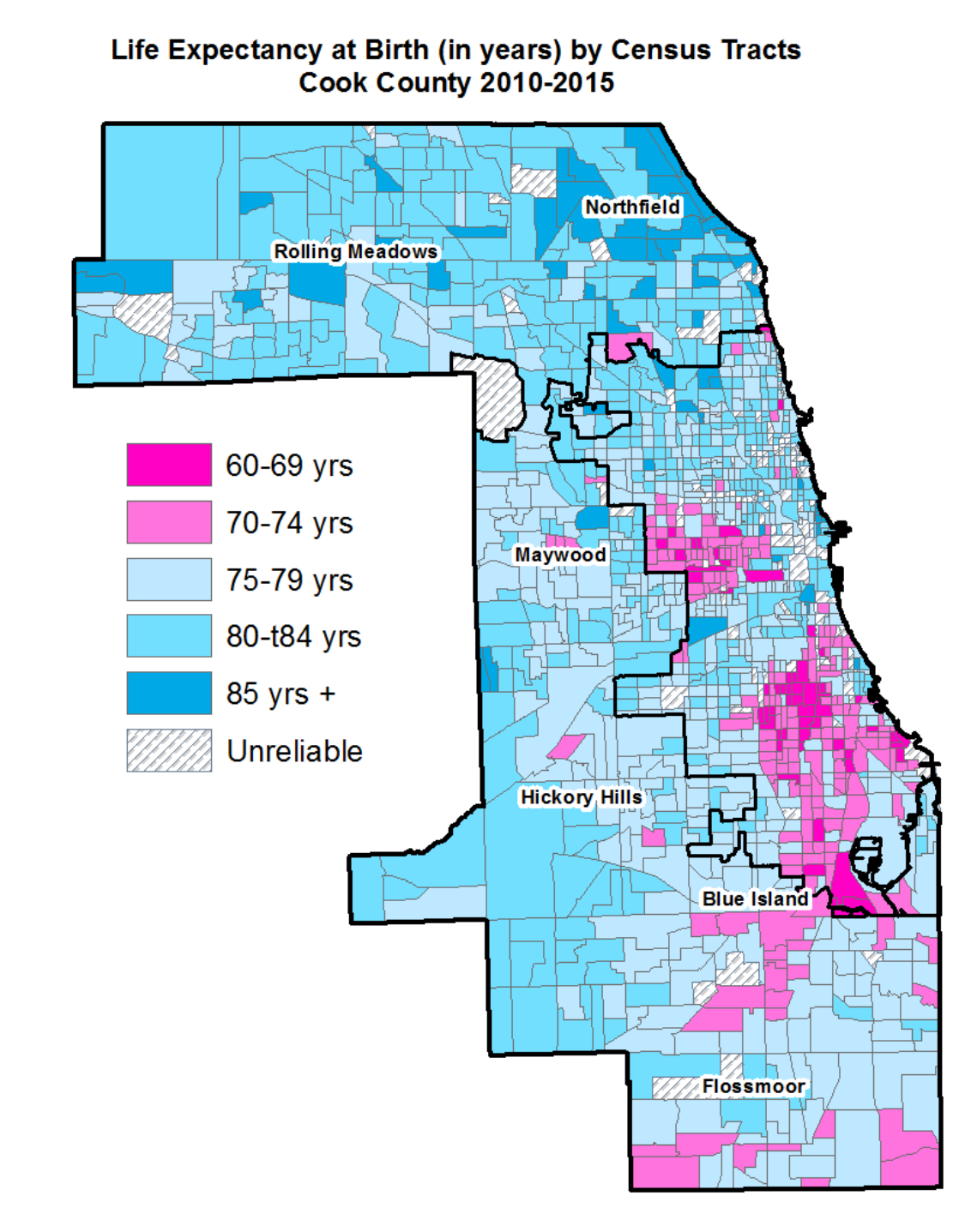

Designated Medically Underserved Areas/Populations
Cook County, IL (2015)
Northfield
Rolling Meadows
Maywood
Hickory Hills
Blue Island
Flossmoor
Designated Type
MU Area
MU Population
MU Population – GE

Figure 5



Access to care is lower on the South Side. For years, most of the area of interest to this collaborative has been designated as medically underserved (Figure 3). This barrier to care is also seen at the specialty level.

The South Side has higher social needs. Economic realities are mirrored by pragmatic challenges with social supports. Housing is a stark example, as is food insecurity[2] (see Figures 6 and 7).

[2] Chicago Department of Public Health. *2021 Data Brief: The State of Health for Blacks in Chicago*

Figure 6

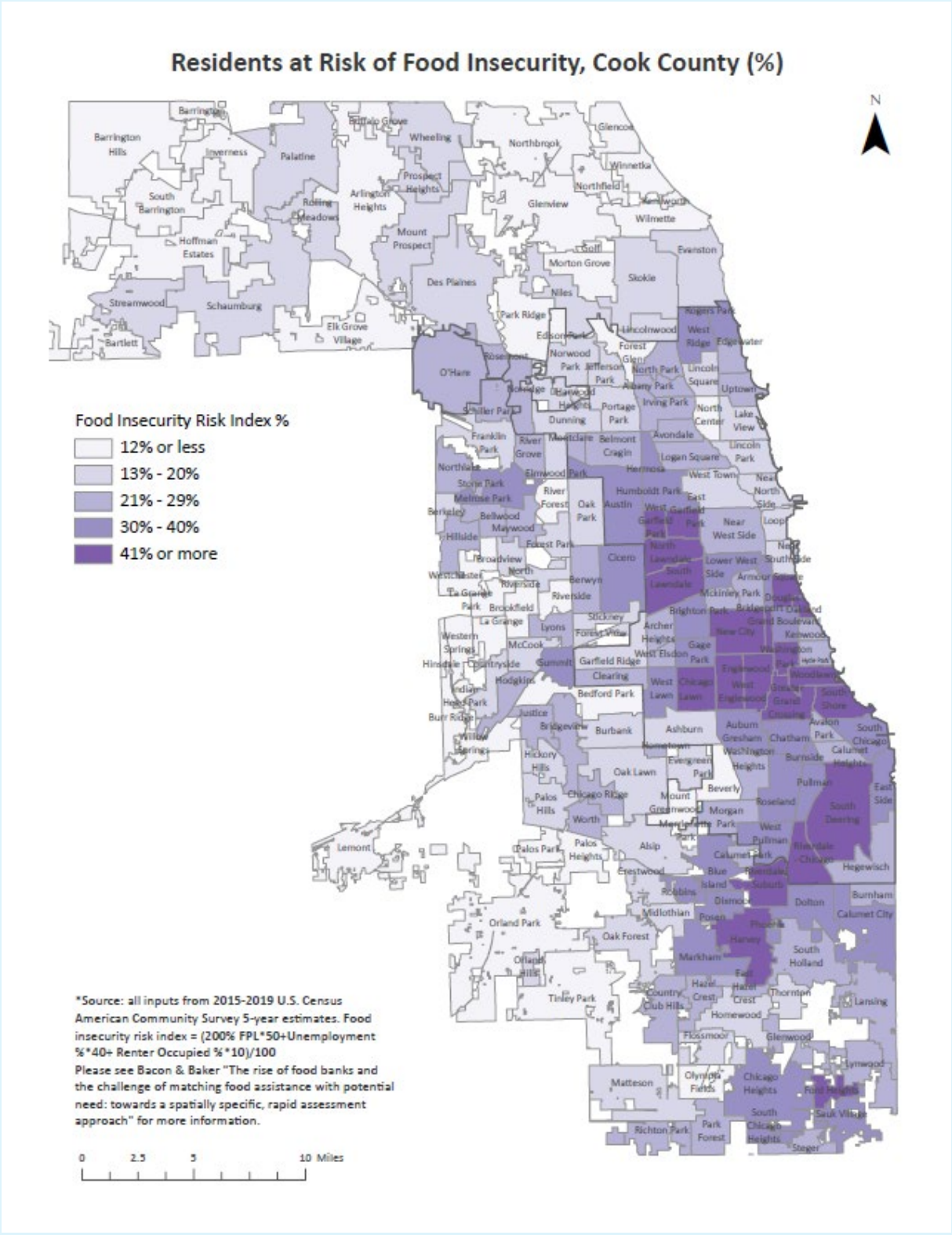
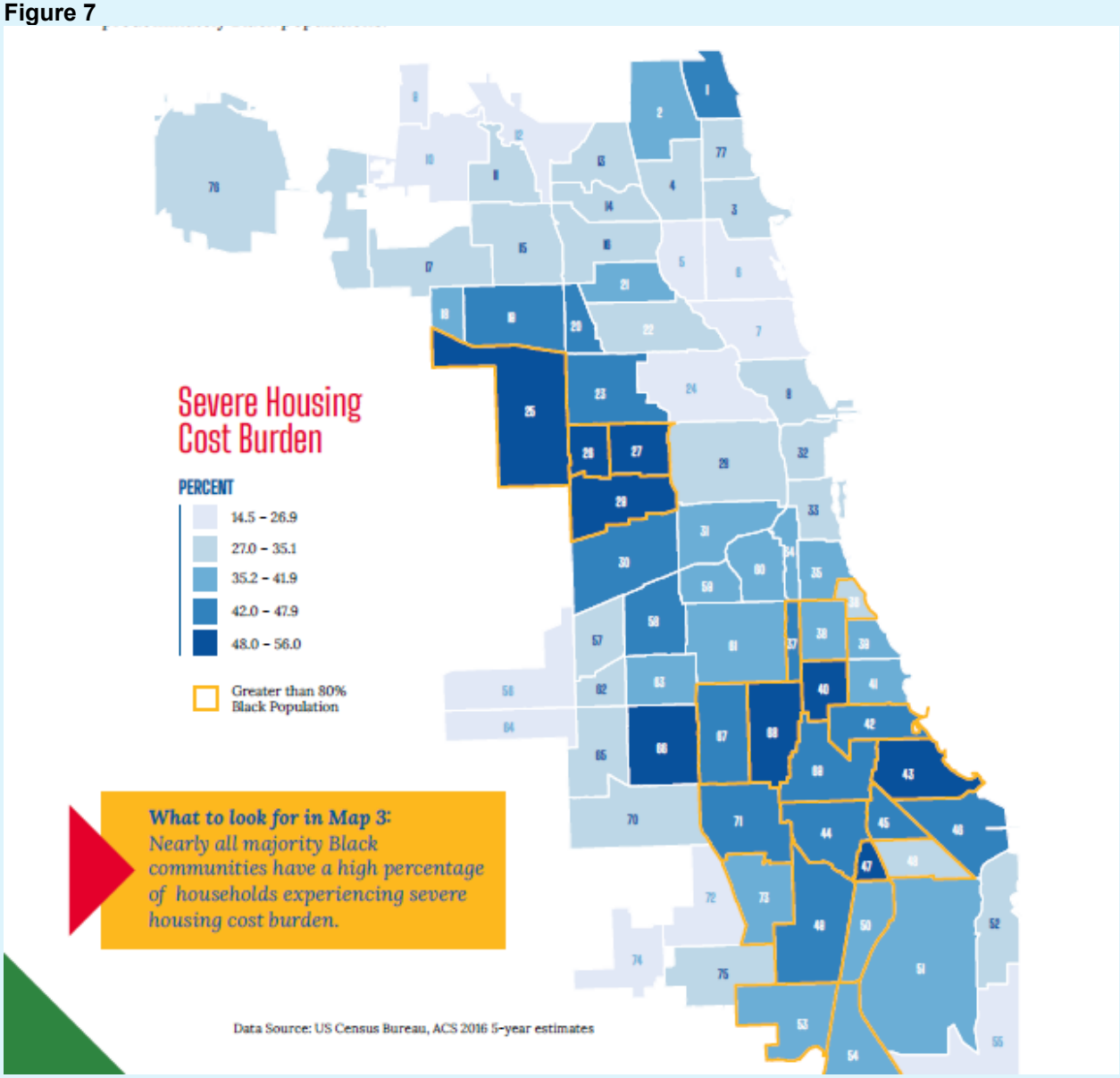

Residents at Risk of Food Insecurity, Cook County (%)
N
Food Insecurity Risk Index %
12% or less
13% - 20%
21% - 29%
30% - 40%
41% or more
*Source: all inputs from 2015-2019 U.S. Census American Community Survey 5-year estimates. Food insecurity risk index = (200% FPL*50+Unemployment %*40+ Renter Occupied %*10)/100
Please see Bacon & Baker "The rise of food banks and the challenge of matching food assistance with potential need: towards a spatially specific, rapid assessment approach" for more information.
0 2.5 5 10 Miles

Figure 7



Transformational partnerships, delivery redesign and innovative approaches to whole-person care

While the care provider organizations in this partnership have had interactions and referral-based relationships for some time, the HFS HTC gives a unique opportunity to accelerate truly transformative partnerships and innovation. Recognizing that resources are spread thin, and that many of our clients are from vulnerable populations that may not be familiar with use of primary care and preventive services, and that even where services exist care is not effectively coordinated, we have joined to synergize in an effort to more effectively serve this vulnerable population. The partnership breadth will allow delivery and coordination of primary care, specialty and diagnostic services, behavioral health services including those aimed at substance use disorders, and care coordination delivering effective connection with community-based social service providers.

Partners

<u>Alivio Medical Center</u>

Alivio Medical Center (AMC) was founded in 1989 as a bilingual, bicultural, non-profit community health center located in the heart of Pilsen, a predominantly Mexican neighborhood of Chicago. AMC was established to meet the needs of historically marginalized, largely Spanish-speaking individuals and families, including the uninsured, working poor immigrants, elderly and homeless. A Federally Qualified

Health Center since 1995, AMC's service area now includes nine communities in the West and Southwest side of Chicago, as well as the western suburbs of Cook County.

Historically, AMC has been a critical safety net provider for working immigrant families and individuals, whose population includes all low-income (≤ 200% FPL), In 2020, AMC's patient population was 83% Hispanic/Latino, 63% were served in language other than English, and 23% were under the age of 18. Through 32 years of service, AMC has developed a deep connection and singular understanding of this community's challenges and assets. AMC has evening and weekend hours and provides culturally sensitive, multi-lingual providers.

Services provided by AMC include Primary Care, Dental, maternal, Behavioral Health, Case Management, Preventive Screenings and Health Promotion / Outreach, Benefits Enrollment, Psychiatry, Urology, and Nutrition Services. AMC started providing Covid-19 testing in March 2020, and Covid-19 vaccine administration in December 2020. As of today, AMC has provided over 17,000 Covid-19 tests and administered 9,468 Covid-19 vaccine doses.

Chinese American Service League (CASL)

The Chinese American Service League (CASL), located at 2141 S. Tan Court Chicago IL 60616, is a nonprofit community-based social service agency founded in 1978 with the purpose of strengthening the physical, economic, and mental health of Chinese Americans and immigrants in the greater Chicago area. CASL is the largest and most comprehensive agency in the Midwest equipped to serve the needs of Chinese-speaking people. Comprehensive program activities strengthen families and lead to economic self-sufficiency; ease the cultural transitions of individuals and families as they integrate into American society; and advocate for positive social systemic change. Our bilingual, bicultural employees know the challenges of the immigrant experience and seek to enhance the lives of the nearly 5,000 people we serve annually.

CASL offers a wide range of services to all age groups in six areas: community and family well-being (CFW), children and youth development (CYD), senior wellness and independence (SWI), employment and financial empowerment (EFE), legal services, and health. Interdepartmental referrals, program support, and community collaborations ensure a holistic approach to service delivery for clients.

CFW programs meet basic needs and help stabilize families with services including citizenship and immigration support, ESL classes, family counseling, benefits enrollment, and health navigation. CFW also oversees CASL's Welcoming Center, a one-stop hub that provides comprehensive and holistic case management and service coordination to immigrants and refugees in a linguistically, culturally sensitive manner.

- CYD programs focus on quality infant development and parental bonding for ages 0-3, kindergarten readiness for ages 3-5, and social/emotional growth and academic success for ages 5-18.
- SWI programs encourage seniors to live healthy, happy, independent, and engaged lives with adult day services, in-home services, and a social/civic engagement group.
- EFE programs focus on employment, housing, and financial education to help improve the social and economic stability of families.
- The legal services department provides linguistically competent pro bono legal services to low-income clients.
- Health services includes the Client Advocacy Unit (CAU) that provides holistic, culturally, and linguistically competent behavioral health services to households with high needs and challenges to help them achieve healthy living, and a planned federally qualified health center (FQHC) will deliver primary health care.

The CASL Center for Social Impact analyzes micro and macro data collected in our agency-wide case management system on Salesforce, evaluates program outcomes compared to best-practice research, and recommends strategies to serve clients with greater impact. Each CASL program has its own logic model to evaluate impact. Program staff use SDoH survey questions borrowed from the Chicago Health Atlas to screen clients and identify potential needs such as potential food insecurity, living in an overcrowded housing situation, or having inadequate health access (to assess client movement from "at risk" to "survival"). CASL also started administering the Quality of Life survey, developed by the World Health Organization (WHO), to measure improvement in quality of life related to

health care and to assess a client's overall life quality and the long-term program impact (to differentiate "survive" and "thrive").

CASL collects data to identify potential trends in programming needs in the community and to make decisions about expanding or evolving existing programs or developing new programs to fulfill the unmet needs. We use validated assessment tools to evaluate program impact and effectiveness, and we compare our strategies with industry best practices to learn and improve programs. CASL staff use data to evaluate methods and understand clients; to identify areas for improvement and program adjustment; and to set and revise program goals. Program progress is evaluated quarterly, with each program area and each specific program submitting reports on activities, numbers of clients, and progress toward outcomes.

In addition, in response to the increase in racially motivated crimes against Asian American, Native Hawaiian, and Pacific Island people, CASL formed Community Equity Research Center (CERC) to promote inclusion and community empowerment. The center uses the research and data from our own CSI in combination with data that will be collected from partner organizations across the country to address disparities and shape policy, advocacy, and education efforts. Rooted in the interconnectedness of social justice work, CERC amplifies the voices of minoritized communities and empowers staff and community members to be equity minded champions for change. CERC is dedicated to increasing representation for AANHPI communities at the local and national policy level and provides strategic, data-informed recommendations to ensure equitable outcomes.

Friend Health

From its launch in 1997 to its present network of community health centers, Friend Health has provided primary health care services to the vulnerable and medically underserved populations in a manner that is accessible, affordable, comprehensive, and culturally appropriate. Friend Health ensures that patients have access to a full range of primary and preventive health care services as well as the necessary supplemental services which are either delivered directly or through established arrangements or referrals.

Friend Health was developed by the Friend Family Foundation through funding from the Michael Reese Health Trust, which enabled the merger of two University of Chicago clinical practices – the Woodlawn Infant Clinic and a clinic housed at Friend Health's current flagship location on the University of Chicago campus. In 1998, Friend Health became a federally qualified health center (FQHC) and soon after expanded its services to additional Chicago communities. A significant number of the census tracts within its service area are designated as Medically Underserved Areas and Health Professional Shortage Areas, which are characterized by insufficient numbers of health care providers.

In December of 2017, Human Resources Development Institute, Inc. (HRDI) merged into Friend Health. Founded in 1974 by Dr. C. Vincent Bakeman and Mrs. Doris M. Lomax, HRDI is a leading provider of behavioral health services in Chicago addressing alcohol and substance abuse, mental health, youth and family services, community health, case management, HIV/AIDS, and gambling addiction.

HRDI, Inc.

HRDI, Inc. (formerly Human Resources Development Institute, Inc.) is a community-based behavioral health and human services organization. HRDI was founded in 1974 by a group of community health advocates on the South Side of Chicago, concerned with mental health and substance abuse problems plaguing their communities. HRDI's population of focus are low-income, uninsured, or underinsured, primarily minority individuals (African American and Latino). Since 1974, HRDI has worked in some of the most poverty-stricken, and under resourced communities on Chicago's South and West side communities. These communities, according to the U.S. Census Bureau, all have at least twice the percentage of impoverished families and have high incidences of crime and violence.

Today, HRDI is a leading provider of behavioral and community healthcare culturally specific services in Illinois, serving approximately 8,000 clients annually, and offering a number of programs at various sites throughout the Chicagoland area. HRDI provides services in alcohol addiction, substance misuse prevention and treatment (MAT - methadone/vivitrol), mental health (ACT/CST), youth prevention, family services, community health, case management, HIV/AIDS prevention and education, corrective services, and gambling prevention and education. HRDI's mission is to provide a high quality, patient-centered, integrated system of care.

Since HRDI's incorporation on January 22, 1974, HRDI has been awarded and maintained several multi-million-dollar contracts with the Illinois Department of Human Services as well as city, county, state, federal and other state contracts and grants. HRDI has developed, implemented, and facilitated many successful grant-funded programs funded by the City of Chicago, Cook County, the State of Illinois as well as federally funded community health, behavioral health, and substance abuse treatment programs. HRDI maintains full compliance with the operations, management, and requirements of these funded programs.

HRDI effectively manages grant-funded projects with a highly experienced and skilled executive and management staff along with efficient financial management and an active agency-wide Quality Improvement Plan. HRDI will effectively utilize various resources to conduct this project. HRDI's organizational policies, procedures and operational strategies will ensure the successful operations of this project.

Inner-City Muslim Action Network (IMAN)

The Inner-City Muslim Action Network (IMAN) is a community organization that fosters health, wellness, and healing in the inner-city by organizing for social change, cultivating the arts, and operating a holistic health center.

IMAN incorporated as a nonprofit in 1997 through the drive of people directly affected by and deeply invested in social issues affecting communities of color living on Chicago's South Side. Since that time, IMAN has steadily grown and, in 2016, opened a second office in Atlanta to continue mobilizing a cross-section of people committed to this mission.

The organization models an integrative approach that employs holistic interventions to address a spectrum of structural and systemic injustices, incorporating primary and behavioral health; artistic expression; leadership development; organizing and advocacy; housing; and job training, in an effort to substantially increase the quality of life for people in marginalized communities.

Insight Hospital & Medical Center (IHMC)

Insight Hospital and Medical Center, formerly known as Mercy Hospital, is a 414-bed hospital located in the historic neighborhood of Bronzeville. Although it was recently acquired by Insight Chicago Inc, the hospital itself has been a medical anchor in the area since being founded in 1852 by the sisters of Mercy and is considered the oldest hospital in Chicago today. Since its inception, the hospital has continued to serve the surrounding communities with its mission of helping the underserved population on the south side of Chicago. Over the years, this facility has provided medical, surgical, mental health, and social services to people in the surrounding areas regardless of gender, orientation, religious beliefs, or ability to pay.

Insight was founded in 2008 by Dr. Jawad Shah a neurosurgeon, to provide clinical services in neurosurgery and other neurosciences. It started in the 600,000 sq. ft. former GM HQ (Great Lake Technology Centre) in Flint with one neurosurgeon and a staff of four and has since grown to a staff of over 850+. Since that time, Insight has expanded its activities to include additional clinical offerings (multiple physicians, imaging center, physical therapy, and neurological rehabilitation and healing center), research projects, a variety of educational functions, and community activities.

These two institutes have combined to form Insight in June of 2021, a historic institution with a revolutionary vision. Insight is honored by the warm welcome into Chicago and is committed to providing the same dedication to technical excellence paired with community service and engagement that saw success in Flint, Michigan. Insight is committed to rebuilding a storied hospital and looks forward to providing the highest quality of care to our patients. Insight is committed to operating a full-service community hospital; creating a comprehensive plan to increase services and meet community needs; restoring the hospital as a teaching facility and restoring a comprehensive emergency department.

Malcolm X College

Illinois Community College District 508, known as the City Colleges of Chicago (CCC), is one of the largest community college districts in the United States. Serving approximately 70,000 degree-seeking students per year, each of the seven colleges in the district features a Center for Excellence in workforce development and academic programming. On the West Side of Chicago, Malcolm X College (MXC) serves as the City Colleges of Chicago Healthcare Center of Excellence providing a quality healthcare education to enable its students to compete for the 84,000 healthcare jobs that are

anticipated in the region over the next ten years. MXC is located near the Illinois Medical District and offers one of the largest selections of health sciences degrees in Cook County.

MXC is a minority serving institution dedicated to serving communities facing systemic barriers in the Chicago West and South Sides through education and opportunities. 92% of students identify as people of color, 46% identify as Hispanic, and 36% identify as Black, 4% identify as Asian, 2% identify as multi-racial. Malcolm X College is a Hispanic Serving Institution with 46% Hispanic student populations. With an enrollment of nearly 11,800 credit and non-credit students, MXC offers a mix of classroom study, hands-on training, and internship at area healthcare facilities. Because many students who attend Malcolm X College also work, they also offer flexible schedules and "stackable" credentials that allow students to continue and expand on their training in the future. Malcolm X College students have access to a host of resources to support them on their path to success, including academic advising, tutoring, wellness center, transfer center, career center, veteran center, disability access center and more.

MXC has the necessary resources to complete the proposed collaborative activities. MXC's Academic Support Center recruits, trains, and coordinates professional tutors with several years of experience and/or a graduate level of education in their subject. The center will administer placement exams, College Level Examination Program (CLEP) tests, and proctored exams assigned by faculty. The Testing Coordinator will work with Insight staff to provide special placement counseling for participants and connect them to tutors based on need and interest. The Career Planning and Placement Center will assist participants in identifying career opportunities that align with their professional goals and advance the SBEV and youth empowerment mission. This office provides workshops in resume writing and job interview skills, and these workshops will be accessible to participants. The library staff will conduct orientation sessions and tours of the library and database. MXC's Student Advising Center will work with students to enhance rates of retention and graduation. The Transfer Center staff will assist students with the transition to a four-year institution, walking students through the college application process and helping them obtain fee waivers. MXC's Office of Instruction oversees efforts across the institution to strengthen academic offerings and outcomes; senior leaders from this office were involved with the project's design and will play an important role in ensuring STEM faculty are engaged and contributing to activities.

MXC's Wellness Center supports students in their transition to college through personal counseling, support groups, stress and time management coaching, and referrals to community resources. In partnership with the Greater Chicago Food Depository, Malcolm X College has opened a food pantry open to students facing food insecurity each week to select fresh and shelf-stable food. The Disabilities Access Center (DAC) makes every effort to integrate students with disabilities into all courses and programs and will provide support services to meet the specific needs of students with disabilities.

The Business Office processes purchase orders, maintains campus budgets, and provides financial services for the campus. The City Colleges of Chicago District Office has committed to drawing down grant funds, maintaining records of drawdowns and expenditures, and supporting the PI and Director in monthly reconciliation of financial records.

MXC has the capacity to comply with conditions stipulated. MXC is strategic and thoughtful about which funding opportunities it pursues, ensuring a portfolio of projects that squarely aligns with the College's mission and vision. MXC is careful to only partner for grants for which it has the institutional capacity and infrastructure to manage and execute efficiently and responsibly. In the last year, MXC recruited and hired its first Director of Grants Development and Compliance. This staff member is responsible for overseeing extramural fund management efforts and providing technical assistance to PIs and Project Directors to ensure targets and deliverables are successfully met and activities and expenditures comply with funders' regulations and policies. MXC also receives expert support from the City Colleges of Chicago's District Office, which is home to its own grants, compliance, and finance teams whose members work closely with each college's counterparts.

MXC has extensive experience receiving and successfully implementing federal grants from the Departments of Education, Labor, and Health and Human Services. Currently, MXC is implementing a six-year, $3.5 million grant from the Department of Education to increase the number of Black men who

study and pursue a career in the field of health sciences. MXC is in its final year of implementation of this program, the funds for which will mostly be expended by December 2022. MXC is also in its first year of a $2 million, four-year program funded by the Department of Health and Human Services' Health Resources and Services Administration. Through this grant, MXC is equipping students with the skills, credentials, and apprenticeship opportunities to serve as community health workers in the Chicagoland area and provide care to families impacted by opioid use. Over the last decade, MXC has successfully applied for and implemented state and federal grants that have grown in both dollar amount and technical complexity.

As a public institution of higher education and one of the seven City Colleges of Chicago, Malcolm X College is held to the highest standards of integrity and business ethics. MXC maintains strict financial controls that ensure that its campuses contract with vendors whose prices and services are competitive. In accordance with City Colleges of Chicago's Board Policy, purchases between $2,500 and $25,000 must be competitively bid. At least three price quotations must be obtained via telephone, fax, and/or email, and at least one of them must be from a currently certified Minority Business Enterprise (MBE) or Women Business Enterprise (WBE). After staff secure three bids, they prepare a bid recapitulation form and compile all supporting documentation (correspondence, quotes, verification of MBE or WBE status) to the CCC District's Procurement Office, which conducts a thorough review, flags any questions or concerns, and approves if all documentation is in order and all requirements have been met. Additionally, all MXC staff is paid in accordance with established and publicly available salary and wage guidelines, which are monitored by the Board of Trustees of the City Colleges of Chicago.

Sylvester Broome Empowerment Village

At the Sylvester Broome Empowerment Village, the mission is to cultivate leadership capacity. SBEV offers free year-round programming to youth ages 5-17 in the Flint, MI area. Programs emphasize growing youth self-efficacy via Academics, Athletics, and the Arts taught by local professionals who dedicate their time to reinvest their skills and knowledge and give back to the young people. By developing and investing in youth, we desire to transform Flint into a just and equitable city. Covering 10 different areas, many different programs are offered that youth can chose from.

Goals. The overarching goals of the South Side Health Equity Collaborative is to improve health care access, fill gaps in service for community-prioritized and provider-acknowledged needs, identify social support needs and connect individuals to those needs, and address clinical conditions leading to poor quality of life, functional status, and shortened life spans of vulnerable people in our focus area. This will be accomplished by focusing on certain clinical conditions, but also screening and identifying people with underlying depression or substance use disorders and addressing them and coordinating care and social navigation to address gaps in needed social services. This will be accomplished with innovative approaches that maximize community-level resources and adopt data sharing to reduce redundancy and improve awareness of the client needs and progress among clinical providers.

The four clinical conditions targeted by the collaborative are clearly driving poor health status in these vulnerable communities and population, are endorsed as significant concerns in our community interactions, and align with the state's quality improvement pillars: behavioral health, maternal health, chronic conditions associated with cardiovascular morbidity, and youth empowerment. These focus areas were also identified in the background work performed for the Department of Healthcare and Family Services by the University of Illinois School of Public Health[3] and are noted to be common in Medicaid enrollees and a frequent accompaniment to inpatient stays of Medicaid beneficiaries admitted to the hospital in 2020[4].

Overarching strategy. The South Side Health Equity Collaborative will unite primary care, behavioral health, acute care, and specialty services into a coherent ecosystem for Medicaid and uninsured populations served by the partners on the South Side. The partnership envisions building a highly reliable care network by starting with a few strategies focused on conditions identified by the community

[3] Transformation Data & Community Needs Report: Chicago-South Side, February 2021

[4] FY2019 and FY2020 Medicaid Hospitalization and ED Visit Frequencies by Chapter Block and Area

as high priority, undergirded by a standardized approach to assessment of social needs, identification of individuals with mental health and substance use disorders, and addressing these identified issues with effective care coordination and integrated information systems.

The acute care/complex care/specialty services will largely be provided by Insight Hospital & Medical Center (IHMC), which is standing up full acute-care hospital services since taking over ownership of the former Mercy Hospital June 1, 2021. In 2018, that hospital provided care for 8% of the South Side Medicaid enrollees who required inpatient care[5]. Primary care will be provided at the South Side sites of federally qualified health center systems Alivio Medical Center, Friend Health, Inner-City Muslim Action Network, and IHMC. When needed for complex behavioral health needs are identified, Human Resources Development Institute, Inc (HRDI) will be able to meet almost all needs, as a trusted mental health and substance use disorder-focused provider on the South Side for some forty years. These are trusted providers who have been serving the South Side for decades, and they have strong community inputs through the people they serve and through their governing bodies.

Because of the growing recognition of the importance of depression and substance use disorders have especially on adolescents and adults with chronic conditions, this partnership will systematically identify common behavioral health issues and address them with evidence-based interventions. This will include adoption of proven screening tools, use of the integrated care model of primary care, and when needed, care navigation to community-based mental health specialists for support. Therapies including medication for opioid use disorders (MOUD) and cognitive behavioral therapy will be available (see Core Strategy 4 below for details).

Identifying Social Determinants of Health (SDoH) (*for more detail see Section 9 of application*)**.** Social vulnerability is highest on the South Side of Chicago. Many of the Chicago communities with at least 80% Black population are the same areas with high levels of economic hardship, lower per capita income, and higher severe housing cost burden[6] (Figure 7). Addressing barriers to adherence and good outcomes requires identifying missing social supports and finding resources to help an individual address that need. The collaborative will contract Chinese American Service League (CASL) to connect clients to community-based agencies to provide solutions and provide funds to pay for services including housing, food needs, and transportation for clinical services and appointments with social service agencies.

- Screening for SDoH will take place at minimum annually, and more frequently for those identified with an important social driver, using standardized instruments esp. focused on food and housing insecurity, and transportation for clinical and social service visits
- The care coordination process, including the use of community health workers (CHWs) will include pathways to connect patients to community-based organizations (CBOs) to address social determinants of health (SDoH) that individuals encounter as they move through the care continuum.

[5] Transformation Data & Community Needs Report: Chicago-South Side, February 2021

[6] Chicago Department of Public Health. *2021 Data Brief: The State of Health for Blacks in Chicago*

Data and information sharing/technology. Currently, partners are on varying information technology platform with varying degrees of interoperability and advanced analytics.

- Insight Hospital & Medical Center uses the Cerner electronic health record for its inpatient, emergency department, and outpatient specialty and diagnostic services
- Alivio Medical Center, Friend Health, and IMAN use forms of GE Centricity/Athena for documentation of ambulatory services
- HRDI uses Netsmart myAvatar
- CASL uses Salesforce in all CASL programs, integrating focused program logic models and Social Determinants of Health (SDoH), along with Chicago Health Atlas (CHA) data which is all entered into Einstein Analytics. This gives CASL the capability to compare SDoH data sets between clients and citywide health outcomes. This use of Salesforce allows CASL to use data to better understand, communicate with, and serve clients; to track trends, identify service gaps, analyze data, and pivot if necessary.

The South Side Health Equity Collaborative seeks funding to build effective interfaces that will allow important and timely sharing of client information to achieve better outcomes in clinical care, client navigation, and social support. In addition, we will need community-level navigators and community health workers (CHWs) to have access to clinical information as well as social navigation and notes on screenings and so on, all in a safe, privacy-protected environment.

Care integration and coordination. Care integration and coordination will be addressed via data integration and care coordination.

Data integration and information sharing between provider partners, and the Chinese American Service League will be supported by robust

- Data use agreements
- Business associate agreements
- Technology interfaces

Community Health workers will

- Assist individual's understanding of their conditions
- facilitate home monitoring of chronic conditions (HTN and NIDDM) and assure patients know how to connect that information to their medical home
- assure individuals are maintaining appointments for clinical services (including behavioral) and social support commitments
- connect patients to CBOs to address identified social support needs

The SSHEC model is built upon 5 core strategies undergirded by care coordination, identification and mitigation of social support needs and information technology improvements. The 5 core strategies are

- Maternal Health
- Youth Empowerment
- Addressing chronic conditions in adults
- Behavioral Health
- Workforce Development

Core strategy 1: Maternal Health

Illinois is racially and ethnically diverse, with approximately 54% of births to non-Hispanic White women, 17% to non-Hispanic Black women, 21% to Hispanic women, and 8% to non-Hispanic women of other races. In the United States, between 2014-2017 pregnancy-related mortality ratios were three times higher for Black women than White women[7].

In Illinois in 2016-2017:

- 34% of women who died while pregnant or within one year of pregnancy died from a cause related to pregnancy.

[7] Illinois Department of Public Health, 2021

- The leading cause of pregnancy-related death was mental health conditions, including substance use disorders, which comprised 40% of pregnancy-related deaths. The next three most common causes of pregnancy-related death were pre-existing chronic medical conditions that were exacerbated by pregnancy, hemorrhage, and hypertensive disorders of pregnancy.
- Black women were about three times as likely to die from a pregnancy-related condition as White women.
- Black women were more likely to die from pregnancy-related medical conditions while White women were more likely to die from pregnancy-related mental health conditions.
- One-third of pregnancy-related deaths occurred more than two months after pregnancy.
- The Maternal Mortality Review Committee (MMRC) determined that 83% of the pregnancy-related deaths were potentially preventable.
- 85% of the pregnancy-associated deaths by suicide and 35% of the pregnancy-associated deaths by drug overdose were determined to be pregnancy-related.
- The MMRC determined that nearly all the pregnancy-associated homicide, suicide, and drug overdose deaths were potentially preventable[7].
- Social determinants of health that deeply affect a woman's ability to thrive and to be healthy include poverty, quality of education, health literacy, employment, housing, availability of childcare, transportation, community support, and neighborhood safety[7].

Expectant women living within the collaborative's catchment area have limited options for getting maternal health services that meet their specific needs. The available choices have been less than adequate due to multiple factors including inaccessibility due to distance, inconvenience due to clinic hours and insensitivity to the social determinants that inhibit receiving care as required. Successful maternal outcomes are the result of receiving consistent prenatal care. Current South Side choices are limiting the achieving compliance with receiving care, causing added stress to the mother and potential harm to the newborn.

These challenges have been accompanied by a significant loss of healthcare assets on the South Side. The last 35 years have seen the closing of several hospitals on the South Side, including Provident (later reopened by Cook County Health), Doctor's Hospital of Hyde Park, Chicago Osteopathic, Michael Reese, the Hospital of Englewood, Mercy, MetroSouth Medical Center in Blue Island. The area was a so-called "Trauma Desert" until the re-opening of the University of Chicago Medical Center service in 2018, and in the past five years several South Side hospitals closed their doors to delivering babies, including St. Bernard, Jackson Park, South Shore and Holy Cross. Likewise, with overall secular trends in decreasing hospitalization for children, the only general acute care hospital with inpatient pediatric services on the South Side of Chicago is the University of Chicago Comer Children's Hospital. Not only are there fewer hospitals serving redlined communities, but the hospitals that predominantly serve people of color are often subject to cash and capital shortages that limits the types and quality of care they provide[7].

In the summer of 2020, the number of hospitals offering maternity services on Chicago's South Side dropped to three. The former Mercy Hospital's maternity services was included in the remaining three.

The pandemic has added additional stresses and barriers to achieving appropriate services. Pregnant women living within the marginalized catchment area have experienced behavioral and traumatic impact of the pandemic stemming from loss of family members, loss of school and religious support network, severe reductions in childcare options, housing challenges, food insecurity, and transportation challenges to get to require in-person visits for herself and her newborn. This has been the reality during the last 18 months impacting the ability to focus on the pregnancy and contributing to feeling that the impact of these very real barriers is not understood and having a healthy baby not valued by the community.

To improve maternal health and reduce the stress for pregnant women living on the South Side, the South Side Health Equity Collaborative is taking a wholistic, patient centered, multi-faceted approach that improves access to quality care, addresses social determinants of health leading to a successful pregnancy and healthy newborns. Our model is based on the concept that the best outcome can only be achieved by addressing clinical needs and the social determinants of health

specifically tailored for the individual while doing so in a way that is respectful and with humility. Our collaborative is committed to giving a choice that values and is truly supportive of the pregnant woman and her family. This choice will also achieve a major goal of the maternal strategy which is to keep pregnant women 100% engaged in ongoing care throughout their pregnancy. Focusing on engagement provides the opportunity to identify issues that could impact achieving a normal delivery and taking the required actions to address these issues.

The population served by the maternal strategy will include patients from Alivio and Friend Health FQHCs along with IHMC's prenatal clinic patients living on Chicago's South Side, the designated catchment area for this collaborative. But it is the collaborative's intent to create a model that sets the standard for care that will be available for all women within the catchment area.

The South Side Health Equity Collaborative believes that women should receive health care that is respectful, culturally competent, safe and of the highest quality. High quality will be achieved by understanding, respecting, and responding to a patient's experiences, values, and beliefs. The care to be provided by the collaborative will be patient-centered care that focuses on individualized needs including non-clinical, social needs. This will remove barriers that have often prevented women from this catchment area getting the required pre- and postnatal care that yields the most positive outcomes.

The South Side Health Equity Collaborative maternal strategy will provide services that are community based, recognizing the trust relationship that many women have in community providers. The strategy includes services to be provided by IHMC at the former Mercy Hospital, which delivered 1454 babies in 2019. IHMC is committed to resumption of labor and delivery services and developing a birthing center providing patient experience that is second to none. Transformation funding is requested to upgrade equipment and technology in the birthing center to achieve this objective.

The innovative components of the collaborative's maternal strategy include:

- Connecting pregnant women to prenatal care. If pregnant and without a medical home, women will be connected by care navigators to medical homes at Alivio Medical Center or Friend Health based on geography, cultural congruence, and stated preferences. CHWs will assure promptly follow-up of these referrals and connection to the first medical home visit.
- Establishing a certified centering pregnancy certifying entity program that will be available to eligible patients referred from IHMC OB clinic, Alivio, Friend Health
- Improving prenatal access to lifestyle services that will foster engagement and provide a quality experience – by addressing common discomforts and painful conditions with proven therapies
- Creating a service navigation program to address SDoH concerns by providing maternal clients access to community-based organizations (CBOs) that will provide needed services using a closed loop process beginning from the assessment through communication to providers indicating issues have been addressed
- Using technology to share real time information among partners and to provide closed loop communications between CBOs and providers.

The foundation of the maternal strategy is to use an innovative approach to improve prenatal services that address concerns hat community providers have heard from patients over the years. The innovations will meet patients where they are. Unique to our collaborative the centering pregnancy certifying entity concept will be used in a shared model that expands across the three entities, IHMC, Alivio and Friend Health.

The South Side Health Equity Collaborative will use a centering pregnancy certifying entity concept that is a complementary group prenatal care model that is relationship-centered, holistic in its attention to non-medical aspects of health and wellbeing and provides the opportunity for socializations through group discussions. In Centering patients participate in group sessions with a small number of other pregnant women who are at the same stage of pregnancy. Centering provides patients with the ACOG/ACNM recommended prenatal visits over a longer time span usually 90 minutes. This allows patients to spend more time with providers and gives the opportunity to encourage self-care by exploring such topics as monitoring weight and blood pressures. A centering pregnancy certifying entity breaks down barriers. Providing care this way allows moms and providers to remain fully engaged throughout the entire pregnancy with a staff committed to addressing their concerns and forming a support network with others from the community.

A centering pregnancy certifying entity will be available in-person and virtually for patients referred by collaborative providers. A centering space is required for group sessions and space will be made available at IHMC as the hub, with each FQHC providing space as required. Transportation will be available for in person participation. Classes covering topics including birth preparation, pregnancy side effects and discomforts, nutrition, stress management, breast feeding, infant development, family planning will be held monthly. Group sessions conducted in Spanish will be held and in other languages as required. Each cohort will include 10 patients. A new position, a centering coordinator will be created to manage and support the centering programs. Collaborative partners will provide subject matter experts to discuss each topic. Promoting self-care is a key component of the program and participants will receive equipment for self-care items including weight scales and blood pressure monitors. The equipment will be used for training and ongoing use in the home. The items will also be provided to uninsured participants to allow them to receive the full benefit throughout their pregnancy.

Benefits identified from a centering pregnancy certifying entity program includes a reduction in the rate of preterm and low birth weight babies, increased rates of breastfeeding and leads to better pregnancy spacing. One of the major benefits of the centering pregnancy certifying entity program is how the model fosters birth equity.

A centering pregnancy certifying entity creates a bond among the participants in the program. To leverage this bonding the centering model also includes a centering pregnancy certifying entity component that is designed to maintain the engagement, education and support systems after the baby is born. The Collaborative's intent is to implement a centering pregnancy certifying entity in year 2 because the program will use a similar structure to enable parents to become more informed, engaged, and confident contributors to their children's health. A centering pregnancy certifying entity will also involve cross partner collaboration. With a centering pregnancy certifying entity, the model keeps families engaged and active participants in the child's development. Evidence is showing that this centering concept boost visit attendance, breast feeding and on time immunizations. A centering pregnancy certifying entity is one mechanism to get the full benefit from Illinois recent extension of post-partum insurance eligibility to 12 months because the program keeps the mother and child engage through a peer-oriented support group.

Transformation funding is requested to cover implementation expenses associated with setting up a centering pregnancy certifying entity program in Year 1 and centering pregnancy certifying entity in Year 2. The expenses will include annual license fee, equipment, and educational materials (provided in multiple languages) for the sessions and other expenses as identified in the budget. The request will include the cost of onboarding staff required for the program including the coordinator and session facilitators.

Prenatal access to therapeutic services. The South Side Health Equity Collaborative will improve access to therapeutic services that will lead to a better prenatal experience and address common discomfort conditions such as chronic pain while also increasing opportunities for pregnant

women to be consistently engaged in ongoing care. The therapeutic services will address issues that in the past women may have suffered through due to lack of access or lack of resources to use existing services. The therapeutic services include acupuncture, massage therapy and physical therapy.

Providing supportive services will improve the overall pregnancy experience and facilitate consistent engagement in prenatal care that also allows clinical or SDoH problems to be identified as they develop, and interventions taken to avoid negative impact on the pregnancy. The supportive services include lactation consultants and doulas to be present on the labor and delivery service and to lead discussions during a centering pregnancy certifying entity group sessions. The South Side Health Equity Collaborative will hire or contract for therapeutic services specifically for the maternal population to provide these services.

The South Side Health Equity Collaborative is requesting funds to cover expenses for the initial setup and the costs associated with expanding the number of therapeutic providers recognizing that these services are reimbursable [and to cover the cost for the uninsured until patient qualifies for emergency Medicaid program for pregnant women. The request includes funding for the total costs for hiring lactation consultants and doulas to provide these support services. The funding request will include an amount to cover costs for additional equipment and technical staff that may be needed to provide these services.

The benefits to be gained from these programs include those identified for the centering pregnancy certifying entity program and reduction in postpartum depression, increased breast feeding and reduction in pain scores.

Effective Social Service Navigation. A service navigation program to address SDoH concerns by providing maternal clients access to community-based organizations (CBOs) will be created using transformation funding.

A major component of the South Side Health Equity Collaborative's program will be to complete initial and ongoing assessments for patients in all strategies including the Patient Health Questionnaires 2 and 9 to determine individual needs especially those that fall under social determinants and behavioral health categories. Assessments will identify all areas that may impact obtaining prenatal care and having a successful pregnancy including housing and food insecurities, childcare needs, transportation needs, behavioral needs with stress management, intimate partner violence, and employment security as key issues in this category.

The assessment is the initial and a key step in identify patient' s holistic needs. There is significant documentation in the literature of the impact SDoH issues have on patient outcomes. The Centers for Medicare and Medicaid Services in a January 7, 2021 letter to the states said, 'there is a growing body of evidence that indicates that these challenges can lead to poorer health outcomes for beneficiaries and higher health costs for Medicaid and CHIP programs and can exacerbate health disparities for a broad range of populations including…pregnant and postpartum women and infants.'

The collaborative is creating a program to connect patients with services to address the social determinants at each encounter, using the concept of no wrong door. The program will accept a warm hand off from providers during regular visits, receive a centering pregnancy certifying entity program referrals, therapists providing care will make referrals and patients may also make requests for assistance. The model includes process and tracking to capture referrals from these sources. The SDoH service navigation coordinators will close the loop, ensuring that the needed services are provided.

The SDoH program will include specific CBOs for each of the targeted determinants and will contract to obtain guaranteed services including assisting with benefit enrollment, housing placements, childcare and transportation as required. Food insecurity will be addressed by the

collaborative's village market and nutrition initiatives including access to a food pantry located on IHMC campus.

CASL will provide SDoH service navigation coordination. The members of the collaborative will use a common assessment tool and follow a standard referral protocol. All new patients will be assessed for SDoH during their initial encounter. During subsequent encounters including a centering pregnancy certifying entity sessions mini- assessments may be conducted to identify issues that may have developed since the initial assessment. Referrals will be made to CASL. CBOs that provide benefit enrollment assistance, housing, childcare, domestic violence assistance and transportation will be selected through a process and will enter into a contract with the collaborative to provide services within a specified timeframe. CBOs will be required to communicate with CASL so that CASL can close the loop with the providers. As described below, technology will be used to facilitate this communication. Transformation funding will be requested to pay for services provided by CBOs.

A major impediment to timely addressing SDoH issues is the lack of consistency in completing assessments. This inconsistency is the result of insufficient resources to devote to this task. The collaborative will request funds to hire Community Health Workers *CHWs) and medical assistants (Mas) to work in the OB areas to complete the assessment and to make referrals. The budget request will also include funds for CASL's coordination and CHWs to assist patients as required to obtains SDoH services. The community college partners will be contracted to help with workforce training. The CHW/ M.A.s who will work on SDoH service navigation and work in the maternal clinics will receive specialized training with curriculum developed by community college partners.

The assessment has questions to specifically identify behavioral needs especially as related to stress and domestic violence. The referral resources available on the South Side to address these issues are limited. The collaborative will enhance behavioral health services by improving access to BH specialists as required for all strategies. Included in the BH strategy will be resources to focus on stress and traumatic issues impacting the maternal population.

Technology: sharing of real-time information. The success of the collaborative's initiatives will depend on partners providing a seamless experience for patients. An experience that does not overwhelm and confuse patients with unnecessary duplications and extended wait times to access needed care and services. Also important is increasing provider effectiveness to focus on clinical needs and to create a climate where all can work at the top of their license. The collaborative recognizes that effective use of technology will be instrumental in meeting these objectives. The maternal strategy will include real time sharing of information among member entities. The entities use different platforms. Current interfacing technology allows information to be shared across these platforms. This sharing will be made possible using a commonly used health information platform and the use of CERNER's maternal module. CBOs communicating with providers is essential to closing the loop when coordinating access to SDoH services.

The use of telehealth for OB patients during the pandemic has demonstrated that this technology can be used effectively with this population. The collaborative's goal is to have telehealth services used across the entities.

The collaborative's technology transformation request includes funding for the following: the maternal module; to create the interface; to connect to the health information exchanges; to upgrade equipment for telehealth services; and to acquire the equipment needed for the centering pregnancy certifying entity program.

Outcomes. The outcomes that will be achieved as result of this maternal strategy align with the HFS quality pillar for maternal health. See Section 13 for details, but at a high level, the collaborative seeks to improve processes of care (prenatal visits) and outcomes (preterm birth, low birth weight, peripartum depression). The information in **Metrics and Outcome Table** is a list of the outcome measures with specific goals the collaboratives will achieve.

Sustainability (see Section 16 for broader context). Provider visits that occur as part of the centering pregnancy certifying entity program and the lifestyle therapeutic visits are billable. Several states have implemented enhanced rates for centering pregnancy certifying entity programs. It is hoped that as evidence of continued positive results from centering programs around the country and for the programs in Illinois are reported, Illinois will also implement enhanced rates. In the near-term applications for grants will be submitted to cover centering pregnancy certifying entity fees. Other funding sources will be identified to pay the costs of services provided by the SDoH. To cover the cost of care coordination associated with SDoH referrals, funds will be requested from MCOs to pay these expenses similar to a model that is currently in place between MCO and providers.

Budget relevance. The maternal strategy relies on innovations that should reduce stress and improve health for these mothers. Staff needs include the development of the innovative centering pregnancy certifying entity model, including coordinator, facilitators, a doula and a lactation consultant. In addition, the therapists that will be providing therapeutic services are likely to encourage deeper engagement and ongoing bonding to the care process by expectant mothers.

As IHMC re-establishes critically needed delivery service options on the South Side during a pandemic-driven professional service shortage, assistance with staffing up will be critical. While the plan is to simply reestablish Level I service for non-complex patients, there is nonetheless a requirement for staff roles (including pediatric care in the immediate peripartum) to assure excellent outcomes.

Finally, capital needs regarding information technology and classroom and technology supports for the centering pregnancy certifying entity program will be essential. Once established as noted in the budget and our sustainability plan, many of these services should be reimbursable and thus ongoing operational costs should be covered.

Core strategy 2: Youth Empowerment

IHMC has a comprehensive perspective to meeting the health and wellness of the community. Embracing the concept that strong families are the hallmark of a strong community IHMC is committed to providing support and tools that have a demonstrated ability to strengthen families. Families on the South Side are faced with many challenges, paramount among these challenges are the needs of their children, especially youth. Providing Bronzeville and the South Side of Chicago with a safe, nurturing space for children to grow and develop was key in the decision to acquire the former Mercy hospital campus and continues to be a major driver for achieving our mission. [Taking on the goal to improve the quality of life for disadvantaged youth in an urban setting is not a novel idea for IHMC. In IHMC launched a successful youth empowerment program, the Sylvester Broome Employment Village (SBEV) in Flint, Michigan. In assessing the needs of youth on the South Side of Chicago, the SBEV model can be used to create a safe space and environment for youth. The SBEV model is uniquely designed to help underserved, at risk youth develop life skills that will inspire them to be active, informed and feel valued, these life skills will lead to improve academics, behavior, while reassuring parents and community a safe place exists for this development. We firmly believe that investing in young people is the key to generating healthy lifestyles for the youth, their family, and the community.

SBEV Chicago is designed to improve the overall health and provide a safe space for at risk youth that simultaneously improve well-being of their families. This will be achieved through access to designated facilities and programs that centered on athletics, academics, nutrition, and counseling. Enhancing physical activity, nutrition programming and counseling services will assist youth in reaching their highest potential. Facilitating access to healthy, nutritious foods will foster long term health lifestyles.

Why is this important? Educational opportunities and resources in the Chicago Public School (CPS) system are unevenly distributed along lines of race and ethnicity. Struggling schools are concentrated in communities of color, while white students are overrepresented in the district's most advantaged educational environments. CPS schools with 85% or more black students are just as likely to be on

academic probation as they are in good standing. Black CPS students comprise over 60% of students at schools that do not offer AP/IB, Calculus, and/or Physics. They are also nearly seven times more likely than other groups to attend a school without art or music classes[8]. Approximately 42,000 Black teenagers in the south and west neighborhoods of Chicago have been affected by school closings since the 1980s[7].

A large majority of CPS 9th graders say they want a college degree (75%), but obstacles and barriers prevent them from achieving this goal[8].

- Of the nearly 4,000 CPS high school graduates that annually enroll in an Illinois community college, about 70% cannot begin with entry-level coursework and must take at least one remedial course Black students are suspended, both in school (24.2 per 100 students) and out of school (16.1 per 100 students), at double the district rate.
- Black students are expelled at four times the rate of Latinxs and twenty-three times the rate of whites.
- Black youth are more likely to have student misconduct escalated to the attention of the Chicago Police Department. For every 2.1 police notifications black youth receive per 100 students, their Latinx and white counterparts receive 0.7 and 0.3 notifications, respectively.

To assure relevance of the Flint, MI model to the South Side of Chicago, a survey was developed to collect input from the community. A copy of the survey instrument is attached. The survey was distributed at community events held at multiple locations in the catchment area. The results of the survey are shown in the **Metrics and Outcome Table**. The results indicate strong community support for programs that will be included under SBEV Chicago.

SBEV Chicago will include and be supported by community-based partners for each of the program component, athletics, arts, nutrition, and counseling. The partners provide nutrition instructors, athletic trainers, fresh food vendors, behavioral health counselors, mindfulness trainers, transportation vendors. Each partner tracks and monitor performance goals.

The Safe Space and After School Program. The collaborative is requesting funding to create a youth empowerment center on Chicago's South Side using the successful and innovative SBEV model. SBEV Chicago functions in a facility that accommodates athletics, art therapy, music therapy and health education classes. The space will have a gym, music laboratory, art workshop, classrooms, and counseling rooms. The program begins using temporary space leased from the XS Tennis Village located on Chicago's South Side and temporary IHMC space not currently used for clinical services. The Collaborative is requesting transformation funding to construct a permanent SBEV Chicago facility on the IHMC campus. The facility will provide a comprehensive location to achieve synergies among the programs that is most effective for engaging youth. This space is a safe harbor and an alternative to street violence and drugs. Transportation will be provided for participants to safely reach the temporary and final locations. This space will also house the Village Market nutrition programs described below. The SBEV Chicago safe space and after school program initiatives will both transform the lives of at-risk program youth participants and will positively impact families on the South Side.

The SBEV Chicago model is an after school-based program that provides a safe, healing space for children with focused activities in arts, athletics, and academics. The interweaving of these programs is intentionally designed to achieve sustainable engagement. This model can only be effective if it is tailored to the needs of the population to be served. Children and youth living on the South Side of Chicago experience violence and trauma daily. Additionally, the lack of economic opportunity, the prevalence of food deserts, school closures- that also closed athletic programs place enormous uncertainty, stress, and hopelessness particularly on youth. The manifestation of these conditions is exhibited by self-defeating behaviors and actions that spiral into adverse events that begin a path to lifelong challenges including but not limited to mental disorders and frequently

[8] Institute for Research on Race and Public Policy. A Tale of Three Cites: The State of Racial Justice in Chicago Report.

take a toll on other family members. The SBEV Chicago model includes a counseling component that is also interwoven with the arts, athletics, and academic components. Recognizing that youth empowerment also depends on healthy lifestyles, the model includes a 'Village Market', described below that promotes healthy eating for the entire family.

Community surveys show that South Side residents overwhelmingly want a safe space for their children to go both after school and during the summer not only for supplemental academic support but also for access to sports, art, music, and healthy meals. This safe place would allow learning, developing, and counseling so that youth may be active informed and relentless agents for their success.

A healthy lifestyle includes exercise and physical activity beginning in childhood. We are living in a time with an inverted indoor culture of play, owing both to safety concerns and the absence of public playscapes, and ever-increasing homework demands, partially due to school performance and behavioral issues, all which further fashion a sedentary lifestyle. The athletics and sports component of our model address this need. Sports are vehicles to help define and build character. When athletes are driven to reach their full potential while training and striving for athletic goals the efforts will develop respect, confidence, and trust. Moreover, teamwork develops not only healthy social skills but also the crucial professional and personal mindset like hard work and dedication that are vital to success in life.

A key component of our model is working with community partners. The workgroup developing the SBEV Chicago model included community partner representatives. The collaborative FQHCs will be the source of the initial participants for the program, utilizing the model to enhance the FQHCs' school-based health centers (SBHC). There are three FQHCs (Alivio, Friend Health, IMAN) that are part of the collaborative. At risk youth from these centers will be the initial target group for the program. Working with school- based programs will assure the SBHC's objectives for the students are aligned specially to address the impact of violence and trauma in the neighborhoods. The targeted population is school aged, grades K – 12. Community health workers (CHW) will be hired to assist with recruiting youth for the program. A CHW will be assigned to work with each of the FQHCs to facilitate recruitment and to assist with program activities. Other community organizations including justice involved adolescent programs will also be a source for referrals from the catchment area.

After youth have been accepted into the program, they will be given a baseline assessment of physical activity, nutritional literacy, social determinants of health (SDoH) issues and stress factors. Youth will be placed in appropriate activities based on the needs identified by the assessment and performance improvement objectives will be established. Reassessments will be completed at the necessary intervals and adjustments made accordingly. Feedback and progress reports will be provided to families and providers.

On a contractual basis, the collaborative's community college partners and other community-based organizations shall provide instructors, coaches and mentors for the athletics, arts, music, academic and health education courses, and activities. The instructors will develop specific program objectives and performance goals that will achieve the outcome metrics.

The after-school program will run from 4p to 7p on weekdays. A summer schedule continuing the weekday activities when school is not in session is also part of the model creating year-round program. Transportation based on specific needs of each student will be provided to and from SBEV facility and to programs occurring at FQHC locations.

Village Market. The Village Market nutrition concept is to create a healthy food program that empowers community residents to make lifestyle changes that drive health and wellness. The concept includes a setting that provides convenient access to fresh foods, empowering families to incorporate healthy food choices into their lifestyles and teaching families to prepare culturally appropriate meals that include fresh, wholesome foods. The program includes direct food

distribution and instruction on basic concepts of financial literacy designed to help families budget and make their own choices about purchasing and preparing healthy food.

It is well established that schools are essential for more than classroom education. The major example cited to prove this is true, is access to healthy meals that schools provide when located in food deserts such as Chicago's South Side. Beyond regular school hours, the need exists for students and their families to have consistent access to nutritious meals. Filling this gap requires access to healthy food, understanding how to use limited resources to purchase healthy food products, and skills to prepare nutritious, culturally appropriate meals. To achieve lifelong good eating habits, introducing children to healthy foods early is very important.

A pernicious culture of survival rooted in poverty encourages parents to purchase the cheapest available foods, which, living in a food desert tend to be either pre-packaged or fast food. Additionally, malnourished, low-income people are disproportionately classified as obese and overweight, which are traced to lifestyle changes, disappearing exercise opportunities and diets rich in fats and sugar. Furthermore, nutritionally dense foods, such as fruits and vegetables, are out of reach financially and spatially and are therefore, not eaten as frequently. It is, however, possible to mitigate the impact of this situation by giving tools that will help increase access to nutritional foods and promote meal preparation that is nutritionally sound and culturally appropriate. These are the model's nutrition objectives.

There are historical food traditions in communities of color that resist as either neo-imperialist or neo-colonial 'white people food' as a hegemonic representation of healthy and good, 'for you change folks' food – especially people of color- it's like you're asking them to change who they are.' That's why it's so important not only to start where folks are and introduce foods with which they are going to be familiar but also demonstrate food preparation in a manner that is culturally sensitive, respectful, easy to cook and most important affordable. The cultural connections to food can be addressed with variances in preparation that both preserve and protect identity (e.g., culinary techniques and technologies through nutritionally sound advice).

The Village Market will include food distribution programs, a food pantry and a farmer's market. The market will be located on the IHMC campus and will eventually reside in the new SBEV Chicago facility, fully accessible to residents of the catchment area. The main goal of this program is to use sustainable methods to increase ongoing access to fresh fruits and vegetables. The objectives for these activities are for community participants to improve their diets, access fresh food products and encourage healthy habits.

The food distribution program will include distribution of food boxes that contain fresh fruits and vegetables. The boxes will provide menus, meal preparation suggestions and invitations to participate in classes sponsored by the Village Market. The classes will cover nutrition concepts, budgeting to purchase healthy choices, developing culturally appropriate healthy menus, meal preparation tips and food preparation demonstrations. The nutrition and healthy eating classes will be available for all patients coming from the FQHCs or IHMC. Invites to the classes will be sent to all participants in other collaborative's strategies (maternal, chronic conditions, behavioral health). The classes and demonstrations will be designed for a general audience but there will also be classes developed for specific groups as needed.

On a contractual basis, SSHEC's community college partners and other community-based organizations shall provide instructors for the nutrition classes, courses, and demonstrations. The instructors will develop specific program objectives and performance goals that will achieve the outcome metrics. The Village Market activities will be led by a nutritionist and assistant. The CHWs will also assist with program implementation and will receive training to support ongoing Village Market activities.

Elements of the nutrition program will be incorporated into the youth athletics programs to encourage children to talk with their parents and incorporate healthy food choices into their

lifestyles. The model includes a holistic approach to exposing youth and families to the nutrition program benefits and the importance of maintaining a healthy diet in conjunction with their physical activity. Families will also be engaged to help them better utilize financial resources (EBT cards, wages, etc.,) to support healthy food choices, with this knowledge lasting beyond the food distribution programs.

Working with community-based vendors the Village Market at IHMC will be the location and hub for the nutrition classes, healthy food box distribution, for a food bank, and regularly scheduled farmer's market. Patients and families from collaborative partners will be invited and encouraged to visit the Village market and participate in the educational programs. The pantry and the farmer's market will be open to the public. The Village Market will be available to populations in all of the collaborative's strategies. The nutrition programs will be developed to meet the special needs of patients participating in the maternal, chronic conditions and behavioral health strategies.

CHWs will be on site to provide information on selecting culturally appropriate healthy food choices, meal preparation and healthy menus. CHWs will also provide assistance and answer questions on nutrition related entitlement programs such as SNAP and WIC encouraging participants to use the resources provided by these programs to select and purchase nutritious foods. Additional resources for achieving and maintaining a healthy lifestyle will also be distributed.

Numerical participation goals will be established for each of the Village Market programs.

Counseling and Trauma-Informed Care: empowering Youth through Counseling, Trauma Informed Care linked to Art, Music Therapy Programs. Chicago South Side youth have experienced community violence (see Figures 8 and 9), structural economic neglect, and closed neighborhood schools. SBEV Chicago's focus on athletics and arts is an outlet that will enable most youth to thrive. The maligned nature of the violence in the community, however, leads to a communal PTSD that will require behavioral health support.

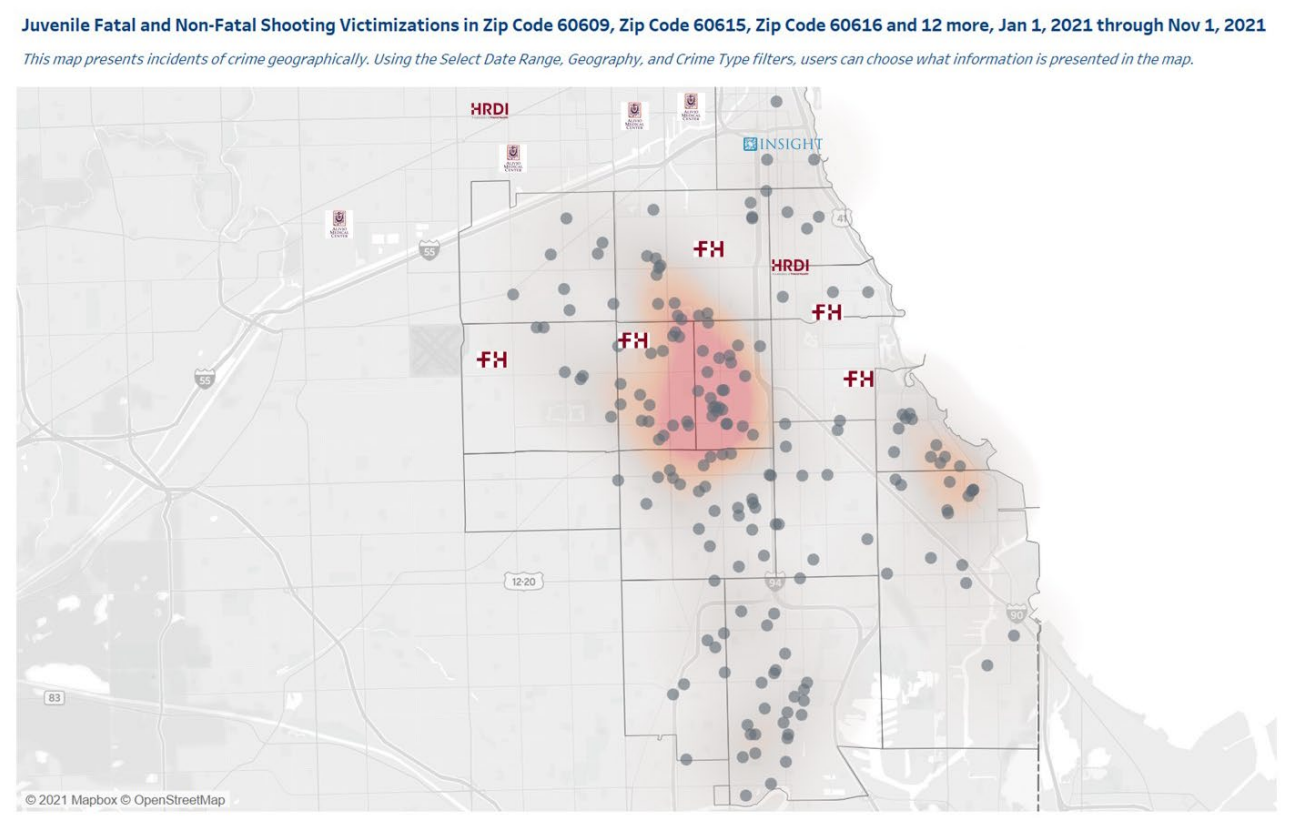
An assessment will be completed for each participant in the youth programs to screen for the social determinants of health (SDoH), stress factors, or other behavioral concerns. Referrals will be made to collaborative behavioral health providers or contracted adolescent health providers. As noted under the behavioral health strategy HRDI will provide a variety of services for youth aged 5-20, including:

- Behavioral Health/Mental Health Services for youth who meet Medical Necessity.
- Community Base Outpatient for Youth & Families, including individual & Family therapy, therapy in schools, and
- Daily living and coping strategies, anger control, social strategies

The SBEV Chicago concept incorporates music and art therapy programs with the clinical counseling programs, using the after-school space as appropriate to increase accessibility and acceptance of the programs.

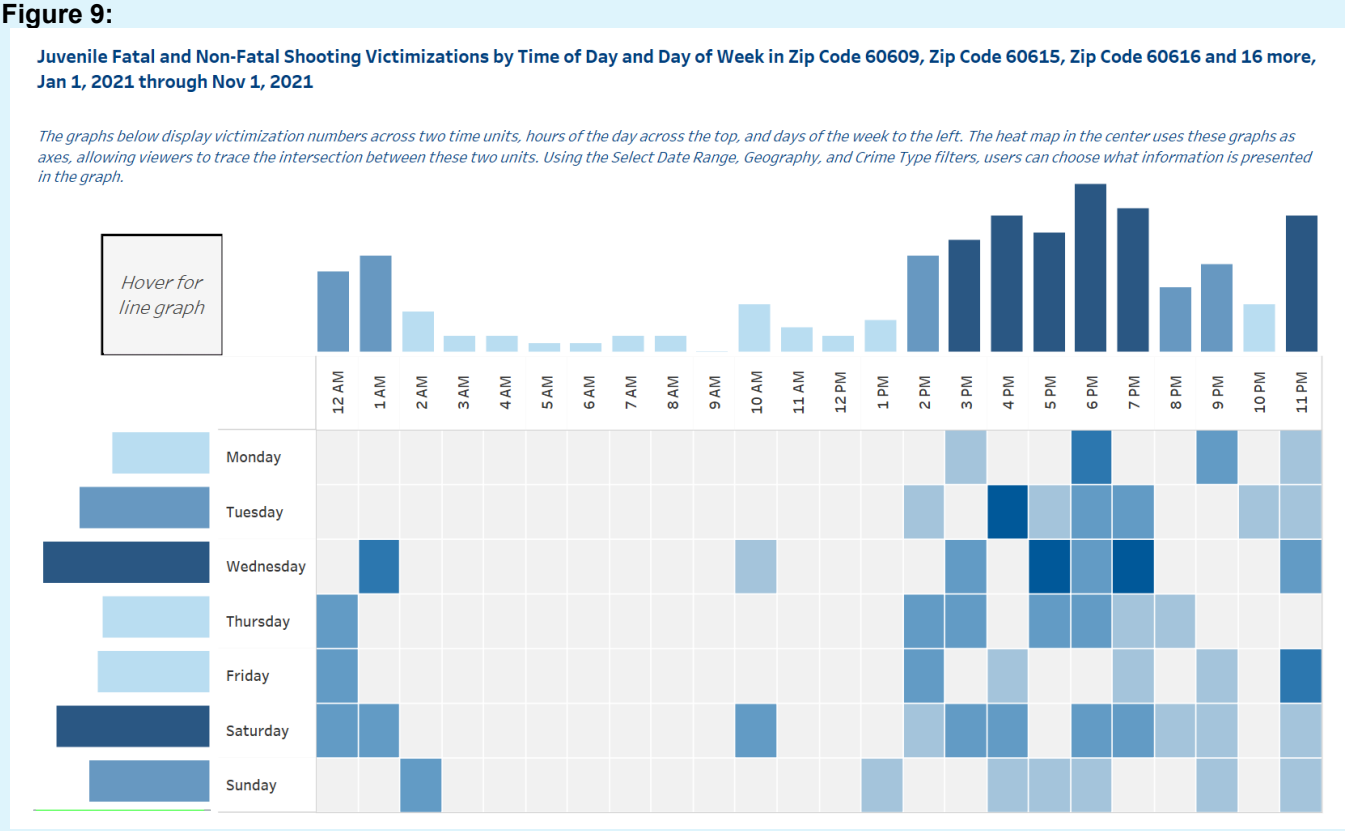
Individuals participating in all SBEV Chicago programs will be assessed and provided with referrals to CASL our care coordinating partner to address SDoH concerns and access social services.

Figure 8:



Key: ● : Address/location of crime
Red area: High-density crime
Orange area: Medium-density crime
Source: [Violence Reduction Dashboard: Violence and Victimization Trends— Chicago Data Portal]

Figure 9:



Source: Violence Reduction Dashboard: Violence and Victimization Trends— Chicago Data Portal

Outcomes. The outcomes that will be achieved as result of the youth empowerment strategy align with the HFS quality pillar for child behavior health. The information in the **Metrics and Outcome Table** is a list of the outcome measures with specific goals the collaboratives will achieve **(**See Section 13 for details) but at a high level, the collaborative seeks to improve processes of care and outcomes.

Youth Empowerment Goal 1: To increase physical activity literacy among youth in racial/ethnic minority and/or socioeconomically disadvantaged children and youth residing on Chicago's South Side. *Objectives and anticipated outcomes for goal 1*: 80% of regularly participating youth show an improvement in physical activity literacy.

Youth Empowerment Goal 2: To Increase nutrition comprehension skills among youth in racial/ethnic minority and/or lower socioeconomic status children and youth on Chicago South Side.
Objectives and anticipated outcomes for goal 2: 80% of regularly participating youth show an improvement in nutrition comprehension skills.

Youth Empowerment Goal 3: To promote and increase the consumption of dark green, orange, and red vegetables and whole fresh fruit and decreased consumption of sugar-sweetened beverages.
Objectives and anticipated outcomes for goal 3: 80% of regularly participating youth show increased access and awareness of dark green, orange, and red vegetables and whole fresh fruit.

Youth Empowerment Goal 4: To expand youth participation in sports and encourage regular physical activity, especially for youth populations with lower rates of sports participation and communities with limited access to athletic facilities or recreational areas.
Objectives and anticipated outcomes for goal 4: 80% of regularly participating students will show an improvement in physical activity literacy

Youth Empowerment Goal 5: Village Market concept provides access to fresh healthy food choices, while empowering families to incorporate healthy food selections into their lifestyles and teaches families to prepare culturally appropriate meals, using fresh, wholesome foods. *Objectives and anticipated outcomes for goal 5:* 70% of the families taking advantage of food distribution and nutrition programs to make substantial changes in food choices

Sustainability (see Section 16 for broader context). At the end of transformation funding, we will seek grant sources and community partnerships to assist youth in reaching their best version of themselves.

Budget relevance. The Youth Empowerment strategy is about people helping people; thus, a significant part of the funding request is staff for programs: academic, athletic, outreach, operational and finally oversight. These individuals will be on-site working with high-risk youth each day, proving safe, therapeutic alternatives that intrinsically lower stress-but in addition, there will be staff with backgrounds in counseling, de-escalation, and relating to troubled youth.

While the program will begin modestly, it will require rehabilitation of dedicated space at the IHMC campus, and while those renovations are underway, leasing of space at the local community XS Tennis site.

Core strategy 3: Chronic Conditions
The goal of the chronic condition strategy is to ultimately reduce premature cardiovascular morbidity due to poorly controlled diabetes and hypertension in patients under care. It will do so by strengthening community services on Chicago's South Side, an area that has a shortage of medical specialists.

Life spans in some South Side neighborhoods are 12-30 years less than in wealthier parts of Chicago, and While across Chicago as a whole the life expectancy gap between black and non-black residents is approximately 9 years, parts of the South Side have life expectancies more than 20 years behind that of

Whites in the wealthiest parts of the city. Multiple sources including the Chicago Department of Public Health (ref) and the University of Illinois School of Public Health (ref) show how shortened lifespans on the South Side are driven by early mortality related to these common chronic conditions of adulthood. "Black Chicagoans are about 2.9 times more likely to die from stroke and 2.1 times as likely to die from heart disease compared to white Chicagoans."[8]

A recent study has shown that despite overall trends of improvement in control of risk factors that drive cardiovascular mortality, control of those factors seriously lags for non-Hispanic Black Americans compared to Whites. The same study showed that lesser control of these factors drives a significantly higher 10-year risk for cardiovascular disease, and that lower income and lower education are also associated with lower control of these driving risk factors[9].

The percentage of premature death among Black Chicagoans is more than quadruple the percentage among non-Black Chicagoans. Since 2012, the life expectancy gap between Blacks and non-Blacks has increased from 8.3 to 9.2 years This gap is being driven by 5 main causes of death[2]:

- Chronic Diseases (e.g., heart disease, cancer and diabetes; the diabetes-related death rate among Blacks is 70% higher than among non-Blacks)
- Homicide
- Infant mortality
- HIV, influenza and other infections
- Opioid overdose

The prevalence of adult diabetes is higher among non-Hispanic blacks, Hispanic/Latinx, and those of mixed races than among Asians and non-Hispanic whites[10] About 8.6% of Latinx Chicagoans have been diagnosed with diabetes compared to 12.3% of blacks and 8.6% of whites. In Chicago and Suburban Cook County, diabetes mortality rates are highest among African American/blacks at 84.7 and 74.9 per 100,000 total population, respectively[11]. Obesity, which is an important risk factor for ethe development of diabetes, is unequally found across race and ethnicity. About 32.1% of Latinx Chicagoans have been diagnosed with obesity compared to 37.8% of blacks and 23.7% of whites.

Control of chronic conditions like hypertension (HTN) and non-insulin dependent diabetes mellitus (NIDDM) and obesity are intertwined with living conditions, as control of these disorders is highly dependent upon patient activation and choices for healthy options related to diet, exercise and stress, which are fueled by limited access to nutritious foods and safe space for exercise, reduced access to care including medical specialists, and adoption of self-assessment techniques common in better-off populations that lead to better disease control. Related to food insecurity, access to healthy foods is another important factor needed to support chronic disease prevention. Low-income communities of color are less likely to have access to supermarkets and healthy foods and tend to have higher density of fast-food restaurants and other sources of unhealthy food, such as convenience stores[11, 12] .Approximately seven percent of households in Cook County overall are below the poverty level and not receiving SNAP benefits[11, 13].

Focusing on control of these chronic conditions aligns with Illinois HFS transformation pillars to maintain and improve access to care in vulnerable areas such as Chicago's South Side. Primary care providers and community residents relate limited access to endocrinologists, lifestyle coaches, nutritionists, and healthy food choices for individuals in the area. An analysis of conditions contributing to poor health in Chicago's black and brown residents found that "Black and Latinx Chicagoans tend to be overrepresented on the bottom-end of most every indicator of inequality available while white Chicagoans tend to be overrepresented at the top……. Health outcomes are improving across Chicago, but inequalities between blacks and whites are either stagnant or widening on major indicators of mortality like heart disease, stroke, and mortality in general."[8]

[9] He et al. JAMA 2021;326: 1286-1298

[10] Centers for Disease Control and Prevention, 2013

[11] Mercy Hospital and Medical Center, Community Health Needs Assessment 2019

[12] N. Larson, Story, & Nelson, 2009

[13] Feeding America, 2018

The same study noted that:

- Those living on the North Side of Chicago, or in the Loop, routinely have about ten times as many health care provider options located in or adjacent to their neighborhood than do predominantly black communities of the far South Side.
- As many as 1 million residents on Chicago's South and West Sides live in areas without a drug store within a half-mile radius.
- Chicago's food deserts cluster in almost exclusively black census tracts. As many as 183,200 Chicagoans live in a low-income census tract that is at least one mile away from a supermarket or large grocery store.

The intent of this strategy is to unify the approach of the partners to identification and management of these chronic conditions, use of evidence-based practices shown to improve outcomes, enhance care coordination with community health workers and deploy modern technologies that enhance patient empowerment and self-care. The majority of the interventions will stem from care in the medical home, but IHMC will play a vital role in providing specialists needed for care of individuals with HTN and DM, including cardiologists, endocrinologists, nephrologists, podiatrists-and with the development of a Lifestyle Center.

This initiative tackles health inequity head on because rather than apply a service as optional or an add-on for all, it seeks to identify individuals with need and match resources to fit that need-the definition of an equity approach.

Access to care will be improved for adults with chronic conditions through multiple approaches:

- Community health workers
- Telehealth
    - access to needed specialists
        - synchronous
        - asynchronous
            - retinal screening for persons with diabetes
            - eConsultation
- Providers recruited to IHMC who are committed to seeing vulnerable individuals on the South Side

Evidence-based medicine. In 2020, Alivio Medical Center cared for 2359 adults with HTN and 2367 adults with NIDDM; corresponding numbers for Friend Health were 5578 and 2152 respectively; corresponding numbers for the former Mercy Hospital were 2335 and 2353 respectively (and at the former Mercy Hospital, ED visits for those disorders were approximately twice those numbers in 2020).

A specific objective is to connect patients with community-based providers in the partnership that use evidence-based clinical care to reduce unplanned ED visits and inpatient stays. Patients in primary care in a partner organization will have enhanced access to specialists based at IHMC as needed.

- Hypertension
    - Partner organizations may choose (as Friend Health has) to enroll in the Million Hearts campaign (see https://millionhearts.hhs.gov)
    - Partner organizations will adopt The American Heart Association and American Medical Association's "Target BP" approach (ref https://targetbp.org/) and pursue certification. This program is described for clinicians as an approach to "**MAP**" blood pressure:
        - accurately **M**easure blood pressure by health center staff
        - **A**ct upon elevated blood pressure readings (overcome clinical inertia)
        - **P**artner with patients to promote self-awareness and monitor progress, including self-measured blood pressure (SMBP) monitoring by a patient at their home, enabling self-activation and better communication with their care team.
- Diabetes mellitus
    - Partner organizations will focus on the "ABCs" of diabetes care:
        - Measure and control the hemoglobin **A**1C

- Home monitoring with glucometers and interfaces to allow remote uploads of home glucose monitoring
- **B**lood pressure control
- **C**holesterol management

- Also, partners will use standardized practice patterns including electronic health record templates and prompts to assure persons living with diabetes are receiving annual
  - Foot exams
  - Retinal exams-Alivio has capability for retinal cameras to enhance annual diabetic retinal screening in order to prevent avoidable blindness brought on by proliferative diabetic retinopathy. Cameras will be placed in one additional Alivio site, 3 additional Friend Health sites
  - Microalbuminuria screening
- A Lifestyle Center will be developed at Insight Hospital and Medical Center that will be a referral source for clients to access empowerment strategies for living with chronic condition, including improved access to
  - Specialists in need
    - Diabetic educators
    - Nutritionists
    - Endocrinologists (for difficult-to-control diabetes)
    - Podiatrists to evaluate foot issues before they advance
    - Pharmacist to help with medication interactions and optimizing therapies
    - Cardiologist for evaluation of high-risk individuals with diabetes mellitus
    - Smoking cessation counselors
  - Nutrition counseling, including education on selecting the most nutritious items within available budget
  - Exercise counseling and coaching from a local certified exercise trainer
  - instructional information or online links help achieve and track healthy lifestyles
  - space that simulates scenarios to assist individuals with good choices in reading food labels, cooking in adaptive ways that are culturally competent but stress healthy methods and portions, and motivational nudges provided by staff and invited subject matter experts

- Concomitant behavioral health issues and Social Determinants of Health
  - Screening for concomitant depression and substance use disorders (SUD, esp. alcohol tobacco, and opioid use disorders) will take place at minimum annually, (and more frequently for those identified with threshold depressive symptoms or identified substance use disorders)
    - QuitLine Illinois will be recommended for all smokers
    - Screening for SDoH using standardized instruments esp. focused on food and housing insecurity

Practice Redesign: Screening for and addressing Social Determinants of Health. Addressing barriers to adherence and good outcomes required identifying missing social supports and finding resources to help an individual address that need. The collaborative will contract CASL to connect patient community-based agencies to provide solutions for patients and provide funds to pay for services including housing, food needs, and transportation for clinical services.

- Screening for SDoH will take place at minimum annually, and more frequently for those identified with an important social driver, using standardized instruments esp. focused on food and housing insecurity
- The care coordination process, including the use of CHWs, will include pathways to connect patients to CBOs to address SDoH that individual patients encounter as they move through the care continuum.

Care Integration and coordination. Care integration and coordination will be addressed via

- Data integration and information sharing between Provider partners, and the Chinese American Service League
  - Data use agreements
  - Business associate agreements
  - Technology interfaces

- Community Health workers who will
  - assist patient understanding of their conditions
  - facilitate home monitoring of HTN and NIDDM and assure patients know how to connect that information to their medical home
  - connect patients to CBOs to address identified social support needs

Outcomes. The outcomes that will be achieved as result of the chronic condition strategy align with the HFS quality pillar for chronic disease management. At a high level, the collaborative seeks to improve processes of care and clinical outcomes.

The Quality/Milestones Committee will track outcomes. The targeted outcomes for improvement in this core strategy include the following important process measures:

- Primary care site Staff trained on proper bp measurement
- Calibration of blood pressure cuffs in primary care practices
- Proportion of patients with identified HTN
  - counseled on diet
  - screened for tobacco use
  - screened for substance use disorders
- Patients with difficult-to-manage HTN (lack of bp control despite ≥3 prescriptions for HTN) will be
  - given home blood pressure cuffs for monitoring and demonstration of use
  - screened for obstructive sleep apnea
  - screened for tobacco use
  - screened for substance use disorders

See Section 13 for details, and **Metrics and Outcomes Table** for a list of the clinical outcome measures the collaboratives aims to achieve.

Sustainability (see Section 16 for broader context). Provider visits that occur as part of much of this core strategy are billable. As evidence of continued positive results from improved blood pressure and diabetes control leads to a reduction in complications and acute care visits, there will be abundant savings to be realized. As part of the early discernment of the role of partnership-driven care coordination and the role of the Managed Care Organizations in this regard, we will engage MCOs to reimburse these expenses similar to a model that is currently in place between MCO and providers.

Budget relevance. The access to physician specialists and clinical support staff needed for expert management and avoidance of disastrous long-term complications of hypertension and diabetes form a significant part of the funding request. Based at IHMC, these specialists who will see patients, direct relevant course material and messaging for the Wellness Center, and decrease waits for specialty care on the South Side are expensive-but once recruited, they should be sustainable through billing for clinical services they provide in person and via telehealth. While we do not immediately foresee them traveling to provide services directly for individuals at the community health center partner sites, this is a possibility. Each specialist will be supported by a medical assistant for optimal efficiency.

Support for the CHWs and CBOs who will assist individuals identified with needs for food, housing and transportation will help ensure the stability of the individuals cared for and lessen psychic stressors for them (a major driver of anxiety and poor chronic condition control).

Capital equipment requests in this strategy include monitoring devices including internet-capable blood pressure monitoring equipment and retinal cameras to improve screening for individuals with diabetes in care who often cannot afford transportation to a hospital site for this service.

Core strategy 4: Behavioral Health

The goal of the behavioral Health strategy is to strengthen community based mental health and substance abuse services on Chicago's South Side, with a particular focus on supporting transition of care for individuals with acute hospital utilization for a mental health disorder and supporting the core

strategies of the Insight partnership focusing on maternal health, youth empowerment, and adults with chronic medical conditions.

It is understood that behavioral health disorders are the largest domain of disability related burden in the United States, as measured by disability-adjusted life years lost per 100,000 population.[14] Depression is common in primary care, with up to 10% of adults meeting criteria for major depression, but despite this, screening for depression is uncommon, with only 4% of the population receiving such screening[15]. Because of these shortcomings, it is estimated that as many as half of all patients in primary care with depression are never diagnosed. People with serious mental illness are known to die many years earlier than individuals without mental illness[16]. Serious mental illness is undertreated; approximately 10.4 million adults in the United States had an SMI in 2016, but only 65 percent received mental health services in that year[17].

Disorders of adult personality and behavior are in the top quartile for frequency of admission and for acute hospital length of stay in South Side residents, and three of the top ten reasons for hospital readmission on the South Side are behavioral health disorders according to background analysis performed for the department of HFS by the University of Illinois School of Public Health[18].

There are glaring disparities in access to behavioral health services. At the national level, 58.2 percent of Black young adults 18-25 and 50.1 percent of Black adults 26-49 with serious mental illness did NOT receive treatment in 2018. 90 percent of African American people over the age of 12 with a substance use disorder did NOT receive treatment. 34% of Hispanic/Latinx adults with mental illness receive treatment vs. the U.S. average of 45%. While some of this barrier is related to lack of insurance, the disparity is greater than would be explained by that alone, suggesting structural barriers, including stigma, language and other cultural concordances.

Importantly, the COVID pandemic has seen marked increases in opioid related deaths in many municipalities, in some, related to fentanyl-containing projects, and disproportionately affecting people of color[19]. In fact, in November 2021 the Centers for Disease Control and Prevention reported that in the most recent year of data, more than 100,000 people died from fatal drug overdoses for the first time in U.S. history has been demonstrated that medication-assisted treatment (MAT) is an effective intervention that decreases craving, drug-seeking behaviors, overdose deaths, and keeps individuals engaged in ongoing cognitive therapy for their underlying conditions. Racial disparities in MAT are profound. Among patients who experience non-fatal overdoses, African Americans are half as likely to obtain follow-up appointments for OUD care after discharge from emergency department care. A 2018 study showed highest access for whites and those with commercial, employer-based insurance[20].

Last year saw the largest single-year increase in drug overdose deaths ever reported in the United States, with more than 93,000 deaths in 2020, an increase of nearly 30% over 2019. The CDC's most recent estimate for predicted deaths related to opioid overdose was over 100,000 from May 2020 to April 2021[21]. There was a 29.7% rise in reported drug overdose deaths between February 2020 and February 2021; opioids accounted for the highest number of overdose deaths.

Aside from that national lens, the South Side community recognizes the importance of substance use. The 2019 Mercy Hospital Community Health Needs Assessment (CHNA) found the community identify substance use disorders as one of the top three concerns, cited by 34% of those surveyed as a major

[14] Kamal R, Cox C, Rousseau D, et al. Costs and Outcomes of Mental Health and Substance Use Disorders in the US. JAMA 2017;318(5): 415

[15] Bhattacharjee et al. Psychiatr Serv 2018: 69: 1098-1100

[16] National Association of State Mental Health Program Directors Council. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: Parks, J., et al.

[17] Center for Medicaid Services https://www.cms.gov/newsroom/press-releases/cms-announces-new-medicaid-demonstration-opportunity-expand-mental-health-treatment-services)

[18] Transformation Data & Community Needs Report: Chicago-South Side, February 2021

[19] See CDPH table opioid deaths Chicago 2019

[20] Roberts et al., 2018

[21] https://apnews.com/article/overdodse-deaths-fentanayl-health-f34b022d75a1eb9776e27903ab40670f)

issue for the community. People living with mental health and substance use disorders were named as one of the priority special populations of focus. They noted 6 key takeaways related to behavioral health issues:

- Access and Quality of care
- Fragmentation of care, needing integration and coordination
- Social/structural determinants of health
- Trauma and adverse childhood events
- Stigma and discrimination
- Workforce shortages and gaps in training

Adjusted for age, mental health related emergency department visits are the highest on the South Side over any other sector of Chicago, as are those for substance use disorders. The report prepared by the University of Illinois at Chicago School of Public Health and Institute for Healthcare Delivery Design for the Illinois Department of Healthcare and Family Services also described glaring health disparities related to behavioral health issues on the South Side. Mental, behavioral, and neurodevelopmental disorders were among the top 5 most frequent inpatient drivers of hospitalization on the South Side (expressed as rate per 10,000 Medicaid Enrollees), and mental health disorders were in the Top Quartile[1] for Both Frequency Rate and Average Length of Hospital Stay. Mood disorders and serious mental illness were in the in the top sextile for frequency rate and average hospital early readmission score for the South Side of Chicago. For Medicaid patients in the South Chicago area who went to the ED or were hospitalized for mental disorders, only 10.0% received outpatient care within 3 months prior to hospital-level care and only 14.5% received outpatient care within 3 months after hospital-level care. Among Hospitalizations for Alcohol and Opioid Use Disorders, on the South Side, opioid related use outnumbers alcohol 2:1[22].

Partners in our collaborative see a significant number of adults with high depressive symptom burdens. In 2020, Friend Health cared for almost 400 individuals with a positive Patient Healthcare Questionaire-9 screen; Alivio Medical Center had 700.

Data support

Table 1. Overdose deaths involving opioids –Chicago, 2018-2019

	2018			2019			2018 to 2019	
	N	%	Rate[ii]	N	%	Rate[ii]	Absolute	% Change
Chicago	793	100%	28.7	855	100%	31.6	2.9	10.1
Race-Ethnicity								
NH Black or African American	425	53.6%	45.5	483	56.5%	50.8	5.3	11.6
NH White	244	30.8%	24.6	260	30.4%	27.6	3	12.2
Latinx	121	15.3%	15.8	103	12%	14.1	-1.7	-10.8
NH Asian or Pacific Islander	3	0.38%	1.9^	4	0.5%	1.8^	--	--

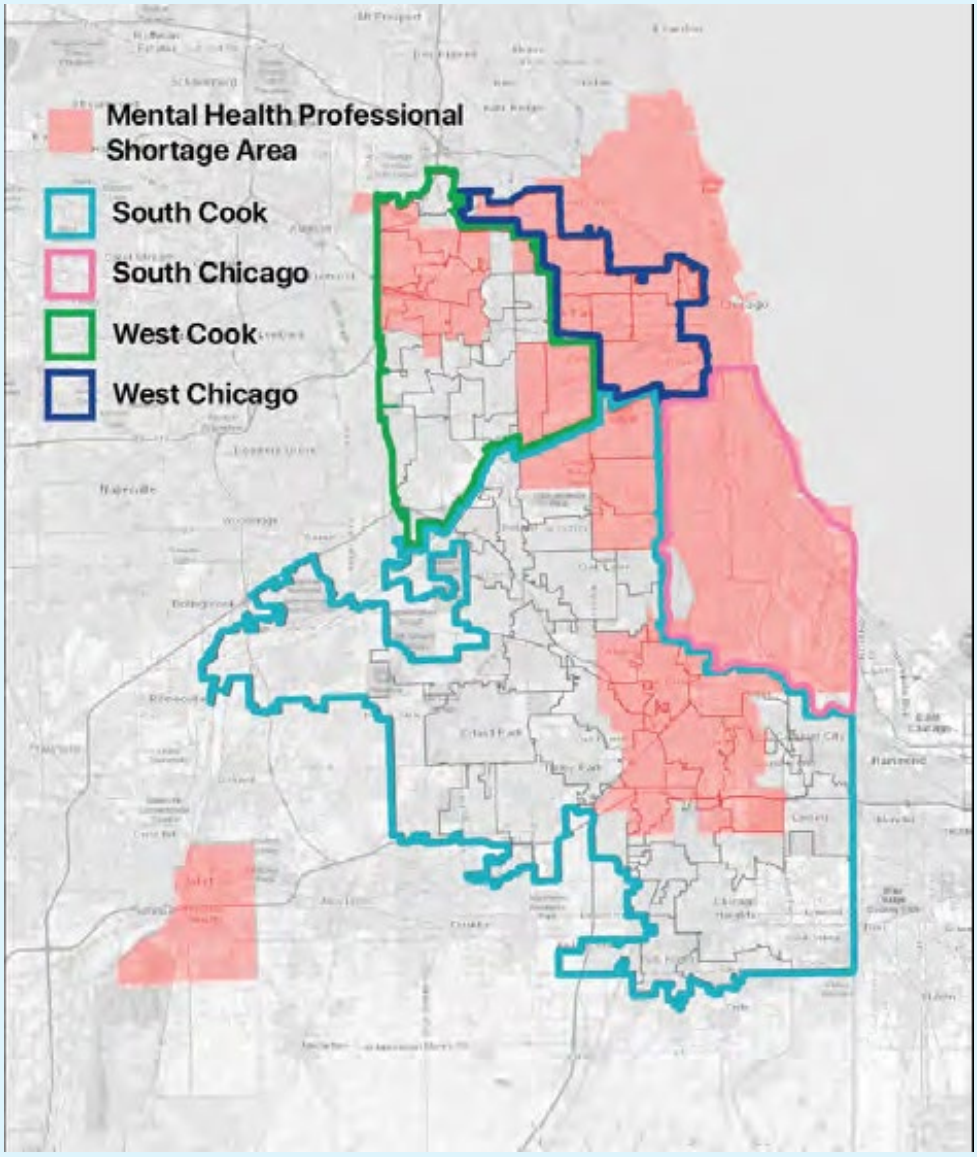
Capacity. The demand for behavioral health care outstrips the current supply, things are worse for vulnerable populations including the urban poor and have worsened still during the pandemic. 78% of 260 behavioral health Providers surveyed by the National Council for Mental Wellbeing in September 2021 say demand for their services has increased over the past 3 months (since August 2020, this percentage has increased 26%). Demand has specifically increased over the past 3 months for organizations offering mental health treatment, crisis services, social support services, and youth services. According to HRSA, the average percent of mental health care provider need that is met in the United States and territories was only 27%. The entire South Side of Chicago is a designated HSRA Mental Health Professional Shortage Area.

[22] UIC SPH Transformation Data & Community Needs Report: Chicago-South Side, February 2021

The South Side of Chicago has seen the loss of several city-run mental health clinics over the last few years. Insight acquired the former Mercy hospital in June 2021. Reinstating the psychiatric inpatient services at the former Mercy hospital and facilitating community-based services for patients transitioning from hospital care are priorities for Insight. This strategy aligns with the Illinois Department of Healthcare and Family Services 'Transformation pillar to maintain and improve the quality of behavioral Health services in vulnerable areas such as Chicago's South Side. The current array of BH services available in the community is limited. The intent of this application is to obtain funding to leverage the limited existing services while simultaneously expanding BH services. This will be achieved by working with community partners including FQHCs, CMHCs, CBOs and a care coordination company.

See Figure 10 from Transformation Data & Community Needs Report: Chicago-South Side, February 2021.

Figure 10



Tactical partner roles and collaboration. IHMC will create a specialty psychiatric clinic to care for patients with the highest level of need including particularly challenging diagnoses and medication management. HRDI, a community mental health center, operates a 24/7/365 community triage center on the South Side, which gives partnership providers another alternative to ED care for a patient in crisis with complex needs and will provide the full spectrum of ambulatory and residential behavioral health services for adults. Child and adolescent community-based psychiatry and case management are available. Patients enrolled in primary care with less intense behavioral health diagnoses will receive care in their medical home (Alivio, Friend Health, IMAN, IHMC) utilizing the evidence-based integrated

care model. The care coordination agency, working with community-based workers will facilitate the necessary warm hand-offs between providers. Of note, the Chinese American Service League is starting behavioral health services and is in the process of completion of accreditation under HFS Rule 140. Revenue projections may be better estimated once the preceding events have been completed. Finally, the collaborative will work with local community colleges and the Chicago-Cook Workforce Partnership to identify and train potential community health workers, preferably residents of the catchment area.

Improved care coordination: Behavioral Health care transitions. IHMC recognizes behavioral Health needs on the South Side require improvement in care beyond insuring access to hospital inpatient care. A primary goal is to reduce unnecessary emergency department (ED) visits and inpatient stays that could be prevented if patients were connected with appropriate mental health and substance abuse in the community. The collaborative seeks funding to address this situation by creating a system of care based on care coordination that will connect patients seamlessly with behavioral health services provided by the members of the partnership. Care coordination will begin in the ED, following the patient if necessary, through inpatient service and connecting the patient with behavioral health providers based at the IHMC or community health center and community mental health center partners. Care plans will be developed for the patient to place the patient at the appropriate level of service providers.

IHMC, Alivio, Friend Health and HRDI will work collaboratively to improve connection of patients post-ED and post-inpatient stay to the right community-based provider. Hospital-based care coordinators who will coordinate discharge planning, bolstered by technological interfaces to smooth transitions. The targeted clinical outcomes for improvement include improved follow-up of acute hospital care (ED And inpatient) and reducing the number of readmissions for a primary behavioral health diagnosis. Analyses indicate achieving better outcomes requires addressing the SDoH that present barriers to obtaining the needed care. The care coordination process, including the use of CHWs, will include pathways to connect patients to CBOs to address SDoH that individual patients encounter as they move through the care continuum.

HRDI will deploy Peer Specialists to see clients at the time of discharge from ED or hospitalization to assist in engagement into treatment. Many of these individuals are lost to follow up. With this initial contact, information for future contact can be confirmed-a key feature as many of these individuals lead chaotic lives and often fail to keep follow-up and conventional outreach typically fails them often due to inaccurate contact information.

Improve access to mental health and substance use specialists. Transformation support will allow the SSHEC to decrease wait times for services by the addition of local resources in the form of psychiatrists stationed primarily at IHMC and HRDI, other licensed professionals (LCSWs, and LCPCs) for Alivio, Friend Health; certified peer specialists, certified recovery peer advocate and recovery coaches for HRDI; and youth and family peer advocates (for the Youth Empowerment strategy).

Supporting other IHMC partnership strategies. It is acknowledged that other clients will require BH services. Patients with BH needs from the three other core strategies (maternal, chronic conditions and youth empowerment) will be provided with care coordination to connect them to community-based BH care. A goal would be to have BH providers that have special affinity and expertise for these special groups. Many maternal, chronic condition, youth and BH patients, are at the highest risk for SDoH. If the SDoH issues are not addressed immediately, even those initially assessed at low risk will move into the higher risk category. Addressing SDoH factors requires thorough initial assessment, care management to connect patients SDoH, affiliation with SDoH agencies to provide solutions, and community-based care coordinators or health workers to assist patients with getting the care or services needed.

Thus, for individuals in the Chronic Conditions in Adults and Maternal Health care, there will be

- Uniform screening for depression in primary care
    - Diagnosed depression managed with a combination of medication and cognitive behavioral therapy

    - Collaborative care model
    - Periodic reassessment to assure improvement
- Uniform screeding for substance use disorders in primary care
    - **Medical homes will adopt Screening, Brief Intervention and Referral to Treatment** (SBIRT). This is an evidence-based methodology to identify and assist individuals with problematic alcohol and drug use, with a harm reduction strategy to prevent especially accidents and injuries
    - Positive screens for alcohol and opioid use disorders receive
        - Medication if indicated (buprenorphine, naltrexone, methadone)
        - Cognitive behavioral therapy
        - Day or residential treatment for select individuals (removes the most frequent barrier to program entry for mothers)
        - Periodic reassessment to assure improvement

For individuals in the Youth Empowerment programs, there will be

- Family support therapeutic sessions will be part of services that will be made available to strengthen the for the patient and ensure compliance with the care plan. These sessions may also provide opportunities beyond routine office visits for early warning signs of potential issues including but not limited to SDoH.
- The youth empowerment strategy will identify potentially depressed adolescents. Care coordination will connect those individuals appropriate partner resources in their medical homes or HRDI. We will follow those with diagnosed depression for progress towards remission.
- For youth aged 5-20, HRDI will provide a variety of services including
    - Behavioral Health/Mental Health Services for youth who meet Medical Necessity.
    - ADHD, PTSD, Oppositional Defiance, Depression, Anxiety, Adjustment Disorders, Bi-polar, and Schizophrenia
    - Community Base Outpatient for Youth & Families, including individual & Family therapy, Case Management, Psychiatry, Medication Monitoring, Crisis Services
    - In schools: therapy in schools, intake and admission evaluation
    - Skill Building, inc. daily living and coping strategies, anger control, social strategies

HRDI will pursue status as a Certified Community Behavioral Health Clinic (CCBHC). CCBHCs earn national certification status by addressing specific required scope of services and timeliness of access. This will require adoption of CCBHC standardized data and quality reporting but should provide funding to cover service integration, expansion, and/or enhancement, including traditionally non-billable activities like outreach and care coordination. CCBHC funds can support providers to build capacity to address the significant and increasing impact of behavioral health problems on communities, as well as support providers to move toward value-based care. Securing revenue to facilitate successful application completion will greatly increase the likelihood of being awarded. Technical assistance for this effort will include a needs assessment that looks at disparities in the population it and the partnership serve, and development of a certification program for Recovery Specialists.

Substance use disorder workforce development sub strategy. HRDI will pursue training and workforce development, including Implementation of a certification program for Recovery Specialist. The program will directly benefit individuals with established success in a treatment modality and a personal plan of recovery. This program will provide valuable service to community and serve as a motivator for individuals in treatment.

Outcomes. The outcomes that will be achieved as result of the behavioral health strategy align with the HFS quality pillar for adult and youth behavioral health. At a high level, the collaborative seeks to improve processes of care, including effective screening for common mental health and substance use disorders, as well as prompt follow-up for individuals who experience emergency department of inpatient care for a primary mental health or substance use disorder.

Additionally, we will monitor clinical outcomes (care coordination following acute hospital visits for behavioral health diagnoses, appropriate use antidepressant medications, reduction in PHQ-9 scores, etc.).

The youth empowerment strategy will identify potentially depressed adolescents. Care coordination will connect those individuals appropriate partner resources in their medical homes or HRDI. We will follow those with diagnosed depression for progress towards remission.

See Section 13 for details, and **Metrics and Outcomes Table** a list of the clinical outcome measures the collaboratives aims to achieve.

Sustainability (see Section 16 for broader context).
Support for HRDI developing as a CCBHC will be vital to sustainability, as the enhanced care processes and breadth of services of a CCBHC, along with enhanced reimbursement rates, will insure the long-term viability, relevance, and financial health of this key south side mental health resource.

Budget relevance.

Support for the CHWs and CBOs who will assist individuals identified with needs for food, housing and transportation will help ensure the stability of the individuals cared for and lessen psychic stressors for them (a major driver of anxiety and poor chronic condition control).

The addition of specific behavioral health roles will address significant unmet community needs. From psychiatrists serving adolescents and adults, to peer coaches, there is a dearth of resources on the South Side. The addition of psychiatrists and licensed clinical social workers will improve access to care for these at-risk populations who currently suffer horrifically long waits for support. The development of peer coaches and educators with lived experiences of recovery from substance use will not only enhance the success of services for individuals with active substance use disorders, but it will also reinforce community stability with solid jobs for the recovery specialists and develop a true community asset in those individuals.

The additional psychiatrist will address needs on the South Side, which has the greatest gap in services for such across the city. We will augment with LCSWs at community health centers, working within the integrated healthcare model.

Additional staff brought along in the training program at HRDI for recovery coaches, peer specialists, and youth peer advocates will greatly expand the reach and enhance the effectiveness of the primary care team.

Core Strategy 5: Workforce Transformation

The South Side Health Equity Collaborative (SSHEC) intends to push the boundaries of innovation by revitalizing and repurposing resources to elevate and empower individuals seeking family sustaining careers in the Healthcare industry of Chicago and the surrounding suburbs. Through developing entry points and education pathways for our youth and young adults, we can transform the workforce landscape of Chicago. SSHEC will take on the challenge of coordinating and aligning a collaborative system of partnerships made up of subject matter experts with the necessary experience to galvanize Chicago's educational landscape.

Safety net hospitals and clinics in our immediate region have experienced a tremendous loss of staff and overall talent that have traditionally been the backbone of modern healthcare facilities. Now in our post Covid society, access to quality healthcare is imperative. There is an ever-increasing demand for treatment and hospitals / clinics are struggling with the volume of patients and lack of staff. Nearly every local employer is seeking out ways to develop a "go-to" pool of qualified, certified and job ready individuals for medical careers. This is no easy task to manage. 2021 has shown that even though work has returned, people have not. These conditions are even more compounded in the healthcare field due to the historic barriers related to medical careers. Misinformation about required education certifications, obtuse education pathways and total education costs are all factors that discourage entry into healthcare related careers. All of these issues are most acute in Chicago's underrepresented and underserved communities of color. Many of which are situated in the same geographic location as the individual member organizations of The South Side Health Equity Collaborative: the south and west side communities. SSHEC intends to deploy a comprehensive high-impact program model targeted for the

recruitment, training and placement of job seeking individuals in the healthcare field. Funds from this grant will be utilized to fill current gaps in education and workforce delivery by working in tandem with city colleges of Chicago and local nonprofits. Together we have the ability to implement a robust system that moves individuals of color seamlessly through post-secondary education onto professional medical careers, without the financial burden.

The workforce section of our Transformational grant submission will be anchored by three strategies. Each one independent of the other two but collectively working together to identify one complete system. This strategy has the ability to move underserved youth and young adults of Chicago into a coordinated system of support, education, employment and equality. The end goal is full-time employment structured under a career pathway plan. Our three targeted grant impact areas are 1) Healthcare Pathway Entry Inclusion: create more supported “on-ramps” into the field direct from high school and community-based organization into college level coursework. 2)Advancing the pipeline of interested individuals through continuing education curriculum, course studies with wrap-around support. 3)Transition from school directly into the workforce properly mentored with the understanding of the pathway progression. SSHEC initiated planning sessions where leadership level discussions were held to establish synergy between Insight Hospital and transformational collaborative partners. Each party offered their particular perspective on workforce challenges, level of skill required and other deterrents to modern Healthcare careers. This collaborative also incorporated representation from local community leaders, identifying challenges and potential solution and incorporating the most recent Healthcare Community Needs Assessment data. That data is extremely valuable for positioning the hospital for success amongst program partners, community members as well as local officials. Racial inequality, local economic factors, demographics, education, lack of technology, and family structure have become the realities of citizens that The South Side Health Equity Collaborative serves. Through our detailed understanding of the situation, current workforce bottlenecks and the needs of the local community, SSHEC is confident in our grant request and ability to achieve successful outcomes.

Address the messaging aimed at youth and young adults. We will address the narrative aimed at youth and young adults. There is a current lack of messaging targeting youth to consider employment as frontline entry-level medical workers. Simultaneously, growing stigmas for medical career tracks are impacting decisions of young adults. Feedback received are that most individuals feel that securing a good paying job requires extra years of schooling that significantly increases the amount of debt a person carries. It is oftentimes hard for elementary and high school students to see light at the end of their education pathway. SSHEC’s strategy is to position the collaborative in supportive roles to magnify positive career messaging in the medical field. Through use of the transformation budget The South Side Health Equity Collaborative can lead the charge for “modern day digital” advertisements, testimonials, literature, white paper, events, and all other forms of communication. Through short run engaging videos and social media campaigns we can meet the youth where they are at and infuse excitement, social justice and opportunities for building new ramps into the career funnel. In addition to digital information, we will focus and build-out additional collaboration amongst our partner network for career days, medical exploration days, job shadowing, guest speakers, work-based learning, internships and other programming to excite individuals about considering professional career in healthcare. Putting significant emphasis on highlighting healthcare career hierarchy of positions, competencies required, daily work responsibilities, and career advancement.

Cultivate leadership capacity. SSHEC will work directly with nonprofit leader Sylvester Broome Empowerment Village (SBEV). SBEV's mission is to cultivate leadership capacity serving all people in a dignified manner regardless of gender, race, or religion, and work to empower the youth in their communities to give them a voice in the world. Partnerships such as this one is extremely important as most providers and businesses do not reach a common level of understanding, where both can leverage a wealth of knowledge based on past experiences as subject matter experts in their respective fields. Traditionally these two groups work in silos and miss critical opportunities to share resources. SSHEC leadership will collaborate to create Healthcare introductory programs for youth to experience firsthand what it would be like to work as a healthcare professional; quickly establishing programs for youth that can be sustained through ongoing support from the local workforce investment board, WIOA and other city youth programs. The South Side Health Equity Collaborative will coordinate efforts to align under the transformation grant by creating positive program messaging, work base learning components,

student stipends, student materials and all other necessary components to support the ongoing inclusion of education for our underrepresented community residents.

Design alternative pathways into professional careers. SBEV and similar nonprofit groups have become the norm in designing alternative pathways into professional careers. Through funds obtained under this transformation grant, key medical staff can become proactive "champions" for elementary and high schools. This will empower them to provide support through use of technology, classroom materials/equipment, speakers, scholarships and mentors for students and teachers. Providing direction, consultation, and support with pathway steps in a student's successful journey to a healthcare career. SSHEC and its collaborative partners will begin this messaging and interaction in elementary and middle schools. Under this transformation grant The South Side Health Equity Collaborative in conjunction with CPS can build out "Healthcare Enrichment Days" working with city colleges on CPS off days, after-school and on weekends. The goal here is to immerse student learners into the medical industry, while providing hands-on real-world experiences. Reports have shown that students who do not have inspiration for a defined career by high school often do not make informed decisions and miss out on job opportunities and potential earnings. This collaborative will build additional capacity working with CPS schools to educate school boards, principals, teachers and parents/guardians to promote a career first mentality, and not necessarily perpetuating the need for a 4-year university level education as the only option for success. These conversations must begin to take place to impact future change. SSHEC will leverage transformation grant dollars working with area stakeholders and local schools building relationships and introductions to principal and key staff. The goal is to establish this collaborative as go to partners, seeking to be all inclusive of nonprofit, colleges and other community-based organizations for career sustainability in healthcare.

Engage and acclimate the student's parent/guardian. At this early stage of a student's education, it is imperative to engage and acclimate the student's parent/guardian regarding the importance of career pathway identification as well. An overwhelming number of adults still passionately believe that the best route for their children to take is attending a four-year university immediately after high school graduation. With these ever-changing times, workforce studies are informing parents/guardians that this route is expensive and has a much higher probability of student attrition. Some factors which contribute are time, family dynamics, cost, and travel. Through this grant, The South Side Health Equity Collaborative can immediately increase capacity and serve as career support specialists holding workshops, lectures, and conversations with parents/guardians about career pathways in healthcare, anticipated outcomes, and realistic career opportunities. This parent/guardian support led by the hospital working through local schools is currently rare in communities of color. Traditionally our community has not had the dynamic parent/guardian support network nor employer lead committees that can help support career verticals and learning pathways in the medical field. Most local elementary schools do not have the business service staff to continuously engage the employer community for parent/guardian support. But through use of funds from this transformation grant our consortium can quickly implement and lead the buildouts and help to design a structure where SSHEC will play a key role as ambassadors to the healthcare industry. Best practices will be utilized, outreach will be supported, and success will be measured to be standardized as a model for all future student career programming. Additional engagement activities are targeted to parents/guardians highlighting the realities of the community college system of Chicago and illuminating accurate information. Currently Chicago resident have a variety of ways to be provided no cost tuition, student loan forgiveness, continuing ed programming, and earning college credits in high school. These need to be highlighted to promote informed decision making.

Target training efforts. Healthcare professions truthfully can be incredibly involved requiring a great deal of time and resources to become successful with increasingly challenging level of studies. This pathway can be cumbersome and opaque if the sequencing of classes, required certificates/licensing and career advancement opportunities as entry level workers is not fully understood. Training efforts will need to be targeted to healthcare positions that are considered to be the most in demand regionally by hospital and clinics. Registered Nurses (RNs) and medical assistants are identified gaps in the healthcare workforce. This gap is especially prevalent in the catchment area of the South Side Health Equity Collaborative. These two positions account for more than half of the current openings spread throughout the Chicagoland area. Individuals that currently hold such baseline skill sets and

certifications can quickly become gainfully employed as they embark on their career pathway working at hospitals and clinics.

Basic Nursing Assistant program. It is our intention to focus our efforts on increasing the volume of individuals of color in healthcare positions such as nursing. Much effort and consideration are placed on the creation of a vertical pathway that begins with a robust Basic Nursing Assistant program. This is where individuals can gain the required skill set and then seamlessly transition into the college's Registered Nursing program. This strategy will allow for students that have traditionally lacked the educational background due to shortfalls in education, to now gain the necessary competencies and bridge themselves into the registered nursing program. We plan to address the challenge of college credit transfer from community college to four-year universities through strategic partnerships. In some instances, students were being forced to repeat courses on their way to a bachelor's degree. This system is unfair and costly. It lengthens the pathway to employment. Through the development of the Basic Nursing Assistant program, students can complete their first-year classes in a much more efficient and cost-effective fashion while receiving full credit transfers.

Living expense assistance. As students' progress through their college coursework, they quickly begin to spend money on tuition and other course related costs, such as transportation, equipment, and course materials. Pell grants are popular for students but get exhausted quickly. The South Side Health Equity Collaborative can now help to transform these monetary challenges into practical solutions by leveraging new student scholarships. In addition, the collaborative will create a "graduate-commitment" program in partnership with Insight and other Chicago-area safety net hospitals where students can anticipate a higher rate of pay as they attend school and work at the same time. This balance historically presented an enormous challenge as students find it difficult to balance classes and work considering financial constraints. Now students can financially plan for success as they receive more compensation per hour so they will not have to work as many hours. This will allow them much more time to focus on their course work and increase the chance of success. An investment in the future talent for emerging diverse and inclusive healthcare professionals is essential for sustained growth.

Specific to monetary expenses of the students of Malcolm X, the college has developed a "First Dollar" program. This program is designed to immediately infuse funds for students to augment Pell grants (or other forms of financial assistance) to spread expenses more evenly throughout the course of their studies. This helps to ensure they do not run short of funds when they are needed the most. SSHEC will incorporate transformation dollars into this program helping to cover the front-end expenses as a student begins their classes. Certification and licensing fees are another barrier to entry into the workforce. These fees are normally not attached to tuition and come as "extra" costs. Often these additional expenses are not properly planned for and students are forced to wait for the next rounds of licensing/certification in hopes they will at that time be able to cover the costs. Again, this is an item where The South Side Health Equity Collaborative can quickly leverage grant funds in direct support of eliminating the costs of licensing and/or certification fees. Through this transformation grant it is the intention of this collaborative to significantly reduce as many student costs as possible.

Exposure to sciences and simulation. Once expenses have been mitigated this grant's collaborative partnership will showcase success in revitalizing traditional structures that present barriers to inclusion, diversity and overall program success. One of the very first initiatives to be undertaken has been creating transitional "feeder" courses within colleges departments like biology. Another area where investment is overlooked but essential is the field of midwifery. This is desperately needed in neighborhoods that have been underserved with medical resources and opportunities on the south and west sides of Chicago. Over the last years Midwifery programs have been gaining in popularity as the Midwifery Education Accreditation Council (MEAC) is seeking to pass a House Bill (3401) for Illinois to develop a state-wide Midwifery supported program. Aimed at individuals of color from areas which have been severely under serviced, programs like these supported by the transformation grant will allow the ability for investment in our community residents in need of gainful career sustaining employment. Properly funded and supported these programs and ones similar to it will be able to increase the availability of qualified nurses and also secure much longer career retention.

Hands on simulated technology is another area where investment is sorely needed. Malcolm X College over the most recent years have invested a great deal of time, resources and dollars into their simulated

hospital on site. This simulated hospital includes equipment, materials, supplies, software and all other necessary nursing protocols. But as with all cutting-edge technology it quickly becomes outdated and needs to be replaced to keep up with the pace of what is being used on the front lines at hospitals and clinics. Malcolm X College has an immediate and pressing need to upgrade specific equipment such as high-fidelity simulators that are necessary for students to gain experience as they transition into employment opportunities. SSHEC will leverage transformation grant funds to upgrade equipment to be inclusive of all current industry standard operating policies for patient care.

Develop nurse preceptor support. Another reality of Malcolm X and similar institutions is the pressing need for Nursing Preceptors to become involved with the college. Traditionally this has always been a pain point of post-secondary education within healthcare education. Due to the nature and demand of healthcare work it is difficult to bring in faculty to educate students and be paid as nursing preceptors. The difficulty lies in time availability and instructor cost of adjunct faculty working with employers as active clinicians. Under the focus of this transformation grant, Malcom X college alongside The South Side Health Equity Collaborative will dedicate time, budget and effort to identify a working solution to utilize hospital staff in this capacity for educational purposes. Initial targets have been to develop a working contract for staff to serve as nursing preceptors to upcoming future nursing professionals. This will not only serve to strengthen nurse education for the blossoming professional, but mentorship will also bolster tenured nursing staff's connection with our community and help to mitigate the efflux of talented healthcare professionals from safety net hospitals where they are so greatly needed.

College Career navigator. Integral to this program is the role of the College Career Navigator. This is an academic position tasked with curating working pathways models in healthcare, reporting to city colleges, linkage to logistics of student entry and off ramps and function as the liaison/ambassador to make the pathway visible to underserved and under resourced community members. This position will help to coordinate student-based learning activities in partnership with The South Side Health Equity Collaborative and other safety net hospitals.

The outcomes achieved with the workforce strategy align with the HFS pillar aimed at addressing social determinants of health related to economic stability. It also serves to support, at a high level, the promotion of improved health outcomes by increasing the pool of qualified, culturally congruent healthcare professionals in our area.

Outcomes. We will aim to enroll 75 students per year in the program. We will assess process goals of program design and setup, but thereafter measure

- Student attraction and retention
- Coursework completion
- Certifications achieved
- Employment offers in service area at completion of program
- Outcomes (meaningful related employment) one year out from certification, including locations specific to our geographic focus area
- Change in knowledge base/attitude towards healthcare careers in youth and adults as measured on pre/post curriculum surveys

See Section 13 for details, and **Metrics and Outcome Table** a list of the clinical outcome measures the collaboratives aims to achieve.

Sustainability (see Section 16 for broader context).

Budget relevance. The awarded funds will be critical to support staff for the workforce pipeline, especially liaison working at health centers and related training sites, instructors including adjunct faculty at Malcom X College. Program support will allow 75 students/year to receive enhanced curricula, support for tuition and fees, assistance with certification and licensing costs, books, and a modest stipend to offset living expenses, broadband monthly fees, and technology aids such as laptop computers and portable electronic devices necessary for modern healthcare education.

The maternal simulator purchase will replace outdated/nonfunctional equipment currently used. Studies on simulation models have amply demonstrated the criticality of simulation training on responsiveness to maternal emergencies and interdisciplinary training. Improvements in skill acquisition, maintenance, team building, and response times are all essential in reducing maternal and neonatal morbidity and mortality.

Program navigator will oversee the workforce arm of this transformation effort. Responsibilities will include coordination between staff at each respective institution which may include but is not limited to community colleges such as Malcom X, safety net hospitals, clinics in underserved communities, and schools in these areas. The program navigator will be involved in each enrollee's trajectory to ensure that resources are available and allocated efficiently, and that milestones are being met.

Hospital workforce champions will work closely with each enrollee to secure hands-on education opportunities at area safety net hospitals which include but are not limited to Insight Hospital & Medical Center. These individuals will also collaborate with hospital administration to ensure that each student is engaged in meaningful clinical activity while maintaining a professional relationship with the host institution, adhering to all applicable regulations and bylaws.

Continuing Education support instructors will engage directly with schools to provide educational opportunities for students including exposure to STEM and healthcare careers. These instructors will also engage the parents of these students in order to expand their understanding of the potential careers that their children may be interested in as well as the process by which the parent can assist their children with their career goals.

The adjunct faculty stipend will reimburse nursing instructors for their time dedicated to providing directed hands on in-hospital training for nursing.

Curriculum development coursework will include multimedia focused, dynamic, and interactive courses catered to career development in healthcare. These courses will be administered by the continuing education support instructors and will target students ages 12-18.

3. Governance Structure

Structure and Processes

1. Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated and priorities set?

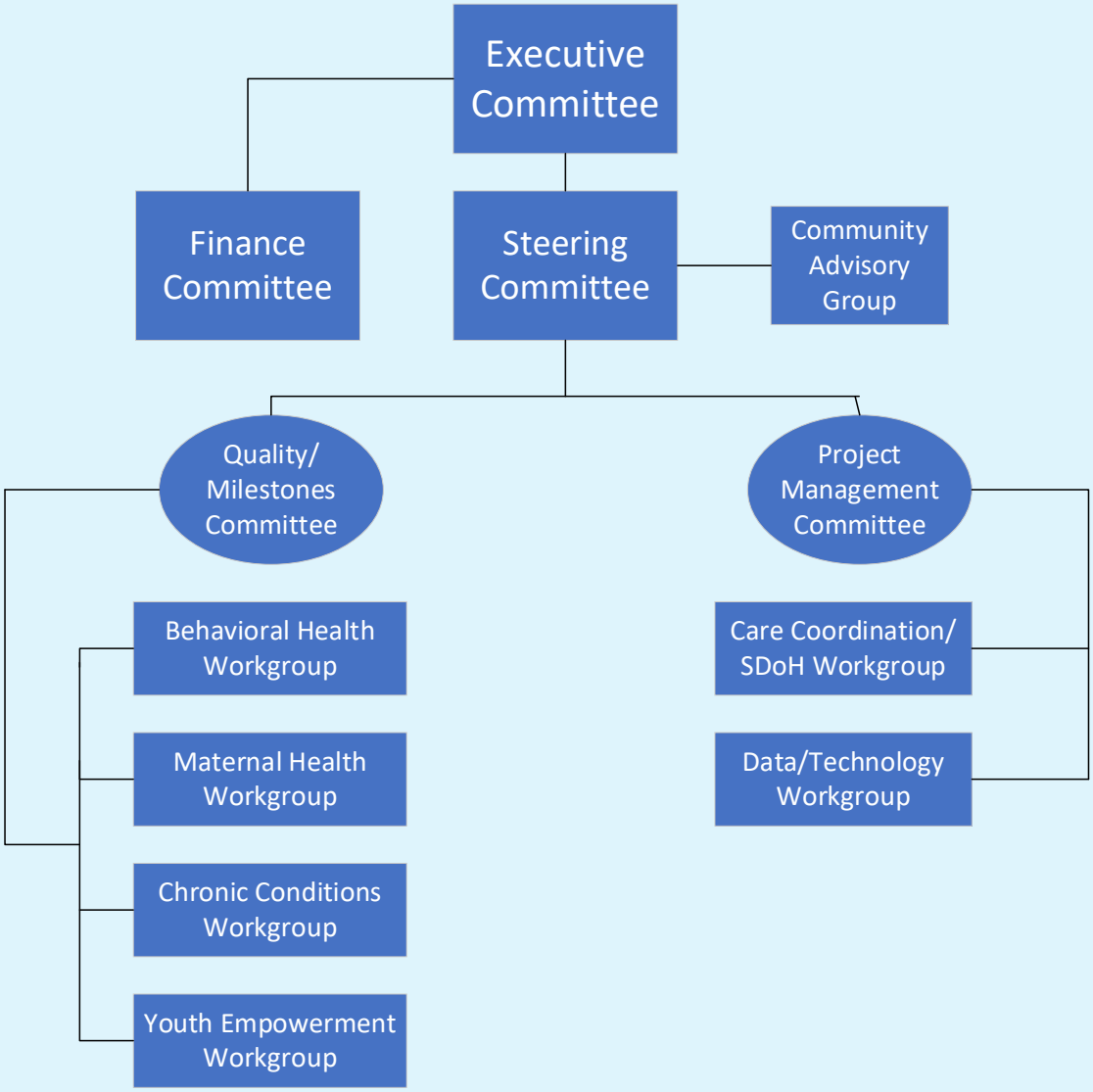
The Insight Hospital and Medical Center is the lead entity for this collaborative and will serve as the fiscal intermediary. It is not presently contemplated that the collaborative will form a new legal entity. All partner entities have compliance programs to assure they maintain policies to assure ongoing awareness and practice of their staff related to non-discrimination, sexual harassment, diversity, and regular training in ethics and requirements regarding record keeping and reporting. When an award has been determined, all partners will execute a formal contractual agreement that describes the terms of the collaborative, including rules of data sharing, including data use agreements and business associate agreements where appropriate.

The collaborative has agreed to abide by the following principles, and all have signed letters of partnership commitment (please reference the attached Letters of Commitment).

- Honesty
- Respect
    - Transparency
        - funds will be tracked centrally, to ensure funds continue are spent as agreed with HFS and for the purposes of the partnership
        - data sharing and protection (compliance with HIPAA)
    - Confidentiality, esp. re strategies
    - Timeliness
    - Equity
    - Engagement (active participation in collaborative planning, implementation and ongoing improvement efforts)
- Compliance with all federal, state and local regulations
- Decisions will be made by the collaborative as a fiduciary for the individuals and communities being served

See Figure 11 for organization of the collaborative's governance.

Figure 11



Accountability

2. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally, and with extensive participation from each participating entity?

Executive Committee. There will be an executive committee composed of the senior executive (with signatory authority) from each partner institution. This committee will have the responsibility to ultimately assure compliance with any contracts and deliverables with the Department of Healthcare and Family Services. It will make final decisions on strategies and commitments of partnership; approve expansion of the collaborative to new members, oversee the agreed allocation of funds. Once an agreement has been reached with the state on the final details of the strategy, this committee will assure that there is clear definition of expectations from each partner, including staffing, in-kind contributions, number and types of employees assigned to the collaborative and their respective proportional effort.

Members of the Executive Committee will report progress of the collaborative periodically to their own governing bodies. While the goal will always be to reach consensus on significant matters, on the occasion that a vote is needed, simple majority rule will be followed, with each partner organization given a single equal vote. The group will select a chair each year from among its membership.

Insight Hospital and Medical Center will serve as the fiscal agent. The Executive Committee will create polices including fiscal integrity measures and safeguards to ensure that the funds are distributed and used for the collaborative's agreed purpose, fund distribution policy and procedures, and timeliness of fund distributions. As the fiscal agent, IHMC will receive and distribute funds as directed by Executive Committee and per the agreement with HFS. Annual assessment of the fidelity of each partner to policies and procedures will be performed, with opportunities to improve communication and performance discussed within the group and shared with the department of HFS. Once detailed requirements of the contract with the department of HFS have been clarified, the collaborative will develop tools for assessing compliance of each partner with the pertinent requirements of the contract. The Executive Committee will also be responsible for assuring that any contracted service providers including BEPs meet all contractual and regulatory requirements.

The Steering Committee and the Finance Committee will report to the Executive Committee.

Steering Committee. The Steering Committee will be the lead group operating and implementing the strategy. It will be comprised of a single leader from each partner organization, and the Chair of the Finance Committee. This group will be responsible for development of partnership, community relations and input, modification of strategies to changes on the ground. It will complete a regular analysis of the strengths and weaknesses of partnership along with recommendations for improvement, including an evaluation of the need for additional partners for strategic effectiveness. The Quality and Milestones, and Project Management Committees as well as the Community Advisory Board will report up to the Steering Committee.

Quality/Milestones Committee. This group will be comprised of clinical and operational leaders from the provider and care coordination partners. They will oversee progress toward agreed clinical and structural goals and milestones and will identify and notify when course corrections or assessment are indicated. The Quality/Milestone committee will have a standing report on the Steering Committee agenda, reporting on progress, submitting recommendations and requests for actions as needed.

Project Management Committee. Workgroups focused on supporting and enabling strategies critical to the success of the clinical focus areas will report up to the Project Management Committee. These will include:

- Data and technology-for development and recommendation of innovative information transfer that fosters excellence in care
- Care coordination and social determinants of health- for development and oversight of care coordination, including identifying and clarifying roles among roles in practices, within managed care organization functions and within the partnership
- Social Determinants of Health-to assure that service connections are being made, with appropriate and effective community-based organizations, and that processes are put in place to allow partners to see when identified needs have been met for an individual

Community Advisory Group. The Community Advisory Group will consist of eight to ten of the community, selected through a nomination process (that includes criteria) and voted on by the Executive Committee to serve a term of 2 years. They may include leaders of community-based organizations, patients receiving services within the strategic objectives, elected officials, and members of the faith community. They will advise the Steering Committee regarding ongoing community needs and concerns, targeted populations, Business Enterprise Program vendors capable of meeting strategic objectives.

What methods will be used to enforce policy and procedure adherence?

Workgroups reporting to the Quality/Milestones Committee

Workgroups for each major strategic domain will be comprised on content experts from the member organizations, and they will report up to the Quality and Milestones Committee. These will include:

- Maternal health
- Behavioral health
- Chronic conditions in adults
- Youth empowerment
- Care coordination and social determinants of health

Payments and Administration of Funds

4. How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's intended purpose? If the plan is to use a fiscal intermediary, please specify.

Finance Committee. The Finance Committee will include the lead financial leader from each partner organization. It will directly and regularly oversee funds allocation consistent with the agreement with the state and in keeping with the agreed goals and distribution of funds per decisions of the Executive Committee. When the collaborations receive reports of payments going to partners as part of the Directed Payment methodology, this committee will assure that the project funds are distributed to partners and contractors in a manner consistent with the agreed and approved collaborative plan. This group will meet on a monthly basis and will prepare reports on a monthly, quarterly and annual basis to the Executive Committee.

4. Racial Equity

High-Level Narrative

A fundamental focus of healthcare transformation is racial equity. Please provide a high-level description of how the design of your proposal incorporates racial equity. (Greater detail will be requested in the questions below.)

The collaborative consists of partners organizations led by people of color, governed by people of color, and serving people of color. Collectively, they have years of experience addressing, and in many cases, defining healthcare disparities through the work they do and the experiences they generate that ultimately comes from their care.

The strategies herein were informed by community, and because it focuses on the most vulnerable individuals and those most at risk for suboptimal outcomes or defined by their social need-and positive effects form these interventions will almost by definition mitigate health disparities. Unlike interventions broadly offered, ours will be narrowly focused on those most in need.

Racial Equity Impact Assessment Questions

1. Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?

As of 2019, the total population in our service area was 1,134,216. Of that population 521,920 (52%) identified as non-Hispanic African American, 368,860 (33%) as Hispanic/Latinx, 59,716 (5%) as non-Hispanic Asian, and the remainder were non-Hispanic White. By virtue of proximity, the historical usage patterns at the former Mercy Hospital, and the makeup of patients using the partner community health centers and our care coordination partner, we expect to serve a predominant minority population, these are the groups who are most affected by this initiative.

Organization	Patients Served	Demographics
CASL (Data request)	5,583	• 5,418 (97%) Asian • 93 (2%) Black/African • 38 (1%) White/Caucasian • 6 Multi-Racial • 1 American Indian/ Alaskan Native • 21 N/A
Friend Health (UDS 2020)	47,801 (6,383 Hispanic or Latino/a)	• 36,621 Black/African American • 7,457 White/Caucasian • 3,408 N/A • 157 Asian • 80 American Indian/Alaskan Native • 60 more than 1 race • 9 Native Hawaiian • 8 Other Pacifier Islander
Alivio (UDS 2020)	30,783 (25,428 Hispanic or Latino/a)	• 721 Black/African American • 4,249 White/Caucasian • 24,923 N/A • 753 Asian • 120 American Indian/Alaskan Native • 13 more than one race • 0 Native Hawaiian

		• 4 Other Pacifier Islander
IMAN (UDS 2020)	1370 (443 Hispanic or Latino/a)	• 605 Black/African American • 735 White/Caucasian • 10 Asian • 0 Native Hawaiian • 0 Other Pacific Islander • 3 American Indian/Alaskan Native • 17 More than one race

2. Have stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities — been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged?

Yes. We have reached out and partnered with entities in the area that represent different racial/ethnic groups, as in essence the entire focus area of interest to our strategy is a vulnerable community except for certain gentrified regions in Hyde Park and the lakefront. Alivio Medical Center cares for a predominantly Hispanic population. Friend Health and IMAN care for predominantly African American and Hispanic populations. CASL serves a very diverse population across the state, but their clients in our area of focus are largely lower income individuals of color.

In addition, we anticipate a robust Community Advisory Group that will inform our partnership's Steering Committee (see governance section of application). The governing bodies of our community health center partners structurally require a majority of seats occupied by community members they serve (this is a requirement of their funder, the Health Resources and Services Administration), and the governing board of Insight Hospital and Medical Center includes prominent and representative members of the community that it serves, including business leaders and faith leaders.

The SSHEC prioritized racial equity in all aspects of the development of our proposal. Through engaging community stakeholders in our target service delivery area, as well as examining priorities identified through the current community health needs assessment, the collaborative has developed a clear plan to work with the significant constituency of stakeholders to advance equity and improve the overall health of our community. By assembling a team of long-standing, trusted healthcare providers and community-based organizations focused on decreasing health inequities in our most vulnerable communities, the collaborative's goals of improving health outcomes and decreasing disparities can be targeted to achieve a greater probability of success in addressing social determinants of health.

The Patient Protection and Affordable Care Act (ACA) requires every non-profit to conduct Community Health Needs Assessments (CHNA) and implement plans that address identified community health needs. These assessments are performed every three years, with implementation occurring in the ensuing years between the assessments.
Members of the SSHEC have historically participated in the Alliance for Health Equity, which is a partnership between the Illinois Public Health Institute, hospitals, health agencies, and community organizations throughout the region. The Alliance for Health Equity was developed to allow participating organizations to assess community health needs, create implementation plans, and efficiently share resources to have a greater impact on the outcomes of those identified needs. The collaborative continues to be informed by and guided in our efforts through the responses and priorities identified by the community with a particular focus on improving health equity, wellness, and quality of life.

The 2016 CHNA identified the following 3 areas as significant health needs to be addressed:
1. Preventing and Reducing Chronic Disease
2. Improving Social, Economic, and Structural Determinants of Health
3. Increasing Access to Care and Community Resources

Several initiatives were completed during the three-year implementation period between the completion of the 2016 assessment and the undertaking of the 2019 assessment. These initiatives partnered with local and national organizations to impact the identified needs.

The 2019 CHNA was adopted in June 2019. The 2019 CHNA included the same three needs identified in the 2016 assessment but added two additional areas of concern:
1. Mental Health and Substance Abuse Disorders
2. Maternal and Child Health

Currently, in year two of the 2019 CHNA implementation period, the collaborative continues to be informed by the health needs identified in the CHNA and examining the initiatives currently underway as a result. What has become increasingly obvious is that those identified community health needs remain a top priority and there needs to be a comprehensive sustained approach to developing a long-term programmatic system to confront historic and systemic racism and provide culturally competent and equitable healthcare delivery. Community engagement remains a critical aspect of addressing community health needs. The SSHEC has engaged numerous community organizations and stakeholders to ensure their significance in the development of our Healthcare Transformation Collaborative

Members of the SSHEC have actively engaged the Bronzeville and broader southside communities over many years. Led by the new management team of Insight Hospital & Medical Center (formerly Mercy Hospital), the SSHEC was formed to ensure maximum healthcare options and awareness is brought to the greater southside. As a new entrant into the Chicago healthcare delivery system, the senior leadership of Insight felt the imperative to partner with long-standing experienced and respected healthcare delivery partners to ensure maximum penetration into the service delivery areas of the hospital, and to engage in the exemplary work already underway in Chicago to confront inequities in healthcare delivery and negative outcomes in our most vulnerable communities.

Starting with reviewing past and ongoing community engagement initiatives designed to solicit the thoughts and concerns of residents and community-based organizations related to healthcare delivery and access, the SSHEC sought to understand the historical inequities experienced by these communities. As the newest healthcare delivery partner in the collaborative, it was imperative that Insight first researched and acknowledged the historical patterns of discrimination and lack of quality healthcare options that have created disparities and negative outcomes for generations in the service area identified in our proposal.

Working with established community leaders, the Insight team began engaging residents by attending and hosting events throughout the Bronzeville, Grand Boulevard, and Chinatown communities. Participating in and hosting events with established community leaders, elected officials, and local organizations provided a platform and opportunity to establish credibility and solicit sincere feedback from a community reeling from the fight which ensued to keep the former Mercy Hospital open. As the new stewards of this historic institution, and following months of uncertainty over the hospital's future, the Insight team understood there would be a level of distrust and uncertainty about their motives and ability to deliver the quality, comprehensive, and long-term healthcare needs of the community.

By attending and participating in events hosted by leaders such as State Senator Mattie Hunter, State Representative Lamont Robinson, the Pui Tak Center, XS Tennis and Educational Foundation, Bright Star Community Outreach, and others, the Insight team has been able to engage with residents and gain invaluable insights into the healthcare concerns and community needs. The interactions with hundreds of residents, and the information gleaned from over 120 community surveys completed, informed and confirmed for the Insight

team the focus areas chosen by the collaborative for the healthcare transformation proposal in development at the time.

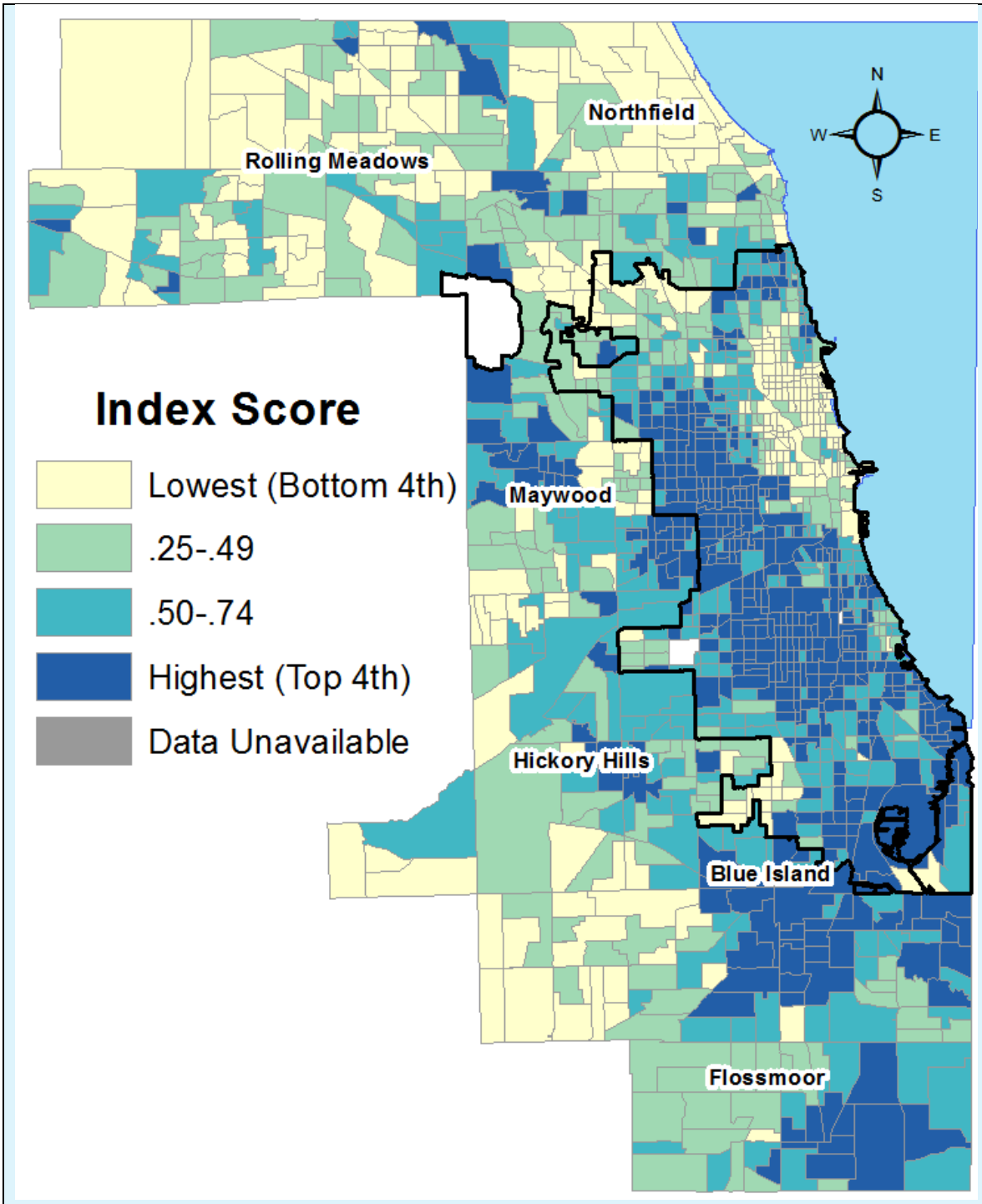
Since assuming operational control of the hospital on June 1, 2021, from the former owners, Insight and its leadership team have met with numerous organizations and leaders. The list below is a sampling of the input we have solicited from the specific service areas identified in our proposal:

ABJ Community Services
Addiction Counseling & Education Services
Alliance for Community Peace
Annie B. Jones Community Services
Brighton Park Neighborhood Council
Brightstar Church of Chicago
Brightstar Community Outreach
Catholic Charities of Chicago
Centers for New Horizons
Chicago Child Care Society/Family Focus
Chicago Commons
Chicago Cook Workforce Partnership
Chicago Health Equity Collaborative
Chicago Mayor's Office
Chicago Urban League
Children's Home & Aid Society
Chinese American Service League
Chinese American Service League
Coalition for a Better Chinese American Community
Daniel J. Nellum Youth Services
Family Focus Englewood
Greater Auburn Gresham Development Corp
Greater Bronzeville Neighborhood Network
Greater Englewood Community Development Corpora
Greenlight Family Services
Henry Booth House
Hyde Park - Kenwood Community Conference
Hyde Park Chamber of Commerce
Hyde Park Neighborhood Club
Italian American Club
Kenwood Oakland Community Organization (KOCO)
KLEO Center
Malcolm X College
Midwest Asian Health Association
Morning Star Baptist Church
Mother's Opposed to Violence Everywhere
Near South Planning Board
Neighborhood Network Alliance
Project Hood
Quinn Chapel AME Church
Rainbow PUSH Coalition
Salvation Army
SEIU Healthcare II
South Loop Chamber of Commerce
Urban Youth & Family Outreach
US Senate
YMCA

3. Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

There is clear evidence even on the South Side that White populations serve as the reference population in most measures of health status, with populations of color (African American and Hispanic) almost always doing less well. Certainly, this is the case in the domains we focus on: maternal health, behavioral health, chronic conditions of adulthood, and youth-related traumas including Adverse Childhood Events. Those realities are driven by strong correlations with educational attainment, household income and household wealth. Our partnership will address health disparities at the community level, improve access to care and offer sustainable interventions to address social determinants of health within the communities we serve-but by infusing jobs into these neighborhoods, it should also indirectly address the root causes of these disparities. The vast majority of those served by the partner organizations are African American and Hispanic Medicaid participants and uninsured who are living the vulnerability index created by the Centers for Disease Control and Prevention (Figure 12).

Figure 12



The White population (as above, often the 'reference populations) usually has higher income and family wealth, thus improved access to insurance, thus better access to care (primary and specialty). They have higher educational attainment, higher health literacy, and they live in neighborhoods with abundant access to grocery stores with nutritious options, parks where they can exercise, and neighborhoods and households with easy access to broadband and the Internet. Thus, when they suffer from a health condition, it is understandable how they may more easily receive needed care, health education, and even be empowered to personal change with fewer barriers than the people we serve.

The data on this is abundant and is accurately reflected in annual reports and occasional strategic plans from the Chicago Department of Public Health and mirrored by data and telehealth improvement plans from the Illinois Department of Public Health. In addition, the background information from the University of Illinois School of Public Health that made the

case for the Healthcare Transformation Collaborative clearly points out the differences at the population, neighborhood, and race/ethnicity level.

Regarding missing data, we know that the specter of the Public Charge and immigration enforcement looms large in the Hispanic communities of Chicago. This makes is quite possible that many issues exist in those communities and households but are not counted.

4. What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

There are a multitude of factors that have historically contributed to racial inequalities and the resultant differences in health outcomes. Access to nutrition, the prevalence of violence in the community, housing insecurity, access to transportation, economic instability, access to education, and healthcare literacy all contribute to these racial inequalities. Historic disinvestment in these communities following the "White Flight" following the Great Migration, coupled with loss of good-paying jobs associated with now-obsolete industries on the South Side (steel, meatpacking, and so on) have led to economic decline. Structural racism in the form of red-lining that prevented the accretion of household wealth despite monthly mortgage payments, and environmental racism that allowed particulate pollution levels to rise from idling trucks and locomotives in transportation centers contributed to these historic trends. Lower household wealth means less local funding for school support, leading to fewer opportunities for youth in the classroom and in extracurriculars, and ultimately in less desirability for excellent teaching in the schools, setting off a trajectory of lower educational attainment overall-highly corelated with adult income and wealth. These inequalities arose over time and each one perpetuates the rest.

Finally, structural barriers to care (it was not until the 1970s that many of the racist practices that blocked African American clinicians from joining hospital staff, and even segregation on hospital wards was conquered, with help from Medicare regulations.

For some conditions (breast cancer is a good example) disparities are being addressed in Chicago, with improvements in care access and outcomes. For others-and importantly, for life expectancy-the disparities are worsening. A recent analysis by the National Academic of Sciences, Engineering and Medicine has shown that while the past 3 years have seen significant drops in life expectancy across the United States, there has been a marked and serious worsening of the gap in life expectancy in Africana American men and White men.

5. What does the proposal seek to accomplish? Will it reduce disparities or discrimination?

The proposal aims to improve access to care, improve outcomes, identify and address social support needs, and improve quality of life. It will direct resources disproportionately to those in need, and thus should narrow disparities. Historically, quality improvement efforts that have been "colorblind" and offered to all with a condition have been taken up more by those with higher education and means, worsening health disparities. Our partnership offers pragmatic interventions to address social determinants of health, and while they cannot directly reduce discrimination in these communities, they will do that for the individuals and families we touch. In addition, we plan to infuse job and income opportunities in the communities we serve, ideally through community dwelling BEP vendors. These actions are fundamental to addressing the most powerful mover of health status for individuals and families.

6. What are negative or unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized?

We don't see any negative or unforeseen consequences or a specific racial/ethnic group that could be harmed. We see positive impacts and opportunities for the African American,

Hispanic, Asian and Caucasian populations who lack of access to care. All will be given opportunities for care and resources. Many may not know that services are available, and thus our efforts in outreach need to be thoughtfully distributed within our service area. WE will monitor effects over time and look to our Community Advisory Group to keep us apprised of potential unforeseen consequences of the interventions.

Our interventions are not enough to address decades of repressive structures put in place and decades of disinvestment-so at one level, the amount of our budgetary investment is puny compared to need for a population of almost 250,000 in poverty.

In addition, challenges in childcare worsened by the pandemic may interfere with individuals stepping forward for entry-level job opportunities of schooling. Hiring will be difficult, especially for behavioral health provides who re in such demand that they can typically command a high salary at a place less stressful that our partner organizations.

Gaining trust in the communities of interest takes time and is done through often "inefficient methods", so we will need to recognize stops and starts and learn from errors early in our course; we of course hope that our community advisory group will help us anticipate and mitigate some of those challenges.

7. Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

The crux of our proposal is youth empowerment. This will truly reduce racial disparities, and advance racial equity. This has the potential to improve quality life across the board and create an opportunity for generational change. With the Sylvester Broome Empowerment Village, we will assure that children and families from the service area get access and prioritization of services. Continued opportunities to grow jobs, thus income and wealth-and stability of these interventions-could improve the positive impacts we will achieve. A social marketing campaign touting the objectives of the Healthcare Transformation Collaboratives could assist in community level awareness and enhance not only subscription to these initiatives but a greater public understanding of the health disparities in our own communities and the social drivers behind them- "connecting the dots". The current public television series highlighting poverty and its impact in Chicago is an example (see https://interactive.wttw.com/firsthand/living-in-poverty).

Continued cross-sector collaboration on community investment including access to jobs, affordable housing, transportation and education is needed. An equity lens to community development-which unevenly distributes resources to communities historically disinvested-is needed. This must come from both government and private sectors. Increased focus on youth development and youth opportunity promises the highest yield on investment.

8. Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

Yes. We used frontline providers and community input to describe the care and social need gaps related to the clinical conditions we are addressing. Our governance structure defines specific workgroups of partner providers overseeing quality outcomes and process milestones, we have a robust financial oversight plan, and we have deep community engagement and input (see above).

9. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

Please see the milestones and outcomes section of our application for details. Briefly for our clinical targets will assess progress for the various clients enrolled in specific programs. See section 13 for details. In addition, we will monitor

- new jobs added on the South Side, including the race and ethnicity of new hires related to the program.

- feedback from our community meetings.

Stakeholder engagement will be assessed by recording the number, content, and attendance of varied community engagement meetings.

5. Community Input

Service Area of the Proposed Intervention

1. Identify your service area in general terms (e.g., "West Chicago", "East St. Louis Metro Area", "Southeastern Illinois").

South Side of Chicago

2. Please select all Illinois counties that are in your service area. (NOTE: Selecting a county does not mean that your intervention must service the entire county.)

Select counties:

Cook County

3. Please list all zip codes in your service area, separated by commas.

60609, 60615, 60616, 60617, 60619, 60620, 60621, 60628, 60629, 60631, 60632, 60633, 60636, 60637, 60638, 60643, 60649, 60652, 60653, 60655

Community Input

1. Describe the process you have followed to seek input from your community and what community needs it highlighted.

A major focus of the HFS Healthcare Transformation Collaboratives initiative is innovating to achieve racial equity in all forms of the healthcare delivery system. This principle is at the forefront of the South Side Health Equity Collaborative's application for Transformation funding. Our strategy was informed by data, community input, and the Racial Equity Impact Assessment. We feel it will significantly advance racial equity and reduce racial discrimination and inequities in the communities we serve.

The South Side Health Equity Collaborative prioritized racial equity in all aspects of the development of our proposal. Through engaging community stakeholders in our target service delivery area, as well as examining priorities identified by the most recent community health needs assessment by the former Mercy Hospital, the collaborative has developed a clear plan to work with the significant constituency of stakeholders to advance equity and improve the overall health of our community. By assembling a team of long-standing, trusted healthcare providers and community-based organizations focused on decreasing health inequities in our most vulnerable communities, the collaborative's goals of improving health outcomes and decreasing disparities has a greater probability of success. Importantly and uniquely, this strategy also prioritizes addressing social determinants of health-a need clearly articulated by the community.

The Patient Protection and Affordable Care Act (ACA) requires every non-profit hospital to conduct a Community Health Needs Assessment (CHNA) and implement plans that address identified community health needs. These assessments are performed every three years, with implementation occurring in the ensuing years between the assessments. This partnership has been informed by the CHNA completed for the former Mercy Hospital in 2016 and 2019; their findings resonated clearly in our recent community meetings as ongoing issues.

Members of the South Side Health Equity Collaborative have historically participated in the Alliance for Health Equity, which is a partnership between the Illinois Public Health Institute, hospitals, health agencies, and community organizations throughout the region. The Alliance for Health Equity was developed to allow participating organizations to assess community health needs, create implementation plans, and efficiently share resources to have a greater impact on the outcomes of those identified needs. The collaborative continues to be informed by and guided in our efforts through the responses and priorities identified by the community with a particular focus on improving health equity, wellness, and quality of life.

The 2016 CHNA identified the following 3 areas as significant health needs to be addressed:

1. Preventing and Reducing Chronic Disease
2. Improving Social, Economic, and Structural Determinants of Health
3. Increasing Access to Care and Community Resources

Several initiatives were completed during the three-year implementation period between the completion of the 2016 assessment and the undertaking of the 2019 assessment. These initiatives partnered with local and national organizations to impact the identified needs. The 2019 CHNA was adopted in June 2019 to inform fiscal years 2020-2022. The 2019 CHNA included the same three needs identified in the 2016 assessment but added two additional areas of concern:

1. Mental Health and Substance Abuse Disorders
2. Maternal and Child Health

In addition to the former Mercy Hospital CHNA, the Chinese American Service League (CASL) conducts annual surveys of the impact of Social Determinants of Health on its constituents and the Chinese American community each spring. Those results are published on the CASL website and an "e-blast" is sent to the public health and health care sector for use and further dissemination. In addition, as the largest employer in the Chinatown and surrounding community, and with a large majority of our staff living in the community, CASL is acutely tuned into the needs of the community[23].

The governing bodies of our community health center partners (Alivio Medical Center, Friend health, Inner-City Muslim Action Network) structurally require a majority to be composed by community members they serve (a requirement of their funder, the Health Resources and Services Administration), and the governing board of Insight Hospital & Medical Center includes prominent and representative members of the community that it serves, including business leaders and faith leaders.

Our strategy is informed by the health needs identified in the CHNA and examining the impact of historical initiatives by area providers. Our community interactions make clear that those identified community health needs remain a top priority and there needs to be a comprehensive sustained approach to developing sustainable community-based strategies to confront historic and ongoing systemic racism and provide culturally competent and equitable healthcare delivery.

Community engagement remains a critical aspect of addressing community health needs. The South Side Health Equity Collaborative has engaged numerous community organizations and stakeholders to ensure their significance in the development of our Healthcare Transformation Collaborative. Members of the South Side Health Equity Collaborative have actively engaged the Bronzeville and broader southside communities over many years. Convened by the new management team of Insight Hospital & Medical Center Chicago, the South Side Health Equity Collaborative was formed to address pressing healthcare issues identified by the community we serve. As a new entrant into the Chicago healthcare delivery system, the senior leadership of Insight felt the imperative to partner with long-standing experienced and respected healthcare delivery partners to ensure maximum penetration into the service delivery areas of the hospital, and to engage in the many efforts already underway in Chicago to confront inequities in healthcare delivery and negative outcomes in our most vulnerable communities.

Starting with reviewing past and ongoing community engagement initiatives designed to solicit the thoughts and concerns of residents and community-based organizations related to healthcare delivery and access, the South Side Health Equity Collaborative members investigated the historical inequities experienced by these communities. As the newest healthcare delivery partner in the collaborative, it was imperative that Insight first researched and acknowledged the historical patterns of discrimination and lack of quality healthcare options that have created disparities and negative outcomes for generations on the South Side.

[23] https://www.caslservice.org/wp-content/uploads/2021/07/2021-SDoH-Report.pdf

Participating in and hosting events with established community leaders, elected officials, and local organizations the Insight team directly engaged residents by attending and hosting events throughout the Bronzeville, Grand Boulevard, and Chinatown communities. They provided a platform and opportunity to establish credibility and solicit sincere feedback from a community reeling from the fight to keep the former Mercy Hospital open. As the new stewards of this historic institution, and following months of uncertainty over the hospital's future, the Insight team understood there would be a level of distrust and uncertainty about their motives and ability to deliver the quality, comprehensive, and long-term healthcare needs of the community.

By attending and participating in events hosted by leaders such as State Senator Mattie Hunter, State Representative Lamont Robinson, the Pui Tak Center, XS Tennis and Educational Foundation, Bright Star Community Outreach, and others, the Insight team has been able to engage with residents and gain invaluable insights into the healthcare concerns and community needs. The interactions with hundreds of residents, and the information gleaned from over 120 community surveys completed, informed and confirmed for the Insight team the focus areas chosen by the collaborative for the healthcare transformation proposal in development at the time.

Since assuming operational control of the hospital on June 1, 2021, from the former owners, Insight and its leadership team have met with numerous organizations and leaders. The list below is a sampling of the input we have solicited from the specific service areas identified in our proposal:

From August 1st through October 30th, 2021, the community engagement team from Insight Hospital & Medical Center attended 10 community events held throughout Chicago's Southside:

- Summer Bash Family Music Festival – August 1st (XS Tennis Village – Washington Park)
- Senator Mattie Hunter's Family Health & Fitness fair – Saturday, August 7th (IIT Campus – Bronzeville)
- Bud Billiken Parade – August 14th (Bronzeville)
- Star Farms Chicago Fall Festival – Saturday, September 11th (Back of the Yards)
- Unity In the Community Resource Fair – Saturday, September 11th (Kennedy King College – Englewood)
- Bronzeville Community Celebration – Saturday, September 25th (Ellis Park - Bronzeville)
- Insight Hospital Ice Cream Social – Saturday, September 25th (Ellis Park/Insight Hospital – Bronzeville)
- Chicago Tennis Festival – September 25th (XS Tennis Village – Washington Park)
- State Representative Lamont Robinson's Senior Appreciation Fair – Friday, October 15th (Paul G. Stewart Apartments – Bronzeville)
- Pui Tak Center Senior Fair – Saturday, October 30th (Chinatown)

At these events the engagement team talked to community residents, elected officials, leaders of community-based organizations, community college and FQHC representatives, health care providers, youth empowerment advocates, and others. During this period health equity survey responses were collected from over 120 community residents.

During the community interactions, a common theme that was shared by many community residents was the need for improved mental health and trauma care services due to the increased levels of violence experienced in the community over recent years. Many healthcare providers also indicated the need for increased behavioral health resources in South Side communities where inequities in health care are prevalent and have existed for many years.

Parents and youth that participated in the survey indicated they would like to see more attention focused on violence intervention, organized after-school and athletic programs, and

arts-focused activities. Working with local service providers such as XS Tennis Foundation, Brightstar Community Outreach Corporation, and others, the Health Equity Initiative collaborative intends to focus heavily on youth empowerment as one of the core pillars of the transformation collaborative's efforts.

The community engagement team also found that many community residents had past experiences of themselves, and their loved ones, being cared for by the medical team at the former Mercy Hospital. The team identified generations of families that were born at Mercy over the past half-century. As a matter of fact, it was found that the hospital in recent years had one of the highest rates in Chicago of babies delivered in its obstetrics unit, second only to Northwestern Memorial. Residents were extremely pleased that the team at Insight Chicago has come in to work with community leaders and other healthcare service providers to continue comprehensive maternal services and clinical care at the hospital in conjunction with local service providers and FQHCs.

ABJ Community Services
Addiction Counseling & Education Services
Alliance for Community Peace
Annie B. Jones Community Services
Brighton Park Neighborhood Council
Brightstar Church of Chicago
Brightstar Community Outreach
Catholic Charities of Chicago
Centers for New Horizons
Chicago Child Care Society/Family Focus
Chicago Commons
Chicago Cook Workforce Partnership
Chicago Health Equity Collaborative
Chicago Mayor's Office
Chicago Urban League
Children's Home & Aid Society
Chinese American Service League
Chinese American Service League
Coalition for a Better Chinese American Community
Daniel J. Nellum Youth Services
Family Focus Englewood
Greater Auburn Gresham Development Corp
Greater Bronzeville Neighborhood Network
Greater Englewood Community Development Corpora
Greenlight Family Services
Henry Booth House
Hyde Park - Kenwood Community Conference
Hyde Park Chamber of Commerce
Hyde Park Neighborhood Club
Italian American Club
Kenwood Oakland Community Organization (KOCO)
KLEO Center
Malcolm X College
Midwest Asian Health Association
Morning Star Baptist Church
Mother's Opposed to Violence Everywhere

Near South Planning Board
Neighborhood Network Alliance
Project Hood
Quinn Chapel AME Church
Rainbow PUSH Coalition
Salvation Army
SEIU Healthcare II
South Loop Chamber of Commerce
Urban Youth & Family Outreach
US Senate
YMCA

Input from Elected Officials

1. Did your collaborative consult elected officials as you developed your proposal?

☒Yes
☐No

1A. If you consulted Illinois federal or state legislators, please select all legislators whom you consulted.

IL Senate President Don Harmon
State Senator Mattie Hunter
State Senator Robert Peters
State Representative Lamont Robinson
State Representative Theresa Mah
State Representative Greg Harris
State Representative Cyril Nichols
Deputy House Minority Leader Tom Demmer
State Representative Justin Slaughter

1B. If you consulted local officials, please list their names and titles here.

Cook County Board President Toni Preckwinkle
Cook County Commissioner John Daley
Cook County Commissioner Bill Lowry
Cook County Commissioner Dennis Deer
Chicago Alderwoman Sophia King
Chicago Alderwoman Pat Dowell

Healthcare Transformation Collaboratives

6. Data Support

1. Describe the data used to design your proposal and the methodology of collection.

We retrieved from several sources to identify and prioritize community-responsive needs. The HFS background study performed by the University of Illinois School of Public Health contained critical data, as did the HFS-supplied Medicaid utilization files specific to the South Side.

Public health commissioned reports

- Transformation Data & Community Needs Report: Chicago-South Side, February 2021
- Institute for Research on Race and Public Policy. *A Tale of Three Cites: The State of Racial Justice in Chicago Report.*
- Illinois Department of Public Health, 2021
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- Transformation data and community needs reports, Chicago-South Side (January 2021) https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportSouthChicagoDigitalCMP.pdf
- Fiscal Year 2019 and 2020 Medicaid Claims summary data and raw count tables for nine of the most socially vulnerable areas in the State of Illinois.

Summary data:

- FY2019 and FY2020 Crude Ambulatory Care Sensitive Condition (ACSC) Rates for ED visits and Hospitalizations by Area (xlsx)
- FY2019 and FY2020 Medicaid Hospitalization and ED Visit Frequencies by Chapter Block and Area (xlsx)

Raw Counts:

FY2019 and FY2020 Medicaid Hospitalization and ED Visit Raw Counts by ICD-10s Blocks Chapters and Area (xlsx)

Data from partners

- Reimbursement data
- Community Health Center Uniform Data System reports

7. Health Equity and Outcomes

1. Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes.

To identify the healthcare disparities to address requires understanding the meaning of health equity and health disparities. The collaborative embraces the definition of health equity as everyone, especially groups that have been historically economically and socially disadvantaged, having an equal opportunity to live the healthiest life possible. Achieving health equity requires reducing and eliminating health disparities and its determinants.
A health disparity is a particular type of health difference that is closely link with social, economic and/or environmental disadvantage or stated differently the existence of greater obstacles based on an individual's racial or ethnic group, religion, socioeconomic status, gender identity, geographic location or other characteristics historically linked to discrimination or exclusion. The other determinants that also need to be addressed along with health disparities to achieve health equity include ensuring availability and access to safe housing, nutritious food, educational opportunities, safe and affordable transportation, high quality health care delivered consistently and by providers who are culturally sensitive.

Using these definitions for health equity, health disparities and the social determinants of health, the collaborative assessed current status of health services on the South Side, the catchment area selected by the collaborative. The South Side has the highest economic hardship index (EHI) value, with most of the neighborhoods exceeding 90%. The EHI is composite ranking of social determinant (housing, poverty, unemployment, education, income, entitlement dependency) indicators. The area is more than 80% Black, although the population has smaller ethnic and religious subgroups who have specific needs.

Between 2012 and 2017 the life expectancy gap between blacks and nonblacks residing on the South Side increased by ~ 10 years. Five main causes of death contributed to this gap including, chronic conditions, homicide, infant mortality, HIV, and opioid overdose. Additionally, there are gaps in the provision of health care services. There are limited numbers of specialists in general and the number is smaller if factoring in providers who do not accept Medicaid or provide services to the uninsured. For expectant women, the number of OB options has been reduced with the loss of several OB programs on the South Side in the last five years. The prenatal experience for pregnant women has been challenging and not addressing problems encountered during pregnancy. With this information, data from other studies and understanding the needs of the communities in the catchment area the collaborative determined it was imperative to develop programs and creative solutions that would address underlying conditions linked to the main causes of death and the lack of access to services. We are requesting funding for programs in this application that will focus on health disparities that relate to pregnancy/infant mortality, the chronic conditions of hypertension and diabetes, behavioral health including substance abuse, disconnected youth who are directly impacted by the violence in the environment.

As a result of the severe economic hardship experienced by residents of the South Side it is not sufficient to only develop clinical solutions to eliminate health disparities. The literature documents clearly that the SDoH create as much of a barrier or obstacle to getting needed health care as providing clinical services. Eliminating health disparities is only possible if clinical barriers and SDoH obstacles are part of the solution. Our request includes responding to housing insecurity, food insecurity, transportation insecurity and need for a safe space for youth to achieve school age wellness while promoting nutrition & physical activity. These programs will enable residents in the community to thrive because barriers and obstacles have been removed that interfered with achieving wellness and having a healthy lifestyle.

Our partners will provide the initial program participants, most of whom are African American, but the catchment area is also home to Chinese Americans and Latinx Americans. These

populations are also diverse in many other ways. The programs will be available to all living on the South Side.

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

Our strategies and programs are detailed above under the program description. Our intent is to provide maternal services, services for patients with diabetic and hypertensive chronic conditions, behavioral services and counseling and safe space for youth to fill the gaps that exist in the community. Hiring and workforce development will be used to fill gaps in specialty services and increase CHWs, peer workers as well as RNs, and medical assistants. Each of the groups will received services that are coordinated across partners. Assessment for SDoH and behavioral needs will be completed for all patients and SDoH services provided as needed. The guiding principle for care coordination and connecting to community-based services is a warm handoff in a closed loop process. The use of technology for coordination and referrals is key to connecting patients to clinical and community-based services.

The outcomes identified for each strategy is described in detail in the quality section of this application. The outcomes will address health disparities and foster health equity by providing access to needed specialists, by providing nutritious foods to promote healthy eating, reducing the number of low-birth-weight babies, providing a safe healing space for youth that reduces stress and promotes their drive to succeed, closing the significant gap for behavioral health services that exist on the South Side. Most importantly across all of the strategies is to provide community-based care that keep the population actively engaged in their own healthcare thereby leading to wellness.

Maternal Program

- Centering pregnancy certifying entity/Parenting Group Sessions
- Therapeutic Services – massage, PT, acupuncture
- Support – Doulas, Lactation Consultants
- Service Navigation to SDoH services using CHWs
- Screened for SDoH, depression and SUD
- Technology to support coordination across partners

Youth Empowerment Program

- Safe Space and After School Program – Arts, Athletics, Academics
- Village Market, Nutrition Literacy, Food Distribution, Food Bank, Farmers' Market
- Counseling, Trauma-Informed, Art, Music Therapy
- Refer patients for SDoH Service
- All screened for depression and SUD, SDoH

Chronic Condition Population:

- adults in primary care with HTN or NIDDM
- TARGET BP (AMA, AHA)
- ABCs of NIDDM (glucose, lipid, bp control)
- Lifestyle Center at IHMC,
- Hiring specialists
- All screened for depression and SUD, SDoH
- Technology to support access (e.g., retinal cameras, eConsult)

Behavioral Health Population: - adults d/c from ED or admission for primary BH dx

- Clients in other maternal, chronic conditions, youth empowerment strategies
- Care coordination at discharge
- Support for identified depression, youth mental health issues, substance use disorders
- Capacity building (CCBHC, workforce development)
- Care coordination (addressing TOC and SDoH)
- Technology to support information (interfaces, use agreements)

Workforce Transformation

- Student attraction and retention
- Coursework completion

- Certifications achieved
- Employment offers in service area at completion of program
- Outcomes (meaningful related employment) one year out from certification, including locations specific to our geographic focus area
- Change in knowledge base/attitude towards healthcare careers in youth and adults as measured on pre/post curriculum surveys

3. Why will the activities you propose lead to the impact you intend to have?

The proposal aims to improve access to care, improve outcomes, identify and address social support needs, and improve quality of life. It will direct resources disproportionately to those in need, and thus should narrow disparities. Historically, quality improvement efforts that have been "colorblind" and offered to all with a condition have been taken up more by those with higher education and means, worsening health disparities. Our partnership offers pragmatic interventions to address social determinants of health, and while they cannot directly reduce discrimination in these communities, they will do that for the individuals and families we touch. In addition, we plan to infuse job and income opportunities in the communities we serve, ideally through community dwelling BEP vendors. These actions are fundamental to addressing the most powerful mover of health status for individuals and families.

The efforts all have a proven track record that is either in the peer-reviewed literature or has been experienced and demonstrated directly by the partners themselves (e.g., Youth Empowerment by SBEV). The providers have established trust in the community and from individuals by their approach, their embedded nature in the communities they serve rather than in an ivory tower of privilege.

Assistance will be mediated in many cases by trusted partners from the community in the form of CHWs.

8. Access to Care

1. Name the specific obstacles or barriers to healthcare access you are targeting in your service area. Describe the causes of these obstacles that your project specifically seeks to address and explain why you have chosen to address these causes.

Causes of obstacles and barriers

Shortened life spans and poorer quality of life in highly vulnerable communities of color that have been historically disinvested and disproportionately harmed by structural racism.

Significant loss of healthcare assets on the South Side. The last 35 years have seen the closing of several hospitals on the South Side, including Provident (later reopened by Cook County Health), Doctor's Hospital of Hyde Park, Chicago Osteopathic, Michael Reese, the Hospital of Englewood, Mercy, MetroSouth Medical Center in Blue Island. The area was a so-called "Trauma Desert" until the re-opening of the University of Chicago Medical Center service in 2018.

In the past five years several South Side hospitals closed their doors to delivering babies, including St. Bernard, Jackson Park, South Shore and Holy Cross.

Not only are there fewer hospitals serving the communities, but the hospitals that predominantly serve people of color are often subject to cash and capital shortages that limits the types and quality of care they provide. (IDPH)

In addition to these reduced physical and "operational" assets, the area is experiencing barriers due to the lack of specialists, too few maternal/delivery sites, lack of behavioral health providers. For years, most of the area of interest to this collaborative has been designated as medically underserved (Figure 4). These barriers result in long waiting and travel time to obtain care, or the needed care is not obtained leading to a deterioration of patients' conditions. The data and community input identified a major need for specialists to address diabetes, hypertension and behavioral health.

Patients encounter difficulty obtaining needed social services and assistance because of the lack of services to address the social drivers of health and the lack of coordinating system to efficiently link patients to services resulting in healthcare disparities and lower life expectancy birth (see Figure 5).

There is a lack of organized after-school and athletic programs, and arts-focused activities that could mitigate the impact of violence and trauma in the community.

Rationale for Collaborative Projects

The partnership's strategic approach is to implement innovative programs to improve maternal services, create a youth safe space, address diabetes and hypertension chronic conditions, increase access to behavioral health services, connect patients to SDoH services and to coordinate care across all of these areas. The partners have synergy that will more effectively serve the needs of the vulnerable population. Very importantly, the partners are providers who have been serving the South Side for decades and enjoy the community's trust.

Partners have basic infrastructures in these areas to build on to address the underlying causes creating a lack of clinical care and social services through the strategies and innovative programs.

The initiatives were identified based on the existence of evidenced based protocols and a path to getting to an improved defined outcome.
In reference to the safe space for youth, we firmly believe that investing in young people is the key to generating healthy lifestyles for the youth, their family and the community. Parents and youth that participated in the survey indicated they would like to see more attention

focused on violence intervention, organized after-school and athletic programs, and arts-focused activities.

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

Collaboratives projects that will improve access

The collaborative will unite primary care, behavioral health, maternal care, and specialty services into a coherent ecosystem for Medicaid and uninsured populations served by the partners on the South Side. The partnership envisions building a highly reliable care network by starting with a few strategies focused on conditions identified by the community as high priority, undergirded by a standardized approach to assessment of social needs, identification of individuals with mental health and substance use disorders, and addressing these identified issues with effective care coordination and integrated information systems.

The inpatient care, birthing center, specialty services will largely be provided by Insight Hospital & Medical Center (IHMC). Primary care including prenatal services will be provided at the South Side sites of federally qualified health center systems Alivio Medical Center, Friend Health, Inner-City Muslim Action Network, and IHMC. When needed for complex behavioral health needs are identified, Human Resources Development Institute, Inc (HRDI) will be able to meet almost all needs, as a trusted mental health and substance use disorder-focused provider on the South Side for some forty years.

Evidenced based practices including a Wellness Center will be key elements for improving management of diabetic and hypertensive patients. Behavioral health will be improved by leveraging the limited existing services and simultaneously expanding BH services. This will be achieved by creating a continuum of care including IHMC, Alivio, FH, HRDI and with CASL providing care coordination. HRDI will become a CCBHC to provide an enhanced level of care.

Another partnership program will greatly improve the quality of maternal services for women by providing health care that is respectful, culturally competent, safe and of the highest quality using the certified centering pregnancy certifying entity program concept that is open to eligible patients referred from IHMC OB clinic, Alivio, Friend Health. This program will keep pregnant women engaged throughout their pregnancy and will also give them access to therapeutic services that will foster engagement and provide a quality experience – by addressing common discomforts and painful conditions with proven therapies.

SBEV Chicago is designed to improve the overall health and provide a safe space for at risk youth that simultaneously improve well-being of their families. This will be achieved through access to designated facilities and programs that centered on athletics, academics, nutrition, and a strong counseling component. Enhancing physical activity, nutrition programming and counseling services will assist youth in reaching their highest potential. Facilitating access to healthy, nutritious foods will foster long term health lifestyles.

The collaborative will contract Chinese American Service League (CASL) to connect clients to community-based agencies to provide solutions and provide funds to pay for services including housing, food needs, and transportation for clinical services and appointments with social service agencies. Will also provide oversight of the SDoH screening and care coordination processes, including the use of community health workers (CHWs) and pathways to connect patients to community-based organizations (CBOs). Existing relationships between FQHCs and CBOs will be leveraged to help patients address issues related to SDoH.

Currently, partners are on varying information technology platform with varying degrees of interoperability. Our collaborative seeks funding to build effective interfaces that will allow important and timely sharing of client information to achieve better outcomes in clinical care, client navigation, and social support.

The measurable impacts that will result from these programs are listed in the quality section of this application. Specific measures are identified for the core strategies.

3. Why will the activities you propose lead to the impact you intend to have?

Collaboratives programs impact

The collaboratives programs will have the following impact:

- Seamless transition of BH patients from inpatient to community-based care and access to BH services as required
- FQHC Patients will have access to chronic condition specialists when required.
- Maternal patients will be engaged ongoing in prenatal care through Centering program
- Patients in all strategies will receive social services removing barriers to receiving care.

Vulnerable patients will receive care at the appropriate level in a system that provides ongoing support including a system that will have continuous monitoring to sustain patients' engagement in health care.

The partnership includes community health center providers who offer evidence-based care that best meets the needs of the target population including high utilizers of high-cost services. We identify and prioritize patients for comprehensive care engagement and connection to appropriate services and providers at partner locations for face-to-face visits, or where appropriate, telehealth support (synchronous or asynchronous as with eConsult). We expect these partnerships to continue to mature.

In assessing the needs of youth on the South Side of Chicago, the SBEV model can be used to create a safe space and environment for youth. The SBEV model is uniquely designed to help underserved, at risk youth develop life skills that will inspire them to be active, informed and feel valued, these life skills will lead to improve academics, behavior, while reassuring parents and community a safe place exists for this development.

The selected outcome measures will be used to monitor and ensure improvements are being made. Collaborative partners are well grounded in the community and will be trusted by patients. Partners have a long history in the community, with staff who know the community and are committed to ensuring improved access.

9. Social Determinants of Health

1. Name the specific social determinants of health you are targeting in your service area. Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes.

The social determinants to be addressed include ensuring availability and access to safe housing, community-based access to nutritious food, a safe space to promote youth and school age wellness and physical activity, safe and affordable transportation for healthcare and for evaluation for social services, access to childcare for prenatal visits, assistance with enrollment in entitlement programs that facilitate health and wellness.

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

The most impactful actions that will be taken across all the strategies is to consistently assess the need to address SDoH. It is acknowledged that a person's status can change at any point along the continuum of care, Initial assessments will be conducted follow by brief mini reassessment at each 'open door'. Equally important is timely addressing or resolving specific SDoH issues. CASL as the collaborative's designated care coordination entity will provide oversight of the process to connect participants with SDoH services. The collaborative is seeking funds to hire CHWs to be the navigators, working directly and assisting patients in accessing SDoH services. The CHWs will be recruited from the catchment area and will receive training on coordination and navigation.

The collaborative will identify community-based organizations (CBOs) that provide the services needed to address SDoH. The CBOs will be selected through a structured process. The intent is to select CBOs from the catchment area if possible. SDoH contracts will be developed with CBOs that incorporate incentives for achieving service specific objectives.

A service navigation program to address SDoH concerns will be created using transformation funding to provide patients and families access to community-based organizations (CBOs). A major component of the collaborative's program will be to complete initial and ongoing assessments for patients in all strategies. Assessments will identify any and all areas that may impact obtaining housing, food, childcare, transportation needs, and entitlements,

The collaborative is creating a program to connect patients with services to address the social determinants at each encounter, using the concept of no wrong door. The program will accept a warm hand off from providers during regular visits, health education classes, during specialty and therapeutic referrals, and patients may also make requests for assistance at any time. The model includes process and tracking to capture referrals from these sources. CHWs functioning as service navigation coordinators will close the loop, ensuring that needed services are provided. The CHWs will be recruited from the catchment area and will receive training on coordination and navigation.

CBOs that provide entitlement enrollment assistance, housing, childcare, domestic violence assistance and transportation will be selected through a process and will enter into a contract with the collaborative to provide services within a specified timeframe at a guaranteed service level. The contracts may also include incentives for achieving service specific objectives. The intent is to select CBOs from the catchment area if possible.

Food insecurity will be addressed by the collaborative's Village Market described under the Youth Empowerment strategy that includes nutrition initiatives including initial access to a food pantry located on IHMC campus (in the Wellness Center) with the development of food pantries at a designated Friend Health and HRDI site after the second year. Alivio sites are likely close enough to significant food pantries already supported by the Greater Chicago Food Depository that we believe partnership arrangements will meet the needs of their clients and foster stronger community ties.

CASL will provide SDoH service navigation coordination. The members of the collaborative will use a common assessment tool and follow a standard referral protocol. The assessment is the initial and a key step in identify patient's holistic needs. New patients will be assessed for SDoH during their initial encounter. During subsequent encounters mini- assessments will be completed to identify issues that may have developed since the initial assessment. Referrals will be made to CBOs via an interface connection with CASL. CASL will also use updates to close the loop with providers. Technology will be used to facilitate this communication. Transformation funding is requested to pay for services provided by CBOs and to develop the technology connectivity.

A major impediment to timely addressing SDoH issues is the lack of consistency in completing assessments. This inconsistency is partly the result of not having sufficient resources to devote to this task. SSHEC has an opportunity to leverage best practices form partners and spread to others within the SSHEC. We will assess existing tools and technologies and determine platforms for connections to CBOs and integration of screening into clinical care sites. The collaborative is requesting funds to hire CHWs who will serve a key role as part of the service navigation process. The budget request includes funding for CASL's coordination and CHWs to assist patients as required to obtains SDoH services. The CHWs with certified training from local community college partners will be recruited.

A major goal is to ensure all program participants have access to SDoH services consistently as needed and not based on enrollment in a specific MCO or even because they are uninsured.
Progress will be measured by monitoring completed assessments, calculating the number of services received, and tracking that providers are given timely follow up information, e.g., the loop is closed. Compliance with appointments will also be tracked as indicator that SDoH barriers are no longer keeping patients from remaining engaged in their care.

3. Why will the activities you propose lead to the impact you intend to have?

The proposed activities are ends in themselves; when we identify a person who is food insecure and connect them to reliable local food resources, to a significant degree the proximate driver is addressed. The same reasoning applies (though is more challenging) for housing and transportation. That said, these initiatives on their own do not address the root cause of those social needs, which usually is poverty.

10. Care Integration and Coordination

1. Describe how your proposal improves the integration, efficiency, and coordination of care across provider types and levels of care.

Integration and coordination across this site will be driven largely by two innovations: the development of interoperable health record platforms, and the human touch of CHWs.

Data integration and information sharing between provider partners, and the Chinese American Service League will be supported by robust data use agreements and business associate agreements that will allow information to be shared. Information ultimately WILL be shared using technology interfaces that will connect providers, CASL and CHWs in a manner that enhances communication and reduces redundancy and individuals' burden brought on by needless repetition of a recently done social inventory for instance.

Community Health Workers will

- Assist individual's understanding of their conditions
- facilitate home monitoring of chronic conditions (HTN and NIDDM) and assure patients know how to connect that information to their medical home
- assure individuals are maintaining appointments for clinical services (including behavioral) and social support commitments
- assess SDoH if not already done, and connect patients to CBOs to address identified social support needs
- assist in redetermination for Medicaid if and when indicated
- communicate critical developments timely and accurately to the primary care home
- Advocate for members' medical and social care needs.

The collaborative is creating a program to connect patients with services to address the social with the philosophy of "no wrong door". In our Maternal Health strategy, the program will foster a warm hand off from providers during regular visits, receive centering pregnancy certifying entity program referrals, therapists providing care will make referrals and patients may also make requests for assistance. The SDoH service navigation coordinators will close the loop, ensuring that the needed services are provided.

Support for the CHWs and CBOs who will assist individuals identified with needs for food, housing and transportation and will help ensure the stability of the individuals cared for, and lessen psychic stressors for them (a major driver of anxiety and poor chronic condition control).W will include specific CBOs for each of the targeted determinants and will contract to obtain guaranteed services including assisting with benefit enrollment, housing placements, childcare and transportation as required. Food insecurity will be addressed by the collaborative's village market and nutrition initiatives including access to food pantries located on strategic provider sites.

CASL will provide SDoH service navigation coordination. Providers will use a common assessment tool and follow a standard referral protocol for connection to CASL. CBOs that provide benefit enrollment assistance, housing, childcare, domestic violence assistance and transportation will be selected through a process and will enter into a contract with the collaborative to provide services within a specified timeframe. CBOs will be required to communicate with CASL so that CASL can close the loop with the providers. Technology will be used to facilitate this communication. Transformation funding will be requested to pay for services provided by CBOs.

A major impediment to timely addressing SDoH issues is the lack of consistency in completing assessments, the result of insufficient resources to devote to this task. The collaborative will request funds to hire CHWs.

In the Youth Empowerment strategy, CHWs will provide information on selecting culturally appropriate healthy food choices, meal preparation and healthy menus. They will also provide assistance and answer questions on nutrition related entitlement programs such as SNAP and WIC encouraging participants to use the resources provided by these programs to select and purchase nutritious foods.

In the Behavioral Health strategy, CHWs and care navigators will coordinate care for patients leaving acute care services (ED and inpatient), and work with CBOs to address housing, food needs, and transportation to follow-up care, job interviews, social service eligibility screens.

2. Do you plan to hire community health workers or care coordinators as part of your intervention?

☒Yes
☐No

2A. Please submit care coordination caseload numbers and cost per caseload (stratified by risk, if applicable).

Our standard position will be a caseload of 25-30 individuals supported by a single CHW at a given time. This may need to be modified should the manager observe that a particular CHW's case complexity require adjustment.

We recognize that typical Medicaid MCO practice identifies a small fraction of individuals who need support or cross a threshold for case management, but our experience tells us that the approaches used by those MCOs is insensitive and does not effectively identify many people who would be able to maintain health and independence were their social support needs addressed.

In our first year of funding, we will perform an assessment of current care coordination of the Medicaid enrollees currently in our primary care practices, and inventory the approaches currently used by the Medicaid MCOs for survey, inventory, and stratification of their members.

In our model, we anticipate an overall cost per case per month of $188 in year one to $220 in year 5. If that is extrapolated to an individual CHW's caseload of 30, it would be $5640 in year one to $6600 in year 5.

3. Are there any managed care organizations in your collaborative?

☐Yes
☒No

3A. If no, do you plan to integrate and work with managed care organizations?

☒Yes
☐No

3B. Please describe your collaborative's plans to work with managed care organizations.

We will need to interface with the MCOs in year one of funding for many reasons, including at least the following:

- general awareness
- identification of redundancies or malalignment of any strategies for their enrollees in a primary car relationship with our partners, focusing on the core strategies of this collaborative.
- Reviewing and anticipating our milestones and pathway to sustainability.

In addition, we anticipate working with the MCOs to enhance partner revenues through value-based purchasing contracts:

- The Collaborative will comprehensibly advance value-based purchasing (VBP) in the SDoH and health equity space, qualifying for MCO incentives that reimburse providers when they increase documentation of case history of SDoH experiences and backgrounds of our patients. The collaborative will explore VBP arrangements where there is an opportunity to capitalize on system-level health gains derived from person-level care management and interventions.
- In addition, the Collaborative will partner with community health centers to comprehensively align patient care management, where community health centers already have VBP arrangements with some MCOs, expanding to all MCO enrollees.
- Negotiate enhanced rates for improving outcomes and cost reduction to pay for ineligible programs for Medicaid funding. Use the money saved to create funds for this Collaborative to provide more services to the community.

In collaboration with MCOs, the Collaborative will learn and develop an Alternate Payment model framework in years one and two of the grant. In year three of the grant, the Collaborative will selectively adopt Alternative Payment Models with Shared Savings and Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as cardiology or mental health).

11. Minority Participation

1. Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise Program (BEP) and/or not-for-profit entities majorly controlled and managed by minorities that will be used on the project as subcontractors or equity partners.

List entities here:

Alivio Medical Center
Chinese American Service League
Friend Health
HRDI, Inc.
Insight Hospital & Medical Center
Inner-City Muslim Action Network
Sylvester Broome Empowerment Village

2. Please describe the respective role of each of the entities listed above, and specify whether they will have a role only during the implementation of your proposal or if they will have a role in the ongoing operation of your transformed delivery system.

Those listed are all “foundational partners”, expected to be engaged in all strategies as primary or secondary catalysts, from inception through year 5.

A BEP, Illuminara, has been critical in meetings with community in the run-up to this application. We intend to use South Side BEP vendors whenever possible but esp. for social support services, contracted services for supplies, technology support, products and services such as communication, education and outreach.

12. Jobs

Existing Employees

1. For collaborating providers, please provide data on the number of existing employees delineated by job category, including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these job levels.

Please refer to Appendix A.

New Employment Opportunities

2. Please estimate the number of new employees that will be hired over the duration of your proposal.

84 (including community health workers, licensed clinical social workers, physicians, advanced practice nurses, pharmacists, nutritionists, podiatrist, managers, peer specialists and recovery coaches-for details, see budget)

3. Describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve.

In addition to the specialists and community health workers and other staff directly contemplated in the 5-year plan (see budget for details) we plan to matriculate 75 students/year on our Workforce development program driven by Malcom X College. We hope a significant number of these individuals, recruited heavily form our focus area, will in fact find careers as nurses and medical assistants within partner organizations OR at institutions in need on the South Side. Given the pandemic-driven disruptions to the stability of the healthcare workforce, in addition to assisting in health centers and hospitals on the South Side, these individuals may be a crucial part of the solution to care needs in long term care facilities on the South Side.

4. Please describe any planned activities for workforce development in the project.

See response to Q3 immediately above. In addition, we will enhance the behavioral health professional resiliency on the South Side by training prams that will be developed as part of the CCBHC strategy at HRDI (see Core Strategy 4) and the training of community-derived peer coaches and recovery specialist. Individuals will not only be community assets; the roles can be a steppingstone to more formal education and skills development-one might see a number of these individuals getting advanced degrees in social services as part of their exposure and immersion in our strategies.

We will pilot a program aimed at recruiting individuals from the community who may be interested in healthcare fields, removing some of the barriers to entry into those fields and assisting them with job placement at safety net hospitals on the South Side of Chicago. This comprehensive program will not only directly transpose individuals into healthcare fields, but we will also engage the youth of our community to educate them regarding the opportunities in healthcare. We will foster a sense of inquisitiveness, hope, and opportunity in order to inspire them to reach their highest potential.

13. Quality Metrics

Alignment with HFS Quality Pillars

1. Tell us how your proposal aligns with the pillars and the overall vision for improvement in the Department's Quality Strategy.

Each of the core strategies align with the pillars in HFS Department's quality strategy. Maternal health aligns with the maternal pillar, behavioral health with the adult behavioral pillar, youth employment aligns with the child behavioral health pillar and chronic conditions and workforce strategies align with the equity pillar. The **Metrics and Outcomes Table** will be used to track improvements are presented, grouped by core strategy. The measures are extracted from evidenced based sources including *the National Vital Statistics System, NCQA HEDIS Measures and Technical Resources and the National Quality Forum.*

The Quality/Milestones Committee as described under the Governance section will oversee progress toward agreed clinical and structural outcomes, goals and milestones and will identify and notify when course corrections or assessment are indicated. This group will be comprised of clinical and operational leaders from the provider and care coordination partners. The Quality/Milestone committee reports to the Steering Committee.

The Quality/Milestone committee will establish baseline metrics for each outcome measure that will be achieved over the 5-year period. Data extraction and monitoring will happen based on a schedule determined by the Quality / Milestones Committee. Data will be obtained from partners' EMR and claims databases.

Please reference attached table for outcomes by core strategy.

Outcomes for Core strategy 1: Maternal Health						
MEASURE CATEGORY	MEASURE	MEASURE DEFINITION	Baseline	Goal	Quality/Cost/Utilization	METRIC TYPE
NOM 1: Early Prenatal Care	Percent of pregnant women who receive prenatal care beginning in the first trimester	Number of live births with reported first prenatal visit during the first trimester (before 13 weeks' gestation) in the calendar year. *National Vital Statistics System (NVSS)*			Quality	Rate (%)
NOM 4: Low Birth Weight	Percent of low-birth-weight deliveries (<2,500 grams)	Number of live births weighing less than 2,500 grams *National Vital Statistics System (NVSS)*			Quality	Rate (%)
NOM 5: Preterm Birth	Percent of preterm births (<37 weeks)	Number of live births before 37 weeks of complete gestation *National Vital Statistics System (NVSS)*			Quality	Rate (%)
Prenatal Depression	Percent of women who experience prenatal depressive symptoms	Number of women who report prenatal depressive symptoms (defined as reporting always/often feeling down, depressed, hopeless or always/often having little interest or little pleasure in doing things)/ Number of pregnant women				Rate (%)

		Percent of women screened for depression				
NOM 24: Postpartum Depression	Percent of women who experience postpartum depressive symptoms following a recent live birth	Number of women who report postpartum depressive symptoms following a recent live birth (defined as above)/ Number of women with a recent live birth Percent of women screened for depression. *Pregnancy Risk Assessment Monitoring System (PRAMS)*			Quality	Rate (%)
Outcomes for Core strategy 2: Youth Empowerment						
MEASURE CATEGORY	MEASURE	MEASURE DEFINITION	Baseline	Goal	Quality/Cost/Utilization	METRIC TYPE
Participation and Engagement	Participation	• Percentage of adolescents who participate in recreational, social or leisure activities for a specified time during the day or week (proposed)				
Health and well-being	Outcome	• Prevalence of feeling sad or hopeless for every day for 2 weeks and stopped normal activities				
Outcomes for Core strategy 3: Chronic Conditions						
MEASURE CATEGORY	MEASURE	MEASURE DEFINITION	Baseline	Goal	Quality/Cost/Utilization	METRIC TYPE
Cardiovascular Conditions	Controlling High Blood Pressure (CBP)	Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).				
Cardiovascular Conditions	Statin Therapy for Patients with Cardiovascular Disease and Diabetes (SPC/SPD)	Statin Therapy for Patients with Cardiovascular Disease: Assesses males 21–75 years of age and females 40–75 years of age who have clinical atherosclerotic cardiovascular disease (ASCVD) and who received and adhered to statin therapy.				

		Statin Therapy for Patients with Diabetes: Assesses adults 40-75 years of age who have diabetes and who do not have clinical ASCVD, who received and adhered to statin therapy.				
Diabetes	Comprehensive Diabetes Care (CDC)	Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing. HbA1c poor control (>9.0%). HbA1c control (<8.0%). HbA1c control (<7.0%) for a selected population. * Eye exam (retinal) performed. Medical attention for nephropathy. BP control (<140/90 mm Hg).				
Outcomes for Core strategy 4: Behavioral Health EFFECTIVENESS OF CARE - HEDIS MEASURES[1] AND NQF MEASURES[2]						
MEASURE CATEGORY	MEASURE	MEASURE DEFINITION	Baseline	Goal	Quality/Cost/Utilization	METRIC TYPE
Behavioral Health	Depression Utilization of Validated Instrument	% of Adults with HTN or NIDDM screened for depression with a validated instrument				
Behavioral Health	Depression Utilization of the PHQ-9 Tool	The percentage of adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia Proportion of those with a positive PHQ-2 who got a PHQ-9 Proportion of those with a positive PHQ-9 referred to therapy and kept appointment				
Behavioral Health	Identify and manage opioid use disorder	Proportion of patients Pregnant OR NIDDM OR HTN screened for opioid use disorder with a validated instrument				

		Proportion of those patients that screen positive who were offered Medication-Assisted Treatment for OUD				
Behavioral Health	Depression Response at Six Months- Progress Towards Remission	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with major depression or dysthymia who demonstrated a response to treatment six months (+/- 60 days) after an index visit. (NQF/MN Community Measurement) Numerator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve a response at six months as demonstrated by a six-month (+/- 30 days) PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. Denominator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.				
Outcomes for Strategy 5: Workforce						
Student engagement	Enrollee participation	Numerator: Number of persons enrolled in workforce program Denominator: Total yearly capacity of program (75)				
Student success	Course/certification completion	1a: Numerator: Number of enrolled students who apply for certification Denominator: total amount of enrolled students 1.b Numerator: Number of students who earn certification in their chosen field				

		Denominator: Total number of students who applied for certification				
Employment success	Workforce entry	Numerator: Number of students who received at least one job offer from clinic in southside of Chicago and/or a safety net hospital in South Side of Chicago within 3 months of coursework completion Denominator: Number of students who successfully completed relevant coursework				

2. Does your proposal align with any of the following Pillars of Improvement?

2A. Maternal and Child Health?

☒Yes
☐No

Maternal and Child Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

The quality metrics that will be improved by the maternal strategy include the following:

- Percent of pregnant women who receive prenatal care beginning in the first trimester
- Percent of low birth weight deliveries (<2500 grams)
- Percent of preterm births (<37 weeks)
- Percent of women who experience prenatal depressive symptoms
- Percent of women who experience postpartum depressive symptoms following a recent live birth

2B. Adult Behavioral Health?

☒Yes
☐No

Adult Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

The quality metrics that will be improved by the behavioral health strategy include the following.

- Depression Response at Six Months- Progress Towards Remission
  - % adult patients (18 years of age or older) with major depression or dysthymia who demonstrated a response to treatment six months (+/- 60 days) after an index visit
- % 7-Day PCP follow ups (post discharge of ED visit or Inpatient Admission for Substance Use Disorder
- % 30-Day Readmission for primary mental health disorder (any facility)
- % women who experience postpartum depressive symptoms following a recent live birth
- Proportion of those with a positive PHQ-2 who got a PHQ-9

- Proportion of those with a positive PHQ-9 referred to therapy and kept appointment
- Proportion of patients pregnant OR with NIDDM OR HTN screened for opioid use disorder with a validated instrument
- Proportion of those patients that screen positive who were offered Medication-Assisted Treatment for OUD

2C. Child Behavioral Health?

☒Yes
☐No

Child Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

The quality metrics that will be improved by the youth empowerment strategy include the following:

- Depression Response at Six Months- Progress Towards Remission
  - % adolescent patients (12 to 17 years of age) with major depression or dysthymia who demonstrated a response to treatment six months (+/- 60 days) after an index visit.
- Percentage of adolescents who participate in recreational, social or leisure activities for a specified time during the day or week
- Prevalence of feeling sad or hopeless for every day for 2 weeks and stopped normal activities

2D. Equity?

☒Yes
☐No

Equity: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

The quality metrics that will be improved by the chronic conditions and care coordination strategies include the following:

- Chronic Conditions
  - Controlling High Blood Pressure (CBP)
    - % blood pressure adequately controlled (<140/90 mm Hg).
  - Statin Therapy for Patients with Cardiovascular Disease and Diabetes (SPC/SPD)
    - % cardiovascular and diabetic patients who received and adhered to statin therapy.
  - Comprehensive Diabetes Care: % of adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:
    - Hemoglobin A1c (HbA1c) testing
    - HbA1c poor control (>9.0%).
    - HbA1c control (<8.0%).
    - HbA1c control (<7.0%) for a selected population. *
    - Eye exam (retinal) performed.
    - Medical attention for nephropathy.
    - BP control (<140/90 mm Hg).

3. Will you be using any metrics not found in the quality strategy?

☒Yes
☐No

3A. Please propose metrics you'll be accountable for improving and a method for tracking these metrics.

Please see reference the **Metrics and Outcomes Table** for the outcome measures that will be tracked by this collaborative.

The metrics will be tracked by the Quality/Milestone committee. Data extraction and monitoring will happen based on a schedule determined by the Quality / Milestones Committee. Data will be obtained from partners' EMR and claims databases.

[1] NCQA: HEDIS Measures and Technical Resources. https://www.ncqa.org/hedis/measures
[2] National Quality Forum. https://www.qualityforum.org/QPS

14. Milestones

For all activities described in your proposal, please provide a calendar of milestones to show progress (e.g., when IT will be purchased, when IT will be operative, when construction projects will begin and end, when people will be hired, etc.) The timeline should be in months from award.

Please refer to Milestone Appendix B.

SSHEC MILESTONES BY STRATEGY - TIME PERIOD BEGINS POST AWARD

STRATEGY		YEAR 1 MONTHS												YEAR 2 QUARTERS			
		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4
	PLANNING																
MATERNAL	L&D approval to open																
	L&D onboard staff																
	L&D purchase, install equipment																
	Technology, purchase interfaces, maternal module, setup Centering video																
	Contract to start Centering Pregnancy implementation																
	Hire Centering coordinators, facilitators																
	Select assessment tool																
	Train centering staff																
	Hire therapists - PT, acupuncture, massage																
	Recruit first Centering Pregnancy participants																
	Start referrals to therapists																
	Hire doulas, lactation consultants																
	Start referrals SDOH, BH																
	Start Centering Parenting sessions																
	Implement Centering parenting process																
	Recruit first Centering Parenting participants																
	Start Centering Parenting sessions																
SBEV																	
	Hire outreach workers / SBEV staff																
	Purchase technology, software																
	Contract transportation vendor for youth program																
	Start nutrition/ financial literacy classes																
	Start nutrition food box distribution																
	Start distribution nutritious menus, recipes																
	Recruit initial SBEV participants																
	Start athletic/sport/ physical program																
	Build music studio																
	Renovate IHMC space for SBEV																
	Start art, recreation therapy programs																
	Start group counseling sessions																
	Start music therapy sessions																
	Start food demonstrations																
	Open IHMC food pantry																
	Launch nutrition virtual smart shopping APP																
	Start farmer's market																
	Start sport professional mentors program																
Behavioral Health	Open IHMC Behavioral health clinic																
	Recruit IHMC and HRDI psychiatrists																
	Recruit FQHCs, CMHC LCSWs																
	Hire IHMC ED and inpatient care managers																
	Hire HRDI peer specialists, recovery coaches																
	Install technology interfaces																
	Start uniform screening																
	HRDI begin accepting ED patients to ambulatory and residential care																
	Begin family support therapeutic sessions																
	BeginBH access for other strategies																
	Implement HRDI recovery specialist certification program																
	Begin HRDI CCBHC certification process																
Chronic	Hire IHMC medical specialists																
	Hire lifestyle staff, nutritionist, diabetic educator, certified exercise trainer																
	Create interfaces for all partners																
	Purchase equipment																
	Begin uniform screening																
	Create telehealth connections																
	Setup IHMC lifestyle center																
	Contract for food pantries at IHMC, Freland Health, HRDI																
WELLNESS	Open lifestyle center																
	Open food pantries																
SDOH	Create SDoH care coordination system																
	Contract with CBOS for specific services																
	Train CHW outreach workers																
	Hire CASL community care managers																
	Train care managers																
	Start referrals to CASL																
	Begin warm handoffs to care managers																
	Begin referrals to CBOs																
WORKFORCE	Recruit hire and onboard workforce																
	Develop Marketing pilot																
	Develop high fidelity simulator plan																

15. Budget

1. Annual Budgets across the Proposal

When completed, please upload your spreadsheet here.

2. Number of Individuals Served

Please project the number of individuals that will be served in each year of funding.

Year 1 Individuals Served

5136

Year 2 Individuals Served

7561

Year 3 Individuals Served

7911

Year 4 Individuals Served

8288

Year 5 Individuals Served

8424

Year 6 Individuals Served

Not applicable (0)

3. Alternative Payment Methodologies

Outline any alternative payment methodologies that your proposal might utilize for receiving reimbursement for services from MCOs.

There is considerable variation on how states support and pay for group prenatal care. Alabama, Arkansas, Colorado, Idaho, Massachusetts, Oregon, Rhode Island, Tennessee, and Washington offer reimbursement via alternate payment model mechanisms. California, Louisiana among others, provide enhanced fee-for-service reimbursement.

The Collaborative will seek enhanced reimbursements or alternate payment models based on savings from having fewer low birth weight babies to cover the cost of evidence-based Centering programs that will keep at-risk pregnant women consistently engaged in pre and postnatal care.

16. Sustainability

Include a narrative that describes how your budget will decrease reliance on Transformation funding over time and how reimbursements for services and other funding sources will increase and establish sustainability over time. (i.e., how will your project continue to operate without HTC funding?)

In particular, include how services that address social determinants of health will be funded on an ongoing basis (for example, through existing payment models, alternative payment methodologies for Medicaid services, or through other funding sources).

In your narrative, highlight any key assumptions that are critical to making your project sustainable.

Provide your narrative here:

Sustainability of Services Overview
Health care services in Chicago's South Side are severely burdened by barriers to health care services access, along with provider resistance and acceptance of low Medicaid reimbursement rates for Medicaid-insured patients. The access problem is exacerbated by the geographic distribution of specialty care access in Chicago. Many South Side residents are also challenged by the social determinants of health (SDoH) that create barriers to effective health care. Alternate payment models that reward providers for comprehensively managing the care of covered patients promise better patient outcomes and the potential for contracts that enhance reimbursements and provider accountability. Payment reform, improving and sustaining access to essential health care services, and addressing the SDoH form the backbone of our sustainability strategy.

Insight Hospital and Medical Center and its partners caring for vulnerable populations on the South Side ("the Collaborative") proposes to address sustainability in each of the HFS pillars by focusing on an outcomes-based strategy that enhances a patient-centered approach to care, resulting in better health outcomes and lower utilization of Emergency Department (ED) or Inpatient utilization for ambulatory care sensitive conditions. The sustainability approach includes interlinked value-driven interventions, outcome measurement, leveraging community partnerships, and enhanced/alternate payment models.

In advancing **Maternal health and Child Health**, the collaborative will partner with Alivio and Friend Health FQHCs to sustain and enhance obstetric services on the South Side. The Collaborative will implement a Centering Pregnancy Program and connect pregnant women to therapeutic and lifestyle Services. The Collaborative will address the social support needs of the expectant mother with evidence-based care management, coordination, and navigation. The maternal health centering strategy offers outreach and support to pregnant mothers with pre-and perinatal care appointments, provides childcare and transportation to facilitate participation in group visits, and ensures mother and newborn connection to services twelve months postpartum through the a centering parenting program. The maternal health program screens for postpartum anxiety and depression and offers education to promote a healthy pregnancy and reduce premature births and infant mortality. The program is measured through national outcome measures, including early prenatal care (timeliness of first prenatal checkup), low birth weight, preterm birth, prenatal and postpartum depression.

In advancing **Adult and Child Behavioral health services** in Chicago's South Side**,** the Collaborative understands that primary care providers are usually the first to identify mental health and substance use issues. The collaborative ensures providers have access to behavioral health (BH) screening tools, are trained to recognize potential trauma and adverse experiences, and are supported when referring for BH psychiatric care. The collaborative includes a community-based mental health center (HRDI) for particularly high-risk or complex behavioral health needs. The Collaborative provides care coordination via the Chinese

American Service League and will identify community-based social service providers that will directly address identified Social Determinants of Health (SDoH). Improving access to BH services and creating a patient-centered transition and care coordination processes are central tenets of the approach of this Collaborative, with the noted outcome of reducing avoidable ED utilization and inpatient admissions. The program is measured via a set of mutually informing metrics, including depression screening of adolescent and adult patients using a validated instrument, the proportion of pregnant women, people with diabetes, and patients with a hypertension diagnosis screened for opioid use disorder (OUD) with a validated instrument, use and continuity of pharmacotherapy for OUD, and depression response at six-months after initial diagnosis.

In addressing **chronic adult conditions,** the Collaborative relies on comprehensively designed care management that addresses gaps in care and ensures continuity of care. The Collaborative recognizes that the most significant access barrier is provider availability, both in the number of providers and those with appointments accessible to our clients. To address this barrier, the Collaborative includes community health center providers who offer evidence-based care that best meets the needs of the target chronic condition population of diabetics and hypertension patients, including high utilizers of high-cost services. We identify and prioritize patients for comprehensive care engagement and connection to appropriate specialty providers based at Insight Hospital and Medical Center for face-to-face visits, or where appropriate, telehealth support (synchronous or asynchronous as with eConsult). We expect these partnerships to continue to mature with value-based arrangements for accountability and outcomes-based enhanced payments to reduce the cost of care while delivering better care. The program is measured using HEDIS and National Quality Forum measure framework, including controlling blood pressure (CBP), statin therapy for patients with cardiovascular disease and diabetes (SPC/SPD), and comprehensive diabetes care (CDC).

Proposed Sustainability Approach

- **Substantial and Enduring Improvements in Outcomes-Driven Delivery of Care.**
  - Comprehensive health assessment includes identifying behavioral health (BH) and physical health (PH) conditions and social determinants for a holistic picture of the patients' needs. The Collaborative will use this assessment data to provide patient-focused care and services. The Collaborative will closely monitor the performance of all partner organizations in addressing access barriers. The Collaborative will continue to close gaps in access to care and grow our partnerships with federally qualified health centers and community-based organizations addressing identified barriers to health.
  - The Collaborative will continually test solutions for complex need patients by focusing on prevention, early identification, engagement, and treatment. This coordinated effort is measured through our comprehensive measurement framework, including Prenatal and Postpartum Care (PPC), use of assessment tools, and management of chronic conditions to reduce readmissions for ambulatory-care sensitive conditions. The Collaborative will actively target and close racial behavioral health disparities in access to ambulatory treatment.
  - The Collaborative's Coordination of Care and Risk-Adjusted Utilization measures support outcomes-driven delivery of care, including Potentially Avoidable Outpatient ED Visits, 7-Day medical home follow-ups (post-ED Visits), 7-Day PCP follow-ups (post-discharge of Impactable Inpatient Admissions), and 30-Day Readmissions (all-cause, any facility).

- **Meet Needs of High Acuity Populations**
  - The Collaborative's clinical and care coordination leaders will convene in the first year to determine care pathways for particularly complex, high-risk patients. This might include individuals with a combination of physical and

mental health problems coupled with social support needs that threaten to upset whatever stability might be preserved with timely intervention. This is most likely to occur for individuals with serious mental illness or a combination of mental illness and homelessness.

- **Technology**
  a. Support a shared care management platform that promotes secure health information exchange interoperability between organizations and enables patient-focused care team effectiveness.
  b. Promote and enhance the utilization of the telehealth platform, with a focus on improving specialty care availability.
  c. Promote technology initiatives and seek provider incentives to increase the adoption of information interfaces and common data-sharing platforms that enhance care coordination, reduce duplication of services, and reduce hassle for clients.

- **Evaluate Charge or Fee Structure**
  - There is considerable variation on how States support and pay for group prenatal care. Alabama, Arkansas, Colorado, Idaho, Massachusetts, Oregon, Rhode Island, Tennessee, and Washington offer reimbursement via alternate payment model mechanisms. California, Louisiana among others, provide enhanced fee-for-service reimbursement.
  - The Collaborative will seek enhanced reimbursements or alternate payment models based on savings from having fewer low birth weight babies to cover the cost of evidence-based Centering programs that will keep at-risk pregnant women consistently engaged in pre and postnatal care.

- **Enhance Revenues through Value-Based Purchasing Contracts**
  - The Collaborative will comprehensibly advance VBP in the SDoH and health equity space, qualifying for MCO incentives that reimburse providers when they increase documentation of case history of SDoH experiences and backgrounds of our patients. The collaborative will explore VBP arrangements where there is an opportunity to capitalize on system-level health gains derived from person-level care management and interventions.
  - In addition, the Collaborative will partner with community health centers to comprehensively align patient care management, where CHCs already have VBP arrangements with some MCOs, expanding to all MCO enrollees.
  - Negotiate enhanced rates for improving outcomes and cost reduction to pay for ineligible programs for Medicaid funding. Use the money saved to create funds for this Collaborative to provide more services to the community.
  - In collaboration with MCO's, the Collaborative will learn and develop an Alternate Payment model framework in years one and two of the grant. In year three of the grant, the Collaborative will selectively adopt APMs with Shared Savings and Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as cardiology or mental health).

- **Clinical Integration- Enhance Revenue through Collaborations and Operational Efficiency**

  The Collaborative will focus on creating patient-centered clinical integration via selective alliance with physician partners and community organizations, including community health centers, Cook County Health, Comer Children's Hospital, and the Child Advocacy Center, among others, to deliver evidence-based care, improve quality, efficiency call, and coordination of care and demonstrate value to the market.

- **Fill gaps for services in demand**

With Insight as the hub, the Collaborative will ensure South Side residents have the right services in the right place and right time. The Collaborative's approach will drive patient education on healthcare access, availability, care management engagement, CHC partnerships, and provider engagement to assess and address primary care, behavioral health, maternal and child health, specialty care, and SDoH needs.

Appendix A (Human Resources/Jobs)

Appendix B (Milestones)

Appendix C (Letters of Support)

Appendix A (Human Resources/Jobs)

Job Title	Count	Zip Codes
ADMIN ASSISTANT	1	60626
ADMITTING LEAD	2	60477
ANESTHESIA TECHNICIAN	1	60467
BEHAVIORAL HLTH REPRESENT	1	60628
CARPENTER	1	60053
CASE Y	1	60076
CDM N	1	60659
Centralized Staffing Spec	1	60619
CERTIFIED NURSING ASSISTA	16	60475
CERTIFIED REGISTERED NURS	1	60521
CERTIFIED STERILE PREP TE	2	60148
CHIEF REVENUE OFFICER	1	60466
CLERK COORD	3	60619
CLINICAL DOCUMENTATION SP	1	60629
CLINICAL LAB ASSIST	3	60527
CODER	2	60616
COORD, CREDENTIALING	1	60415
COORD, INFECTION PREVENTI	1	60559
COORD, MARKETING/DEVELOPM	1	60439
COORD, PURCHASING CONTRAC	1	46324
COORD, SEPSIS CLINICAL	1	46322
COORD,UTILIZATION REVIEW	2	60521
CT TECH	1	60077
DEPARTMENT SECRETARY	1	60616
DIR, FACILITIES	1	60154
DIR, PUBLIC SAFETY	1	60655
DIR, RADIOLOGY & ONCO	1	60453
DIR, RESPIRATORY CARE SER	1	60631
DIR,INFECT PREVENT & CONT	1	60435
ECHO TECHNICIAN REGISTERE	1	60440
EDUCATOR, ELECTRONIC MED	1	60609
EKG TECH	1	60621
ELECTRICIAN	1	60637
EMERGENCY DEPARTMENT TECH	3	55304
ENDOSCOPY EQUIP/SUPPLY TE	1	60616
ENVIRON SERV TECH	28	60611
FACILITIES & ENGINEERING	1	60409
HISTOTECHNOLOGIST	1	46383
HOUSE Y	3	60469
HVAC TECH	1	60617
INFORMATION DESK CLERK	3	60610
INTAKE COORD	3	60154
LABORATORY SERVICES FLOAT	1	60467
LEAD CT TECH	2	60613
LEAD MAMMOGRAPHY TECH	1	60162
LEAD MEDICAL TECHNOLOGIST	2	60632
LEAD MRI TECH	1	60657
LEAD NON-INVASIVE CARDIO	1	60649
LEAD NUCLEAR MED TECH	1	60647
Lead Radiation Therapy Te	1	60605
LEAD RADIOLOGY TECH	1	60649

LEAD RECEIVING CLERK	1	60653
LEAD RESP THERAPIST-REGIS	2	60620
MAINTENANCE MECHANIC	2	60629
MAMMOGRAPHY RECORDS COORD	1	60487
MAMMOGRAPHY TECH	1	60643
MANAGED CARE AUDITOR	1	60473
MEDICAL ASST - CERTIFIED	1	60605
MEDICAL EDUCATION COORD	1	60629
MEDICAL RECORDS ASST	2	60429
MEDICAL TECHNOLOGIST	8	60617
MENTAL HLTH TECH	10	60446
MGR, BEHAVIORAL HEALTH	1	60188
MGR, CLINICAL INFORMATICS	1	60655
MGR, CLINICAL NURSE	3	60620
MGR, CONTRACT & LOGISTICS	1	60634
MGR, INFUSION CENTER	1	60616
MGR, PATIENT FLOW	1	60469
MGR,TELECOMMUNTIONS &GUES	1	60653
MONITORING TECH	6	60616
MRI TECH	2	60616
NURSE CASE Y	4	60616
NURSE PRACTITIONER	2	60620
NURSING EDUCATOR	3	60638
OCCUP THERAPIST	1	60632
OPERATING ROOM TECH	1	60447
OR SCHEDULING COORD	1	60464
PATIENT CARE NAVIGATOR	7	60525
Payroll Manager	1	60634
PAYROLL SPECIALIST	1	60608
PFS REPRESENTATIVE	1	60616
PHYSICAL THERAPIST	1	60629
PHYSICIAN	7	60439
PHYSICIAN ASSISTANT ED	5	60608
PHYSICIAN ED	19	60628
PLUMBER	1	60628
PRE-CERTIFICATION SPECIAL	5	60619
QUALITY ASSURANCE OFFICER	1	60652
QUALITY COORD	1	60631
RADIATION THERAPY TECH	1	60620
RADIOLOGY SYSTEMS & DATA	1	60609
RADIOLOGY TECH	6	60615
REGISTRAR	20	60620
REGISTRY CERTIFIED REGIST	2	60411
REGISTRY COTA	2	60610
REGISTRY CT TECH	7	60409
REGISTRY FACILITIES	1	60643
REGISTRY LABORATORY TECH	1	60457
REGISTRY MEDICAL TECHNOLO	2	60629
REGISTRY MENTAL HEALTH TE	2	60653
REGISTRY MRI TECH	1	60653
REGISTRY NUCLEAR MED TECH	3	60426
REGISTRY OCCUP THERAPIST	3	60406

REGISTRY PHYSICAL THERAPI	2	60406
REGISTRY RADIOLOGY TECH	7	60616
REGISTRY RESP THERAPIST R	3	60053
REGISTRY SOCIAL WORKER	3	60609
REGISTRY SPEECH PATHOLOGI	1	60639
REGISTRY ULTRASOUND TECHN	3	60643
REGISTRY SITTER	1	60438
RESP THERAPIST CERT	5	60409
RESP THERAPIST CERT-CRIT	5	60645
RESP THERAPIST REGISTERED	4	60616
RN	94	60619
RN, REGISTRY	18	60422
SECURITY CAPTAIN	3	60101
SITTER	1	60656
SOCIAL WORKER	2	60504
SPEECH PATHOLOGIST	1	60637
STATIONARY ENGINEER	4	60643
STERILE PREP TECH (NON-CE	1	60640
SUPV, LABORATORY	1	60477
SUPV, OCCUPATIONAL THERAP	1	60619
SUPV, PHYSICAL THERAPY	1	60523
SUPV, SPD	2	60624
SUPV, STERILE PREP	2	60620
TELECOM OPERATOR	5	60609
TRANSPORTER	3	60643
ULTRASOUND TECHNOLOGIST	7	60636
UNBILLED SPECIALIST	1	60616
UNIT SUPPLY TECH	5	60605
VP PATIENT CARE SERVICES	1	60611
VP QUALITY PAT SFE RSK MG	1	60611
Total Count	**460**	60609
		60619
		60707
		60611
		60615
		60406
		60613
		60640
		60622
		60465
		60462
		60637
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Zip Code	Job Title Description
60490	ACA CERTIFIED NAVIGATOR
60612	ADMINISTRATIVE ASSISTANT
60632	ADMINISTRATIVE ASSISTANT
60608	ADMINISTRATIVE ASSISTANT
60629	ASST FACILITIES SUPERVISOR
60629	BEHAVIORAL HEALTH COORDINATOR
60638	BENEFITS COORDINATOR
60402	BENEFITS ENROLLMENT COUNSELOR
60456	BENEFITS ENROLLMENT COUNSELOR
60639	BH Care Manager
60638	BILLING MANAGER
60629	CARE COORDINATOR - COMMUNITY HEALTH WORKER
60608	CARE COORDINATOR - COMMUNITY HEALTH WORKER
60623	CARE COORDINATOR - COMMUNITY HEALTH WORKER
60623	CARE COORDINATOR - COMMUNITY HEALTH WORKER
60623	CARE MANAGER
60612	CARE RESOURCE COORDINATOR
60640	CERTIFIED NURSE MIDWIFE
60647	CERTIFIED NURSE MIDWIFE
60615	CERTIFIED NURSE MIDWIFE
60647	CERTIFIED NURSE MIDWIFE
60564	CERTIFIED NURSE MIDWIFE COORD
60623	CFCM CASE MANAGER
60608	CFCM CASE MANAGER
60608	CFCM CASE MANAGER
60546	CHIEF EXECUTIVE OFFICER
60160	CHIEF OPERATIONS OFFICER
60642	CLINICAL TEAM LEAD
60609	COMMUNITY HEALTH WORKER
60402	COMMUNITY HEALTH WORKER
60608-3096	COMMUNITY HEALTH WORKER
60618	COMMUNITY HEALTH WORKER
60641	COMMUNITY HEALTH WORKER
60609	CONTACT INVESTIGATOR
60044	CONTACT INVESTIGATOR
60632	CONTACT TRACER
60632	CONTACT TRACER
60632	CONTACT TRACER
60805	CONTACT TRACER
60629	Contact Tracing Supervisor
60608	COVID Resource Coordinator
60643	CREDENTIALING SPECIALIST
60632	DENTAL ASSISTANT
60623	DENTAL ASSISTANT
60521	DENTAL DIRECTOR
60632	DENTAL OFFICE ASSISTANT
60804	DENTAL OFFICE ASSISTANT
60611	DENTIST
60439	DENTIST
60633	DEVELOPMENT ASSOCIATE
60634	DEVELOPMENT ASSOCIATE
60804	DIABETES HEALTH TRAINER
60513	DIRECTOR OF DEVELOPMENT
60139	DIRECTOR OF FINANCE EXEMPT
60804	EMR TECHNINCIAN
60608	EMR TECHNINCIAN
60629	EMR TECHNINCIAN
60608	EMR TECHNINCIAN
60601	EMR TECHNINCIAN
60623	EMR TECHNINCIAN
60707	EXECUTIVE ADMINISTRATIVE ASSISTANT
60804	EXECUTIVE ADMINISTRATIVE ASSISTANT
60616	Executive Director

UDS CATEGORY	
Eligibility Assistance Workers	6
Management and Support Staff	33
Facility Staff	11
Other Licensed Mental Heatlh Providers	6
Other Mental Health Staff	1
Case Managers	10
Other Enabling Services	28
Certified Nurse Midwives	5
Nurses	28
Community Health Workers	6
Fiscal and Billing Staff	8
Other Dental Personnel	4
Dentist	3
IT Staff	7
Nurse Practitioners	10
Family Physicians	5
Patient Support Staff	31
Internists	3
Other Medical Personnel	49
OB/GYN	1
Outreach Workers	1
Pediatricians	5
Physician Assistants	6
Other Professional Health Services	1
Patient and Community Education Specialists	2
Other Specialty Physicians	1
Other Programs and Services	4

60632	FACILITIES SUPERVISOR
60440	FAMILY NURSE PRACTITIONER
60440	FAMILY NURSE PRACTITIONER
60441	FAMILY NURSE PRACTITIONER
60477	FAMILY NURSE PRACTITIONER
60402	FAMILY NURSE PRACTITIONER
60402	FAMILY NURSE PRACTITIONER
60302	FAMILY NURSE PRACTITIONER
60641	FAMILY NURSE PRACTITIONER
60622	FAMILY PHYSICIAN
60638	FAMILY PHYSICIAN
60641	FAMILY PHYSICIAN
60647	FAMILY PHYSICIAN
60643	Financial Accountant/Analyst
60459	FLOOR NURSE
60402	FLOOR NURSE
60402	FLOOR NURSE
60629	FLOOR NURSE
60803	FLOOR NURSE
60608	FLOOR NURSE
60640	Grants & Foundation Relations Manager
60440	Grants Accountant
60632	GREETER
60632	GREETER
60632	GREETER
60608	GREETER
60644	GREETER
60608	GREETER
60608	GREETER
60652	Health IT Coordinator
60302	HIT SUPERVISOR
60634	Human Resources Associate
60616	INTERNIST
60546	INTERNIST
60514	INTERNIST
60402	LEAD MEDICAL ASSISTANT
60438	LEAD MEDICAL ASSISTANT
60402	LEAD MEDICAL ASSISTANT
60629	LEAD MEDICAL ASSISTANT
60608	LICENSED CLINICAL PROFESSIONAL COUNSELOR
60056	LICENSED PROFESSIONAL COUNSELOR
60651	LICENSED PROFESSIONAL COUNSELOR
60640	LICENSED PROFESSIONAL COUNSELOR
60608	LICENSED PROFESSIONAL COUNSELOR
60609	MAINTENANCE AIDE
60608	MAINTENANCE AIDE
60804	MAINTENANCE AIDE
60609	MAINTENANCE AIDE
60608	MAINTENANCE AIDE
60608	MAINTENANCE AIDE
60618	MAINTENANCE AIDE
60804	MAINTENANCE AIDE
60804	MEDICAL ASSISTANT
60804	MEDICAL ASSISTANT
60804	MEDICAL ASSISTANT
60632	MEDICAL ASSISTANT
60632	MEDICAL ASSISTANT
60804	MEDICAL ASSISTANT
60426	MEDICAL ASSISTANT
60623	MEDICAL ASSISTANT
60651	MEDICAL ASSISTANT
60651	MEDICAL ASSISTANT
60632	MEDICAL ASSISTANT
60629	MEDICAL ASSISTANT

60632	MEDICAL ASSISTANT
60632	MEDICAL ASSISTANT
60642	MEDICAL ASSISTANT
60804	MEDICAL ASSISTANT
60623	MEDICAL ASSISTANT
60629	MEDICAL ASSISTANT
60629	MEDICAL ASSISTANT
60609	MEDICAL ASSISTANT
60636	MEDICAL ASSISTANT
60804	MEDICAL ASSISTANT
60638	MEDICAL ASSISTANT
60609	MEDICAL ASSISTANT
60609	MEDICAL ASSISTANT
60608	MEDICAL ASSISTANT
60638	MEDICAL ASSISTANT
60534	MEDICAL ASSISTANT
60804	MEDICAL ASSISTANT
60513	MEDICAL ASSISTANT
60629	MEDICAL ASSISTANT
60402	MEDICAL ASSISTANT
60632	MEDICAL ASSISTANT
60608	MEDICAL ASSISTANT
60652	MEDICAL ASSISTANT
60623	MEDICAL ASSISTANT
60609	MEDICAL ASSISTANT
60622	MEDICAL ASSISTANT
60634	MEDICAL ASSISTANT SUPERVISOR
60546	MEDICAL DIRECTOR CLINICAL OPS
60546	MEDICAL DIRECTOR CLINICAL OPS
60623	MEDICAL OFFICE ASSISTANT
60641	MEDICAL OFFICE ASSISTANT
60632	MEDICAL OFFICE ASSISTANT
60638	MEDICAL OFFICE ASSISTANT
60441	MEDICAL OFFICE ASSISTANT
60608	MEDICAL OFFICE ASSISTANT
60629	MEDICAL OFFICE ASSISTANT
60623	MEDICAL RECORDS CLERK
60804	MEDICAL RECORDS CLERK
60608	OBGYN
60623	OUTREACH SPECIALIST
60623	Paramedic
60639	Paramedic
60623	Paramedic
60623	Paramedic
60629	Paramedic
60647	PATIENT ACCOUNT ADVISOR
46324	PATIENT ACCOUNT ADVISOR
60608	PATIENT CARE MANAGER
60402	PATIENT CARE MANAGER
60632	PATIENT MEDICAID COORDINATOR
60304	PATIENT NAVIGATOR
60629	PATIENT NAVIGATOR
60623	PATIENT NAVIGATOR
60707	PATIENT NAVIGATOR
60652	PATIENT NAVIGATOR
60629	PATIENT RECALL ASSISTANT
60629	PATIENT REGISTRATION REPRESENTATIVE
60501	PATIENT REGISTRATION REPRESENTATIVE
60641	PATIENT REGISTRATION REPRESENTATIVE
60608	PATIENT REGISTRATION REPRESENTATIVE
60608	PATIENT REGISTRATION REPRESENTATIVE
60805	PATIENT REGISTRATION REPRESENTATIVE
60804	PATIENT REGISTRATION REPRESENTATIVE
60623	PATIENT REGISTRATION REPRESENTATIVE

60608	PATIENT REGISTRATION REPRESENTATIVE
60804	PATIENT REGISTRATION REPRESENTATIVE
60609	PATIENT REGISTRATION REPRESENTATIVE
60629	PATIENT REGISTRATION REPRESENTATIVE
60608	PATIENT REGISTRATION REPRESENTATIVE
60608	PATIENT REGISTRATION REPRESENTATIVE
60608	PATIENT REGISTRATION REPRESENTATIVE
60632	PATIENT REGISTRATION REPRESENTATIVE
60638	PATIENT REGISTRATION REPRESENTATIVE
60629	PATIENT REGISTRATION REPRESENTATIVE
60608	PATIENT REGISTRATION REPRESENTATIVE
60629	PATIENT SERVICE MANAGER
60632	PATIENT SUPPORT SUPERVISOR
60638	PATIENT SUPPORT SUPERVISOR
60618	PEDIATRIC NURSE PRACTITIONER
60521	PEDIATRICIAN
60605	PEDIATRICIAN
60521	PEDIATRICIAN
60162	PEDIATRICIAN
60527	PEDIATRICIAN
60605	PHYSICIAN ASSISTANT
60661	PHYSICIAN ASSISTANT
60640	PHYSICIAN ASSISTANT
60608	PHYSICIAN ASSISTANT
60517	PHYSICIAN ASSISTANT
60523	PHYSICIAN ASSISTANT
60546	PROGRAM COORDINATOR
60615	PROGRAM COORDINATOR
60625	PROGRAM COORDINATOR
60608	PROGRAM COORDINATOR
60804	PROGRAM MANAGER
60640	PROGRAM MANAGER
60608	PROGRAM MANAGER
60634	PURCHASING MANAGER
60139	Recruiter
60623	REGISTERED DIETITIAN
60402	Registered Nurse
60623	Registered Nurse
60641	Registered Nurse
60638	Registered Nurse
60440	Registered Nurse
60608	Registered Nurse
60625	Registered Nurse
60445	Registered Nurse
60647	Registered Nurse
60622	Registered Nurse
60609	Registered Nurse
60652	Registered Nurse
60647	Registered Nurse
60640	Registered Nurse
60629	Registered Nurse
60640	Registered Nurse
60638	Registered Nurse
60438	Registered Nurse
60651	Registered Nurse
60608	RN CLINICAL COORDINATOR
60401	RN Swabber
60616	RN Swabber
60629	SCREENER
60804	SCREENER
60634	SCREENER
60615	SCREENER
60636	SCREENER
60623	SCREENER

60632	SCREENER
60619	SENIOR ACCOUNTING SPECIALIST
60643	SENIOR ADVOCATE PROGRAM COORD
60652	SENIOR CENTER ACTIVITIES SPECIALIST
60632	SENIOR CENTER COORDINATOR
60615	STAFF ACCOUNTANT
60620	STAFF ACCOUNTANT
60608	TITLE X HEALTH EDUCATOR
60632	TITLE X HEALTH EDUCATOR
60657	UROLOGIST
60417	WIC CERTIFIED HEALTH PROF
60632	WIC CLERK
60629	WIC CLERK
60618	WIC MANAGER
60608	WOMENS HEALTH NURSE PRACTITIONER
60629	PURCHASING ASSISTANT
60623	MEDICAL ASSISTANT
60402	MAINTENANCE AIDE
60632	PrEP Navigator
60608	PATIENT REGISTRATION REPRESENTATIVE

BHCMIS ID: 056620 - ALIVIO MEDICAL CENTER, Chicago, IL

Program Name: Health Center 330

Submission Status: Data Entry In Progress

Date Requested: 02/12/2021 12:15 PM EST

Date of Last Report Refreshed: 02/12/2021 12:15 PM EST

UDS Report - 2020

Contact Information

Do you receive Bureau of Health Workforce funding during the reporting year?: No

Title	Name	Phone	Fax	Email
UDS Contact	Sandra Ramirez	(773) 829 6370	Not Available	sramirez@aliviomedicalcenter.org
Project Director	Esther Corpuz	(312) 829 6304	(312) 829 6843	ecorpuz@aliviomedicalcenter.org
Clinical Director	Jennifer Vargas	(773) 850 8220	Not Available	jvargas2@aliviomedicalcenter.org
Chair Person	Not Available	Not Available	Not Available	Not Available
CEO	Not Available	Not Available	Not Available	Not Available

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UDS Report - 2020

Patients by ZIP Code

ZIP Codes

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
60018	3	2		7	**12**
60101	5	3	1	8	**17**
60104	8	11	1	27	**47**
60106	1	1	1	9	**12**
60130	5	14	2	36	**57**
60131	5	5	3	14	**27**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
60133		6		7	**13**
60148	3	2	1	5	**11**
60153	15	27	6	43	**91**
60154	8	9	4	37	**58**
60155	5	14	3	31	**53**
60160	16	19		51	**86**
60162	4	3		11	**18**
60163	3	2		9	**14**
60164	16	11	1	20	**48**
60165	7	5	1	4	**17**
60171	3	5		3	**11**
60181	5	3	1	7	**16**
60302	5	3	2	33	**43**
60304	1	7	2	15	**25**
60402	355	1140	156	2023	**3674**
60403	9			2	**11**
60406	36	34	1	20	**91**
60409	14	11	2	3	**30**
60411	5	10		6	**21**
60415	6	16	2	6	**30**
60426	20	23	2	12	**57**
60428	16	18		5	**39**
60435	9	9	1	4	**23**
60436	3	2		6	**11**
60438	10	10	1	11	**32**
60440	25	5		13	**43**
60441	4	4		3	**11**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
60445	9	13		12	**34**
60446	15	7	2	15	**39**
60452	11	5		9	**25**
60453	36	33	7	55	**131**
60455	17	24	1	20	**62**
60457	4	11	3	7	**25**
60458	14	22	1	27	**64**
60459	42	67	9	55	**173**
60462	7	3		4	**14**
60465	8	7		6	**21**
60469	7	7		5	**19**
60477	2	2	2	13	**19**
60501	40	81	7	88	**216**
60513	10	22	1	70	**103**
60525	3	14	13	36	**66**
60526	1	2	3	24	**30**
60527	3	2	2	22	**29**
60534	16	63	6	70	**155**
60544	1	6	1	4	**12**
60546	19	54	11	152	**236**
60561	2	2		8	**12**
60586	1		4	7	**12**
60604	1	7	1	6	**15**
60605		6		46	**52**
60607	1	10	3	50	**64**
60608	725	1565	272	1913	**4475**
60609	616	887	54	674	**2231**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
60610	4	1		24	**29**
60611	3		1	9	**13**
60612	10	18	2	49	**79**
60613	4	3		16	**23**
60614	1			14	**15**
60615	8	15	1	28	**52**
60616	58	181	141	512	**892**
60617	25	51	5	50	**131**
60618	21	25	4	47	**97**
60619	3	12	1	19	**35**
60620	10	17	3	23	**53**
60621	15	27	1	20	**63**
60622	11	11	2	45	**69**
60623	320	787	51	393	**1551**
60624	9	21		15	**45**
60625	20	10	1	28	**59**
60626	6	3	2	11	**22**
60628	10	16		20	**46**
60629	925	1347	75	715	**3062**
60630	6	6		20	**32**
60632	931	1564	112	895	**3502**
60633	5	26	2	5	**38**
60634	26	17	3	39	**85**
60636	128	175	2	49	**354**
60637	7	12	1	17	**37**
60638	117	175	24	304	**620**
60639	78	68	8	111	**265**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
60640	6	12	1	23	**42**
60641	39	31	2	49	**121**
60642	7	4	1	12	**24**
60643	5	13	1	21	**40**
60644	8	26	4	38	**76**
60645	5	2	1	5	**13**
60647	28	26	3	69	**126**
60649	3	6		14	**23**
60651	22	35	4	37	**98**
60652	173	197	9	126	**505**
60653	1	19	3	23	**46**
60657	1		1	19	**21**
60660	3	3	1	10	**17**
60707	16	1	1	23	**41**
60803	10	12		14	**36**
60804	716	1453	207	2020	**4396**
60805	18	14		22	**54**
60827	6	8		1	**15**

Other ZIP Codes

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
Other ZIP Codes	135	159	26	417	**737**
Unknown Residence					**0**
Total	**6204**	**10965**	**1304**	**12310**	**30783**

Comments

BHCMIS ID: 056620 - ALIVIO MEDICAL CENTER, Chicago, IL

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UDS Report - 2020

Table 3A - Patients by Age and by Sex Assigned at Birth

Universal

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1	346	377
2	Age 1	205	203
3	Age 2	202	186
4	Age 3	198	195
5	Age 4	204	207
6	Age 5	212	212
7	Age 6	178	158
8	Age 7	180	161
9	Age 8	170	178
10	Age 9	172	174
11	Age 10	182	158
12	Age 11	249	239
13	Age 12	219	188
14	Age 13	210	199
15	Age 14	206	258
16	Age 15	247	245
17	Age 16	215	278
18	Age 17	248	310
19	Age 18	209	326
20	Age 19	169	249

Line	Age Groups	Male Patients (a)	Female Patients (b)
21	Age 20	160	264
22	Age 21	168	330
23	Age 22	176	298
24	Age 23	181	324
25	Age 24	212	324
26	Ages 25-29	943	1595
27	Ages 30-34	928	1517
28	Ages 35-39	956	1602
29	Ages 40-44	995	1588
30	Ages 45-49	1052	1420
31	Ages 50-54	872	1090
32	Ages 55-59	710	903
33	Ages 60-64	636	789
34	Ages 65-69	411	493
35	Ages 70-74	248	269
36	Ages 75-79	123	181
37	Ages 80-84	75	107
38	Age 85 and over	37	84
39	**Total Patients (Sum of Lines 1-38)**	**13104**	**17679**

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Table 3B - Demographic Characteristics

Universal

Line	Patients by Race	Hispanic or Latino/a (a)	Non-Hispanic or Latino/a (b)	Unreported/Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)

Line	Patients by Race	Hispanic or Latino/a (a)	Non-Hispanic or Latino/a (b)	Unreported/Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1	Asian	19	734		**753**
2a	Native Hawaiian	0	0		**0**
2b	Other Pacific Islander	3	1		**4**
2	**Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a + 2b)**	**3**	**1**		**4**
3	Black/African American	51	670		**721**
4	American Indian/Alaska Native	98	22		**120**
5	White	2795	1454		**4249**
6	More than one race	4	9		**13**
7	Unreported/Refused to report race	22458	509	1956	**24923**
8	**Total Patients (Sum of Lines 1 + 2 + 3 to 7)**	**25428**	**3399**	**1956**	**30783**

Line	Patients Best Served in a Language Other than English	Number (a)
12	Patients Best Served in a Language Other than English	18626

Line	Patients by Sexual Orientation	Number (a)
13	Lesbian or Gay	87
14	Heterosexual (or straight)	16888
15	Bisexual	88
16	Something else	17
17	Don't know	603
18	Chose not to disclose	3377
18a	Unknown	9723
19	**Total Patients (Sum of Lines 13 to 18a)**	**30783**

Line	Patients by Gender Identity	Number (a)

Line	Patients by Gender Identity	Number (a)
20	Male	8568
21	Female	12978
22	Transgender Man/Transgender Male	66
23	Transgender Woman/Transgender Female	19
24	Other	4
25	Chose not to disclose	141
25a	Unknown	9007
26	**Total Patients (Sum of Lines 20 to 25a)**	**30783**

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Table 4 - Selected Patient Characteristics

Universal

Income as Percent of Poverty Guideline

Line	Income as Percent of Poverty Guideline	Number of Patients (a)
1	100% and below	3856
2	101 - 150%	1541
3	151 - 200%	511
4	Over 200%	262
5	Unknown	24613
6	**TOTAL** (Sum of Lines 1-5)	**30783**

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)
7	**None/Uninsured**	474	5730
8a	Medicaid (Title XIX)	6262	4703
8b	CHIP Medicaid	0	0
8	**Total Medicaid** (Line 8a + 8b)	**6262**	**4703**
9a	Dually Eligible (Medicare and Medicaid)	13	367
9	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)	35	1269
10a	**Other Public Insurance (Non-CHIP) (specify)**	0	0
10b	Other Public Insurance CHIP	0	0
10	**Total Public Insurance** (Line 10a + 10b)	**0**	**0**
11	**Private Insurance**	998	11312
12	**TOTAL** (Sum of Lines 7 + 8 + 9 +10 +11)	**7769**	**23014**

Managed Care Utilization

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)
13a	Capitated Member Months	75012			6405	81417
13b	Fee-for-service Member Months	46199	6299		0	52498
13c	**Total Member Months (Sum of Lines 13a + 13b)**	**121211**	**6299**	**0**	**6405**	**133915**

Line	Special Populations	Number of Patients (a)

Line	Special Populations	Number of Patients (a)
16	**Total Agricultural Workers or Dependents** (All health centers report this line)	67
23	**Total Homeless** (All health centers report this line)	232
24	**Total School-Based Health Center Patients** (All health centers report this line)	1247
25	**Total Veterans** (All health centers report this line)	0
26	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All health centers report this line)	0

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Table 5 - Staffing and Utilization

Universal

Medical Care Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians	2.16	8314	2120	
2	General Practitioners				
3	Internists	2.17	3505	1866	
4	Obstetrician/Gynecologists	0.99	2294	62	
5	Pediatricians	4.45	7919	550	
7	Other Specialty Physicians	0.7	393	328	
8	**Total Physicians** (Lines 1-7)	**10.47**	**22425**	**4926**	
9a	Nurse Practitioners	5.73	15060	1662	
9b	Physician Assistants	2.45	8845	979	
10	Certified Nurse Midwives	8.07	8354	1421	
10a	**Total NPs, PAs, and CNMs** (Lines 9a-10)	**16.25**	**32259**	**4062**	
11	Nurses	7.8			
12	Other Medical Personnel	40.5			
13	Laboratory Personnel				
14	X-ray Personnel				
15	**Total Medical Care Services** (Lines 8 + 10a through 14)	**75.02**	**54684**	**8988**	**30783**

Dental Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
16	Dentists	2.6	1646	5	
17	Dental Hygienists				
17a	Dental Therapists				
18	Other Dental Personnel	3.75			
19	**Total Dental Services** (Lines 16-18)	**6.35**	**1646**	**5**	**903**

Mental Health Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers	5	1347	3140	
20b	Other Licensed Mental Health Providers				
20c	Other Mental Health Staff				
20	**Total Mental Health Services (Lines 20a-c)**	**5**	**1347**	**3140**	**973**

Substance Use Disorder Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21	**Substance Use Disorder Services**	**0**			

Other Professional Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22	**Other Professional Services Specify** Dietitian	1	13	48	53

Vision Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22a	Ophthalmologists	0			
22b	Optometrists	0			
22c	Other Vision Care Staff	0			
22d	**Total Vision Services** (Lines 22a-c)	**0**	**0**	**0**	

Pharmacy Personnel

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
23	**Pharmacy Personnel**	0			

Enabling Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
24	Case Managers	9.02			
25	Patient and Community Education Specialists	9.13			
26	Outreach Workers	2.04			
27	Transportation Staff	0			
27a	Eligibility Assistance Workers	10			
27b	Interpretation Staff				
27c	Community Health Workers	17.56			
28	**Other Enabling Services Specify** Contract Tracer Contract Tracer Investigator Greeters Screeners WIC	6.69			
29	**Total Enabling Services** (Lines 24-28)	**54.44**	**0**	**0**	

Other Programs/Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
29a	**Other Programs and Services specify**	0			
29b	**Quality Improvement Staff**	1.8			

Administration and Facility

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
30a	Management and Support Staff	18.21			
30b	Fiscal and Billing Staff	3.75			
30c	IT Staff	6			
31	Facility Staff	9			
32	Patient Support Staff	34.54			
33	**Total Facility and Non-Clinical Support Staff (Lines 30a-32)**	**71.5**			

Grand Total

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
34	**Grand Total (Lines 15+19+20+21+22+22d+23+29+29a+29**	**215.11**	**57690**	**12181**	

Selected Service Detail Addendum

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than Psychiatrists)	19	1284	474	1195
20a02	Nurse Practitioners	7	320	138	382
20a03	Physician Assistants	5	139	65	171
20a04	Certified Nurse Midwives	9	72	26	80

Substance Use Disorder Detail

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21a	Physicians (other than Psychiatrists)	10	136	38	135
21b	Nurse Practitioners (Medical)	6	46	3	45
21c	Physician Assistants	3	25	8	31
21d	Certified Nurse Midwives	5	23	7	12
21e	Psychiatrists	0			
21f	Licensed Clinical Psychologists	0			
21g	Licensed Clinical Social Workers	3	21	46	20
21h	Other Licensed Mental Health Providers	0			

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Table 6A - Selected Diagnoses and Services Rendered

Universal

Selected Infectious and Parasitic Diseases

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
1-2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21	9	8
3	Tuberculosis	A15- through A19-, O98.0-	14	10
4	Sexually transmitted infections	A50- through A64-	194	125
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.1-, O98.4-	11	8
4b	Hepatitis C	B17.1-, B18.2, B19.2-	15	7
4c	Novel coronavirus (SARS-CoV-2) disease	U07.1	2097	
			1615	

Selected Diseases of the Respiratory System

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
5	Asthma	J45-	645	462
6	Chronic lower respiratory diseases	J40 (count only when code U07.1 **is not** present), J41- through J44-, J47-	87	61
6a	Acute respiratory illness due to novel coronavirus (SARS-CoV-2) disease	J12.89, J20.8, J40, J22, J98.8, J80 (count only when code U07.1 **is** present)	0	0

Selected Other Medical Conditions

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
7	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3-, N60-, N63-, R92-	342	268
8	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820	235	184
9	Diabetes mellitus	E08- through E13-, O24-(exclude O24.41-)	4961	2367
10	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	320	205
11	Hypertension	I10- through I16-, O10-, O11-	4511	2359
12	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-	342	287
13	Dehydration	E86-	8	8
14	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-, W92-, W93-	0	0
14a	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)	3441	2857

Selected Childhood Conditions (limited to ages 0 through 17)

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
15	Otitis media and Eustachian tube disorders	H65- through H69-	289	251
16	Selected perinatal/neonatal medical conditions	A33-, P19-, P22-through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	82	63
17	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3	160	141

Selected Mental Health Conditions, Substance Use Disorders, and Exploitations

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
18	Alcohol-related disorders	F10-, G62.1, O99.31-	139	85
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-	103	66
19a	Tobacco use disorder	F17-, O99.33-	124	93
20a	Depression and other mood disorders	F30- through F39-	2287	700
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F93.0	2544	1092
20c	Attention deficit and disruptive behavior disorders	F90- through F91-	273	117
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0	1810	728
20e	Human trafficking	T74.5- through T74.6-, T76.5- through T76.6-, Z04.81, Z04.82, Z62.813, Z91.42	0	0
20f	Intimate partner violence	T74.11, T74.21, T74.31, Z69.11, Y07.0	1	1

Selected Diagnostic Tests/Screening/Preventive Services

Line	Service Category	Applicable ICD-10-CM, CPT-4/II/PLA, or HCPCS Code	Number of Visits (a)	Number of Patients (b)
21	HIV test	**CPT-4:** 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806	23	23
21a	Hepatitis B test	**CPT-4:** 86704 through 86707, 87340, 87341, 87350	12	12
21b	Hepatitis C test	**CPT-4:** 86803, 86804, 87520 through 87522	11	11
21c	Novel coronavirus (SARS-CoV-2) diagnostic test	**CPT-4:** 87426, 87635 **HCPCS:** U0001, U0002, U0003, U0004 **CPT PLA:** 0202U, 0223U, 0225U	0	0
21d	Novel coronavirus (SARS-CoV-2) antibody test	**CPT-4:** 86328, 86408, 86409, 86769 **CPT PLA:** 0224U, 0226U	0	0

Line	Service Category	Applicable ICD-10-CM, CPT-4/II/PLA, or HCPCS Code	Number of Visits (a)	Number of Patients (b)
21e	Pre-Exposure Prophylaxis (PrEP)-associated management of **all** PrEP patients	**CPT-4:** 99401-99404 **ICD-10:** Z11.3, Z11.4, Z20.2, Z20.6, Z51.81, Z71.51, Z71.7, Z79.899 Limit to emtricitabine/tenofovir disoproxil fumarate (FTC/TDF) or emtricitabine/tenofovir alafenamide (FTC/TAF) for PrEP	1044	909
22	Mammogram	**CPT-4:** 77065, 77066, 77067 **ICD-10:** Z12.31	628	548
23	Pap test	**CPT-4:** 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 **ICD-10:** Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	736	686
24	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); measles, mumps, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4:** 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748	3373	2450
24a	Seasonal flu vaccine	**CPT-4:** 90630, 90653 through 90657, 90658, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90689, 90756	2567	2440
25	Contraceptive management	**ICD-10:** Z30-	2700	1715
26	Health supervision of infant or child (ages 0 through 11)	**CPT-4:** 99381 through 99383, 99391 through 99393 **ICD-10:** Z00.1-	7120	4564
26a	Childhood lead test screening (9 to 72 months)	**ICD-10:** Z13.88 **CPT-4:** 83655	49	48
26b	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4:** 99408, 99409 **HCPCS:** G0396, G0397, G0443, H0050	0	0
26c	Smoke and tobacco use cessation counseling	**CPT-4:** 99406, 99407 **HCPCS:** S9075 **CPT-II:** 4000F, 4001F, 4004F	0	0
26d	Comprehensive and intermediate eye exams	**CPT-4:** 92002, 92004, 92012, 92014	0	0

Selected Dental Services

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
27	Emergency services	**CDT:** D0140, D9110	107	101
28	Oral exams	**CDT:** D0120, D0145, D0150, D0160, D0170, D0171, D0180	891	786
29	Prophylaxis-adult or child	**CDT:** D1110, D1120	851	752
30	Sealants	**CDT:** D1351	78	77
31	Fluoride treatment-adult or child	**CDT:** D1206, D1208 **CPT-4:** 99188	679	655
32	Restorative services	**CDT:** D21xx through D29xx	411	255
33	Oral surgery (extractions and other surgical procedures)	**CDT:** D7xxx	96	79
34	Rehabilitative services (Endo, Perio, Prostho, Ortho)	**CDT:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	52	33

Sources of Codes

ICD-10-CM (2020)-National Center for Health Statistics (NCHS)

CPT (2020)-American Medical Association (AMA)

Code on Dental Procedures and Nomenclature CDT Code (2020)-Dental Procedure Codes. American Dental Association (ADA)

Note: *"X" in a code denotes any number, including the absence of a number in that place. Dashes (-) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect whether or not a code is billable. Instead, they are used to point out that other codes in the series are to be considered.*

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Table 6B - Quality of Care Measures

Universal

[_]: Prenatal Care Provided by Referral Only (Check if Yes)

Section A - Age Categories for Prenatal Care Patients:

Demographic Characteristics of Prenatal Care Patients

Line	Age	Number of Patients (a)

Line	Age	Number of Patients (a)
1	Less than 15 years	2
2	Ages 15-19	69
3	Ages 20-24	206
4	Ages 25-44	612
5	Ages 45 and over	6
6	**Total Patients** (Sum of Lines 1-5)	**895**

Section B - Early Entry into Prenatal Care

Line	Early Entry into Prenatal Care	Patients Having First Visit with Health Center (a)	Patients Having First Visit with Another Provider (b)
7	First Trimester	695	32
8	Second Trimester	120	20
9	Third Trimester	26	2

Section C - Childhood Immunization Status

Line	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	392	392	140

Section D - Cervical and Breast Cancer Screening

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer	10828	10828	4929

Line	Breast Cancer Screening	Total Female Patients Aged 51 through 73 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Mammogram (c)

Line	Breast Cancer Screening	Total Female Patients Aged 51 through 73 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Mammogram (c)
11a	MEASURE: Percentage of women 51-73 years of age who had a mammogram to screen for breast cancer	3171	3171	581

Section E - Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 16 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Percentage of patients 3-16 years of age with a BMI percentile *and* counseling on nutrition *and* physical activity documented	5658	5658	3304

Section F - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	20731	20731	6975

Section G - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use *and* Provided Intervention if a Tobacco User (c)
14a	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, *and* (2) if identified to be a tobacco user received cessation counseling intervention	9941	9941	8162

Section H - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients Aged 21 and Older at High Risk of Cardiovascular Events (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed or On Statin Therapy (c)
17a	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy	2239	2239	1741

Section I - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	196	196	157

Section J - Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 50 through 74 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)
19	MEASURE: Percentage of patients 50 through 74 years of age who had appropriate screening for colorectal cancer	6256	6256	2394

Section K - HIV Measures

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Seen Within 30 Days of First Diagnosis of HIV (c)
20	MEASURE: Percentage of patients whose first-ever HIV diagnosis was made by health center staff between December 1 of the prior year and November 30 of the measurement year and who were seen for follow-up treatment within 30 days of that first-ever diagnosis	7	7	7

Line	HIV Screening	Total Patients Aged 15 through 65 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested for HIV (c)
20a	MEASURE: Percentage of patients 15 through 65 years of age who were tested for HIV when within age range	22630	22630	6070

Section L - Depression Measures

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and*, if screening was positive, (2) had a follow-up plan documented	23492	23492	9964

Line	Depression Remission at Twelve Months	Total Patients Aged 12 and Older with Major Depression or Dysthymia (a)	Number Charts Sampled or EHR Total (b)	Number of Patients who Reached Remission (c)
21a	MEASURE: Percentage of patients 12 years of age and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event	198	198	10

Section M - Dental Sealants for Children between 6-9 Years

Line	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar	55	55	15

Table 7 - Health Outcomes and Disparities

Deliveries and Birth Weight

Line	Description	Patients (a)
0	HIV-Positive Pregnant Patients	3
2	Deliveries Performed by Health Center's Providers	265

Hispanic or Latino/a

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
1a	Asian	0	0	0	1
1b1	Native Hawaiian	0	0	0	0
1b2	Other Pacific Islander	0	0	0	0
1c	Black/African American	0	0	0	0
1d	American Indian/Alaska Native	1	0	0	1
1e	White	18	0	0	19
1f	More than One Race	0	0	0	0
1g	Unreported/Refused to Report Race	331	2	21	326
	Subtotal Hispanic or Latino/a	**350**	**2**	**21**	**347**

Non-Hispanic or Latino/a

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
2a	Asian	8	0	1	7
2b1	Native Hawaiian	0	0	0	0
2b2	Other Pacific Islander	0	0	0	0
2c	Black/African American	3	0	1	3
2d	American Indian/Alaska Native	1	0	0	1
2e	White	0	0	0	1
2f	More than One Race	0	0	0	0
2g	Unreported/Refused to Report Race	11	0	0	3
	Subtotal Non-Hispanic or Latino/a	**23**	**0**	**2**	**15**

Unreported/Refused to Report Race and Ethnicity

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
h	Unreported/Refused to Report Race and Ethnicity	16	0	0	0
i	**Total**	**389**	**2**	**23**	**362**

Controlling High Blood Pressure

Hispanic or Latino/a

Line	Race and Ethnicity	Total Patients 18 through 84 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)

Line	Race and Ethnicity	Total Patients 18 through 84 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
1a	Asian	1	1	0
1b1	Native Hawaiian	0	0	0
1b2	Other Pacific Islander	0	0	0
1c	Black/African American	2	2	0
1d	American Indian/Alaska Native	7	7	5
1e	White	197	197	94
1f	More than One Race	0	0	0
1g	Unreported/Refused to Report Race	2484	2484	1210
	Subtotal Hispanic or Latino/a	**2691**	**2691**	**1309**

Non-Hispanic or Latino/a

Line	Race and Ethnicity	Total Patients 18 through 84 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
2a	Asian	37	37	18
2b1	Native Hawaiian	0	0	0
2b2	Other Pacific Islander	0	0	0
2c	Black/African American	50	50	24
2d	American Indian/Alaska Native	2	2	1
2e	White	47	47	25
2f	More than One Race	0	0	0
2g	Unreported/Refused to Report Race	44	44	19
	Subtotal Non-Hispanic or Latino/a	**180**	**180**	**87**

Unreported/Refused to Report Race and Ethnicity

Line	Race and Ethnicity	Total Patients 18 through 84 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
h.	Unreported/Refused to Report Race and Ethnicity	87	87	41
i	**Total**	**2958**	**2958**	**1437**

Diabetes: Hemoglobin A1c Poor Control

Hispanic or Latino/a

Line	Race and Ethnicity	Total Patients 18 through 74 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
1a	Asian	3	3	3
1b1	Native Hawaiian	0	0	0
1b2	Other Pacific Islander	0	0	0
1c	Black/African American	3	3	1
1d	American Indian/Alaska Native	7	7	3
1e	White	153	153	61
1f	More than One Race	0	0	0
1g	Unreported/Refused to Report Race	2268	2268	987
	Subtotal Hispanic or Latino/a	**2434**	**2434**	**1055**

Non-Hispanic or Latino/a

Line	Race and Ethnicity	Total Patients 18 through 74 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)

Line	Race and Ethnicity	Total Patients 18 through 74 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
2a	Asian	31	31	7
2b1	Native Hawaiian	0	0	0
2b2	Other Pacific Islander	0	0	0
2c	Black/African American	25	25	17
2d	American Indian/Alaska Native	2	2	0
2e	White	32	32	13
2f	More than One Race	0	0	0
2g	Unreported/Refused to Report Race	26	26	9
	Subtotal Non-Hispanic or Latino/a	**116**	**116**	**46**

Unreported/Refused to Report Race and Ethnicity

Line	Race and Ethnicity	Total Patients 18 through 74 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
h	Unreported/Refused to Report Race and Ethnicity	60	60	24
i	**Total**	**2610**	**2610**	**1125**

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Table 8A - Financial Costs

Universal

* Column c is equal to the sum of column a and column b.

Financial Costs of Medical Care

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
1	Medical Staff	6083149	2959401	**9042550**
2	Lab and X-ray	37305	18148	**55453**
3	Medical/Other Direct	906127	440823	**1346950**
4	**Total Medical Care Services (Sum of Lines 1 through 3)**	**7026581**	**3418372**	**10444953**

Financial Costs of Other Clinical Services

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
5	Dental	368834	179435	**548269**
6	Mental Health	314453	152979	**467432**
7	Substance Use Disorder			**0**
8a	Pharmacy (not including pharmaceuticals)	1168124	568283	**1736407**
8b	Pharmaceuticals	762170		**762170**
9	**Other Professional specify** Dieticians	45460	22116	**67576**
9a	Vision			**0**
10	**Total Other Clinical Services (Sum of Lines 5 through 9a)**	**2659041**	**922813**	**3581854**

Financial Costs of Enabling and Other Services

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
11a	Case Management	278987		**278987**
11b	Transportation			**0**
11c	Outreach	133089		**133089**
11d	Patient and Community Education	365526		**365526**
11e	Eligibility Assistance	283520		**283520**
11f	Interpretation Services			**0**
11g	**Other Enabling Services specify** Contact Tracers, Contact Tracer Investigator, Contact Tracing Supervisors, Greeters, Screeners, Title X and WIC	389642		**389642**
11h	Community Health Workers	960692		**960692**
11	**Total Enabling Services (Sum of Lines 11a through 11h)**	**2411456**	**1173153**	**3584609**
12	**Other Program-Related Services specify**			**0**
12a	Quality Improvement	72953	35491	**108444**
13	**Total Enabling and Other Services (Sum of Lines 11, 12, and 12a)**	**2484409**	**1208644**	**3693053**

Facility and Non-Clinical Support Services and Totals

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
14	Facility	1054925		
15	Non-Clinical Support Services	4494904		
16	**Total Facility and Non-Clinical Support Services (Sum of Lines 14 and 15)**	**5549829**		
17	**Total Accrued Costs (Sum of Lines 4 + 10 + 13 + 16)**	**17719860**		**17719860**
18	**Value of Donated Facilities, Services, and Supplies specify** Surgical Masks, N95 Masks, Face Shields, Cloth Masks, Blue Shoe Covers and Disposable Procedure Masks, Donated Vaccines			510235
19	**Total with Donations (Sum of Lines 17 and 18)**			**18230095**

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Table 9D - Patient-Related Revenue

Universal

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliati Wraparoun Current Year (c1)	Collection of Reconciliati Wraparoun Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty / Payback (c4)	Adjustment (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
1	Medicaid Non-Managed Care	5938360	3849402					4739480		
2a	Medicaid Managed Care (capitated)	1575872	1575872							

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliati Wraparoun Current Year (c1)	Collection of Reconciliati Wraparoun Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty / Payback (c4)	Adjustment (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
2b	Medicaid Managed Care (fee-for-service)	1549971	1549744					239811		
3	**Total Medicaid (Sum of Lines 1 + 2a + 2b)**	**9064203**	**6975018**	**0**	**0**	**0**	**0**	**4979291**		
4	Medicare Non-Managed Care	1512356	1414507					365966		
5a	Medicare Managed Care (capitated)									
5b	Medicare Managed Care (fee-for-service)	102153	60436					101685		
6	**Total Medicare (Sum of Lines 4 + 5a + 5b)**	**1614509**	**1474943**	**0**	**0**	**0**	**0**	**467651**		
7	Other Public, including Non-Medicaid CHIP, Non-Managed Care									
8a	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)									
8b	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)									
8c	Other Public, including COVID-19 Uninsured Program	530964	94089					52724		
9	**Total Other Public (Sum of Lines 7 + 8a + 8b + 8c)**	**530964**	**94089**	**0**	**0**	**0**	**0**	**52724**		
10	Private Non-Managed Care	2227744	1346606					2902216		

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliati Wraparound Current Year (c1)	Collection of Reconciliati Wraparound Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty / Payback (c4)	Adjustment (d)	Sliding Fee Discounts (e)	Bad Debt Write-Off (f)
11a	Private Managed Care (capitated)	47674	18621					23833		
11b	Private Managed Care (fee-for-service)	85814	8407					194430		
12	**Total Private (Sum of Lines 10 + 11a + 11b)**	**2361232**	**1373634**			**0**	**0**	**3120479**		
13	**Self-Pay**	3231666	999273						1229842	167000
14	**TOTAL (Sum of Lines 3 + 6 + 9 + 12 + 13)**	**16802574**	**10916957**	**0**	**0**	**0**	**0**	**8620145**	**1229842**	**167000**

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Table 9E - Other Revenues

Universal

BPHC Grants (Enter Amount Drawn Down - Consistent with PMS-272)

Line	Source	Amount (a)

Line	Source	Amount (a)
1a	Migrant Health Center	
1b	Community Health Center	2806805
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	**2806805**
1k	Capital Development Grants, including School-Based Health Center Capital Grants	0
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	85486
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	509009
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	118253
1o	Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES)/ Health, Economic Assistance, Liability Protection and Schools Act (HEALS)	0
1p	**Other COVID-19-Related Funding from BPHC specify**	0
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p)	**712748**
1	**Total BPHC Grants** (Sum of Lines 1g + 1k + 1q)	**3519553**

Other Federal Grants

Line	Source	Amount (a)
2	Ryan White Part C HIV Early Intervention	
3	**Other Federal Grants specify**	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Provider	0
3b	**Provider Relief Fund specify** Covid-19 Cares Dept of Treasury pass thru HFS Covid FQHC	8006857
5	**Total Other Federal Grants** (Sum of Lines 2 through 3b)	**8006857**

Non-Federal Grants Or Contracts

Line	Source	Amount (a)

Line	Source	Amount (a)
6	**State Government Grants and Contracts specify** Infant Mortality, Cancer Screening Program, Family Planning, Community Grants, Governmental discretionary project, Welcoming Center, Maternal and Child Health Programs	446094
6a	**State/Local Indigent Care Programs specify**	0
7	**Local Government Grants and Contracts specify** Women, Infant and Children, Senior Services -Satellite Senior Centers	249349
8	**Foundation/Private Grants and Contracts specify** Donations: Cabrera Capital - Merchant BankCD ACH - Julian Grace Foundation - Fronstream - Amazon - AT&T - AARP - Network for Good Ilinois Children Healthcare Foundation- United Way-Sloan Kettering Inst. for Cancer Research - Community Memorial Foundation - Schwab Charitable Covid Foundation - Covid Grant - Berwyn Public H -National Council of Aging - Colman Foundation - Healthy Communities Foundation - Consulate/Ventanilla de Salud - Age Options - TCLIP - AADE - Diabetis Prevention - Healthy Illinois	1849684
9	**Total Non-Federal Grants and Contracts (Sum of Lines 6 + 6a + 7 + 8)**	**2545127**
10	**Other Revenue (non-patient related revenue not reported elsewhere) specify** Donation - Midwest Emergency Fund - The Trustm -Benevity Fund -Friendly , Individuals Donations, Investment Income and Interest Income.	196300
11	**Total Revenue (Sum of Lines 1 + 5 + 9 + 10)**	**14267837**

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Health Center Health Information Technology (HIT) Capabilities

HIT

1. Does your center currently have an electronic health record (EHR) system installed and in use?:

[X]: Yes, installed at all sites and used by all providers

[_]: Yes, but only installed at some sites or used by some providers

[_]: No

1a. Is your system certified by the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program?:

[X]: Yes

[_]: No

1a1.Vendor: Other (Please specify)

Other (Please specify): Virence Health Technologies

1a2.Product Name: Athena Practice

1a3.Version Number: 12.3

1a4.ONC-certified Health IT Product List Number: 15.04.04.3039.Cent.12.01.1.181231

1a1.Vendor: Select one

Other (Please specify):

1a2.Product Name:

1a3.Version Number:

1b. Did you switch to your current EHR from a previous system this year?:

[_]: Yes

[X]: No

1c. Do you use more than one EHR or data system across your organization?:

[_]: Yes

[_]: No

If yes, what is the reason?:

[_]: Second EHR/data system is used during transition to primary EHR

[_]: Second EHR/data system is specific to one service type (e.g., dental, behavioral health)

[_]: Second EHR/data system is used at specific sites with no plan to transition

[_]: Other (please describe)

Other (please describe):

1d. Is your EHR up to date with the latest software and system patches?:

[_]: Yes

[_]: No

[_]: Not sure

1e. When do you plan to update/install the latest EHR software and system patches?:

[_]: a. 3 months

[_]: b. 6 months

[_]: c. 1 Year or more

[_]: d. Not planned

2. Question removed.

3. Question removed.

4. Which of the following key providers/health care settings does your center electronically exchange clinical information with? (Select all that apply.):

[_]: Hospitals/Emergency rooms

[_]: Specialty clinicians

[_]: Other primary care providers

[_]: Labs or imaging

[_]: Health information exchange (HIE)

[X]: None of the above

[_]: Other (please describe)

Other (please describe):

5. Does your center engage patients through health IT in any of the following ways? (Select all that apply.):

[X]: Patient portals

[_]: Kiosks

[X]: Secure messaging

[X]: Other (please describe)

[_]: No, we do not engage patients using HIT

Other (please describe): Text messaging

6. Question removed.

7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?:

[X]: We use the EHR to extract automated reports

[_]: We use the EHR but only to access individual patient charts

[_]: We use the EHR in combination with another data analytic system

[_]: We do not use the EHR

8. Question removed.

9. Question removed.

10. How does your health center utilize HIT and EHR data beyond direct patient care? (Select all that apply.):

[_]: Quality improvement

[_]: Population health management

[_]: Program evaluation

[_]: Research

[_]: Other (please describe)

[X]: We do not utilize HIT or EHR data beyond direct patient care

Other (please describe):

11. Does your health center collect data on individual patients' social risk factors, outside of the data reportable in the UDS?:

[_]: Yes

[X]: No, but we are in planning stages to collect this information

[_]: No, we are not planning to collect this information

12. Which standardized screener(s) for social risk factors, if any, do you use? (Select all that apply.):

[_]: Accountable Health Communities Screening Tools

[_]: Upstream Risks Screening Tool and Guide

[_]: iHELLP

[_]: Recommend Social and Behavioral Domains for EHRs

[_]: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

[_]: Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE)

[_]: WellRx

[_]: Health Leads Screening Toolkit

[_]: Other (please describe)

[X]: We do not use a standardized screener

Other (please describe):

12a. Please provide the total number of patients that screened positive for the following:

Food insecurity:

Housing insecurity:

Financial strain:

Lack of transportation/access to public transportation:

12b. If you do not use a standardized assessment to collect this information, please indicate why. (Select all that apply.):

[_]: Have not considered/unfamiliar with assessments

[_]: Lack of funding for addressing these unmet social needs of patients

[_]: Lack of training for staff to discuss these issues with patients

[_]: Inability to include with patient intake and clinical workflow

[_]: Not needed

[X]: Other (please describe)

Other (please describe): We will be training staff to do so in 2021

13. Does your center integrate a statewide Prescription Drug Monitoring Program (PDMP) database into the health information systems, such as health information exchanges, EHRs, and/or pharmacy dispensing software (PDS) to streamline provider access to controlled substance prescriptions?:

[_]: Yes

[_]: No

[X]: Not sure

Comments

Other Data Elements

Other Data Elements

1. Medication-Assisted Treatment (MAT) for Opioid Use Disorder

a. How many physicians, certified nurse practitioners, physician assistants, and certified nurse midwives,[1] on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?: 0

b. How many patients received MAT for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?: 0

2. Did your organization use telemedicine to provide remote clinical care services? *(The term "telehealth" includes "telemedicine" services but encompasses a broader scope of remote health care services. Telemedicine is specific to remote clinical services, whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.)*:

[X]: Yes

[_]: No

2a1. Who did you use telemedicine to communicate with? (Select all that apply.):

[X]: Patients at remote locations from your organization (e.g., home telehealth, satellite locations)

[_]: Specialists outside your organization (e.g., specialists at referral centers)

2a2. What telehealth technologies did you use? (Select all that apply.):

[X]: Real-time telehealth (e.g., live videoconferencing)

[_]: Store-and-forward telehealth (e.g., secure e-mail with photos or videos of patient examinations)

[_]: Remote patient monitoring

[_]: Mobile Health (mHealth)

2a3. What primary telemedicine services were used at your organization? (Select all that apply.):

[X]: Primary care

[_]: Oral health

[X]: Behavioral health: Mental health

[_]: Behavioral health: Substance use disorder

[_]: Dermatology

[_]: Chronic conditions

[_]: Disaster management

[_]: Consumer health education

[_]: Provider-to-provider consultation

[_]: Radiology

[X]: Nutrition and dietary counseling

[_]: Other (Please specify)

Other (Please specify):

2b. If you did not have telemedicine services, please comment why. (Select all that apply.):

[_]: Have not considered/unfamiliar with telehealth service options

[_]: Policy barriers (Select all that apply)

[_]: Inadequate broadband/telecommunication service (Select all that apply)

[_]: Lack of funding for telehealth equipment

[_]: Lack of training for telehealth services

[_]: Not needed

[_]: Other (Please specify)

Other (Please specify):

Policy barriers (Select all that apply):

[_]: Lack of or limited reimbursement

[_]: Credentialing, licensing, or privileging

[_]: Privacy and security

[_]: Other (Please specify)

Other (Please specify):

Inadequate broadband/telecommunication service (Select all that apply):

[_]: Cost of service

[_]: Lack of infrastructure

[_]: Other (Please specify)

Other (Please specify):

3. Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.

Enter number of assists: 1006

4. How many patients received a FDA-approved COVID-19 vaccine during the calendar year at your organization?: 8

[1] With the enactment of the Comprehensive Addiction and Recovery Act of 2016, PL 114-198, opioid treatment prescribing privileges have been extended beyond physicians to include certain qualifying nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs).

Workforce

Workforce

1. Does your health center provide health professional education/training that is a hands-on, practical, or clinical experience?:

[X]: Yes

[_]: No

1a. If yes, which category best describes your health center's role in the health professional education/training process? (Select all that apply.):

[_]: Sponsor [2]

[X]: Training site partner [3]

[_]: Other (please describe)

Other (please describe):

2. Please indicate the range of health professional education/training offered at your health center and how many individuals you have trained in each category[4] within the reporting year.

	Medical	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)

	Medical	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
1.	Physicians	2	
	a. Family Physicians		
	b. General Practitioners		
	c. Internists		
	d. Obstetrician/Gynecologists		
	e. Pediatricians		
	f. Other Specialty Physicians		
2.	Nurse Practitioners		
3.	Physician Assistants	16	
4.	Certified Nurse Midwives	1	
5.	Registered Nurses		
6.	Licensed Practical Nurses/Vocational Nurses		
7.	Medical Assistants	1	

	Dental	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
8.	Dentists		
9.	Dental Hygienists		
10.	Dental Therapists		
10a.	Dental Assistants		

	Mental Health and Substance Use Disorder	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)

	Mental Health and Substance Use Disorder	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
11.	Psychiatrists		
12.	Clinical Psychologists		
13.	Clinical Social Workers		
14.	Professional Counselors		
15.	Marriage and Family Therapists		
16.	Psychiatric Nurse Specialists		
17.	Mental Health Nurse Practitioners		
18.	Mental Health Physician Assistants		
19.	Substance Use Disorder Personnel		

	Vision	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
20.	Ophthalmologists		
21.	Optometrists		

	Other Professionals	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
22.	Chiropractors		
23.	Dieticians/Nutritionists		
24.	Pharmacists		
25.	**Other please specify**		

3. Provide the number of health center staff serving as preceptors at your health center.: 10

4. Provide the number of health center staff (non-preceptors) supporting ongoing health center training programs.: 5

5. How often does your health center implement satisfaction surveys for providers? (Select one.):

[_]: Monthly

[_]: Quarterly

[X]: Annually

[_]: We do not currently conduct provider satisfaction surveys

[_]: Other (please describe)

Other (please describe):

6. How often does your health center implement satisfaction surveys for general staff (report provider surveys in question 5 only)? (Select one.):

[_]: Monthly

[_]: Quarterly

[X]: Annually

[_]: We do not currently conduct staff satisfaction surveys

[_]: Other (please describe)

Other (please describe):

[2] A sponsor hosts a comprehensive health profession education and/or training program, the implementation of which may require partnerships with other entities that deliver focused, time-limited education and/or training (e.g., a teaching health center with a family medicine residency program).

[3] A training site partner delivers focused, time-limited education and/or training to learners in support of a comprehensive curriculum hosted by another health profession education provider (e.g., month-long primary care dentistry experience for dental students).

[4] Examples of pre-graduate/certificate training include student clinical rotations or externships. A residency, fellowship, or practicum would be examples of post-graduate training. Include non-health-center individuals trained by your health center.

BHCMIS ID: 056620 - ALIVIO MEDICAL CENTER, Chicago, IL

Program Name: Health Center 330

Submission Status: Data Entry In Progress

Date Requested: 02/12/2021 12:15 PM EST

Date of Last Report Refreshed: 02/12/2021 12:15 PM EST

UDS Report - 2020

Data Audit Report

Table 3A-Patients by Age and by Sex Assigned at Birth

Edit 02160: Patients in Question - The total number of patients differs substantially from the prior year. Please correct or explain. Current year - (30783). Prior Year - (22351).

Related Tables: Table 3A(UR)

Sandra Ramirez (Health Center) on 02/10/2021 7:10 PM EST: Alivio provided Covid-19 testing to patients and non-patients. Therefore the increase is attributed to Covid-19 Testing.

Table 3B-Demographic Characteristics

Edit 07247: Unreported/Refused to Report greater than 25% of Total Patients - Patients reported on the 'Unreported/Refused to Report' Line 7 (24923) is greater than 25% of total patients (Line 8) (30783). Please correct or explain.

Related Tables: Table 3B(UR)

Sandra Ramirez (Health Center) on 02/10/2021 7:45 PM EST: Historically, Alivio's Hispanic/Latino patients tend not to check off race as they do not identify with any of the race categories. The majority of Alivio's patients are of Mexican heritage and within their ethnicity can have multiple race origins and may not feel that they can fit into any of the current options (White, Black, Asian, etc.) Alivio finds this data culturally appropriate given the high number of Mexican patients.

Edit 03953: Inter-year change in users - Proportion of Asians differs substantially from last year. CY (2.45)%; Prior Year (1.06)%. Please correct or explain.

Related Tables: Table 3B(UR)

Sandra Ramirez (Health Center) on 02/10/2021 7:47 PM EST: Due to the Covid-19 testing, patients in this category increased as Alivio partnered with community based organizations that serve Asian population in a neighboring community.

Table 4-Selected Patient Characteristics

Edit 03851: Inter-year change in patients - Proportion of patients at or below 100 percent of the federal poverty guidelines for this year (12.53) differs substantially from last year (18.00). Please correct or explain.

Related Tables: Table 4(UR)

Sandra Ramirez (Health Center) on 02/10/2021 7:54 PM EST: Due to Covid-19 testing being open to all, Alivio drew in patients with more diverse income background.

Edit 04167: Patients Unknown Income in question - More than 50% of Total Patients are reported as having Unknown Income. Grantees are expected to collect income data on all patients. Please correct or describe your process for collecting income information. Total Patients (30783); Patients having Unknown Income (24613).

Related Tables: Table 4(UR)

Paul Nagpal (Health Center) on 02/11/2021 11:36 AM EST: The patient income information is collected via registration form.

Edit 03852: Inter-year change in patients - The percentage of Uninsured patients to total patients has significantly decreased when compared to prior year. Current Year ((20.15)%, (6204)); Prior Year ((35.58)%, (7952). Please review the insurance reporting to ensure the information reported is patient's primary medical care insurance. Please correct or explain.

Related Tables: Table 4(UR)

Sandra Ramirez (Health Center) on 02/10/2021 7:50 PM EST: Due to Covid-19 testing being open to all, we drew in patients that had more diverse insurance statuses.

Edit 04202: Inter-year Member Months in question - A significant change in managed care participation on Table 4 Line 13b Column d (0) is reported compared with the prior year (72448). Please correct or explain.

Related Tables: Table 4(UR)

Paul Nagpal (Health Center) on 02/11/2021 12:10 PM EST: Alivio Medical Center haven't received missing member month totals from Ambetter payer. as of Feb 11, 2021 Last year we reported 72448 . We have made several attempts to collect this information from Ambetter.

Table 5-Staffing And Utilization

Edit 06809: Virtual Visits greater than Clinic Visits - Other Professional virtual visits on Line 22 Column b2 (48) are greater than or equal to Other Professional visits reported on Line 22 Column b (13). Please correct or explain.

Related Tables: Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 7:57 PM EST: Due to Covid-19 restriction of in person services and a pivot to telehealth, Alivio had a significant amount of virtual visits to help maintain social distancing while serving patients.

Edit 07251: Virtual Visits greater than Clinic Visits - Mental Health virtual visits on Line 20 Column b2 (3140) are greater than or equal to Mental Health visits reported on Line 20 Column b (1347). Please correct or explain.

Related Tables: Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 7:58 PM EST: Due to Covid-19 restriction of in person services and a pivot to telehealth, Alivio had a significant

amount of virtual visits to help maintain social distancing while serving patients.

Edit 00024: Family Physicians Productivity Questioned - A significant change in Productivity (visits/FTE) of Family Physicians Line 1 (4830.56) is reported from the prior year (2285.38). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 7:59 PM EST: 2 physicians that were hired late in year 2019, ramped up productivity significantly in 2020.

Edit 00123: Ob/Gyn Productivity Questioned - A significant change in Productivity (visits/FTE) of Obstetrician/Gynecologists on Line 4 (2379.80) is reported from the prior year (1711). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Sandra Ramirez (Health Center) on 02/11/2021 4:58 PM EST: Alivio contracted a group of OB providers that started Midyear in 2019, therefore not many pts seen befor they joined. However, in 2020 they provided care the entire year therefore increasing productivity from prior year.

Edit 00033: Peds Productivity Questioned - A significant change in Productivity (visits/FTE) of Pediatricians on Line 5 (1903.15) is reported from the prior year (2537.03). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Sandra Ramirez (Health Center) on 02/11/2021 5:00 PM EST: A pediatrician decreased her hours in 4/2020 and therefore affected our productivity. Also we started Telehealth services in 2020 and pediatric visit were found to be difficult to complete virtually therefore our visits were decreased during the Pandemic shut down,

Edit 04134: Substantial Inter-year variance in Providers - The number of Physician FTEs reported on Line 8 Column a differs from the prior year. Current Year - (10.47). Prior Year - (12.67). Confirm that this is consistent with staffing changes and that the FTE is calculated based on paid hours.

Related Tables: Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 8:03 PM EST: Confirmed that this is consistent. 4 providers job status went down to part-time.

Edit 00158: PA Productivity Questioned - A significant change in Productivity (visits/FTE) of PAs on Line 9b (4009.80) is reported from the prior year (2178.72). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 8:04 PM EST: Numbers are correct. More PA's were hired in 2020. PA's were assigned to Covid-testing which reflects the significant increase.

Edit 00038: CNM Productivity Questioned - A significant change in Productivity (visits/FTE) of Certified Nurse Midwives on Line 10 (1211.28) is reported from the prior year (988.41). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 8:05 PM EST: This is correct.

Edit 04135: Substantial Inter-year variance in Providers - The number of Mid-Level FTEs reported on Line 10a Column a differs from the prior year. Current Year - (16.25). Prior Year - (19.47). Confirm that this is consistent with staffing changes and that the FTE is calculated based on paid hours.

Related Tables: Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 8:06 PM EST: This is confirmed. Staff changes consistent with paid hours.

Edit 04139: Inter-year Patients questioned - On Universal - A large change in Medical patients from the prior year is reported on Line 15 Column C. (PY= (21971), CY = (30783)). Please correct or explain.

Related Tables: Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 8:07 PM EST: Due to Covid-19 testing being open to all and the significant amount of testing done at Alivio, this increase is correct.

Edit 00052: Dentist Productivity Questioned - A significant change in Productivity (visits/FTE) of Dentists on Line 16 (635) is reported from the prior year (1313.75). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 8:09 PM EST: These are correct. Dental was closed due to Covid-19 CDC recommendations from March thru July for in-person services. Additionally a new dental director started in May.

Edit 04141: Inter-year Patients questioned - On Universal - A large change in Dental patients from the prior year is reported on Line 19 Column C. (PY = (1426), CY = (903)). Please correct or explain.

Related Tables: Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 9:14 PM EST: Dental patient decrease is due to dental services being closed for 3 months according to CDC guidelines during Covid-19 pandemic.

Table 6B-Quality of Care Indicators

Edit 06824: Line 11 Compliance Rate Questioned - Cervical Cancer Screening Line 11: The proportion of patients in compliance 45.52% dropped significantly when compared to the prior year 72.94%. Please review and correct or explain.

Related Tables: Table 6B

Sandra Ramirez (Health Center) on 02/10/2021 8:14 PM EST: Alivio conducted Covid-19 testing as drive up and walk up during 2020 at Morgan and Berwyn locations. We opened testing to patients and non-patients. Covid-19 test patients did not get screened for this measure.

Edit 06822: Line 21 Compliance Rate Questioned - Preventive Care and Screening: Screening for Depression and Follow-Up Plan Line 21: The proportion of patients in compliance 42.41% dropped significantly when compared to the prior year 98.98%. Please review and correct or explain.

Related Tables: Table 6B

Sandra Ramirez (Health Center) on 02/10/2021 8:13 PM EST: Alivio conducted Covid-19 testing as drive up and walk up during 2020 at Morgan and Berwyn locations. We opened testing to patients and non-patients. Covid-19 test patients did not get screened for this measure.

Edit 06815: Line 13 Compliance Rate Questioned - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan Line 13: The proportion of patients in compliance 33.65% dropped significantly when compared to the prior year 80.83%. Please review and correct or explain.

Related Tables: Table 6B

Sandra Ramirez (Health Center) on 02/10/2021 8:13 PM EST: Alivio conducted Covid-19 testing as drive up and walk up during 2020 at Morgan and Berwyn locations. We opened testing to patients and non-patients. Covid-19 test patients did not get screened for this measure.

Edit 07437: Line 20a Universe in Question - You are reporting (100.45)% of total possible medical patients in the universe for the HIV Screening measure (Table 6B, Line 20a Column A). This appears high compared to estimated medical patients in the age group being measured. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 4(UR), Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 8:14 PM EST: This is correct. Alivio conducted Covid-19 testing as drive up and walk up during 2020 at Morgan and Berwyn locations. We opened testing to patients and non-patients. Covid-19 test patients did not get screened for this measure.

Edit 06155: Line 14a Universe in Question - You are reporting (43.20)% of total possible medical patients in the universe for the Tobacco Use Screening And Cessation Intervention (Line 14a Column A). This appears low compared to estimated medical patients in the age group being measured. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 4(UR), Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 8:16 PM EST: Alivio conducted Covid-19 testing as drive up and walk up during 2020 at Morgan and Berwyn locations. We opened testing to patients and non-patients. Covid-19 test patients did not get screened for this measure.

Edit 05788: Line 18 Universe in Question - Based on the universe reported for total patients with Ischemic Vascular Disease (IVD) on line 18 column A we estimate a prevalence rate of (0.85)%. This appears low compared to the prior year national average. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 4(UR), Table 5(UR)

Sandra Ramirez (Health Center) on 02/12/2021 1:11 PM EST: The prevalence rate actually calculated to be 80%. Pt's were not seen in 2020 for IVD, they were seen for covid testing only.

Edit 05866: Line 20 Compliance Rate Questioned - A compliance rate of 100% is reported for the Newly Identified HIV Cases and Follow-up measure, Line 20. Please review the reporting of Column c in relation to the sample or universe reported in Column b for accuracy and correct or explain.

Related Tables: Table 6B

Sandra Ramirez (Health Center) on 02/10/2021 9:15 PM EST: This is correct.

Edit 06176: Line 22 Universe in Question - You are reporting (136.76)% of total possible dental patients in the universe for Patients with Sealants to First Molars (Line 22 Column A). This appears high compared to dental patients in the age group being measured. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 4(UR), Table 5(UR)

Sandra Ramirez (Health Center) on 02/11/2021 5:01 PM EST: Our dental department primarily sees pediatric patients which is why our number is high.

Table 7-Health Outcomes and Disparities

Edit 03959: Low Birthweights Questioned - The White LBW and VLBW percentage of births reported appears low. Please correct or explain. CY (0)%;PY National Average (7.05)%

Related Tables: Table 7

Sandra Ramirez (Health Center) on 02/11/2021 5:02 PM EST: We did not have any low birth weight white babies ,in the Hispanic /latino we only had 2

Edit 05792: Hypertension Universe in Question - Based on the universe for Total Patients with Hypertension reported on Line i Column 2a we estimate a prevalence rate of (12.92)%. This appears low compared to national averages. Please review and correct or explain.

Related Tables: Table 7, Table 3A(UR), Table 4(UR), Table 5(UR)

Sandra Ramirez (Health Center) on 02/11/2021 5:02 PM EST: During the Covid pandemic 2020 many of our pts with HTN were seen via telehealth and therefore were unable to assess if their Blood pressure was controlled even if we adjusted their medication the previous visit.

Edit 05467: Hypertension Universe in Question - The universe of hypertensive patients reported on Table 7 is greater than the total hypertensive patients reported on Table 6A. This is possible only if you have seen hypertensive patients during the year without diagnosing them with hypertension. Please review and correct or explain.

Related Tables: Table 7, Table 6A(UR)

Sandra Ramirez (Health Center) on 02/12/2021 1:12 PM EST: Patients on Table 7 not appear on Table 6A because they were not seen in 2020 for HTN. Patients came in for Covid-19 testing and/or other sick visit.

Edit 05468: Diabetic Universe in Question - The universe of diabetic patients reported on Table 7 is greater than the total diabetic patients reported on Table 6A. This is possible only if you have seen diabetic patients during the year without diagnosing them with diabetes. Please review and correct or explain.

Related Tables: Table 7, Table 6A(UR)

Sandra Ramirez (Health Center) on 02/12/2021 1:14 PM EST: . Patients on Table 7 not appear on Table 6A because they were not seen in 2020 for DM 2. Patients came in for Covid-19 testing and/or other sick visit, or are being followed by Endocrinology.

Table 8A-Financial Costs

Edit 00201: Costs less than reasonable for staff only - Dental Accrued Cost Line 5 Column a on Table 8A (368834) are lower than typical salaries alone for the FTE reported on Table 5 Lines 16-18. Please correct or explain. (Cost/FTE=(58084.09)); May be explained if significant level of services are donated).

Related Tables: Table 8A, Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 2:45 PM EST: Costs for FTE is correct. Dental Director left organization in 2020, therefore reducing salary. Additionally dental assistants left organization due to Covid-19 factors.

Edit 04125: Cost Per Visit Questioned - Dental Care Cost Per Visit is substantially different than the prior year. Current Year (332.08); Prior Year (283.95).

Related Tables: Table 8A, Table 5(UR)

Paul Nagpal (Health Center) on 02/10/2021 10:50 PM EST: Dental Care Cost Per Visit is substantially different than the prior year. Current Year due to change in accrued cost and allocation of facility and non clinical costs to the dental.

Edit 04126: Cost Per Visit Questioned - Mental Health Cost Per Visit is substantially different than the prior year. Current Year (104.17); Prior Year (145.69).

Related Tables: Table 8A, Table 5(UR)

Paul Nagpal (Health Center) on 02/10/2021 10:52 PM EST: Mental Care Cost Per Visit is substantially different than the prior year. Mental Care Cost current year change is due to change in accrued cost and allocation of facility and non clinical costs to the mental.

Edit 04136: Costs and FTE Questioned - Other Professional Services are reported on Table 8A, Line 9 (45460)(Dieticians) and Table 5, Line 22 (1)(Dietitian) . Review and confirm that FTEs relate to costs or correct.

Related Tables: Table 8A, Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 2:38 PM EST: Confirmed. FTE relates to costs.

Edit 00146: Costs less than reasonable for staff only - (278987) on Table 8A Line 11a Column a are lower than typical salaries alone for the FTE (9.02) on Table 5 Line 24 Column a. Please correct or explain. (Cost/FTE ((30929.82)) May be explained if significant level of services are donated.)

Related Tables: Table 8A, Table 5(UR)

Paul Nagpal (Health Center) on 02/11/2021 11:32 AM EST: Cost per FTE is $30,929.82 for 9.02 FTE's

Edit 04137: Costs and FTE Questioned - Other Enabling Services are reported on Table 8A, Line 11g (389642) (Contact Tracers, Contact Tracer Investigator, Contact Tracing Supervisors, Greeters, Screeners, Title X and WIC) and Table 5, Line 28 (6.69) (Contract Tracer Contract Tracer Investigator Greeters Screeners WIC). Review and confirm that FTEs relate to costs or correct.

Related Tables: Table 8A, Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 2:37 PM EST: Confirmed. FTE's relate to costs.

Edit 06301: Costs and FTE Questioned - Community Health Workers are reported on Table 8A, Line 11h (960692) and Table 5, Line 27c (17.56). Review and confirm that FTEs relate to costs or correct.

Related Tables: Table 8A, Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 2:35 PM EST: Confirmed. FTE's relate to costs.

Edit 06306: Costs and FTE Questioned - Quality Improvement is reported on Table 8A, Line 12a (72953) and Table 5, Line 29b (1.8). Review and confirm that FTEs relate to costs or correct.

Related Tables: Table 8A, Table 5(UR)

Sandra Ramirez (Health Center) on 02/10/2021 2:35 PM EST: Confirmed. FTE's relate to costs.

Edit 03727: Inter-Year Variance Questioned - Current Year Facility costs vary substantially from last years cost for Line 14 Column a on Table 8A. (Current Year: (1054925); Prior Year: (1326408)). Please correct or explain.

Related Tables: Table 8A

Paul Nagpal (Health Center) on 02/11/2021 3:20 PM EST: Alivio Medical Center Medical Health Centers which includes urgent care, Behavioral Health Clinics are not at full capacity since March 2020. The dental clinic were closed for six months and our four school based health centers are still closed since March 2020 due to pandemic resulting in lesser use of our facilities in current year compared to the prior year resulting in lesser use of our facilities and costs related to the facilities.

Edit 03945: Inter-Year variance questioned - Current Year Non-Clinical Support costs, Line 15 Column (a) (4494904) varies substantially from cost on the same line last year (5320153). Please correct or explain.

Related Tables: Table 8A

Paul Nagpal (Health Center) on 02/11/2021 3:20 PM EST: Alivio Medical Center Medical Health Centers which includes urgent care, Behavioral are not at full capacity since March 2020. The dental clinic were closed for six months and our four school based health centers are still closed since March 2020 due to pandemic resulting in lesser use of Non–Clinical services and staff in current year compared to the prior year. In comparison non-clinical support costs are less than prior year.

Table 9D-Patient Related Revenue (Scope of Project Only)

Edit 04155: Inter-year Capitation PMPM questioned - The average Medicaid capitation PMPM reported on Line 2a (21.01) is significantly different from the prior year (37.21). Please correct or explain.

Related Tables: Table 9D, Table 4(UR)

Paul Nagpal (Health Center) on 02/11/2021 5:08 PM EST: We have recorded PMPM on Table 9D line 2a column (a) column (b)

Edit 05144: Adjustments in Question - Medicaid Managed Care (capitated) - Charges or Collections are reported on (Line 2a) without adjustments. This is unusual. Please correct or explain.

Related Tables: Table 9D

Paul Nagpal (Health Center) on 02/11/2021 4:06 PM EST: Charges and collections reported are equal with no adjustments.

Edit 02019: Large change in accounts receivable for Total Medicaid is reported - Total Medicaid, Line 3: When we compared the sum of collections (Column b) and adjustments (Column d) to total Medicaid charges (Column a) there is a large difference (-31.88)%. While we do not expect it to be zero, a difference this large is unusual. Please explain or correct.

Related Tables: Table 9D

Paul Nagpal (Health Center) on 02/11/2021 12:32 PM EST: Alivio Medical Center moved to Medicaid Managed Care Model April 2020. We have reported Medicaid Managed Care collections $1,575,872 on 2a col. b

Edit 01965: Large change in accounts receivable for Total Other Public is reported - Total Other Public, Line 9: When we compared the sum of collections (Column b) and adjustments (Column d) to total Other Public charges (Column a) there is a large difference (72.35)%. While we do not expect it to be zero, a difference this large is unusual. Please explain or correct.

Related Tables: Table 9D

Paul Nagpal (Health Center) on 02/11/2021 5:02 PM EST: We have updated Table 9D line 9 clolmn a, b and d

Edit 03997: Accounts Receivable not equal to zero - Line 11a, Capitated Private Charges - Collections - Adjustments does not equal zero (5220). Adjustments for capitated plans are the difference between charges and payments unless payments are not received in the month of service. Please correct or explain.

Related Tables: Table 9D

Paul Nagpal (Health Center) on 02/11/2021 12:46 PM EST: Alivio Medical Center haven't received $5,220 payments in the month of service(s). Due to Covid 19 there is delay in receiving payments in timely manner.

Edit 04158: Inter-year Capitation PMPM questioned - The average Private capitation PMPM reported on Line 11a (2.91) is significanlty different from the prior year (18.67). Please correct or explain.

Related Tables: Table 9D, Table 4(UR)

Paul Nagpal (Health Center) on 02/11/2021 5:09 PM EST: We have recorded PMPM on Table 9D line 2a column (a) column (b)

Edit 05100: PMPM collections in question - Private Capitation PMPM (2.91) is outside the typical range. Check to see that the revenue and member months are entered correctly or explain.

Related Tables: Table 9D, Table 4(UR)

Paul Nagpal (Health Center) on 02/11/2021 5:09 PM EST: We have recorded PMPM on Table 9D line 2a column (a) column (b)

Edit 02028: Large change in accounts receivable for Total Private is reported - Total Private, Line 12: When we compared the sum of collections (Column b) and adjustments (Column d) to total Private charges (Column a) there is a large difference (-90.33)%. While we do not expect it to be zero, a difference this large is unusual. Please explain or correct.

Related Tables: Table 9D

Paul Nagpal (Health Center) on 02/11/2021 3:24 AM EST: Line 12: Private Payer write off's are included in the adjustments (column d).

Edit 02021: Large change in accounts receivable for Total Self Pay is reported - Total Self Pay, Line 13: When we compared the sum of collections (Column b), sliding discounts (Column e), and bad debt (Column f) to total Self Pay charges (Column a) there is a large difference (25.86)%. While we do not expect it to be zero, a difference this large is unusual. Please explain or correct.

Related Tables: Table 9D

Paul Nagpal (Health Center) on 02/11/2021 12:55 PM EST: Alivio Medical Center switched to Telehealth/Virtual environment due to Covid at the end of March 2021 resulting in decrease of self pay/slide collections because patient was not present face to face to make payment. We are making efforts to collect for these visits by notating patient accounts and educating our patients to pay on patient portal upon receipt of balance due statements.

Table 9E-Other Revenues

Edit 03466: Inter-Year variation in grant funds - Current year Community Health Center(Section 330(e)) funds vary substantially from the prior year on Table 9E Line 1b. This may occur if BPHC has substantially changed the grant amount or may be due to the timing of draw downs. Please correct or explain. Current Year - On Table 9E Line 1b Column a (2806805). Prior Year - On Table 9E Line 1b Column a (4084783).

Related Tables: Table 9E

Sandra Ramirez (Health Center) on 02/10/2021 2:30 PM EST: Alivio received Covid-19, ECT and Cares funding from BPHC.

Edit 06346: Change in Revenues - You report a large change on Line 8/Foundation/Private Grants and Contracts revenues when compared to the prior year. Please correct or explain.

Related Tables: Table 9E

Sandra Ramirez (Health Center) on 02/10/2021 2:27 PM EST: The large change is due to HFS (CARES) Provider Relief funding 8,006,857 received in 2020.

Edit 03736: Inter-Year variance questioned - Total income reported on Tables 9D and 9E for this year varies substantially from the prior year. Please correct or explain. Current Year (25184794); Prior Year (16097795).

Related Tables: Table 9E, Table 9D

Sandra Ramirez (Health Center) on 02/10/2021 2:25 PM EST: Edit 3736: This variance is due to HFS (CARES) Provider Relief funding 8,006,857 received in 2020.

Edit 04094: Profit and Loss - When comparing cash income to accrued expenses a large surplus or deficit is reported. Please correct or explain. Surplus or Deficit = $(7464934); Percent Surplus or Deficit (42.13)%. Note: If the value is a surplus it will be distinguished as a number inside a parentheses (Value). If the value is a deficit it will be distinguished as a number with a negative sign inside a parentheses (-Value).

Related Tables: Table 9E, Table 8A, Table 9D

Sandra Ramirez (Health Center) on 02/10/2021 2:26 PM EST: This surplus is due to HFS (CARES) Provider Relief funding 8,006,857 received in 2020.

BHCMIS ID: 056620 - ALIVIO MEDICAL CENTER, Chicago, IL

Program Name: Health Center 330

Submission Status: Data Entry In Progress

Date Requested: 02/12/2021 12:15 PM EST

Date of Last Report Refreshed: 02/12/2021 12:15 PM EST

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Comments

Report Comments
Not Available

Table 9E Comments
Edit 3736:This variance is due to HFS (CARES) Provider Relief funding 8,006,857 received in 2020

JOB TITLE	ZIP CODE/POSTAL CODE
Accountant	60616
Behavioral Health Care Coord.	60466
Behavioral Hlth Consultant	60615
Behavioral Hlth Consultant	60617
Behavioral Hlth Consultant	60640
Behavioral Hlth Consultant	60643
Benefit Specialist	60162
Bill Coder	60445
Billing Specialist	60458
Billing Specialist	60473
Billing Specialist	60619
Billing Specialist	60827
Billing Supervisor	60643
Call Center Mgr	60425
Care Coordinator-MHN	46406
Care Coordinator-MHN	60409
Care Coordinator-MHN	60475
Care Coordinator-MHN	60615
Care Coordinator-MHN	60619
Care Coordinator-MHN	60620
Care Coordinator-MHN	60628
Care Coordinator-MHN	60628
Care Coordinator-MHN	60643
Care Coordinator-MHN	60649
Care Manager - MHN	60411
Care Manager - MHN	60473
Care Manager - MHN	60619
Care Manager - MHN	60620
Care Manager - MHN	60827
Care Manager - RN	60471
Care Manager - RN	60619
Care Manager - RN	60632
Chief Compliance Officer	60620
Chief Executive Officer	60653
Chief Financial Officer	60619
Chief Human Resources Officer	43035
Chief Medical Officer	46321
Chief Officer, Strategy & Development	60643
Chief Operating Officer	60653
Clinic Coordinator	60438
Clinic Coordinator	60615
Clinic Coordinator	60617
Clinic Coordinator	60617
Clinic Coordinator	60619
Clinic Coordinator	60619
Clinic Coordinator	60619

Clinic Coordinator	60619
Clinic Coordinator	60620
Clinic Coordinator	60623
Clinic Coordinator	60628
Clinic Coordinator	60629
Clinic Coordinator	60629
Clinic Coordinator	60629
Clinic Coordinator	60632
Clinic Coordinator	60638
Clinic Coordinator	60652
Clinic Coordinator	60805
Clinical Operations Coordinator	60660
Community Health Worker	60609
Community Health Worker	60612
Community Health Worker	60617
Community Health Worker	60617
Community Health Worker	60624
Community Health Worker	60629
Controller	60659
Customer Support Rep	60617
Customer Support Rep	60619
Customer Support Rep	60621
Customer Support Rep	60636
Customer Support Rep	60638
Customer Support Rep	60643
Customer Support Rep	60649
Dental Assistant	60617
Dental Assistant	60629
Dental Assistant	60629
Dental Assistant	60638
Dental Director	60605
Dental Hygienist	60487
Dentist	60603
Dentist	60616
Director of Clinical Innovation	60089
Director of Information Technology	60653
Director of Nursing	60618
Director of Patient Services	60431
Director of Provider Services	46410
Director of Quality Improvement	60661
Director of Talent Acquisition & Training	60601
Director, Care Coordination	60411
EA - Executive Assistant	60107
EMR Data Analyst	60643
Facilities Supervisor	60620
Family Medicine Nurse Practitioner	60463
Family Medicine Nurse Practitioner	60475

Family Medicine Nurse Practitioner	60620
Family Medicine Nurse Practitioner	60629
Family Medicine Nurse Practitioner	60631
Family Medicine Nurse Practitioner	60643
Family Medicine Physician	60062
Family Medicine Physician	60607
Finance & Administration Coordinator	60155
Finance Projects	60473
Financial Analyst	60613
Health Info Mgmt Specialist	60162
Health Info Mgmt Specialist	60628
Health Info Mgmt Specialist	60643
Health Information Lead	60619
HR Business Partner	60422
HR Business Partner	60712
HR Operations Specialist	60619
Internal Medicine Physician	60305
Internal Medicine Physician	60615
Lead Care Manager-MHN	60609
Lead Clinic Coordinator	60621
Lead Clinic Coordinator	60638
Lead Clinic Coordinator	60804
Lead Customer Srvc Rep	60629
Lead Dental Assistant	60803
Lead MedAsst	60411
Lead MedAsst	60456
Lead MedAsst	60615
Lead MedAsst	60619
Lead MedAsst	60629
Lead MedAsst	60652
Lead Referral Coord	60805
LPN	60411
LPN	60615
LPN Charge Nurse	46323
LPN Charge Nurse	60409
LPN Charge Nurse	60615
LPN Charge Nurse	60620
Medical Assistant	60077
Medical Assistant	60411
Medical Assistant	60419
Medical Assistant	60419
Medical Assistant	60438
Medical Assistant	60443
Medical Assistant	60458
Medical Assistant	60608
Medical Assistant	60616
Medical Assistant	60619

Medical Assistant	60620
Medical Assistant	60620
Medical Assistant	60620
Medical Assistant	60620
Medical Assistant	60621
Medical Assistant	60621
Medical Assistant	60623
Medical Assistant	60628
Medical Assistant	60628
Medical Assistant	60629
Medical Assistant	60629
Medical Assistant	60632
Medical Assistant	60649
Medical Assistant	60649
Medical Assistant	60649
Medical Assistant	60649
Medical Assistant	60827
Medical Director, Pediatrics	60605
Medical Director, Women's Health	60615
Medical Office Coordinator	60649
Medical Scriber	60565
Nurse Mid-Wife	60628
Nurse Practitioner	60423
Nurse Practitioner	60603
OB/GYN Nurse Practitioner	60619
OB/GYN Nurse Practitioner	60620
OB/GYN Nurse Practitioner	60637
OB/GYN Nurse Practitioner	60645
OB/GYN Physician	60618
OB/GYN Physician	60642
OBGYCORD	60632
Operations Coordinator	46323
Outreach Program Manager	60643
Outreach Specialist	60620
Outreach Worker	60626
Patient Educator	60443
Payroll Specialist	60449
Pediatric Nurse Practitioner	60467
Pediatric Physician	60487
Pediatric Physician	60605
Pediatric Physician	60607
Pediatric Physician	60616
Pediatric Physician	60617
Pediatric Physician	60653
Pediatric Physician	60707
Peer Counselor	60402
Physician	60521

Physician	60615
Physician - Osteopathic Medicine	60521
Physician Assistant	60515
Physician Assistant	60640
Population Health Analyst	60637
Program Coord - Illinois Colon Cares	60622
Psychiatric Nurse Practitioner	60645
Purchasing Assistant	60429
Referral Coordinator	46406
Referral Coordinator	60418
Referral Coordinator	60637
Referral Coordinator	60652
Site Manager	60639
SR Lead Medical Receptionist	60619
Sr. Care Manager, LPN	60624
TA-PED PHYSICIAN	60302
TA-PED PHYSICIAN	60607
TA-PED PHYSICIAN	60615
TA-PED PHYSICIAN	60618
TA-PED PHYSICIAN	60637
TA-PED PHYSICIAN	60637
TA-PED PHYSICIAN	60639
TA-PED PHYSICIAN	60714

JOB TITLE	ZIP CODE/POSTAL CODE
ACT Case Manager	60609
ACT Case Manager	60633
ACT Case Manager	60652
ACT Case Manager	60653
ACT Outreach Case Manager	60655
ACT Supervisor	60473
Administrative Assistant (Non Exempt)	60428
Administrative Assistant (Non Exempt)	60620
Administrative Assistant (Non Exempt)	60649
Adult Mental Health Therapist	46311
Behavioral Health Director	60409
Benefits Coordinator	60162
Billing Clerk	60619
Billing Coordinator	60639
CADC-Direct Care Staff	60643
Care Coordinator	60617
Case Manager	60419
Case Manager	60438
Case Manager	60617
Case Manager	60617
Case Manager	60620
Case Manager	60643
Case Manager	60649
Case Manager	60660
Case Manager	60803
Case Manager - Shelter Plus Care	60419
Case Manager Assistant	60620
Chief Administrative Officer	60661
Clinical Supervisor	60637
Clinical Supervisor	60643
Clinical Therapist - Adult Outpatient Services	60617
Clinical Therapist - QMHP	60615
Controller	60661
Cook	60471
Counselor - CADC	60617
Counselor - CADC	60643
Counselor - QMHP	60409
Counselor - QMHP	60417
Counselor - QMHP	60615
Counselor - QMHP	60615
Counselor - QMHP	60617
Counselor - QMHP	60619
Counselor - QMHP	60620
Counselor - QMHP	60643
Counselor - QMHP	60649
Counselor Substance Use Disorder	60411

Counselor Substance Use Disorder	60628
Counselor Substance Use Disorder	60637
Crisis Assessor CIP	60624
Crisis Worker QMHP	60401
Crisis Worker QMHP	60482
Crisis Worker QMHP	60615
Crisis Worker QMHP	60643
CST Case Manager	46403
CST Case Manager	60478
CST Case Manager	60649
CST Supervisor	60619
CST Supervisor	60628
DCFS Clinical Coordinator	60406
Deputy Director Behavioral Health	60155
Director of Budgets & Contracts	60649
Director of Prevention and Support Services	60628
Driver	60619
Drop-in Center Coordinator	60637
Executive Administrative Assistant	60446
Family and Community Service Nurse	60629
Financial Analyst	60620
HR RECRUITER	60302
Intake Specialist	60428
Intensive Community Support Supervisor	60466
Intensive Community Support Worker MHP	60438
Intensive Community Support Worker MHP	60471
Lead Cook	60466
Lead LPN Supervisor	60475
Lead Therapist	60425
LPN	60409
LPN	60425
LPN	60429
LPN	60617
LPN	60619
LPN	60620
LPN	60620
LPN	60628
LPN	60640
LPN	60649
LPN	60827
LPN/CASE MANAGER	60620
Maintenance Supervisor	60443
Maintenance Technician	60628
Maintenance Technician	60637
Maintenance Technician	60649
Nurse Practitioner	60419
Occupational Therapist	60608

Office Manager	60409
Outreach Worker	60624
Outreach Worker	60649
Outreach Worker	60653
Peer Specialist	60649
Prevention Specialist	60409
Prevention Specialist	60419
Prevention Specialist	60419
Prevention Specialist	60425
Prevention Specialist	60443
Prevention Specialist	60443
Prevention Specialist	60651
Prevention Specialist	60655
Prevention Specialist	60655
Program Coordinator	60653
Program Manager	60628
Program Supervisor	60605
Program Supervisor	60615
Program Supervisor	60628
Psychiatric Assessment Specialist	60411
Psychiatric Assessment Specialist	60417
Psychiatric Assessment Specialist	60484
Psychiatric Assessment Specialist	60617
Psychiatric Assessment Specialist	60628
Psychiatric Assessment Specialist	60637
Psychiatric Assessment Specialist	60649
Psychiatric Assessment Specialist	60649
Psychiatric Assessment Specialist	60660
Psychiatric Assessment Specialist PT	60609
Psychiatric Assessment Specialist PT	60653
QMHP - Clinical Therapist	60077
QMHP - Clinical Therapist	60406
QMHP - Clinical Therapist	60617
QMHP - Clinical Therapist	60652
QMHP - Clinical Therapist	60652
QMHP - Clinical Therapist	60805
Quality Support Specialist	60620
Receptionist	60619
Recovery Support Specalist	60035
Recovery Support Specalist	60628
Recovery Support Specalist	60649
Recovery Support Specialist (CRSS)	60827
Registered Nurse	60639
Registered Nurse	60649
Residental Support Worker	60475
Residental Support Worker	60617
Residental Support Worker	60619

Residental Support Worker	60619
Residental Support Worker	60620
Residental Support Worker	60636
Residental Support Worker	60649
Residental Support Worker	60653
Residental Support Worker	60620
Residential Case Manager	46410
Residential Supervisor	60827
Residential Support Worker	60426
Residential Support Worker	60466
Residential Support Worker	60615
Residential Support Worker	60617
Residential Support Worker	60619
Residential Support Worker	60620
Residential Support Worker	60620
Residential Support Worker	60621
Residential Support Worker	60621
Residential Support Worker	60628
Residential Support Worker	60628
Residential Support Worker	60629
Residential Support Worker	60637
Residential Support Worker	60805
Secretary	60615
Staff Accountant	60660
Supervisor	60153
Vice President	60620
Williams Clinical Reviewer Aged Options	60619
Williams Clinical Reviewer Aged Options	60649
Williams Clinical Supervisor	60649
Williams Comprehensive Administrative Assista	60619
Williams Comprehensive Housing Specialist	60649
Williams Comprehensive Integrated Nurse	60805
Williams Comprehensive Quality Assessor	46319
Williams Comprehensive Registered Nurse	60615
Williams Comprehensive Transition Assistant	46342
Williams transition coord	60615
Williams transition coord	60639
	60607
	60615

Inner City Muslim Action Network

Health Center Staff

Primary Address: Zip/Postal Code	Job Title Description	Benchmarks
60202,60629,60621,60629	Medical Assistant	2 Professional Developments
60418	Lab technician	
60629,60617	Patient Care Specialist	2 Professional Developments
60419	Practice Manager Center Operations	2 Professional Developments
60462	Director of Health Center Operations	2 Professional Developments
60616	Medical Director	2 Professional Developments
90027	Administrative Assistant	2 Professional Developments
60457	Director of Behavioral Health	2 Professional Developments
60527	Senior Community Health Organizer	2 Professional Developments
60462	Senior Manager HC Revenue and Compliance	2 Professional Developments

60607	Director of Health Center	2 Professional Developments
60430	Physician Assistant	2 Professional Developments
60653,60652,60654	Physician	2 Professional Developments
60490	Nurse Practitioner	2 Professional Developments
60601	Licensed Nutritionist	2 Professional Developments
60628	Community Health Worker	2 Professional Developments
60608,60628	Licensed Clinical Professional Counselor	2 Professional Developments
60623	Licensed Professional Counselor	2 Professional Developments
60618	Licensed Clinical Social Worker	2 Professional Developments

Appendix B (Milestones)

SSHEC MILESTONES BY STRATEGY - TIME PERIOD BEGINS POST AWARD

STRATEGY		YEAR 1 MONTHS												YEAR 2 QUARTERS			
		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4
	PLANNING																
MATERNAL	L&D appproval to open																
	L&D onboard staff																
	L&D purchase, install equipment																
	Technology, purchase interfaces, maternal module, setup Centering video																
	Conract to start Centering Pregnancy implementation																
	Hire Centering coordinators, facilitators																
	Select assessment tool																
	Train centering staff																
	Hire therapists - PT, acupuncture, massage																
	Recruit first Centering Pregnancy participants																
	Start referrals to therapists																
	Hire doulas, lactation consultants																
	Start referrals SDOH, BH																
	Start Centering Parenting sessions																
	Implement Centering parenting process																
	Recruit first Centering Parenting participants																
	Start Centering Parenting sessions																
SBEV																	
	Hire outreach workers / SBEV staff																
	Purchase technology, software																
	Contract transportation vendor for youth program																
	Start nutrition/ financial literacy classes																
	Start nutrition food box distribution																
	Start distribution nutritious menus, recipes																
	Recruit initial SBEV participants																
	Start athletic/sport/ physical program																
	Build music studio																
	Renovate IHMC space for SBEV																
	Start art, recreation therapy programs																
	Start group counesling sessions																
	Start music therapy sessions																
	Start food demonstrations																
	Open IHMC food pantry																
	Launch nutrition virtual smart shopping APP																
	Start farmer's market																
	Start sport professional mentors program																
Behavioral Health	Open IHMC Behavioral health clinic																
	Recruit IHMC and HRDI psychiatrists																
	Recruit FQHCs, CMHC LCSWs																
	Hire IHMC ED and inpatient care managers																
	Hire HRDI peer specialists, recovery coaches																
	Install technology interfaces																
	Start uniform screening																
	HRDI begin accepting ED patients to ambulatory and residential care																
	Begin family support therapeutic sessions																
	BeginBH access for other strategies																
	Implement HRDI recovery specialist certification program																
	Begin HRDI CCBHC certification process																
Chronic	Hire IHMC medical specialists																
	Hire lifestyle staff, nutritionist, diabetic educator, certified exercise trainer																
	Create interfaces for all partners																
	Purchase equipment																
	Begin uniform screening																
	Create telehealth connections																
	Setup IHMC lifestyle center																
	Contract for food pantries at IHMC, Freiend Health, HRDI																
WELLNESS	Open lifestyle center																
	Open food pantrIES																
SDOH	Create SDoH care coordination system																
	Contract with CBOS for specific services																
	Train CHW outreach workers																
	Hire CASL community care managers																
	Train care managers																
	Start referrals to CASL																
	Begin warm handoffs to care managers																
	Begin referrals to CBOs																
WORKFORCE	Recruit hire and onboard workforce																
	Develop Marketing pilot																
	Develop high fidelity simulator plan																

Morning Star Baptist Church of Chicago

3993 South Martin Luther King Drive
Chicago, IL 60653
773-285-8111 (Office) - 773-536-3467 (Fax)
admin@morningstarbcofchicago.org

Reverend Dr. H. A. Barlow, Pastor

Deacon Isiah Langston	Brother Chester Mitchell	Sister Dorothy J. Buck
Chairman of Deacon Board	Chairman of Trustee Board	Church Clerk

October 28, 2021

To Whom It May Concern:

I want to express my full support of Insight Hospital and its partners as a beneficiary of the Department of Healthcare and Family Services Health Care Transformation Collaborative. If granted, this will help fund a combination of initiatives set forth by Alivio Medical Center, Chinese American Service League, Friend Health, HRDI, Inner-City Muslim Action Network, Insight Hospital and Medical Center, Kennedy King College, Malcolm X College and the Sylvester Broome Empowerment Village with Insight Hospital and Medical Center to help restore Chicago's Southside hospital.

The Health Care Transformation Collaborative will distribute $150,000,000 annually across the State of Illinois to health care organizations and collaborate to improve health outcomes.

This partnership has innovative plans that will help complete projects that are expected to increase access to community-based healthcare, expand services, improve care for patients and increase the number of medical specialists working in the communities. They are dedicated to restoring their emergency care department to begin accepting ambulatory patients to decrease the overflow in other Chicago community hospitals and provide better care in their community.

Additionally, a few of their goals are to reinstate their perinatal OB/GYN service line, expand behavior health treatment programs and create safe spaces and special programs for youth to prevent and mitigate the efforts of violence and trauma.

I commend these partners for providing excellent medical services to an underserved community and better the future of many youths who would not otherwise have an opportunity to seek care in their community. I support this partnership and its worthwhile imitative.

Best regards,

Rev. Dr. Henry A. Barlow

Reverend Dr. Henry A. Barlow

COUNTY BUILDING
118 N Clark St #567
Chicago, Illinois 60602
(T) 312-603-6391

BILL LOWRY

COMMISSIONER – THIRD DISTRICT
COOK COUNTY BOARD OF COMMISSIONERS

Committees
Cook County
Emergency Management & Regional Security (Chairman)
Cannabis Commission (Chairman)
Audit
Business & Economic
Contract Compliance
Criminal Justice
Environment Sustainability
Finance
Finance Subcommittee on Litigation
Finance Subcommittee on Tax Delinquency
Legislation & Intergovernmental Relations
Rules & Administration
Transportation
Veterans
Workforce, Housing & Community Development
Zoning & Building

Forest Preserve
Litigation (Vice Chairman)
Audit
Contract Compliance
Environmental & Sustainability
Finance
Labor
Legislation & Intergovernmental Relations
Real Estate
Rules

November 1, 2021

To whom it may concern:

As Cook County Commissioner of an already underserved community, I wish to express my strong support of Insight Hospital's goals to restore a Chicago Southside Institution along with its community peers. The funding will help not only residents in their area but also their peers in other Chicago area hospitals experiencing an overflow of patients.

Insight would be an ideal recipient of the Healthcare Transformation Collaborative grant. They have created a long-term plan to restore the former Mercy Hospital to a fully operational hospital with outstanding healthcare initiatives. Not only are they well on their way to operating a comprehensive emergency room, but they plan to expand the hospital's perinatal OB/GYN service line, create additional outpatient mental health services, and create safe spaces and special programs for youth to prevent and mitigate the effects of violence and trauma.

The Illinois Department of Healthcare and Family Services (HFS) awards this grant to reorient the State's current healthcare delivery system by investing in sustainable projects that focus on community needs and decrease health disparities. Insight Hospital's goals align with the purpose of the Transformation initiative and the operators of the former Mercy hospital have my full confidence in their ability.

Insight Hospital is currently facing significant financial obligations to restore and run the hospital with capital infrastructure and operations funding to restore the vital role the hospital plays in its community. I

commend them for taking the initiative to seek feedback from the community and use it to develop a plan to support and meet the needs of Southside Chicago residents.

Sincerely,

Bill Lowry
Cook County Commissioner, 3rd District

118 N. CLARK STREET, ROOM 567
CHICAGO, IL 60602
312.603.4400 OFFICE
312.603.6688 FAX
E-MAIL: john.daley@cookcountyil.gov

JOHN P. DALEY
CHAIRMAN
COMMITTEE ON FINANCE

COMMISSIONER - 11TH DISTRICT
COOK COUNTY BOARD OF COMMISSIONERS

November 2, 2021

To Whom It May Concern:

Insight Hospital and Medical Center is currently working with community partners to apply for funding from the Department of Healthcare and Family Services Health Care Transformation Collaboratives. The partnership includes Alivio Medical Center, Chinese American Service League, Friend Health, HRDI, Inner-city Muslim Action Network, Insight Hospital, and Medical Center, Kennedy King College, Malcolm X College, and Sylvester Broome Empowerment Village, with Insight Hospital and Medical Center as the lead entity and anticipated fiscal intermediary should funding be awarded. The Illinois Department of Healthcare and Family Services (HFS) awards Healthcare Transformation Collaborative funds to reorient the state's current healthcare delivery system by investing in sustainable projects that focus on community needs and decrease healthcare disparities. I believe this partnership will be an effective and innovative Transformation recipient.

Insight and their partners have the goal of restoring the hospital to its former status as an influential Chicago healthcare institution that will address health inequity and healthcare disparities seen in vulnerable populations on the Southside of Chicago. Not only do they aim to reinstate ambulance services and operate a comprehensive emergency room, but they want to expand the hospital's perinatal OB/GYN service line, create additional outpatient mental health services, and create safe spaces and special programs for youth to prevent and mitigate the effects of violence and trauma.

In an already underserved community, I cannot help but support and commend Insight and its partners for wanting to set a new standard for medical care on Chicago's Southside. Please consider this letter as an expression of my support for this partnership's goals of restoring an important Chicago hospital and helping Chicago residents maintain healthy and productive lives.

Best regards,

John Daley
Cook County Commissioner, 11th District

Theresa Mah
State Representative • 2nd District
2108 W. 35th Street • Chicago, IL 60609
Phone: (872) 281-5775

November 8, 2021

To whom it may concern:

When considering applications for the Healthcare Transformation Collaborative grant, I urge you to support Insight Hospital and Medical Center and their partners, Alivio Medical Center, Chinese American Service League, Friend Health, HRDI, Inner-city Muslim Action Network, Kennedy King College, Malcolm X College, and Sylvester Broome Empowerment Village. Insight Hospital and Medical Center would be the lead entity and anticipated fiscal intermediary should funding be awarded.

This partnership is well structured to address needed services for vulnerable populations on the South Side who are facing racial disparities leading to significantly shortened lifespans. I have confidence in the new operators of the former Mercy hospital to restore needed services including obstetric services, mental and behavioral healthcare, and support for youth experiencing trauma. I am particularly encouraged by the partner organizations involved and believe their collaboration will lead to innovation and increase the likelihood of success in care delivery.

It is vital that access to care is restored in our community. The partners have solicited and directly incorporated feedback from residents and community leaders into the direction of this application and other hospital operations. The Transformation program is a crucial component to the long-term vision of reestablishing an essential institution and building vibrant communities.

Thank you for your consideration.

Sincerely,

Theresa Mah, Ph.D. 馬靜儀博士
Illinois State Representative - 2nd District 伊州第二區眾議員

BRIGHT STAR
COMMUNITY OUTREACH

Strengthening Hope & Saving Lives

October 28, 2021

To Whom it May Concern:

I want to express my full support of Insight Hospital and its partners as a beneficiary of the Department of Healthcare and Family Services Health Care Transformation Collaborative. If granted, this will help fund a combination of initiatives set forth by Alivio Medical Center, Chinese American Service League, Friend Health, HRDI, Inner-City Muslim Action Network, Insight Hospital and Medical Center, Kennedy King College, Malcolm X College and the Sylvester Broome Empowerment Village with Insight Hospital and Medical Center to help restore Chicago's Southside hospital.

The Health Care Transformation Collaborative will distribute $150,000,000 annually across the State of Illinois to health care organizations and collaborate to improve health outcomes.

This partnership has innovative plans that will help complete projects that are expected to increase access to community-based healthcare, expand services, improve care for patients and increase the number of medical specialists working in the communities. They are dedicated to restoring their emergency care department to begin accepting ambulatory patients to decrease the overflow in other Chicago community hospitals and provide better care in their community.

Additionally, a few of their goals are to reinstate their perinatal OB/GYN service line, expand behavior health treatment programs and create safe spaces and special programs for youth to prevent and mitigate the efforts of violence and trauma.

I commend these partners for providing excellent medical services to an underserved community and better the future of many youths who would not otherwise have an opportunity to seek care in their community. I support this partnership and its worthwhile imitative.

Best regards,

Pastor Chris Harris, Jr.

Pastor Chris Harris
Founder/CEO

BRIGHT STAR
COMMUNITY OUTREACH

Strengthening Hope & Saving Lives

Bright Star Community Outreach

培德中心
Pui Tak Center

2216 S. Wentworth Ave
Chicago, IL 60616

Tel: 312-328-1188
www.puitak.org

November 2, 2021

Dear IL DHFS Health Care Transformation Collaborative:

Pui Tak Center is a 27 year old church-based community center in Chicago's Chinatown. In FY2021, we served over 4500 community members through our Adult Education, Children and Youth, and Community programs.

I want to express my full support of Insight Hospital and its partners as a beneficiary of the Department of Healthcare and Family Services Health Care Transformation Collaborative. If granted, this will help fund a combination of initiatives set forth by Alivio Medical Center, Chinese American Service League, Friend Health, HRDI, Inner-City Muslim Action Network, Insight Hospital and Medical Center, Kennedy King College, Malcolm X College and the Sylvester Broome Empowerment Village with Insight Hospital and Medical Center to help restore Chicago's Southside hospital.

As the Health Care Transformation Collaborative will distribute $150,000,000 annually across the State of Illinois to health care organizations in order to promote collaborations to improve health outcomes, it is imperative that these funds be used in communities that face health inequities such as Chicago's southside.

This partnership has innovative plans that will help complete projects that are expected to increase access to community-based healthcare, provide language access to immigrant communities, expand services, improve care for patients and increase the number of medical specialists working in the communities. They are dedicated to restoring their emergency care department to begin accepting ambulatory patients to decrease the overflow in other Chicago community hospitals and provide better care in their community.

I commend these partners for providing excellent medical services to an underserved community and better the future of many youths who would not otherwise have an opportunity to seek care in their community. I support this partnership and its worthwhile imitative.

Sincerely,

David Wu
Executive Director

ILLINOIS HOUSE OF REPRESENTATIVES

SPRINGFIELD OFFICE:
290-S Stratton Building
Springfield, Illinois 62706
(217) 782-4535 (Office)

DISTRICT OFFICE:
5048 S. Indiana Ave
Chicago, Illinois 60615
(773) 924-4614 (Office)
(773) 924-4652 (Fax)

COMMITTEES:

- **Chair:** Cybersecurity, Data Analytics, IT
- **Chair**: Tourism
- **Appropriations:** Human Services
- Healthcare Accessibility & Access
- Public Utilities
- Special Issues (AP) Subcommittee
- Prescription Drug Affordability

Lamont J. Robinson, Jr.
STATE REPRESENTATIVE
5th DISTRICT

Chicagi, November 1, 2021

To whom it may concern:

As State Representative of an already underserved community, I wish to express my strong support of Insight Hospital's goals to restore a Chicago Southside Institution along with its community peers. The funding will help not only residents in their area but also their peers in other Chicago area hospitals experiencing an overflow of patients.

Insight would be an ideal recipient of the Healthcare Transformation Collaborative grant. They have created a long-term plan to restore the former Mercy Hospital to a fully operational hospital with outstanding healthcare initiatives. Not only are they well on their way to operating a comprehensive emergency room, but they plan to expand the hospital's perinatal OB/GYN service line, create additional outpatient mental health services, and create safe spaces and special programs for youth to prevent and mitigate the effects of violence and trauma.

The Illinois Department of Healthcare and Family Services (HFS) awards this grant to reorient the State's current healthcare delivery system by investing in sustainable projects that focus on community needs and decrease health disparities. Insight Hospital's goals align with the purpose of the Transformation initiative and the operators of the former Mercy hospital have my full confidence in their ability.

Insight Hospital is currently facing significant financial obligations to restore and run the hospital with capital infrastructure and operations funding to restore the vital role the hospital plays in its community. I commend them for taking the initiative to seek feedback from the community and use it to develop a plan to support and meet the needs of Southside Chicago residents.

Sincerely,

Lamont Robinson
State Representative Lamont Robinson
Illinois District 5

Chinese American Service League

2141 South Tan Court | Chicago, Illinois 60616 | 312.791.0418 | CASLservice.org

October 11, 2021

Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

This letter signifies the intention of Chinese American Service League, Inc to partner in an application for funding from the Department of Healthcare and Family Services Health Care Transformation Collaboratives. The partnership includes Alivio Medical Center, Chinese American Service League, Friend Health, HRDI, Inner-city Muslim Action Network, Insight Hospital and Medical Center, Kennedy King College, Malcolm X College w and Sylvester Broome Empowerment Village, with Insight Hospital and Medical Center as the lead entity and anticipated fiscal intermediary should funding be awarded. The primary objective of the partnership is to address health inequity and healthcare disparities seen in vulnerable populations on the South Side of Chicago.

The target population to be served by this partnership includes Medicaid and uninsured individuals in the following zip codes on the South Side (in essence an area bounded by the Stevenson Expressway to the north, the lake to the east, and the western and southern borders of Chicago): 60609, 60615, 60616, 60617, 60619, 60620, 60621, 60628, 60629, 60631, 60632, 60633, 60636, 60638, 60643, 60649, 60652, 60653, 60655.

The partnership plans to improve health in these populations focusing on four overarching strategies:

1. Improving outcomes for pregnant mothers
2. Improving care for adults with chronic conditions leading to premature cardiovascular complications (hypertension and diabetes mellitus)
3. Youth empowerment
4. Improving behavioral health care

For each of these strategies, there will be supporting strategies of enhanced care coordination, improved data sharing using technology, and identifying and addressing social determinants of health.

Chinese American Service League, Inc is a nonprofit organization serving the target area and populations of this partnership. We commit to participating in the strategies described above. We think these strategies present an approach that is consistent with community needs, and will address some of the significant health care disparities seen on the South Side. They should result in better access to care, and improve the cross-discipline collaboration and communication necessary for a better experience for individuals.

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Chinese American Service League, Inc agrees to work collaboratively with these partners, any community-based organizations ultimately brought into this work. We look forward to a positive review of the application and recognize that there is not a formal commitment or contract until such time as awards are given and any needed negotiations with the Department of Healthcare and Family Services are completed.

Sincerely,

Jered Pruitt
Chief Operating Officer
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