


1. COVER SHEET

Healthcare Transformation Collaboratives Cover Sheet



1. Collaboration Name: Southside Center for Excellence in Older Adult Health and Wellness

2. Name of Lead Entity: St. Bernard Hospital and Health Care Center

3. List All Collaboration Members:

- St. Bernard Hospital
- Chicago State University
- Chicago Commons
- Smyl Fitness Rx, LLC
- Kennedy King College
- DL3 Realty, L.P.
- Loyola School of Medicine

4. Proposed Coverage Area: Chicago Southside

5. Area of Focus: Collaborative model for "whole-person" care designed to meet the unique needs of older adults by improving their health, wellbeing, and ability to remain independent/age at home.

6. Total Budget Requested: \$132,972,895

SOUTHSIDE CENTER FOR EXCELLENCE IN OLDER ADULT HEALTH & WELLNESS

Collaborative model for “whole-person” care designed to improve health, wellbeing, and ability to age at home



St. BERNARD HOSPITAL
AND HEALTH CARE CENTER



SINCE 1894
CHICAGO
COMMONS™
helping families GO further



CITY COLLEGES of CHICAGO
Kennedy-King

Smyl
Fitness Rx



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2. PROJECT DESCRIPTION

Brief Project Description

Provide an official name for your collaboration. NOTE: Please ensure that this name matches the name given in the "Application Name" field in the Project Information form at the beginning of the application.

Southside Center for Excellence in Older Adult Health and Wellness

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

This cross-provider collaborative will transform health outcomes and reduce disparities among older adults on the Southside by delivering “whole-person” care designed to meet the unique needs of an aging community that is medically underserved and disproportionately poor. Our comprehensive approach will address clinical needs, facilities modernization, coordinated social/wellness services, workforce development, and economic opportunity for minorities.

3. DETAILED PROJECT DESCRIPTION

Provide a narrative description of your overall project, explaining what makes it transformational.

Specify your service area, identify the healthcare challenges it faces, and articulate your goals in addressing these challenges; explain your strategy and how it addresses the causes of these challenges, and lay out the expected timeframe for the project.

Describe any capital improvements, new interventions, delivery redesign, etc. Your narrative should explain the need for each significant item in your budget, clarifying how each connects to the overall goals and operations of the collaboration. [Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.

Southside Center for Excellence in Older Adult Health and Wellness

For decades, residents on the Southside of Chicago have experienced health disparities ranging from higher chronic disease burden to lower quality of life. These adverse health outcomes are particularly acute among the rapidly aging population of 160,170 older adults (age 65+) which living on the Southside of Chicago [1]. Seniors on the Southside face dire health disparities such as higher rates of hospitalization, disability, and a host of health issues such as heart disease, cancer, and stroke [2]. These disparities reflect a fragmented healthcare delivery landscape, underinvestment, and other inequities largely driven by race and segregation. As a result, Chicago has the largest life expectancy gap in the country, with Black residents on the Southside expected to live 30 years less than white residents a few miles North [3].

Key Facts:

According to detailed analysis and data from sources including IL Department of Healthcare and Family Services, IL Department on Aging, and the Chicago Department of Public Health Report on Older Adult Health, we are facing an unprecedented growth in our aging population. This rapid aging is set to collide with a shortage of health providers, care workers, and services to meet the unique needs of older adults [4] [2].

- ✓ **84% growth in the number of older adults** – In 2000, there were 1.96 million older adults in Illinois. Today, we 3 million older adults with projections to soar to 3.6 million by 2030 [4].

- ✓ **Minorities remain underserved with worse health outcomes** – in general, minorities in Chicago face higher rates of hospitalizations, stroke, Alzheimer’s, COVID, nursing home deaths, etc. [2] [5].
- ✓ **The Southside is disproportionately impacted** – the Southside is disproportionately impacted, it has the largest share of older adults that are poor, medically underserved, and at risk for disability due to functional limitations [1].

The Southside does not currently have the infrastructure to meet the unique needs of its rapidly aging population. The year 2030 is a turning point for this rapidly aging population because it marks the year where all baby boomers will be older than sixty-five. **Without transformative action, this rapid aging is set to have a devastating impact on older adults living on the Southside.**

What if there was a way to transform the lives of thousands of older adults and their families on the Southside by implementing a model uniquely designed to meet their needs both within and beyond the four walls of the medical clinic?

Our aim is the do just that. The Southside Center for Excellence in Older Adult Health and Wellness (SSCOE) will tackle this issue head-on with a cross-provider partnership of entities committed to improving equity and outcomes for older adults by focusing on five specific aims.

Specific Aims:

- 1) *Clinical*: Address unmet healthcare needs (physical and behavioral) by recruiting and retaining committed physicians, nurse practitioners, specialists, etc.
- 2) *Facilities*: Invest in St Bernard Hospital’s physical and digital infrastructure to make it modernized and responsive to the service needs of older adults
- 3) *SDoH*: Improve coordinated access to social determinants of health (SDoH) services with a focus on non-medical factors impacted by aging (e.g., access to nutritious food, reliable transportation, social support, personal care, etc.)
- 4) *Wellness*: Implement evidence-based wellness programs that facilitate aging-in-place (e.g., functional mobility screening, fall prevention, health education, exercise and social activities to reduce isolation)
- 5) *Workforce*: Build a diverse workforce pipeline and economic empowerment for minority communities on the Southside by providing opportunities in the business and practice of care for older adults

AIM 1: CLINICAL - Address shortage of primary and specialty providers with the clinical expertise to meet the unique physical and mental health needs of older adults

- *Situation*: The current and future geriatrician shortfall in Illinois is estimated to be over 700, and the ratio of primary care providers to residents in the majority of Southside neighborhoods is less than half of the Chicago average [6]. The Southside is one of the most medically underserved communities in the U.S. with 7 of the 8 poorest areas in Chicago [7]
- *Impact*: Skyrocketing costs due to hospitalizations, nursing home admissions, and devastating health disparities. For instance, According to the IL State Plan on Aging, African-Americans are nearly twice as likely to suffer from Alzheimer’s or other dementias, a discrepancy exacerbated by poverty, discrimination, and other disparities [4].
- *Action*: We will hire, train and recruit 18 primary and specialty providers with expertise to meet the needs of older adults with complex clinical and social needs. Our “whole-person” model includes enhanced coordination and focus on proactively managing chronic conditions and physical/cognitive health.
- *Outcomes*: Improved access to ambulatory/preventative care and follow-up visits. Reduced hospitalizations, emergency department (ED) visits, and healthcare costs.

AIM 2: FACILITES - Invest in St. Bernard Hospital's physical and digital infrastructure to make it modernized and responsive to the service needs of older adults

- **Situation:** St. Bernard Hospital has under resourced medical facilities in need of modernization to become a sustainable institution that is an attractive destination for patients, providers, and value-based care networks. The COVID-19 underscored the need for investment in Southside health institutions that are aging, distressed, and under ongoing threat of closing and cutting services [8].
- **Impact:** lack of adequate systems and infrastructure to meet evolving service needs contributes to increased risk of adverse events and poor outcomes, longer length of stay [9], and eventual admission to overcrowded and understaffed nursing homes that have a disproportionate number of deaths in facilities that serve minority communities [10][5].
- **Action:** transform St. Bernard into an anchor institution on the Southside with state-of-the-art facilities needed to become a sustainable destination serving the unique needs of older adults.
 - **Physical infrastructure:** demolish an old hazardous structure and prepare land to be used for community benefit (e.g., affordable senior housing), convert an unused hospital unit into state-of-the-art skilled nursing unit (SNU) for short-term rehabilitation, expand intensive care unit to serve unmet demand etc.
 - **Digital infrastructure:** investment in EMR upgrade and personal emergency response system (PERS) technology to reduce hospitalizations, help manage chronic conditions, track population health, and coordinate care beyond the four walls of the hospital.
- **Outcomes:** St. Bernard Hospital will be an anchor institution serving the needs of the Southside with high quality infrastructure, clinical outcomes, and expert clinicians. In addition to outcomes, and cost savings, key milestone will include achieving a Geriatric Emergency Department Accreditation (GEDA) and positioning to improve sustainability by contracting with value-based partners such PACE (Program for All Inclusive for the Elderly and Medicare Advantage.)

AIM 3: SDOH – Integrate social determinants as a core part of a “whole-person” care model designed to promote health and health equity for aging adults and their families

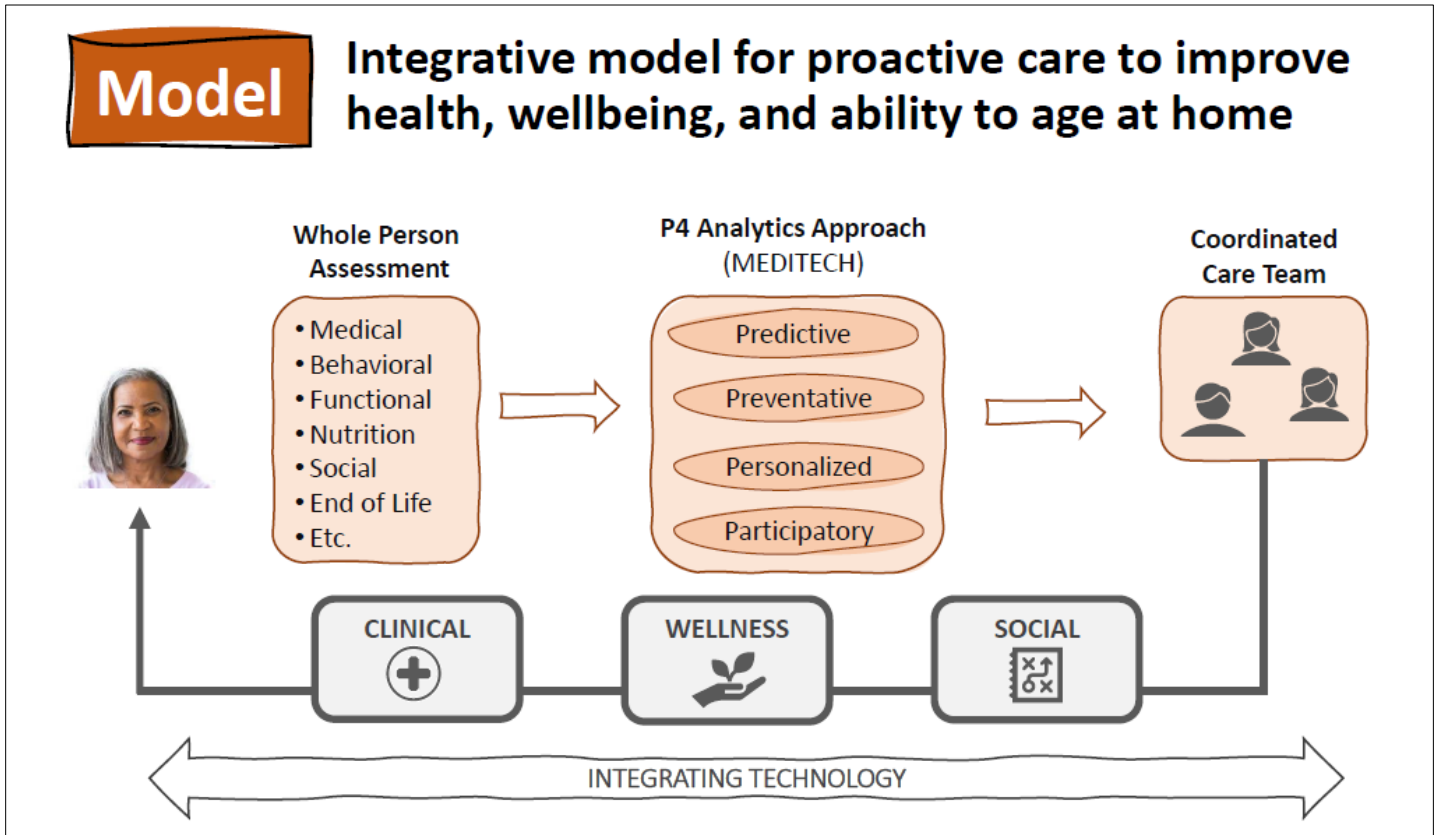
- **Situation:** Social determinants of health are a significant factor in improving health outcomes but they still go largely unaddressed. For older adults in particular, SDoH factors significantly impact their health and experiences aging, especially their ability to live independently and age in place (i.e., live in one's own home and community safely and independently)
- **Impact:** social determinants drive more than 50% of health outcomes [11]. For communities that are disproportionally poor and medically underserved, the compounding impact of care that does not address SDoH needs often leads to poor health outcomes, disability, and long-term nursing home placement, and skyrocketing healthcare costs.
- **Action:** Our “whole-person” care model will prioritize SDoH screening and coordinating services both within and beyond the four walls of the medical clinic. Services will be delivered via partnerships with local community-based organizations/small business. Our specific areas of focus will include the following: economic stability, health education, housing, home safety, transportation, food security, and social isolation.
- **Outcomes:** key outcomes related to SDoH will be improved healthcare access, health literacy, higher percentage of frail elderly that are able to remain in their home, and improved economic stability due to increased workforce pipeline and growth in our small local/minority owned business vendors.

AIM 4: WELLNESS – integrate evidence-based programs that support older adults’ wellbeing and ability to age-in-place by addressing age specific wellness areas such as functional status

- **Situation:** 90% of older adults want to age in place [12]. However, by age sixty-five, 1 in 4 will experience functional decline, a life altering loss of independence associated with a limited ability to perform activities of daily living (ADLs) like bathing, dressing, or getting out of bed [13]. Declining functional status puts older adults at risk for poor health outcomes, disability, and higher likelihood of being placed in a nursing home vs. living independently at home.
- **Impact:** medically underserved communities experience higher prevalence and earlier onset of functional decline [14]. This is in part due to the fact that most older adults are cared for in settings where approaches to address functional status are poor, limited, or non-existent [15] [16]. The end result often shows up in *nursing home admissions. Illinois is one of the most over-bedded nursing home states in the country* [5].
- **Action:** Functional status is a potent predictor of nursing home admission and many other costs/outcomes not predicted by medical diagnoses [17]. In alignment with CMS guidance to prioritize care models that address functional decline in disadvantage populations (e.g., PACE) [18] [19], our “whole-person” model will include a scalable process to implement mobility and functional status assessments along with evidence-based wellness programs shown to manage and reverse functional decline and frailty (e.g. exercise, fall prevention training, education, etc.) [20] [21].
- **Outcomes:** a key outcome for this aim will be the percent of frail/nursing home eligible patients that are able to remain at home. In addition to improving functional scores, this aim will also improve age-specific quality measures such as “*the % of older adults that receive functional screening,*” and “*the % percent referred for programs (e.g., fitness) designed to address functional status.*”

AIM 5: WORKFORCE - Build a workforce pipeline for fields in the business and practice of care for older adults with Chicago State University as an anchor partner

- **Situation:** Numerous reports, including the Illinois FY 2022 – 2024 State plan on Aging, have underscored an urgent concern with a shortage of health care workers [4] and physicians [7] trained to provide services to meet the unique needs of older adults.
- **Impact:** issues around poor recruitment, low pay (for both physicians and other care workers) and student loan/educational costs are associated the shortage of workers [22]. This workforce shortage results in limited access to care results in health outcomes, multiple complex chronic conditions, and higher healthcare costs.
- **Action:** we will focus on recruitment/retention and training to build a workforce pipeline
 - **Recruitment/retention:** in addition to a competitive salary, our program will include graduated loan repayment program (i.e., payments increase over service length) etc.
 - **Training:** we have partnered with collaborators such as Chicago State University (CSU), Loyola University Chicago Stritch School of Medicine, and Kennedy-King College to create training and workforce development programs. These programs will lead to jobs opportunities at SSCOE, partner entities, and our vendors.
- **Outcome:** results will include the creation of 159 new jobs and a strong and workforce development pipeline that will serve a rapidly aging community of Southside older adults that is disproportionately poor, clinically complex, and medically underserved.



Our Approach:

We will work to address the enormous level of healthcare need among older adults on the Southside with a **thoughtful approach that fosters strategic alliances across the healthcare ecosystem; all working together towards a higher mission of achieving healthcare transformation on the Southside.**

Geriatric Primary Care:

- **Target:** older adults with complex needs (medical, cognitive, functional), yet do not have an established relationship with a primary care provider (PCP)
- **Service:** we will assume a PCP role delivering longitudinal care with an interdisciplinary team including a geriatric trained physician that oversees all aspects of care (physical, functional, cognitive, etc.)
- **Market size:** based on our analysis, the total addressable market (TAM) for this service is 14,484 older adults on the Southside. We plan to target 46% (6,662 older adults) of the TAM in our immediate service area (see Map 1 for primary and secondary service area map).
- **Outreach:** build community trust and attract patients with direct-to-consumer engagement efforts (e.g., wellness workshops, free health screenings, other community outreach).

Geriatric Consult Services:

- **Target:** older adults with complex needs, however already have an established PCP
- **Service:** provide specialty consult services working in tandem with their PCP (e.g., comprehensive geriatric assessment, care plan recommendation, ongoing follow-up with patient and PCP as-needed).
- **Market size:** this service model is appropriate for a TAM of 17,552 older adults living on the Southside. Our target market is 8,074

- Outreach: education and relationship building with community-based PCPs serving geriatric populations (e.g., senior living facilities, FQHCs, small/medium PCP practices)

Primary Care:

- Target: older adults without complex needs, yet in need of a dedicated PCP
- Service: we establish primary care with an interdisciplinary team led by an Advanced Care Provider (APP) focused on age-appropriate preventive care, screenings, health monitoring, and counseling to reduce risk
- Market size: our analysis shows 78,483 older adults on the Southside in this category. We plan to target 36,102 older adults residing in our immediate service.
- Outreach: direct-to consumer engagement and outreach efforts

Wrap-around services:

- Target: older adults without complex needs, yet have an established PCP
- Service: work with PCPs to offer wellness focused wrap-around services and other services provided at STBH (e.g., wellness workshops, SDoH services, outpatient therapy, dental, etc.)
- Market size: this service model is appropriate for 81,687 older adults of which we plan to target 37,576
- Outreach: education and relationship building with community-based PCPs

There remains a large unmet need for specialized services to meet the unique needs of older adults. Our strategy will be to begin by addressing need in our immediate service areas before expanding to address need across the Southside TAM. Within the target populations outlined above, is a **frail population with complex needs would also benefit from our older adult focused complex and post-acute services** that are part of this transformation (i.e., accredited geriatric emergency department, rehab focused skilled nursing unit, and expanded intensive care unit).

- **There are no EDs on the Southside staffed to meet the unique needs of older adults.** The nearest geriatric staffed ED is at Northwestern.
- According to a study published in The Journal of the American Medical Association (JAMA), since launching its geriatric emergency program in 2013, Northwestern's **geriatric ED has seen a decrease of unnecessary hospitalizations of older patients by 33% [23].**

Key Outcomes:

Our “whole-person” model would be transformational in addressing disparities by focusing on specific aims related to clinical needs, facilities modernization, coordinated social/wellness services, and workforce development initiatives.

- ✓ **Health Equity**: care for a vulnerable senior community, specifically designed to meet the unique needs of an aging population that is disproportionately sick, poor, medically underserved
- ✓ **Aging in place**: “whole-person” care model designed to reduce costs, improve outcomes, and support older adults’ ability to remain independent and in their own homes
- ✓ **Workforce development**: Robust workforce training program for a range of clinical and non-clinical opportunities (159 in new job creation)
- ✓ **Economic growth**: and economic growth and scale for 20+ local minority owned business that have committed to serve as business partners and vendors
- ✓ **Governance**: The SSCOE will be governed by a 5-member board that will include representatives from all partnering entities including the executive director of a new non-profit 501(c)(3) that will be hired to execute daily operations.

- ✓ **Sustainability:** The Southside will have a sustainable safety-net in St. Bernard hospital (STBH) and a cross-provider ecosystem of partners that can meet the specialized need of older adults and is **positioned to be Southside anchor and destination/in-network for all PACE providers** (Program for All Inclusive Care for the Elderly), participate in value-based contracts, and deliver outcomes that warrant commercial and government payers attributing (assign patients) that STBH is held accountable for. *Between 7,316 – 9,642 older adults on the Southside are PACE eligible and would benefit from our model [1].*

We will seek approximately \$26M in Healthcare Transformation Collaboratives funding per year for five years from the state to help finance its broad-based community-wide start up, roll-out and adoption. This project is designed to be complementary to other transformation projects the have been funded, avoids duplicative services, and fills an unmet need (care for older adults) that remains and is rapidly growing.

Our Collaborative:

Our cross-provider collaborative includes an anchor **safety net hospital** (St. Bernard Hospital), **workforce development partners** (Chicago State University, Kennedy-King College, Loyola School of Medicine, Loyola School of Public Health), **non-profit** community organizations such as Chicago Commons, and numerous local **minority and women owned small businesses**. Under the advisement of community input and data to drive programmatic decisions, we have proposed implementation of a 5-year transformation that will deliver “whole-person” care designed to meet the unique needs of older adults.

This proposal aligns with IL Health and Family Services (HFS) commitment to healthy aging, the Age-Friendly Chicago Plan, and the IL Department on Aging priorities related to:

- 1) **Supporting** older adults’ ability to remain independent and in their own homes through the provision of quality home and community-based services with a strong focus on healthy aging and prevention
- 2) **Expanding** equitable access to care and programs that address the SDoH with a focus on identifying and understanding the needs of underserved and diverse populations, and
- 3) **Maximizing** federal, state, local, and private resources to sustain and expand services and supports to older adults.

4. Governance Structure

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 Southside Center for Excellence in Older Adult Health and Wellness (SSCOE) consists of a cross-provider collaborative with St. Bernard Hospital as an anchor partner, and numerous non-profits, and an many small minority and women owned business in the community.

Our rich network of partners also includes a host of local minority businesses that will be vital partners in executing our workplan. There will be a key collaborator for each specific aim:

1. *St. Bernard Hospital* (Clinical) – a **safety-net hospital** that provides a significant level of care to low-income, uninsured, and vulnerable populations on the Southside.

2. Smyl Fitness Rx, LLC (Wellness) – **minority owned business** on the Southside founded by a Board-Certified Geriatric Clinical Specialist. Launched with support from the National Science Foundation to use the evidence-based benefits of exercise to help older adults stay healthy, mobile, and independent.
3. Chicago Commons (SDoH) – **minority led non-profit** of senior services with a strong focus on helping seniors and stay in their homes, maintain their independence and quality of life.
4. DL3 Realty (Facilities) – **minority owned business** founded by a native Southsider with a track record of developing and managing high-impact real estate projects. Co-founder of the Chicago Emerging Minority Developer Initiative.
5. Chicago State University (Workforce) – **predominantly Black, public university** focused on training, developing, and graduating minority and underrepresented students. Track record of developing non-credit and workforce programs to fill high demand areas and diversify the healthcare landscape.

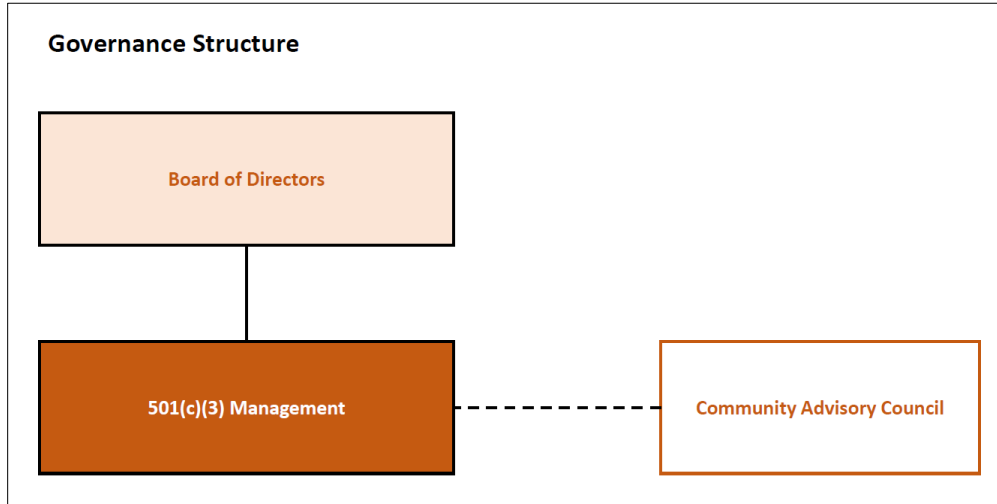
We will establish a new, 501(c)(3) not for profit organization, the SSCOIE, which will serve as the vehicle to facilitate health care transformation for seniors on Chicago's Southside. The SSCOIE will have a dedicated management team supported by a Board of Directors and a Community Advisory Board. Authority and responsibility will be distributed across these three bodies as outlined below

1. **Board of Directors (BOD)** – The board will have a strategic function in providing the vision, mission and goals of the organization. BOD will have responsibilities including, but not limited to:
 - a. Mission: help keep the SSCOIE on mission (e.g., each trustee continuously asking “What is our mission?” and “Does this action serve our beneficiaries?”)
 - b. Executive Director/CEO: approve selection, provide oversight, and support the Executive Director/CEO.
 - c. Committee Work: provide oversight for specific operations and support the staff in successfully carrying them out.
 - d. Finance: ensure that SSCOIE is financial accountable, transparent with Transformation funds, and on a path to sustainability
 - e. Advocate in the Community: To advocate for and serve as ambassadors for the SSCOIE in the community and among peers.

The initial BOD slate will be nominated by collaborative partners. Terms for the initial slate of board members will be staggered in 2- and 3-year service lengths to allow for continuity across election cycles. Upon installment, the current BOD will draft and approve the bylaws before filing formation documents with the state. The bylaws will outline how policies be formulated and priorities set, e.g., establish mission and vision, code of ethics, duties and liabilities, etcetera. The Board Chair will be elected by popular vote of the appointed BOD on an annual basis. Each newly-elected board member will take the oath of office prior to any action.

2. **Non-profit Entity (SSCOIE)** – The nonprofit entity will play a vital role in building a healthy community and executing the mission to bring critical infrastructure and services that contribute to improved health equity for older adults and economic value to the local community. The SSCOIE will be a steward of the Transformation funds and a voice of the people they serve. The new 501 (c)(3) will be created if/when the Transformation project is selected for funding. The executive director will work with the board to review/revise the 5-year plan set forth in this proposal. The first major task of the executive director will be working with the BOD to establish a 90-Day Action Plan to break down key priorities into smaller chunks of time that are more manageable for the new entity.

- 3. **Community Advisory Council** – the Community Advisory Council will be a formal channel for community engagement and input into the direction of the SSCOE. The members of the Council (~5 to 9 seats) will be independent community members and leaders who provide input and guidance to the SSCOE management team.



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

To ensure collaborating entities be made accountable for achieving desired outcomes, a **binding collaboration agreement** will be put in place and signed by all entities before any Transformation funds are administered. This agreement will set out the scope of the project, guidance on how the parties will work together, and responsibilities and obligations. This agreement will also include a process for reporting and enforcing policy and procedure adherence. We will craft this agreement with extensive participation from each participating entity under independent legal counsel.

New Legal Entity

Will a new umbrella legal entity be created as a result of your collaboration? **Yes**

Please give details on the new entity's Board of Directors, including its racial and ethnic make-up.

There will be 5 members of the SSCOE Board: 3 members from our cross-provider partnership of collaborators, 1 independent/community member, and the SSCOE CEO. The initial Board of Directors is described in detail below:

NAME	ORGANIZATION	RACE / ETHNICITY	GENDER
Zaldwaynaka (“Z”) Scott, Esq.	President <i>(Chicago State University)</i>	Black / African American	Female
Leon Walker, Esq.	Managing Partner <i>(DL3 Realty)</i>	Black / African American	Male
Charles Holland	President & CEO <i>St. Bernard Hospital and Health Care</i>	White / Caucasian	Male
Derek Robinson, MD, MBA	Vice President & Chief Medical officer <i>(Blue Cross and Blue Shield of Illinois)</i>	Black / African American	Male
TBD	Executive Director <i>Southside Center for Older Adult Health and Wellness</i>	TBD	TBD

Payments and Administration of Funds

Note: It is likely that transformation funds for proposals will come in the form of utilization-based Directed Payments to a healthcare provider(s) or behavioral health provider(s) in the collaboration. These entities will receive a report earmarking these payments as transformation funds. These funds must then be distributed among the collaborating entities.

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

Directed Payments

St. Bernard Hospital and Health Care Center (STBH) is a safety net hospital partner (and Medicaid provider) and will be designated to receive HFS directed payments on behalf of the Collaborative. Directed payments received by STBH will be directed to the nonprofit entity “SSCOE” to execute the proposed transformation project. The Board of Directors Boards will have a fundamental, legal responsibility to provide financial oversight and accountability for the SSCOE, it will be the BOD’s fiduciary responsibility. A key aspect of our financial plan will be to conduct an annual independent audit that will be reviewed by the BOD. The independent analysis will consist of an auditing firm outside of organization examining our financial statements, records, transactions, accounting practices, and internal controls.

5. Racial Equity

Background on HTC and racial equity:

This form contains a racial equity impact assessment, or REIA. An REIA is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision. REIAs are used to minimize unanticipated adverse consequences in a variety of contexts, including the analysis of proposed policies, institutional practices, programs, plans and budgetary decisions. The REIA can be a vital tool for

preventing institutional racism and for identifying new options to remedy long-standing inequities. (Source: Race Forward - "Racial Equity Impact Assessment")

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.)

Over 1.1 million residents live in Southside communities. Its residents include some affluent and middle-class populations; however, the majority are historically underserved, poor, and minority. **Compared to other areas in Chicago, the Southside has lower life expectancy, higher economic hardship and social vulnerability, and striking inequities in chronic disease mortality [24].**

Disparities seen between the Southside and other parts of Chicago is largely due to the fact that Chicago is one of the most racially segregated and medically underserved communities in the United States. Older adults in the region disproportionately suffer from age related health conditions that impact their physical and mental health [7]. Given this, racial equity is at the core of this transformation initiative. The SSCOE will work to deliver integrated care delivery models that offer “whole-person” care that is culturally tailored to address the needs of the diverse populations in our service region.

Two key components of our strategy to address racial equity include prioritizing diversity among 1) the workforce and 2) business/vendor partners that reflect the diversity of the community we aim to serve.

- 1) **Workforce** – evidence shows that diversifying the healthcare workforce is key in addressing health disparities [25]. This project will create a significant number jobs and workforce development/training opportunities for Southside residents.
 - a. **Our projections include hiring approximately 159 new jobs including physicians, advance practice providers, nurses, administrative staff, and other positions.** We will set targets to ensure racial equity in the SSCOE’s hiring practices at all levels, including recruitment, hiring, promotion, and retention practices. We will ensure that hiring directly from the Southside community is the priority of the SSCOE and participant organizations.
 - b. **Our key workforce development partners, such as Chicago State University, have a strong track record of advancing racial equity.** The CSU campus is located in a residential community on Chicago’s Southside, with over 1 million Black and Hispanic residents living within a 10-mile radius. CSU’s enrollment reflects this service area and is classified by the United State Department of Education as a Predominantly Black Institution (PBI). The University’s student population is 70% African American, 5% Caucasian American, 9% Hispanic/Latinos, 3% Asian/Pacific Islander and 13% Other. In addition to accredited advanced and professional degrees, CSU has established multiple non-credit and workforce approved certificates in high demand areas. We have also partnered with Loyola for training geriatric providers and Kennedy-King College to train workers for the project infrastructure.
- 2) **Business Partners** – Execution of the project will require business and vendor partnerships with many stakeholders to deliver products and services. We will make inclusive and intentional consideration for minority and women owned businesses to support the SSCOE’s endeavors to achieve racial equity. The SSCOE will set targets for MBE/WBE utilization for vendor purchasing with a preference for local partners from the Southside community. We have partnered with minority owned or led entities to lead key aspects of this project.

Specific Aim	Lead Entity	Ownership
Clinical: Address unmet medical needs (physical and behavioral) experience by older adults	St. Bernard	Safety-net
Facilities: Invest in St Bernard Hospital’s physical infrastructure to make it modernized and responsive to the service needs of older adults	DL3 Realty	Minority
SDoH: Improve coordinated access to social determinants of health (SDoH) services	Chicago Commons	Minority-led
Wellness: Implement evidence-based wellness programs that facilitate aging-in-place	Smyl Fitness Rx	Minority
Workforce: Build a diverse workforce pipeline for fields in the business and practice of care for older adults	Chicago State Uni.	Minority-led

Our list of vendors includes a rich network of 20+ minority owned businesses and non-profit entities majorly controlled and managed by minorities.

Racial Equity Impact Assessment Questions

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

Given the racial/ethnic makeup of our core service areas, African American and Hispanic groups will be most affected and concerned with issues related to this proposal. Both African American and Hispanic populations have experienced longstanding health disparities such as higher chronic disease incidence, lower access to mental health services and materially lower life expectancies. See Maps 1 – 3 for additional information related to our service area demographics.

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?

Stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities have been meaningfully involved and authentically represented in the development of this proposal. This proposal was designed based on the direct community input of Southside stakeholders from the community. These stakeholders include patients, residents, local business owners, clinicians, healthcare organization leaders, as well as local and state elected representatives.

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?

Non-white communities, particularly the African American community, has been most disadvantaged by systemic issues on the Southside. The evidence linking racism to health disparities is expanding rapidly. A variety of both general and disease-specific mechanisms have been identified; they link racism to outcomes

in mental health, cardiovascular disease, and other outcomes [26]. The vast majority of studies focus on the role of discrimination; that is racially disparate treatment from another individual or, in some cases, from an institution. Among the studies not focused on discrimination, the majority examine segregation. Generally, findings show that racial discrimination is highest among African Americans and, to a lesser degree, Hispanics than among whites [26].

- During our community needs assessments participants noted that geographic areas with the greatest economic disadvantage linked to racism often had the greatest burden of disease. Participants also articulated the impact of poverty on health in terms of the difficult choices low-income families are forced to make. When resources are limited, it becomes very hard to prioritize health.
- **There is overwhelming evidence (both quantitative and qualitative) outlining the disparities that persist along racial and ethnic lines across this region.** These disparities were particularly on display as the pandemic unfolded. City data revealed that Hispanics have the highest Covid-19 infection rates, while Black people have the highest death rates [27]. However, health disparities troubled Chicago long before Covid-19.
- **Evidence shows that racism and inequality show up in doctors' offices, as well.** Nearly half of medical students surveyed believed that Black people have thicker skin, faster-coagulating blood, and/or less sensitive pain nerve endings than white people [27]. Such discriminatory beliefs impact the way doctors respond to patients presenting with health issues.

A key piece of evidence yet to be determined would be definitive data on which racism mechanisms matter most in perpetuating health disparities.

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?

Key conditions such as heart disease, stroke, type 2 diabetes, infant mortality, homicide, opioids, and cancer are the result of health inequities. However, **there is a vast body of scientific evidence that shows racism is at the root of these disparities [26].**

Among other issues related to systemic racism, **in Chicago a primary manifestation of racism is the insidious practice of redlining — the Federal, State, and local government-sanctioned denial of financial services to specific racial groups, primarily Black [27].**

- For decades, the Federal Housing Administration's underwriting manuals instructed banks to "prohibit the occupancy of properties except by the race for which they are intended." Once a neighborhood was redlined, potential Black homebuyers couldn't get loans.
- As a result, of the \$120 Billion in federally guaranteed mortgage lending between 1934 and 1962, 98% went to white families. During this time, real estate speculators would panic white homeowners by telling them their property values would drop if Blacks moved in (blockbusting) and convince them to sell at rock bottom prices. Because Black homebuyers couldn't get bank loans, agents would re-sell them the homes at double the price using predatory housing contracts without mortgage protection.
- The Fair Housing Act of 1968, as well as the Home Mortgage Disclosure Act and Community Reinvestment Act of the 1970s, outlawed racist lending practices. But neighborhoods had already

been polarized, and many remain food and economic deserts. Chicago is particularly malicious when it comes to segregation and plundering the wealth of Blacks.

- **Studies show that Black families on the Southside lost between \$3 billion and \$4 billion in wealth because of predatory housing contracts during the 1950s and 1960s** [28]. Blacks still remain largely segregated into those same areas on the Southside. Even recently in Chicago, JP Morgan Chase has under fire when data revealed that of the financial institution's \$7.5 billion in home loans between 2012 and 2018, only 1.9% went to Chicago's Black communities [27].

The mission of this project goes beyond providing high-quality medical care. We believe we have a duty to participate with the community in addressing the neighborhood's economic health. Bernard Place is a prime example of how our lead entity, St. Bernard, has provided opportunities for families to improve their lives, ultimately benefiting the community that we all share. Between 2000 and 2007 St. Bernard, in collaboration with the city of Chicago and Chicago Neighborhood Initiatives, developed and built Bernard Place, a 77-unit affordable housing development at 64th Street and the Dan Ryan Expressway.

Because of Bernard Place, 77 families have made the Southside their home, bringing vitality and a sense of community pride with them. This Transformation project will seek new ways to bring positive development to the community. Specifically, we will demolish an old structure on the St. Bernard campus so that the land can be in a way that is beneficial to the community.

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

If successful, the SSCOE will, over time, reverse long standing health disparities, improve the health and wellbeing of the most vulnerable Southside seniors; contribute to stabilizing and growing the Southside's employment base, leverage and elevate minority managed, controlled and owned organizations, create a provider workforce that is more reflective of the diversity within community, and enhance care access and experience for individuals facing the highest barriers to high quality care.

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?

This project will improve equity for aging adults on the southside by delivering "whole-person" care designed to improve their health, wellbeing, and ability to remain independent and in their own homes. Another positive outcome is that we will address social determinants of health including but not limited to housing, food, education, employment, healthy behaviors, and transportation to improve health and reduce longstanding disparities in health and health care.

There may be negative or unforeseen consequences for health entities or facilities built on a "sick care" economic model that only thrive financially when community members are disease burdened, hospitalized, and/or institutionalized in nursing homes.

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?

We envision the Southside as a healthy community where everyone has opportunities to thrive (e.g., everyone having access to quality schools, good paying jobs, healthy foods, quality healthcare, affordable housing, and safe neighborhoods, etc.).

The best way to address racial disparities that exist on the Southside of Chicago is to identify the uncomfortable truths and root causes that created them and systematically address those issues head on.

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?

This cross-provider collaboration is proposing “whole-person” care to improve health, wellbeing, and ability of aging adults to remain independent in their own homes. This project will fundamentally transform Chicago’s Southside healthcare delivery landscape, closing longstanding gaps in access, care, and health outcomes for older adults. Accomplishing this objective will require material Transformation funding.

Built with the end in mind, we designed this initiative with mechanisms to ensure successful implementation, community engagement, reporting, and a path to self-sustainability. As outlined in the five-year budget detailed in the proposal, we believe that the funding being requested is sufficient to support the Southside Center of Excellence for Healthy Aging in accomplishing the specific aims that have been outlined in this submission.

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?

We are committed to working with HFS to establish a baseline, set targets and report success indicators and progress benchmarks. The SSCOE will commit to full transparency in reporting. See “Proposed Metrics for Accountability” on page 49.

6. COMMUNITY INPUT

Service Area of the Proposed Intervention

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

Our service area is South Chicago.

Please see maps 1-3 that outline our primary and secondary service area. Our tertiary service area includes contiguous zip codes surrounding our primary and secondary service areas.

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.) Cook

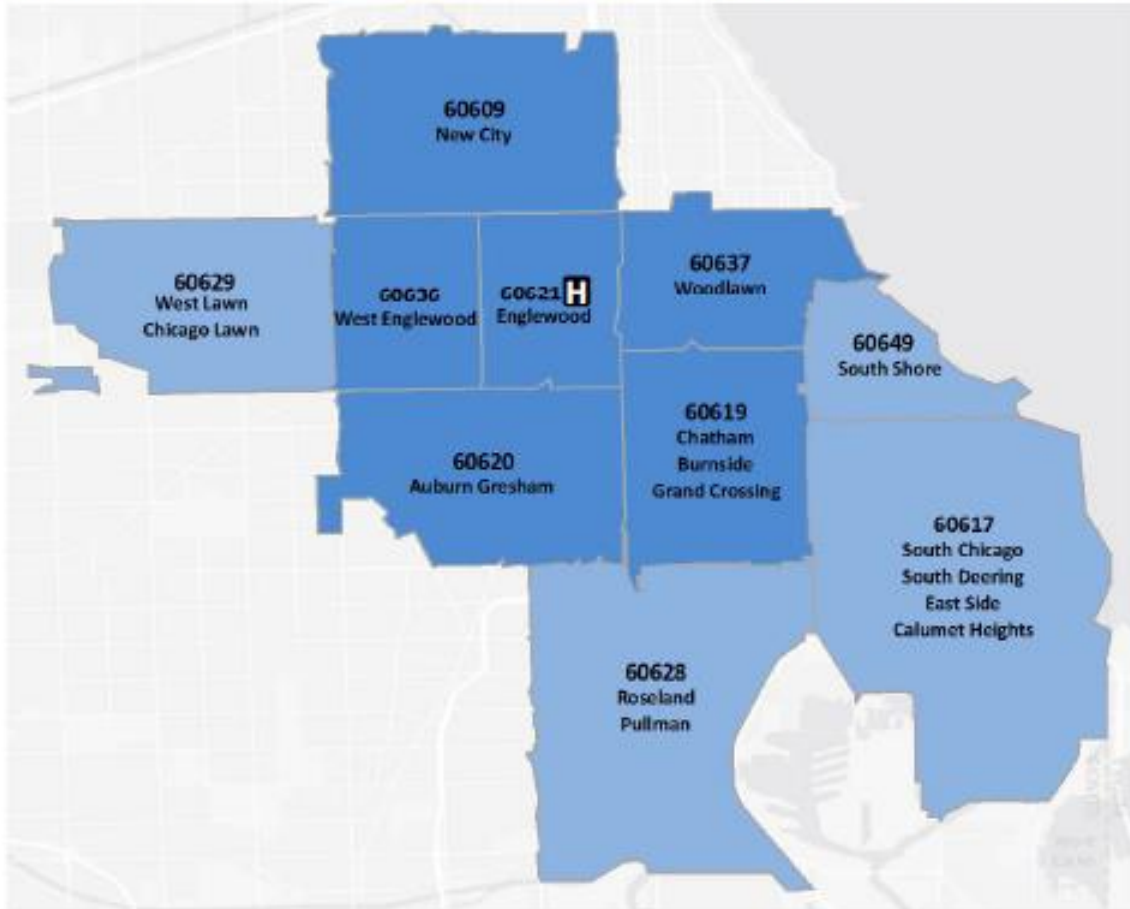
Please list all zip codes in your service area, separated by commas.

60453, 60456, 60459, 60609, 60615, 60616, 60617, 60619, 60620, 60621, 60628, 60629, 60632, 60636, 60637, 60638, 60643, 60649, 60652, 60653, 60655, 60805.

The service area for our total addressable market (TAM) includes all zip codes listed above. However, we will begin by targeting zip codes in our immediate service area (see Map 1 for primary and secondary service map).

Primary and Secondary Service Areas

Map 1. St. Bernard Hospital and Health Care Center's Primary and Secondary Service Areas¹



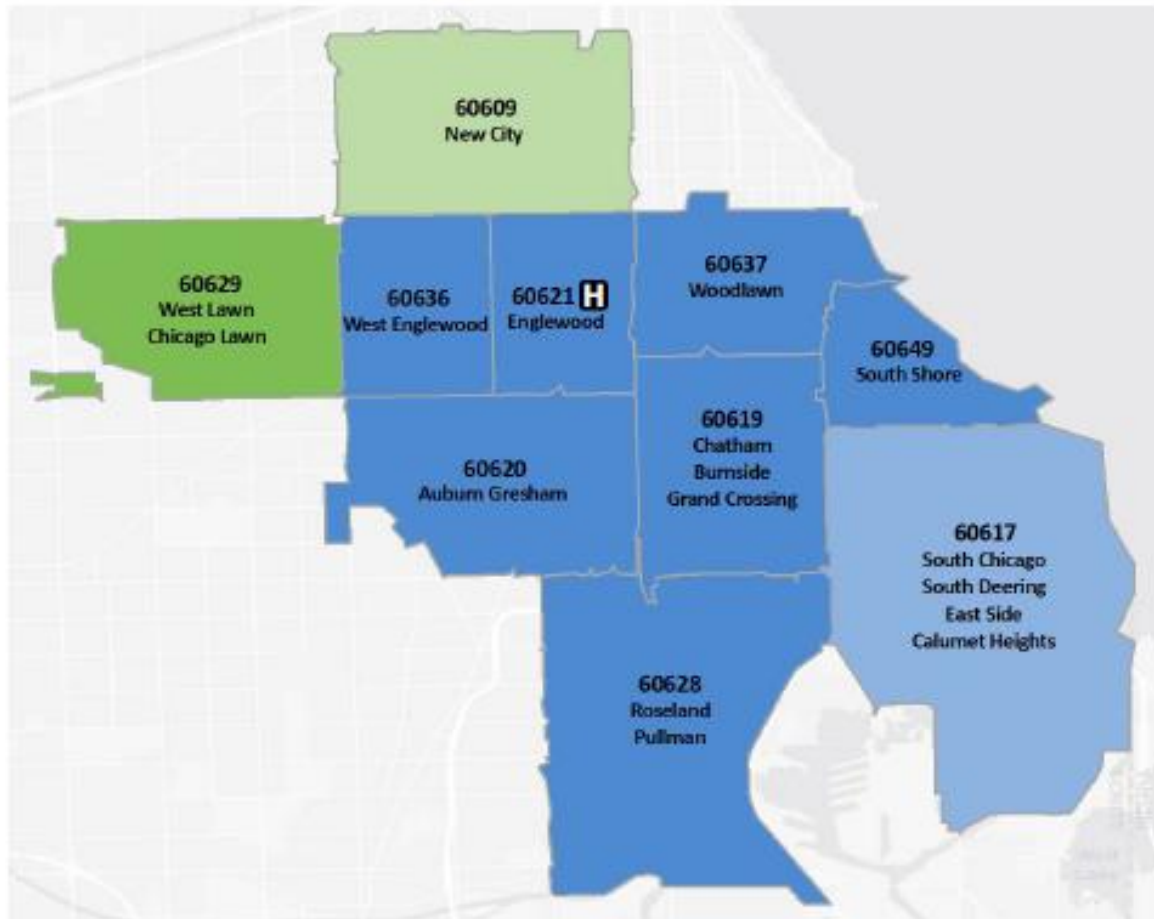
St. Bernard Hospital Service Areas

Primary Service Area Secondary Service Area

1. All Community Areas are approximations, data are representative of the zip codes listed

Service Area Demographics

Map 2. St. Bernard Hospital's Service Area¹ Predominant Racial/Ethnic Groups, American Community Survey 2016 Five-year Estimates

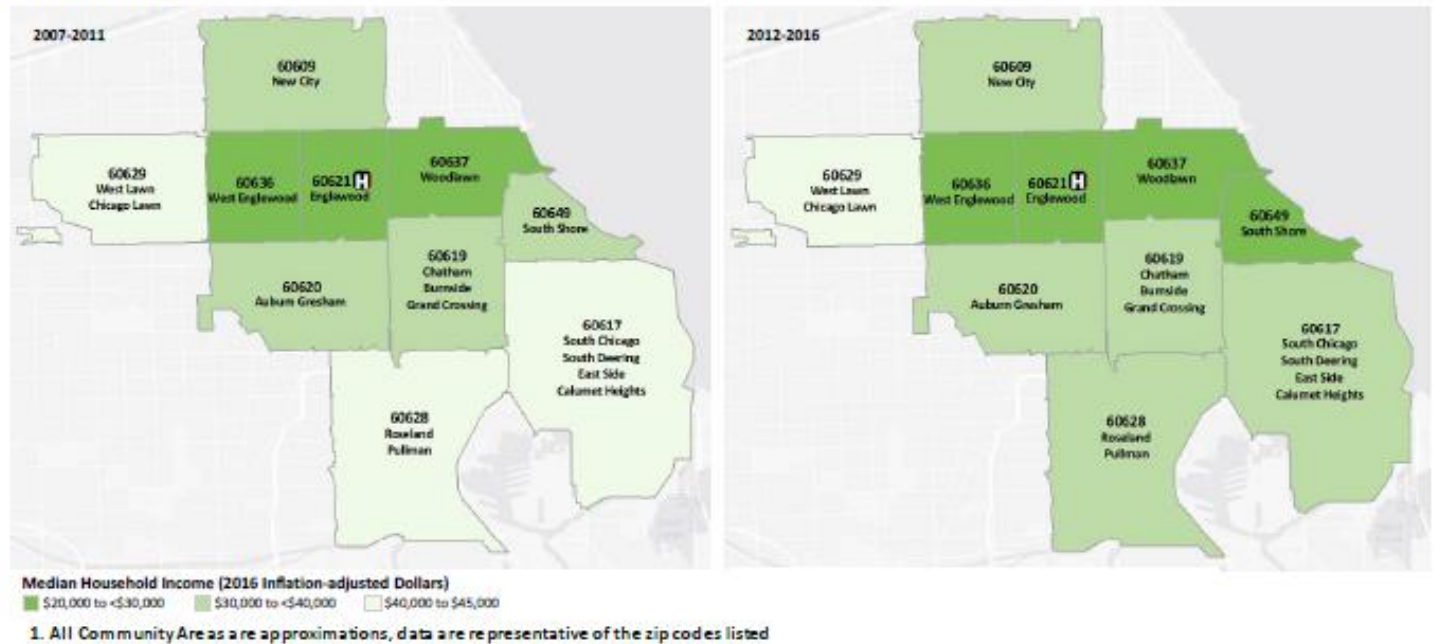


Most Common Racial/Ethnic Group and Proportion of Total Population

- Non-Hispanic Black (50% to <70%)
- Non-Hispanic Black (≥70%)
- Hispanic/Latino (50% to <70%)
- Hispanic/Latino (≥70%)

1. All Community Areas are approximations, data are representative of the zip codes listed

Map 3. Changes in Median Household Income: St. Bernard Hospital's Service Area¹, American Community Survey 2011 and 2016 Five-year Estimates



Community Input

Note on the importance of community input:

For collaborations to meet the real-world needs of the community members they intend to serve, it's imperative that projects be designed with community member input. We are looking for projects that engaged community members in the design of the intervention being proposed. Methods of community participatory research are encouraged.

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

Community engagement and outreach was conducted by the organizations in our cross-provider collaborative. Our primary data collected included focus groups and individual conversations with residents and other stakeholders there were conducted as part of a community health needs assessment (CHNA) and detailed conversations to understand pain points, limitations, and needs specifically related to improving health and wellness of aging adults in our service area.

COMMUNITY INPUT – resident focus

Focus Groups with community leaders and residents, as well as STBH patients and stakeholders, were held to more thoroughly detail out health needs that may not be apparent via secondary data analysis and to contextualize our findings. Secondary data alone cannot tell the whole story of a community; the lived experience and local knowledge of community members is crucial for building a fuller understanding of health and wellbeing.

Conversations began with asset identification, followed by a brief preview of our secondary data analysis results. Participants discussed their reactions to the data, commenting on what surprised them, what was missing, and what else was important to understand about these health issues. Then, participants identified the most important community issues related to health, and shared lessons learned about intervention strategies that have historically worked in the community.

The STBH CHNA Advisory Committee selected and recruited participants with the goal of achieving a diverse cross-section of the community, that focused on representation of seniors, communities of color, and low-income community members. While no group this size can represent the experience or perspectives of the whole community, the participants reflected a broad array of sectors, ages, and lived experiences. In addition to residents, participants had the following affiliations:

- Chicago Department of Public Health (Yaa Simpson, Epidemiologist)
- Englewood Health and Wellness Task Force
- Federation of Block Clubs
- Greater Englewood Chamber of Commerce
- Heartland Alliance
- Heartland Alliance Health, Englewood Health Center
- Howard Brown Health Clinic
- I Grow Chicago
- Imagine Englewood If
- Metropolitan Family Services
- STBH staff and patients
- Voices of West Englewood

Other community-based organizations and non-profits that we engaged included:

- ACCESS Community Health Network (Federally Qualified Health Center)
- Chicago State University
- Chicago Commons

Across these Focus Group conversations, several overarching themes emerged:

Priorities

When asked about what they perceive to be the most important priorities for improving health and quality of life in their community, participants identified the following.

- 1) **Addressing the Social Determinants of Health:** Participants acknowledged poverty as the primary driver of health inequities in the community, and underscored the importance of improving access to quality education and employment in order to build economic wellbeing among community residents. When resources are limited, it becomes very hard to prioritize health. As one participant explained, "If I don't have money for a co-payment, and I had to choose between going with the co-payment or buying my kids' school supplies for school...then I'm not going to the doctor."
- 2) **Specialty Health Care Services:** Participants noted the high need for specialty services. These services are often not covered through medical insurance, particularly among publicly insured populations. Because a high proportion of people in the STBH service area are publicly insured, it is difficult to attract specialty providers to serve the population. As stated by a participant, "A lot of [specialists] don't want to set up offices in our communities...All of those specialties, they don't want to

set up because we don't have the income or we don't have the kind of insurance where they get high reimbursement."

- 3) **Behavioral Health Hospitalizations:** Participants voiced a high need for mental health care in the STBH service area. Participants cautioned that hospitalization data tells an incomplete story of mental health care needs, as many people do not seek mental health care services due to fear, lack of access, or lack of understanding of mental health. One participant stated, "Many of the mental health clinics have closed. People are doing more drugs and...under a whole lot of stress, losing their jobs or whatever...where else can you go to get these people help?"
- 4) **Distrust of the Health Care System:** Distrust of the health care system was another critical component of accessibility. Participants acknowledged a historic distrust of the overall health care system, as well as stigmatization of local health care providers, which prevents community members from seeking care. One of the drivers of this mistrust, in participants' minds, is the complexity and restrictiveness of the health care insurance system, particularly for Medicaid users. Bureaucratic inefficiencies and coverage limitations make it difficult for patients to access the services they need. Participants explained that, "We have a system that doesn't treat patients like people...they become just numbers on a policy or numbers on a list, and they don't get treated like people."
- 5) **Community Outreach:** Participants underscored the need for continued outreach to the community's most vulnerable residents who struggle with social isolation. Speaking of this population, a participant described, "They don't have the support system a lot of communities have, so they have to deal with so much more. It's hard for them to deal with some the very basic things we sort of take for granted, like going to a doctor for a checkup."

COMMUNITY INPUT – healthcare workers (focus on social and wellness prescribing)

Building model that provides "whole-person" care is one that extends beyond the four walls of the healthcare clinic to also address SDOH and wellness. Evidence shows that Clinical care accounts for no more than 20% of a person's health. A full 80% of health can be attributed to a combination of SDOH and individual health behaviors [11].

Social and wellness prescribing is proposed as a way of improving patients' health and well-being by attending to their non-clinical needs that may include:

- SDOH needs (e.g., health education, nutritious food, home modifications to reduce falls)
- Wellness needs (e.g., exercise prescription, smoking cessation, weight loss)

Our wellness partner, Smyl Fitness Rx, conducted interviews with stakeholders 46 (physicians, hospitals, medical practice managers, etc.) to understand pain points and limitations that prevent focus on social and wellness prescribing among providers treating older adults. We also sought feedback on advice for how a "whole-person" care model could be created to address these issues in a meaningful way. Interviews revealed three distinct, yet closely related sets of issues that posed the most significant pain points:

1. TIME AND PROCESS LIMITATIONS

Health providers face numerous frustrating pain points and limitations related (1) lack of time, and (2) poor assessment processes.

- **Lack of time** – Time pressures were the most frequently mentioned pain point. As one physician administrator noted *"bottom line is they're putting the responsibility on the physician; it is just not going to happen, we don't have the time."* Another noted *"the PCP gets dumped on but there is only time to tackle so much."*

- **Poor assessment processes** – staffing and time pressure negatively impact assessment processes. A director of operations at a local healthcare clinic described their assessment process as *“our assessment is weak; we ask maybe 3 questions -- this provides little value if any at all.”*

Ideal solution – participants stated that they want a quick and clinically valid way to assess these issues in a way that fits their current workflow. They also strongly prefer solutions that integrate with their health record.

2. USE OF DATA TO INFORM CARE

Participants were frustrated that current data is (1) too broad to associate with specific actions and is (2) just used for compliance purposes.

- **Data is not actionable** – respondents consistently mentioned that the information is too broad to associate with specific actions. A physician at a senior focused primary care clinic stated *“after we have the information it’s harder to figure out what to do next since the information is so broad.”*
- **Just for compliance** – one healthcare worker stated that *“Medicare requires that we ask some of these questions around social and wellness issues. A concern I have is things are done to remain compliant, but we’re not using that information to have a real impact.”*

Ideal solution – a way to capture meaningful information to inform an evidence-based care plan.

3. CARE OUTSIDE OF THE CLINIC

Participants cited (1) lack of suitable referral sources, and (2) inability to monitor patients between visits as particularly as barriers related to social and wellness prescribing.

- **Lack of referral sources** – although physical activity counseling is a required element of Medicare wellness visits, many felt there were no safe and suitable referral partners to send their older patients. One provider stated *“no, it’s terrible -- there is nothing good out there. This is very much needed -- if you figure it out, let me know.”*
- **Inability to monitor patients** – this was one area where COVID-19 changed everything by exposing a much larger need and willingness to adopt new technology. Respondents expressed pain points around knowing that the patient is receiving the services, if it’s working, and if patients are experiencing any issues. A medical director noted *“we need to know 1) who needs to come back? and 2) who do we have a reason to be concerned about? The health clinic can’t be the one to make that decision because we just don’t have time. This a real gap where patients fall through the cracks”*

Ideal Solution – respondents stated that they need dependable referral sources that can provide wellness/social services, and help monitor patients between clinic visits.

Input from Elected Officials

Did your collaborative consult elected officials as you developed your proposal? Yes

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

- **Mattie Hunter** (State Senator from Illinois' 3rd District)
- **Lamont Robinson** (State Representative from Illinois' 5th District)
- **Sonya Harper** (State Representative from and Illinois' 6th District, Legislative Black Caucus Chair)

7. DATA SUPPORT

Note on the importance of data in proposal design:

It is imperative that applicants use data to design the proposed work. HFS is seeking applications that are "datafirst." This means that applicants used data to determine health needs and designed and targeted the proposed work to meet those needs.

Examples of relevant data include, but are not limited to, data from the community data reports produced by UIC, data analysis of healthcare utilization data, qualitative and quantitative surveys, literary reviews, etc.

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

Overview

We analyzed primary and secondary data to understand the communities in our service area. Collecting our own (primary) data to supplement existing data sources was important for identifying community health needs and barriers to health. Secondary data are often only available for large geographic areas like counties or states; however, examining data at this high level can hide differences that exist at the neighborhood level. Therefore, to understand the unique needs of the neighborhoods served by STBH and identify areas to target for intervention, we assessed health at the zip code level. We compiled and analyzed secondary data from local and national sources for each zip code located within STBH's service area to create the Community Data Summaries included in this report. We collected primary data by conducting Focus Groups with residents in STBH's service area. Lastly, we synthesized findings from these two activities to identify a list of health needs that were subsequently prioritized. The STBH CHNA Advisory Committee, made up of leaders and residents from STBH's service area, informed these activities. STBH worked with the Sinai Urban Health Institute (SUHI) to develop this CHNA.

Data Sources

We leveraged various secondary data sources, including local and federal agencies. Other data sources included public and private resources that synthesize data from statewide hospital databases, national surveys, and surveillance systems such as the Behavioral Risk Factor Surveillance System. Sources used within this include:

- Center for Applied Research and Engagement System (CARES) Engagement Network
- Centers for Disease Control and Prevention
- Chicago Department of Public Health
- Illinois Hospital Association COMPdata Informatics
- Policy Map
- U.S. Census Bureau American Community Survey

Data at the Zip Code Level

Depending on data availability, we collected secondary data at various geographic levels and then converted it to zip code-level estimates as necessary. Generally, data presented in this proposal are for zip code tabulation

areas (ZCTA), which the U.S. Census Bureau creates as an approximation of United States Postal Service zip codes. A measurement exception is preventable emergency department visits which is presented at the zip code level as defined by the United States Postal Service. If data were only available at the census tract level, we aggregated them up to the ZCTA-level. Census tract boundaries do not always align with ZCTA boundaries. Therefore, we only included census tracts with at least 50% of their landmass in the ZCTA as part of the zip code level estimates.

Gaps in Data Collection and Challenges

The main challenges in secondary data collection were identifying the most recent publicly available data, and locating health data at the zip code level.

Please see a detailed list out our sources for this proposal in the attachment titled “References.”

8. Health Equity and Outcomes

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.

Based on findings from our primary and secondary research, we aim to target specific health disparities for focused programming to improve health outcomes.

DISPARITY	OUTCOME
1. Reduced access to primary and specialty providers with expertise to meet the unique needs of aging adults	<p>Increase access key primary care and specialty providers</p> <p><i>The geriatrician shortfall in Illinois is estimated to be over 700 and the ratio of primary care providers to residents in the majority of Southside neighborhoods is less than half of the Chicago average [6].</i></p>
2. Reduced access to mental and cognitive health services	<p>Increase access and follow-up rates for individuals in need of mental health services, including Alzheimer's Disease and Alzheimer's Disease Related Dementias (AD/ADRD)</p> <p><i>The Illinois State Plan on Aging reported that Alzheimer's disease to be more prevalent among African Americans and Hispanics than among other ethnic groups [4].</i></p>
3. Higher than average preventable hospitalizations and ER utilization	<p>Reduce preventable hospitalizations and length of stay through improved referral, outreach, and care coordination</p> <p><i>For example: Falls are a leading cause of injury and preventable utilization among older adults. According to the CDC, in 2014 Illinois Medicaid costs in related to falls among older was over \$263,000,000 [29]</i></p>

<p>4. Higher incidence of frailty and functional decline</p>	<p>Reduce frailty and functional decline through improved screening and proactive referral.</p> <p><i>This disparity leads to numerous adverse outcomes such as falls, ER utilization, hospital length of stay, nursing home admission. [30] [14]. Illinois being one of the most over-bedded nursing home states in the country [8]).</i></p>
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Older adults from the African American and Hispanic communities on Chicago’s Southside are disproportionately affected by very poor outcomes in these conditions, reflecting the scale of needed change across the healthcare and social service delivery ecosystem. Studies have found that lower socioeconomic status is associated with poorer health and reduced lifespan in the U.S. Scientists have also observed sex differences in health and longevity. For example, overall women live longer than men, but are more likely to develop osteoporosis or depressive symptoms or to report functional limitations as they age; men, on the other hand, are more likely to develop heart disease, cancer, or diabetes.

Social environmental factors such as residential segregation, discrimination, immigration, social mobility, work, retirement, education, income, and wealth can also have a serious impact on health and well-being. Economic circumstances can determine whether an individual can afford quality health care and proper nutrition from early life into old age. Individual and family financial resources and health insurance often determine whether an older adult enters an assisted living facility or nursing home or stays at home to be cared for by family members. The causes of health disparities are dynamic and multidimensional, and to address them adequately, SSCOE will consider environmental, social cultural, behavioral, and biological factors. For this reason, we will use an “whole-person” approach to addressing health disparities related to aging.

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?

DISPARITY	ACTIVITES/IMPACT
<p>1. Reduced access to primary and specialty providers with expertise to meet the unique needs of aging adults</p>	<p>Key Activities</p> <ul style="list-style-type: none"> • <i>Recruitment</i> - develop a recruitment and retention program to attract key primary and secondary providers. Key components will include: loan repayment and advanced training opportunities. • <i>Build reputation and trust</i> – to be become a “destination” for both providers and patients. Key aspects of this process will include: analyze customer service data, patients focus groups, building an age-friendly environment, and working with a local branding/marketing firm to keep residents up to date on our improvements, outcomes, and steps to better serve their needs. <p>Measurable Impacts</p> <ul style="list-style-type: none"> • <i>Quality Outcomes</i> – see attachment titled “Proposed Metrics for Accountability” • <i>Visit volume</i> – there a clear unmet need for primary, specialty, and immediate care services for older

	<p>adults in our service region. An immediate measurable metric that we will track is visit volume</p>
<p>2. Reduced access to mental and cognitive health services</p>	<p>Key Activities</p> <ul style="list-style-type: none"> • <u>Screening</u> – incorporate mental and cognitive screening into our “whole-person” intake assessment. This will help to proactively identify underlying issues that are appropriate for referral or follow-up • <u>Virtual Behavioral Health</u> – initiate a program for online counseling and high-quality virtual behavioral health to increase access to services <p>Measurable Impacts</p> <ul style="list-style-type: none"> • <u>Screening rate</u> – analyze the % of older adults served that were screened for mental and cognitive services. • <u>Referral rate</u> – we will use standard screening surveys with pre-determined thresholds to guide referral and follow-up
<p>3. Higher than average preventable hospitalizations and ED utilization</p>	<p>Key Activities</p> <ul style="list-style-type: none"> • <u>Health education</u> – our focus groups revealed the need to improve health literacy to drive utilization of local health care providers for preventive services as key for reducing avoidable ER visits and hospitalization • <u>Risk stratification</u> – proactively identifying patients that are likely for readmission or ER utilization and proactively reaching out and engaging with those members <p>Measurable Impacts</p> <ul style="list-style-type: none"> • <u>Preventable ED visits</u> – we currently analyze the zip codes and diagnoses that drive preventable ED visits. We will measure the impact of the actions above by tracking these results before and after implementation
<p>4. Higher incidence of frailty and functional decline</p>	<p>Key Activities</p> <ul style="list-style-type: none"> • <u>Screening</u> – perform functional assessment screening on every older adult • <u>Proactive referral</u> – proactively refer patients for services (e.g., exercise, home health therapy, fall prevention training, etc.) based on evidence guidelines <p>Measurable Impacts</p> <ul style="list-style-type: none"> • <u>Quality Outcomes</u> – see attachment titled “Proposed Metrics for Accountability” • <u>Functional scores</u> – we will measure the impact of the actions above by tracking functional scores before and after implementation

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

We believe evidence-based practice is key to achieve our intended impact of addressing health disparities that exist on the Southside of Chicago. All of the specific aims outlined above are evidence-based, tailored to meet to the unique needs of older adults, and designed with a health equity lens. However, our respective experiences have taught us that bringing evidence to routine clinical care remains elusive, challenging, and is often underfunded. To facilitate success, we will approach implementation of these initiatives as occurring in phases of change. Early phases of change related to increasing staffing and implementing the “whole-person” care model.” Later phases of change might reflect a readiness for a practice change, widespread rollout, and efforts to institute sustainable change over time. Ultimately, we believe the proposed activities will be successful because we have committed to ensuring that we align all phases of implementation with clinicians, organizational leaders, and key stakeholders (e.g., patients and families).

9. Access to Care

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.

Access to health care on the Southside looks starkly different than other areas in Chicago. As one of the most medically underserved communities in the U.S., this difference is particularly magnified among older adults [31]. The current and future geriatrician shortfall in Illinois is estimated to be over 700 geriatricians and the ratio of primary care providers to residents in the majority of Southside neighborhoods is less than half of the Chicago average [2].

The primary care provider ratio per population is lower on the Southside of Chicago than it is in the city in general. At safety net facilities like STBH providers are often tasked with caring for populations who lack access and resources to easily get the care they need.

- Primary care physicians on the Southside are often under resourced and asked to do more, with less
- Safety net hospitals on the Southside have difficulty maintaining adequate specialty care networks, resulting in long appointment wait times

The SSCOE will increase access to care in key areas that are critical to meeting the growing needs of aging adults on the Southside:

- 1) Ambulatory Care for older adults
 - a) Primary Care
 - b) Specialty Care
 - c) Care coordination
 - d) SDoH services
 - e) Evidence-based wellness
- 2) Geriatric Emergency Department
- 3) Skilled Nursing Unit (SNU)
- 4) Expanded ICU

1. Ambulatory Care Center for Older Adults (ACCOA) will operate as a “clinic within a clinic.”

The Ambulatory Care Center for older Adults will be housed in St. Bernard’s 70,000-square-foot center Ambulatory Care Center (ACC). The ACC currently provides clinical services along with an onsite laboratory and pharmacy. The ACCOA will leverage the existing ACC to offer comprehensive primary and specialty care for older adults. The ACCOA will not require creation of a new facility and operate as a “clinic within a clinic” / interdisciplinary team that operates in St. Bernard’s current facility. The ACCOA will focus on four evidence-

based elements of high-quality care for our older adults known as “4Ms.” **Evidence shows that implementing the 4Ms in primary care leads to improve outcomes for older adults [32].**

Our 4Ms clinical model of care will include:

- What Matters – know and align care with each older adult’s specific health outcome goals and care preferences
- Medication – carefully review each patient’s medication list for proper indication, dosing and drug interactions
- Mentation – prevent, identify and manage dementia, depression and delirium
- Mobility – ensure that older adults move safely every day to maintain function and independence

ACCOA will operate as a “clinic within a clinic” with the addition of new services specifically tailored to meet the unique need of for older adults:

- **Medical Director:** The ACCOA medical director will serve as the clinician who oversees and guides the care that is provided in the ACCOA, a leader to help define a vision of quality improvement, an operations consultant to address day-to-day aspects of organizational function, and a direct supervisor of the medical practitioners who provide the direct patient
- **Clinic Manager:** The ACCOA will be are responsible for overseeing the daily operations of the center. They will provide administrative support and oversee the hiring and training of staff members, manage activity schedule and service vendors (healthy aging workshops, fitness classes, etc.), coordinate with the liaise with patients and healthcare professionals and coordinate patient care plans.
- **Geriatric Specialists:** Geriatricians and family care providers with specific training in the unique health needs of older adults. Under our 4M team-based model, all medical care for patients in the ACCOA will be coordinated through a primary care geriatrician. Even though patients may see several specialists within St. Bernard’s Ambulatory Care Center (e.g., Cardiology) this approach ensures that all members of a patient’s care team are communicating with each other, as well as with the patient’s family.
- **Geriatric Pharmacy:** Our team will include a geriatric pharmacist to perform medication management and counsel older patients and other providers. Given the rapid aging of our population, polypharmacy is becoming a pervasive problem with significant clinical consequences [33]. Polypharmacy occurs when a person is on too many medications can lead to potentially dangerous drug interactions and means exposure to many different side effects all at once (e.g., tiredness, confusion, falls, depression, etc.).
- **Memory Care:** St. Bernard currently offers a number of outpatient behavioral health services including (individual and group counseling). Our memory care addition will include cognitive assessment tools used to identify older adults living with memory loss, including Alzheimer’s and other forms of dementia. These advanced services will be provided by geriatric psychiatrist and behavioral health counseling.
- **Functional Mobility Screening:** Our team will include functional screening that takes place before the patient is seen by the primary physician. Functional assessments will be used to determine/monitor health over time and proactively initiate treatment options shown to prevent frailty and functional decline (e.g., physical therapy, exercise training, etc.). Functional status is a potent predictor of nursing home admission and many other costs/outcomes not predicted by medical diagnoses [17], however most older adults in underserved communities are cared for in settings where approaches to address functional status are poor, limited, or non-existent [15] [16].
- **Geriatric Care Management:** Our geriatric care management program will consist of licensed nurses/and or social workers along with community health workers. These teams will help coordinate and navigate health care services, patient and family counseling, coordination of SDoH services, and

follow-up during and after hospitalizations or ED visits to check up to see how the patient is doing and ensure there aren't any complications.

- **Care Team Meetings:** ACCOA care team meetings will be key for care coordination and outcome improvement to address health disparities. During these sessions members of the interdisciplinary team will review and update a patient's clinical and nonclinical status and make appropriate changes to the care plan to address changing needs. Decisions made during care team meetings will be monitored during subsequent sessions.

2. Geriatric Emergency Department: Older adults are high utilizers of the Emergency Department (ED). In Chicago Black and Hispanic older adults have the highest rates of ED visits and hospitalizations in the city [2]. This is particularly true on the Southside. Despite high utilization, both the physical environment and care processes in the traditional ED are poorly suited to address the complex needs of older adults (for example, equipment crowded into small exam areas and slippery linoleum floors increase fall risk for older adults). As a result, older adults often experience poor outcomes in the ED [34]. **As part of our transformation, we will implement standardized and evidence-based practices to optimize care for older adults in the ED at St. Bernard Hospital.** Sample implementations include:

- Physical: spaces will be refined to incorporate the needs of older adults, including nonskid floors, handrails, and updated lighting.
- Staffing: ED staff will be educated in geriatric principles and specialized geriatrics providers are available for consult.
- Processes: workflows will be implemented for screening older adults for dementia, delirium, falls and other age-specific issues that apply to older adults.

A key part of this process will be preparing and applying for St. Bernard Hospital (STBH) to receive the **Geriatric Emergency Department Accreditation (GEDA)**. The American College of Emergency Physicians developed the GEDA program to ensure that older patients receive well-coordinated, quality care. Research evidence shows that older adults who visit GEDA-certified emergency departments providing specialized geriatric emergency results in lower Medicare expenditures up to \$3,200 per beneficiary [35]. Why is this important:

- 60% of hospitalized Medicare patients arrive through the ED. When considering the potential savings per beneficiary when geriatric ED are implemented, it's a very significant cost reduction for patients and the payers and results in better care for older adults.
- GEDA will help reduce preventable hospitalizations: By providing specialized services to assess older adults, their needs, and living situations in the geriatric ED, the team can connect older patients with necessary resources, such as home care, physical therapy, or medical equipment, making it safe to discharge them home and avoid unnecessary inpatient admissions.
- GEDA will position STBH for sustainability: Better managing unnecessary ED visits will unclog STBH ED, facilitate more outpatient volume to the ACCOA, and position STBH for improved sustainability with a shift to value-based contracts (e.g., PACE, MA, etc.). Longitudinal data on hospital revenue from successful hospital shows that the aggregate share of outpatient services has soared in the last 20+ years. At the same time, inpatient services are making up less and less of health system revenue and will soon become liabilities [36].

3. Skilled Nursing Unit (SNU): STBH will convert an unused hospital unit into a 20 bed SNU. This SNU will be a short stay unit equipped to focus on short-term rehabilitation in a transitional setting for patients who are medically stable and no longer need acute care, but are not yet ready to go home. Given the high rate of hospitalized older adults on the Southside, there is a need for a high performing SNU to serve the Southside

- 60% of hospitalized older adults discharge to skilled nursing: Based on data from 17 million hospitalized older adults on Medicare, 61% currently discharge to skilled nursing after a hospital stay [37].

- **Lower 30-day readmission:** Older adults discharged to skilled nursing after hospitalization have a 30-day readmission rate that is 5.6% lower than those discharged home [37].

With the focus shift in health care delivery from volume to value, it will be important for STBH to operate more efficiently and effectively regarding site of care. Because one of the most expensive sites of care is the hospital, care has been moving from the hospital setting to the skilled nursing facility (SNF). The cost of most hospital stays exceeds \$2000 per day, while SNU stays are typically less than a quarter of that [38]. Across the Southside of Chicago, thousands of high-cost hospital beds routinely lie empty [39]. One sustainable strategy to address this massive oversupply would be to convert a portion of the empty acute-care beds into SNU beds. Because there is a great demand for those types of beds, such conversions have given hospitals more patients and new sources of revenue. **Converting unused hospital beds/unit to SNU positions STBH for improved financial sustainability and improved outcomes.** Our target of 20 SNU beds could easily be occupied using STBH current inpatient admissions. A simplified and illustrative calculation underscores the rationale:

A.	B.	C.
Calendar Days	Ave. patient length of stay for a rehab focused SNU bed	Number of patients for 100% occupancy for 1 bed (A/B) = C
365 Days	18 Days	20 Patients

Based on this illustrative example, 20 patients with an average lengths of stay (LOS) of 18 days could occupy a single SNU bed over the course of 1 year ($365 \text{ days per year} / 18\text{-day LOS per patient} = 20 \text{ patients}$).

Extrapolating that to 20 SNU beds would mean that 400 patients with an average LOS of would occupy at 100% ($20 \text{ Patients} \times 20 \text{ SNU Beds} = 400 \text{ patients for full annual occupancy}$)

- o Based on 2019 data (*pre-COVID*) STBH had 1,237 inpatient hospital admissions age 65 y/o and greater. As the evidence suggests, 60% of older adults are discharged to skilled nursing following an acute hospitalization [37].
- o This would indicate that 742 older adults hospitalized at STBH are being referred to outside skilled nursing facilities following an acute hospitalization. ($1,237 \text{ acute admissions} \times 0.6 \text{ discharge to skilled nursing} = 742 \text{ current STBH patients discharge to skilled nursing}$).

The point of this simplified illustration is to demonstrate that with conversion of empty hospital beds to a SNU, with STBH discharges alone, **there is already enough demand to fill a SNU. This SNU would support STBH, surrounding facilities, and would immediately establish a new source of revenue for sustainability.** Furthermore, adding a SNU to compliment the geriatric emergency department with GEDA accreditation and Ambulatory Care Center for Older Adults would position STBH for revenue sustainability via value-based payment arrangements.

- **Shorter hospital length of stay:** Quality hospitals make money through shorter lengths of stay. Adding a SNU would enable stable patients to be transferred within the hospital from the acute bed to a SNU bed. Also, with hospitals taking on risk to lower the total cost of care, this option positions STBH for more referral volume and value-based contracts.
- **Direct SNU admissions:** In most cases, when it is determined that a patient needs to be admitted to skilled nursing, they are sent to the ED and then admitted to the hospital. Only after they have been evaluated, are they sent to an SNF. This process can be stressful, costly, and time consuming. Direct admission to the SNU could remedy these issues. While hospitals are working toward fewer admissions, alternatively, SNUs benefit from increased admissions and occupancy. For instance, high volume joint replacements done as an acute/inpatient hospital with a subsequent skilled nursing facility referral for rehabilitation. Now value-based providers decrease the total cost of care want to have patients perform those procedures in an outpatient setting with a direct referral home or a direct admission to SNF to rehab following the procedure.

4. ICU Expansion: Expand existing 10 bed intensive care unit (ICU) by 4 beds to meet unmet demand requirements. Geriatric ICU admissions are a common occurrence, with older adults currently comprising half of all critically ill patients [40]. In comparison to their younger counterparts, older patients are prone to longer stays, and thus constitute the majority of all patient days spent in the ICU.

Based STBH's internal ICU admissions there is an unmet need, largely due to increased ICU admissions and increased length of stay among older adults. This phenomenon is due to a healthcare Ecosystem throughout Chicago and Vicinity that has more demands on ICUs and CCUs than available capacity.

- STBH has a 10 bed ICU with maximum patient days per year equaling 3650 (10 beds X 365 days per year = 3650 patient days.)
- As of 12/31/2020 the total ICU patient days was 3233 out of 3650 or *89% capacity*.
- As of 11/15/2021 the maximum patient days calculated is 10 beds X 319 days year to date equaling 3190 patient days. The number of ICU patient days as of 11/15/2021 is 3253 which equates to **102% capacity**.
- **STBH has more ICU admission/patient days than available beds, as a results patients are holding in the ED waiting for ICU beds.**

Technology will be a key aspect the integrates care across care settings and our cross-provider collaborative of partners. Three important components of our technology suite will include an EMR upgrade (MEDITECH), Patient Emergency Response System (PERS), and admission, discharge, and transfer (ADT) alerts:

- 1) **MEDITECH** - care coordination connects every point of patient care. This will allow us to better extend care beyond the hospital and share information across all settings to get a complete view of our patients' needs.
- 2) **PERS** - Personal Emergency Response Systems (PERS) are medical alert systems, designed to serve as a safety net for frail seniors. We will integrate a hospital based PERS to use among our highest risk members. Evidence show that PERS reduce in per person hospital admissions and inpatient days [41]
- 3) **HealthChoice Illinois ADT / Collective Medical Technologies (CMT):** we will leverage the statewide data exchange platform to enable admission, discharge, and transfer (ADT) alerts.

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 SSCOE will increase access to care in key areas that are critical to providing “whole-person” care that can meet the growing needs of aging adults on the Southside: 1) Primary Care, 2) Specialty Care, 3) SDOH services, and 4) Wellness Services.

Primary Care

Key Activities:

- **Recruitment/ retention** – key components of our program will include an attractive salary, loan repayment incentives phased over 5 years, a sustainable workload that includes built in time off for training. We will also create access to community-based colleagues and specialists for consultation via a partnership with training organizations. Our research into successful physician recruitment programs also informs us that a key aspect to retention involves benefits for spouse and children. This, our program will also include community educational opportunities for their children and opportunities for spousal employment. A key aspect of recruitment will focus on practicing physicians they aren't “net new.”

- Growing commitment and coverage among current contracted physicians that see patients at our facility our surrounding locations, this includes some independent physicians. Many of physicians already have older patients' panels that they could bring with them. Our ACCOA would enable these providers to expand and build out their practice with a growing number of older adults (e.g., 2 days per week they see their Medicare patients at the STBH ACCOA). In addition to financial incentives for coverage (e.g., loan repayment etc.) our facility itself and wrap around services for the physician (scribes, training, enhanced EMR, etc.) and wrap around services for their patients (transportation, care coordination follow-up, wellness services) will make STBH a destination for physicians.
- Professional development – our partnership with Loyola School of Medicine will provide an innovative way to provide geriatrics education and consultation for primary care providers that we recruit to increase access across the Southside. This will expand the capacity to provide high-quality care to the rapidly growing older adult population. This training will include a number of modules specific models that will prepare primary care physicians to provide care that meets the unique needs of older adults (e.g., geriatric assessment, Alzheimer's and dementia screening, hospice/palliative care, etc.).
- Scribe/Clinical Informatics Specialists – as part of the incentive this position will to be the personal data assistant to the provider. This means you handle informatics responsibilities for providers during patient visits in our centers. These individuals will make STBH a more attractive option for providers to practice. Local members from the community will be hired to fill these roles, trained to type 70+ wpm and basic medical terminology. Data shows the adding scribes to primary care settings results in lower physician documentation burden, and improved efficiency, workflow and patient-physician interaction [42].

Health Outcomes – see attachment titled “Proposed Metrics for Accountability” on page 49

Specialty Care

Key Activities:

- Recruitment/retention – see above
- Focus areas – older adults living on the Southside to have elevated rates of behavioral health need, diabetes, hypertension, respiratory disease, arthritis, Alzheimer's, and other chronic conditions leading to disability, functional losses, and cognitive decline. Our plan is the increase access to specialists to serve the unmet needs in priority areas including:
 - Geriatrician (Inpatient and outpatient)
 - Geri Psychiatry (Adult and Geri-Psych)
 - Urology (Inpatient and Outpatient)
 - Pulmonology (Inpatient and Outpatient)
 - Hospitalists
 - Surgeons
 - Anesthesia
 - **Given that STBH will be receiving expanded specialty coverage with other transformation projects, our model focuses on areas specific to older adults and are non-duplicative relative to other efforts.**

Measurable Impact

- Visit volume – there a clear unmet need for specialty care services for older adults in our service region. An immediate measurable metric that we will track is visit volume
- Wait time – a key impact metric will be wait time to access services.
- Health Outcomes – see attachment titled “Proposed Metrics for Accountability” on page 49

SDoH Services

Social determinants of health will be a key focus in our “whole-person” care model. Our specific areas of focus will include the following: economic stability, education, housing, home environment, transportation, food security, and social isolation. We have will partner with minority owned businesses and local non-profits such as Chicago Common to provider services. Please see the social determinants of health section of the proposal for additional details.

Wellness Services

Key Activities:

- Functional assessments – functional status assessments are a cornerstone of quality care for older adults [15] and predict outcomes not captured my medical diagnosis (e.g. ED utilization, hospital length of stay, nursing home admission, etc. [14] [30] [43]. However most older adults are cared for in settings where approached to address frailty and functional decline are poor, limited, or not conducted at all [15] [16]. This disparity leads to numerous adverse outcomes. Our “whole-person” model will include functional assessments (onsite or virtual), analysis, and an evidence-based set of personalized recommendations.
- Fitness classes – Regular physical activity helps improve overall health, fitness, and quality of life. It also helps reduce risk of chronic conditions like type 2 diabetes, heart disease, many types of cancer, depression and anxiety, and dementia [44]. However 80% of adults older over adults don’t get the recommended amount of exercise [45]. There is a particular disparity with lack of exercise and physical activity (PA) among low-income and racial/ethnic minority communities [46]. Our model will include low-impact group fitness classes (onsite and virtual) and personalized exercise prescriptions when exercise is indicated as part of a care plan to address specific issues (e.g., weight management, heart health, diabetes, etc.)
- Health aging workshops - these workshops will feature engaging presentations and discussions of health literacy and healthy aging. Potential areas of focus include fall prevention training, chronic disease and medication management, best foods to build strong muscles after 50, advanced care planning, and other topics related to health literacy for aging adult’s people.

Measurable Impact

- Program engagement – an immediate measurable metric that we will track is program engagement (attendees per session and feedback ratings)
- Functional scores – we will measure the impact of the actions above by tracking functional scores before and after implementation
- Clinical outcomes – evidence shows that improving functional status reduces hospitalizations, nursing home admissions, etc. We will track these measures before and after implementing the actions above

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

As with initiatives previously outlines, we believe evidence-based practice is key to achieve our intended impact of addressing health disparities that exist on the Southside of Chicago. All of the specific aims outlined above are evidence-based, tailored to meet to the unique needs of older adults, and designed with a health

equity lens. However, when increasing access, uptake and adoption efforts are key to drive the intended impact. In this regard we will focus on community engagement to build trust and reputation and patient-friendly implementation.

10. Social Determinants of Health

Note on the significance of social determinants of health:

A full 50% of a person's health outcomes can be attributed to social determinants of health (that is, factors such as education, economic stability, housing, access to healthy food, access to transportation, social support and environment). Given this, we are looking for collaborations that meaningfully address social determinants of health in coordination with physical and behavioral health.

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.

Addressing social determinants of health is important for improving health and reducing health disparities. In fact, evidence shows that social determinants of health (SDOH) have a higher impact on population health than clinical and that a higher ratio of social service spending versus healthcare spending results in improved population health. Social determinants of health will be a key focus in our “whole-person” care model. Our specific areas of focus will include the following: economic stability, education, housing, home environment, transportation, food security, and social isolation.

Social Determinant	Key Activities
Economic stability	<ul style="list-style-type: none"> • Community based job created • Credit counseling • Educational workshops in the areas of financial management budget counseling, homebuyer education, foreclosure prevention, and non-delinquency post purchase.
Health Education	<ul style="list-style-type: none"> • Healthy aging workshops • In-clinic education
Housing	<ul style="list-style-type: none"> • Housing counseling assistance
Home environment	<ul style="list-style-type: none"> • <i>Home safety check</i> • <i>Handyman service for installation of minor items to improve safety, mobility, and ability to age in place. Such as:</i> <ul style="list-style-type: none"> — <i>Installation of grab bars</i> — <i>Assembly of tub bench, shower chair, or raised toilet seat.</i>
Transportation	<ul style="list-style-type: none"> • Non-emergency medical transport (doctors' appointment, hospital, physical therapy, etc.) • Transport to and from community-based events (foodbanks, fitness classes, healthy aging workshops, etc.)
Food security	<ul style="list-style-type: none"> • Nutrition counseling • Connection with food banks or other assistance programs • Meals-on-wheels
Social Isolation	<ul style="list-style-type: none"> • Healthy aging workshops

	<ul style="list-style-type: none"> • Fitness classes • Community events • Referral to mental health if need be
Other	<ul style="list-style-type: none"> • Advanced care planning (5 wishes)

Chicago Commons will be one of our key SDoH partners. Chicago Commons is one of Chicago’s largest non-profit providers of senior care and family services in Chicago. Sample services include:

- **Adult Day Services:** setting in which seniors and adults with disabilities are transported to our center to receive individualized care in a community-based group setting, etc.
 - Wheelchair-accessible transportation
 - Nutritious meals
 - Physical exercise and range of motion activities
 - Recreational and social activities
 - Health monitoring and personal care

- **Home Care:** services to support older adults’ ability to remain independent in their home through the help of an aide. A caregiver visits daily or weekly to assist with activities including:
 - Personal care, bath and tuck services
 - Cleaning/light housekeeping
 - Medication reminders
 - Planning and preparing meals
 - Laundry, shopping, running errands and escorting to appointments
 - “Welcome back” after hospital stays
 - Specialty care: Alzheimer’s, Diabetes, Parkinson’s and traumatic brain injury
 - *This program will also integrate with our workforce development pipeline. Chicago Commons will collaborate with CSU in training family members to received employment by providing care giver services.*

- **Family Hub:** *The Family Hub programs empower families to overcome poverty, systemic barriers, and embrace opportunities.*
 - Manage their finances
 - Improve their physical and mental health
 - Gain employment and job-readiness skills
 - Increase digital literacy
 - Advocate for themselves, their children/grandchildren, and their communities

Family Hub’s Pathways also offer a program for parents (or grandparents) to gain a career in early childhood education. This cohort-based program offers fully subsidized college courses conveniently located at one of our early education centers, guidance to become qualified as a teacher’s assistant, and help with transportation, meals, and childcare. After earning just six college credits, participants are qualified to be hired as a Teacher’s Aide in early education.

A core part of our SDOH program will include comprehensive screening to identify gaps/social needs and match older adults with the appropriate vendor and services to help them thrive

Screening:

Our “whole-person” model will include SDOH screening for each patient age 65 and over. Screening will take place at the point-of-service (e.g., primary care offices, emergency departments, during acute stay, etc.) or remotely via phone call or phone-based survey. For scheduled appointments, screening will take place before the patients arrives for the visit (via phone call or phone survey). Pre-visit screening will be conducted from the SSCOE hub by trained community health workers (CHW). For unscheduled visits SDOH screening will take place at the point-of-service by community health worker (CHW) staffed at STBH. data and results from all screening will be included in the “whole-person” assessment. Our SDOH screening will be multi-component and will include program will include two components:

1. **Standardized Screening:** standardized screening like the Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) from the National Association of Community Health Centers (NACHC).
2. **Age Specific Screening:** home safety based on the Centers for Disease Control and Prevention A Home Fall Prevention Checklist for Older Adults, and the Elder Abuse Suspicion Index (EASI). The EASI has been validated in a primary care setting and can be used to screen cognitively intact patients [47]

Training:

Our training will primarily focus on programs for providers and clinical support staff:

- **For providers:** We will contract with external vendors for training programs to prepare family care physicians and advanced practice providers with resources and training to meet the unique needs of older adults. A key aspect of this training is educating providers how to assess for SDOH needs among older adults during initial/follow-up exams and helping providers to understand referral options.
- **For support staff (and pharmacists):** we have partnered with Chicago State University as a partner train and create an employment pipeline, particularly for professionals that will provide and coordinate SDOH supports. The university’s five colleges- Health Sciences, Arts and Science, Business, Education, and Pharmacy offer 36 undergraduate and 30 graduate degree-granting programs. In addition, CSU has a Division of Continuing Education and Non-Traditional Programs that reach out to the community with extension courses, distance learning and not-for-credit workforce programs. Within their Institute for Solutions of Urban Populations, CSU is prepared to propel workforce development; increase economic stability in the region; and create more equitable access to education and healthcare.

See workforce training plans in the “Jobs” section of the proposal for additional details (page 45).

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?

HEALTH OUTCOMES: Mortality, Morbidity, Life expectancy, Health care expenditures, health status, functional limitations

Measuring Success:

The SSCOE will track and measure the model's success by tracking four metrics: 1. Number of patients screened for SDOH, 2. Number of referrals made to social service and community benefit organizations, 3. Number of workforce participants in training programs, and 4. Number of new jobs created by SSCOE related to SDOH.

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

Addressing social determinants of health is not only important for improving overall health, but also for reducing health disparities that are often rooted in social and economic disadvantages. We believe the proposed activities will led to the intended impact because they a part of a “whole-person” care model that centers access and delivery of wellness and SDOH along with clinical care.

10. Care Integration and Coordination

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

In addition to coordinating care “during” visits, we will focus on gap that often arise pre and post-visit. This focus will improve integration, efficiency, and connection across providers within and beyond the four walls of the clinic. As outlined below, certain components of our care coordination efforts will take place onsite at the hospital/ACCOA and others will take place remotely via phone calls, telehealth, etc.

- **Pre- visit:** for example, before an older adult sees a provider in the ACCOA our efforts will focus on conducting components of the “whole-person” screening to assesses issues such as SDoH needs, functional status, and mental health in addition to standard clinicals that are addressed before seeing the doctor.
- **Post visit:** post visit care coordination efforts will focus on follow-up and transitional care process (e.g., getting home safe, medication management, 3, 7, 14, 30-day follow-up). Another key component of our follow-up process will be assisting older adults and their families in navigating the process for specialists' visits, labs, imaging, and services received via local SDoH and wellness vendors in our network.

We will fund, train and deploy care coordination teams to synchronize the delivery of clinical, wellness, and SDoH services. Information from our community input and assessment data inform us that there will be a need for two types of services:

- 1) Medically focused care coordination (e.g., older adults receiving primary care at St. Bernard). These embedded care coordinators will work with their respective teams in the ACCOA and hospital to proactively identify/address patient health needs and provide follow-up care.
- 2) Community based care coordination (local older adults living on the Southside that do not receive primary care at St. Bernard, but are could still benefit from care coordination services for non-clinical needs such as SDoH and wellness services).

In our model, community health workers (CHWs) will be cross-trained to both collaborate with/work alongside medical professionals on a clinical care team and perform community engagement activities. In this capacity, CHW may perform a range of services such as conducting wellness screening questionnaires, patient navigation, community outreach and education, and assisting with referrals.

Teams will engage in three key activities: 1) assessment/screening, 2) integrating clinical, wellness, and SDOH services, and 3) follow-up engagement. The SSCOE will work with local training programs and public health partners to recruit, hire and train a community-based workforce.

Overview of the community and clinic-based care coordination roles:

	Community Based	Medically Based
Target clients	<p>These older adults are “unattached” and represent the broader Southside community (e.g., they have an established PCP outside of STBH and received geriatric consults at STBH).</p> <p>This community-based team will focus on improving outcomes for the entire community regardless if they receive clinical care at STBH or elsewhere.</p> <p>If is unmet clinical need, they can provide warm referral to STBH primary care team. If the patient aligns with a PCP team at STBH they will be assigned to a coordinator on the clinic-based team.</p>	<p>These older adults are <u>“attached”</u> to STBH</p> <p>They are receiving primary care at STBH. The care coordinator will be part of their dedicated medical team (PCP, RN, MSW, etc)</p>
Services	<ul style="list-style-type: none"> • <u>“Whole-person” screening</u>: administer assessments to support older adults in identifying needs (SDoH, wellness, health risk) • <u>Advocate</u>: care plan development and follow-up with patients to monitor and evaluate satisfaction or with care/services delivered. • <u>Coordination</u>: communication between staff, patients, family, community service vendors etc. <p><i>*Clinical coordination: the medical-based model will also provide specific clinical follow-up services such as connection to specialists, follow-up on doctors’ orders, updating on patient status during interdisciplinary meetings, etc.</i></p>	

Engagement	<p>These older adults will be engaged during out community outreach events, health fairs, etc.</p> <p>Once engaged they will be assigned with a CHW to help coordinate SDoH and wellness needs</p>	<p>These older adults will be engaged in before, during and after receiving clinical care at STBH.</p>
Technology	<p>Information from screening and care coordination will be stored on a cloud-based care management platform and securely shared and integrated across the entire care team.</p> <p>Examples include:</p> <ul style="list-style-type: none"> o <u>MEDITECH</u>: upgrading STBH EMR with Meditech Expanse with offers case management and a centralized solution for coordinating all patient activity from admissions through discharge. o <u>HealthChoice Illinois ADT / Collective Medical Technologies (CMT)</u>: we will leverage the statewide data exchange platform to enable admission, discharge, and transfer (ADT) alerts. 	

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

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

Care Coordination Staffing Ratios			
	High Risk	Moderate Risk	Low Risk
RN CM	1: 75	1:200	1:600
Social Worker	1:400	1:800	N/A
CHW	1:700	1:900	1:1000

These staffing ratios are designed for a team-based care coordination approach to serve older adults. For instance, a team serving a high-risk population of 120 older adults might consist of (1 RN, 0.25 MSW, 0.25 CHW). We will build a total of 6 care teams to serve high and moderate/low risk older adults:

- o High Risk = 2 care teams at a cost of \$500,000*
- o Moderate risk = 3 care teams at a cost of \$650,000
- o Low risk = 1 team at cost of \$150,000

*Expenses outlined above are absolute costs that are annualized and based on risk stratified caseload. Actual costs will appear in the budget scaled according the annual FTE onramp rate (e.g., in year 1 some care coordination staff members will operate at 0.5 FTE after hiring in month 5 or 6).

Are there any managed care organizations in your collaborative? **No**

If no, do you plan to integrate and work with managed care organizations? **Yes**

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

The SSCOE is fully planning to engage with the managed care organizations currently contracted with the State of Illinois. The safety net collaborator, St. Bernard Hospital is contracted with all of the companies in the Managed Medicaid program: AetnaCVS, Blue Cross Blue Shield of Illinois, County Care, Meridian, and Molina. St. Bernard will work with each MCO to connect their care coordination efforts to the MCOs.

Specifically, St. Bernard Hospital will build capacity to identify that Medicaid health plan of the patient on admission and alert the health plan:

- 1) **Data:** St. Bernard will contract with the states designated company providing admission, discharge, transfer information to the Medicaid program, CMT, inc. then connect with the MCO care coordination teams. This investment from the transformation funds should facilitate transition of care support for Medicaid beneficiaries who are being discharged from the hospital.
- 2) **Care Coordination:** In collaboration with the MCOs, St. Bernard care coordination team will work to transition all discharged persons to a primary care appointment within 7 days of discharge. The efforts will specifically target people living with hypertension, diabetes, mental health, substance abuse, asthma to facilitate and proper handoff at discharge. Please note that these efforts will not be limited to seniors but will provide to all admitted to the acute care facility and the emergency room. In fact, this is a specific set of activities that the transformation funds will support as a result of an overall buildout of transition of care, discharge, and care coordination back to community.
- 3) **Referral Networks:** The SSCOE and St. Bernard will meet with all MCOs to fully understand their referral networks, disease management programs, incentive programs for quality, and any other programs and benefits they offer to their members.
- 4) **HEDIS/Quality:** The Center and St. Bernard will sit with each MCO to understand St. Bernard's admission and discharge profile and then work with the MCO to strategize about how it can improve follow-up and ultimately improve access of all Medicaid beneficiaries who are admitted and discharged from St. Bernard to receive appropriate preventive services including those that are a part of the states HEDIS/Quality Improvement program. The Center and St. Bernard will work to collaborate with the MCOs to decrease readmission rates if over the national average.
- 5) **Operations:** St. Bernard will meet each MCO to understand their reasons for claims denials. St. Bernard will use this information to improve the completeness of their billing documentation. St. Bernard will work to be sure that their provider roster is fully completed and up to date in the Medicaid Impact system to decrease claims denials due to incomplete or inaccurate provider information.

11. Minority Participation

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.

Health equity, minority participation, and building capacity to empower minority owned businesses that that serve the community are core aspects of this collaborative led by the following:

- o St. Bernard Hospital – safety-net hospital
- o DL3 Realty – minority owned business
- o Chicago Commons (SDoH) – minority led non-profit
- o Smyl Fitness Rx – minority owned business
- o Chicago State University – predominantly Black, public university

Our list of vendors includes a rich network of minority owned businesses and non-profit entities majorly controlled and managed by minorities. Although many minorities business partners have not yet obtained the BEP certification, we value their expertise and culturally tailored approach. Please see below for a list of our business partners/vendors. As part of our commitment to minority participation, the we will target at least 40% of operating spend to service providers that are minority owned businesses and minority managed or controlled not for profit organizations. Examples of these purchased services and funding subsidies include but are not limited to direct care provision, education and training, care coordination, and community services focused on wellness and social determinants of health.

List entities here:

Entities that are majorly controlled and/or managed by minorities:

- o Chicago State University
- o Chicago Commons

Name	Description	Service Area	Ownership
Smyl Fitness Rx	Preventative fitness and wellness solutions for older adults (focus on functional decline and chronic health conditions)	Wellness	MBE in progress
Chicago Commons	Provider of senior services to help older adults with disabilities stay in their homes, maintaining their independence and quality of life.	SDoH	Minority led non-profit
Chicago State University	Public university that offers advanced, professional, and non-credit workforce approved certificates in high demand healthcare areas	Workforce	Predominately Black public university
DL3	Full-service real estate development firm committed to accelerating the transformation of the Southside. DL3 has successfully executed a number of high-profile projects from medical centers to grocery stores.	Facilities	Minority
Purpose Brand, LLC	Award-winning PR, brand and digital content marketing firm in Chicago	Branding and community engagement	WMBE

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Williams Accounting	Williams Accounting provides bookkeeping, tax preparation and financial reporting	Accounting	Minority
CS Strategies	Risk management, commercial insurance, group benefits	Insurance	BEP
EC-United	IT consulting (expertise in healthcare)	IT consulting	Minority
Capgenus	Management consulting, research, and innovation for advancing business growth and population health.	Health consulting	Minority
Chicago Urban League	Chicago Urban League's Housing and Financial Empowerment Center (HFEC) is a HUD-approved housing counseling agency that provides low- to moderate-income residents with professional housing and financial capability/management counseling.	Housing and Economic Security	Non-profit
Around the Clock (ATC)	Non-emergency and private transportation	Transportation	Minority
SCR Medical Transportation	ADA paratransit, non-emergency medical and private transportation	Transportation	M/WME
Kennedy King	Kennedy King College is a public two year community college. We will partner with the Dawson Tech Institute to provide small renovation and handyman installation projects to retro fit seniors homes.	Home Environment	Non-profit
Day Adult Day & Personal Care Provider	Service/care based on client's individualized Plan of Care, Assist with and/or provision of activities of daily living, Meal Planning and Preparation, Health Monitoring, Remind to take medication, Cleaning and maintenance of safe environment, Escort to appointments, Laundry Service, Socialization and companionship	SDoH	Minority owned
Joan's Place	Joan's Place is an adult day care center, located in Chicago, IL 60620. Adult day care can give caregivers respite by providing a center where elderly parents can be taken for a couple of hours or the entire day and picked back up later. The day programs include social activities, meals and general elderly supervision.	SDoH	Minority owned
Doctor's Choice Home Health Agency	Home care services allow seniors to remain safely in their own home while receiving medical care or assistance with personal care and other daily tasks. Services vary, but some providers offer companionship services or skilled home health care services for individuals who require ongoing health monitoring, assistance with administering medications or wound care.	SDoH	Minority owned
Nancy's Home Care	For individuals needing the highest level of attention. For individuals recovering from surgery and/or injury. All services included around the clock. Meal Preparation, Creative Outlets, Light Exercise, Cognitive	SDoH	Minority owned

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	Stimulation, RESPITE CARE, Allows the family caregiver to recharge, physically, mentally and spiritually., Allows family caregiver to take a break.		
Pal Transportation	Pal Transportation is a transportation company. This is a women owned and minority owned business. The owner of this business is African American.	Transportation	WMBE
Catch a Ride Transportation	We are a medical transportation company.. We have been in business 20 years..	Transportation	WMBE
Around the Clock Transportation	Around the Clock Transportation is a transportation company	Transportation	Minority
WR General Contractors, Inc	WR General Contractors is a minority owned general contractor	Home Environment	MBE
Brown & Momen Inc.	General contracting, construction management and carpentry services in the Greater Chicagoland area.	Home Environment	MBE
Woodard & Sons Constructions	Residential and commercial general contractor	Home Environment	Minority owned
200 Pharmacy	200 Pharmacy & Home Medical Supplies has served the community for over 40 years. A vast selection of diabetic shoes, a post-mastectomy suite, and medical supplies a compounding Lab, Personalized Options, Certified Fitters, Full Line of Wellness Supplies and Private Fitting Rooms	Health	Minority owned
Century Medical Supply	Century Medical Supply offers only the best in contractures, orthotics, mobility, neuromuscular and specialty medical equipment	Health	Minority owned

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.

The following entities will have a key role in implementation of the proposal and ongoing operation by serving as the led collaborator for one of the 5 specific aims (with the support of numerous local/minority owned partners)

Specific Aim	Lead Entity	Ownership
<u>Clinical:</u> Address unmet medical needs (physical and behavioral) experience by older adults	St. Bernard	Safety-net
<u>Facilities:</u> Invest in St Bernard Hospital's physical infrastructure to make it modernized and responsive to the service needs of older adults	DL3 Realty	Minority
<u>SDoH:</u> Improve coordinated access to social determinants of health (SDoH) services	Chicago Commons	Minority-led

Wellness: Implement evidence-based wellness programs that facilitate aging-in-place	Smyl Fitness Rx	Minority
Workforce: Build a diverse workforce pipeline for fields in the business and practice of care for older adults	Chicago State Uni.	Minority-led

12. Jobs

HELP AND SUPPORT INFORMATION

Existing Employees

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.

Collectively, the providers in our proposal employ a large number of existing employees, most of whom are residents of the Southside communities we intend to serve. We project that all of these jobs will be maintained. Given the growth of services provided and increased market penetration within the Southside service area we expect that the number of employees listed of above will increase over the course of our 5-year workplan.

Existing Employees

Zip Code	Clinical	Non-Clinical
60602	0	1
60605	0	1
60607	0	1
60609	8	6
60615	10	5
60616	10	2
60617	13	8
60619	21	20
60620	20	15
60621	16	26
60628	20	17
60629	12	8
60632	1	2
60636	13	10
60637	16	9
60640	0	1
60643	6	3
60649	16	10
60653	12	6
60657	0	1
Subtotal	194	152
	Total	346

New Employment Opportunities

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

SSCOE will directly add approximately 159 new jobs in the next five years by training, hiring, or subsidizing providers, care coordinators, community health workers and other staff. We are committed to hiring staff from the community that reflects the diversity within the Southside communities we serve.

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

Direct Employment:

SSCOE will directly add approximately 114 new jobs in the next five years by hiring, funding or subsidizing providers, care coordinators, community health workers and staff. We are committed to hiring staff from the community that reflects the diversity within the Southside communities we serve. Below is an overview of new jobs created:

- **Non-profit entity:** funding for 10 management and support staff members
- **Ambulatory care:** Funding for 78 new FTE positions which include a medical director for the AACOC, primary providers (physician, APP), priority specialists (Geri-psychiatry, urology, pulmonology, etc.), scribes, care coordination teams, and therapists for the outpatient center. Given the higher volume of older adults receiving care we anticipate increased outpatient therapy referrals.
- **Hospital (ED and ICU):** Funding for 10 new positions with include specialists' physicians and a RN
- **Skilled Nursing Unit:** funding for 16 FTE which includes a Director of Nursing, nurses, therapists, and a social worker.

Indirect Employment:

We estimate that we will create at least 45 indirect employment opportunities (construction, wellness, SDoH vendors) through our workforce development programs designed to work to raise employment and economic opportunity across the Southside. This healthcare Transformation project includes a number of workforce development initiatives which will train workers to be hired by lead entities and support vendors that are part of our cross-provider collaborative.

See file title "New Job Creation (FTE)" on next page.

NEW JOB CREATION (FTE)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Non-Profit (SSCOE)						
Management	4	2	-	-	-	6
Staff	2	1	1	-	-	4
Subtotal	6	3	1	-	-	10
Ambulatory (Geriatrics)						
Medical Director	1	1	-	-	-	1
Clinic manager	1	-	-	-	-	1
Geriatric PCP	1	2	2	-	-	5
Geriatric APP	1	2	2	1	-	6
Specialists	2	2	3	2	-	9
Pharmacist	1	1	1	1	-	3
Nurse/ SW	3	6	6	1	-	16
CHWs	4	8	8	2	-	22
Therapy	0	0	1	3	-	4
Scribes	2	4	4	1	-	11
Subtotal	14	25	27	11	-	78
Hospital						
Specialists	2	2	3	-	-	7
RN	0	2	1	-	-	3
Subtotal	2	4	4	-	-	10
SNU						
DON	-	-	1	-	-	1
RN	-	-	2	-	-	2
LPN	-	-	2	2	-	4
Therapy	-	-	3	1	-	4
Therapy Asst.	-	-	2	2	-	4
MSW	-	-	1	0	-	1
Subtotal	-	-	11	5	-	16
New Jobs	22	32	43	16	-	114

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

A core aspect of our work to address health disparities and social equity will be building a pipeline of professionals from underserved communities to serve underserved communities. We will do this by educating and training individuals on the Southside of Chicago to meet the needs of current and future needs of our aging population. Our Center of Excellence for Older Adult Health and Wellness will be enabled by workforce development initiatives with a number of key collaborators:

Loyola Medicine: Geriatrics Training

Loyola has a number of programs focused on training the next generation of geriatrics providers (Geriatric Medicine Fellowship, Geriatrics Interest Group, etc.). They will partner with our collaborative to train and develop primary care providers in best practices for older adult care. These providers will practice at STBH's ambulatory and inpatient facilities.

Chicago State University: Health Profession Education

The CSU College of Health Sciences offers wide spectrum of programs that range from advanced and graduate/professional degrees (Pharmacy, Occupational Therapy, Nursing), and undergraduate programs to a number of non-credit and workforce approved certificates in high demand areas. CSU will partner with the collaborative to develop a workforce pipeline that will a large number of roles (e.g., scribes, community health worker, nurse, pharmacy) with our partnering entities and vendors.

Kennedy-King College: Construction

The Dawson Technical Institute (DTI) of Kennedy-King College is an academic job training center for Construction Technology careers. DTI offers a number of certificate and degree programs that prepare students for jobs in the construction field. Our partnership with DTI will enable development of a pipeline of local/minority workers to be hired as part of the infrastructure development will be a large part of this collaborative.

Chicago Commons: Family Education

The Chicago Commons Family Hub's Pathways also offer a program for parents (or grandparents) to gain a career in early childhood education. The cohort-based program offers fully subsidized college courses conveniently located at one of their early education centers, guidance to become qualified as a teacher's assistant, and help with transportation, meals, and childcare. After earning just six college credits, participants are qualified to be hired as a Teacher's Aide in early education.

13. Quality Metrics

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

See "Proposed Metrics for Accountability" on next page

Southside Center for Excellence in Older Adult Health and Wellness

PROPOSED METRICS FOR ACCOUNTABILITY

Quality and Reporting Metrics	Pillar: Adult BH	Pillar: Equity	Pillar: Community Supports	HEDIS Measure
1) Follow-Up After Hospitalization for Mental Illness (FUH), 7 day and 30 day	X			
2) Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA), 7-day and 30-day	X			
3) Follow-Up After High-Intensity Care for Substance Use Disorder (FUI), and Pharmacotherapy for Opioid Use Disorder (POD)	X			
4) Patient Engagement After Inpatient Discharge: evidence of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.			X	
5) Adult access to preventive/ambulatory health services (AAP): increase number of ambulatory or preventative care PCP visit per 1,000		X		
6) Medication Review: medical record documentation of at least one medication review by a prescribing practitioner or clinical pharmacist during the measurement year				X
7) Functional Status Assessment: at least one complete functional status assessment during the measurement year		X		X
8) Pain Assessment: documentation in the medical record of at least one pain assessment during the measurement year and the date it was performed. Result may include positive or negative findings for pain.				X
9) Advanced Care Planning: Documentation of a discussion, presence, or execution of an advanced care plan		X		X
10) Physical Activity in Older Adults: percentage of adults that received consultation about exercise AND received advice to start, increase or maintain level of exercise or physical activity in the past 12 months		X		X
12) Fall Risk Management: Discussion and management of fall risk among adults 65 and older with balance or walking problems or a fall in the past 12 months.				X
13) ED Visits: increase access to preventable/ambulatory health services: reduce number of avoidable ED visits per 1,000		X		
14) Racial Disparities: Reduce implicit bias and racial disparities by increasing number of Black and Hispanic providers		X		
15) Readmissions: reduce rate of inpatient or observation stays followed by an unplanned acute readmission for any diagnosis within 30 days after discharge		X	X	
16) Osteoporosis Screening: Percentage of women 65–85 years of age who report ever having been screened for osteoporosis using central dual-energy x-ray absorptiometry (DXA)				X
17) Kidney Health Evaluation: Percentage of adults with diabetes (age 65-85) who received an annual kidney health evaluation, including both an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR).				X
18) Comprehensive Diabetes Exam: ercentage of adults 65–75 years of age with diabetes (type 1 and type 2) who had each of the following: Eye exam, HbA1c testing and control.				X
19) Controlling High Blood Pressure: Percentage of adults 65–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).				X
20) Statin Therapy for Patients with Cardiovascular Disease: percentage of adults 65–75 who have clinical atherosclerotic cardiovascular disease (ASCVD) and who received and adhered to statin therapy.				X
21) Medication Management for People with Asthma: percentage of adults who were identified as having persistent asthma and were dispensed appropriate asthma-controlled medications				X
22) Breast Cancer Screening: assesses percentage women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years				X
23) Colorectal Cancer Screening: assess percentage of adults 50–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years.				X
24) Adults Immunization: percentage of adults who are up-to-date on recommended routine vaccines for influenza, pertussis (Tdap), zoster and pneumococcal.				X
25) Smoking Cessation: percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user				X

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

Maternal and Child Health? No

Adult Behavioral Health? Yes

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.

We propose the following quality metrics related to adult behavioral health:

- Follow-Up After Hospitalization for Mental Illness (FUH), 7 day and 30 day
- Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA), 7-day and 30-day

Child Behavioral Health? No

Equity? Yes

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

We propose the following quality metrics related to equity:

- Adult access to preventive/ambulatory health services (AAP): increase number of ambulatory or preventative care PCP visit per 1,000
- *Additional measures related to this pillar are outlined in the proposed metrics section*

Community-Based Services and Supports? Yes

Community-Based Services and Supports: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

We propose the following quality metrics related to community-based services and supports:

- Patient Engagement After Inpatient Discharge: Evidence of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- *Additional measures related to this pillar are outlined in the proposed metrics section*

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

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

Proposed quality metrics and suggested tracking methodology:

Metric	Description	Methodology
Medication Review	Medical record documentation of at least one medication review by a prescribing practitioner or clinical pharmacist during the measurement year	<i>Reported to HFS based on retrospective chart analysis</i>
Pain Assessment:	Documentation in the medical record of at least one pain assessment during the measurement year and the date it was performed.	
Emergency Department Visits	Increase access to preventable/ambulatory health services: reduce number of avoidable ED visits per 1,000	
Readmissions:	Reduce rate of inpatient or observation stays followed by an unplanned acute readmission for any diagnosis within 30 days after discharge	
Functional Status Assessment	At least one complete functional status assessment during the measurement year	<i>Reported to HFS based on retrospective chart analysis (to be tracked via care integration platform once fully operational)</i>
Advanced Care Planning	Documentation of a discussion, presence, or execution of an advanced care plan	
Physical Activity in Older Adults:	Consultation with a doctor or other health provider about exercise and received advice to start, increase or maintain level of exercise and received advice to start, increase or maintain level of exercise or physical activity in the past 12 months	
Fall Risk Management	Discussion and management of fall risk among adults 65 and older with balance or walking problems or a fall in the past 12 months.	
Racial Disparities	Reduce implicit bias and racial disparities by increasing number of Black and Hispanic hires (physicians and other staff)	<i>Commitment to report race and ethnicity of newly hired or funded staff to HFS</i>

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.

TASK	Year 1											
	1	2	3	4	5	6	7	8	9	10	11	12
Management & Governance												
Finalize Board and bylaws	█	█										
Nonprofit ED in place	█											
<i>Finalize establishment of new entity and 501(c)(3) status</i>			█									
Collaborative and funds flow agreements in place (partner entities)				█								
Allocate resources and begin operations/workplan execution				█	█	█	█	█	█	█	█	█
Recruit and hire nonprofit management team			█	█	█	█						
Nonprofit executive leadership team hired							█					
Establish community advisory board							█	█				
Identify additional CBOs for programming, recruitment, workforce dev, etc.					█	█	█					
<i>Yr. 1 review outcomes and begin Yr. 2 strategic planning</i>											█	█
Clinical Services (Primary and Specialty Care)												
Validate provider capacity and prioritize areas for recruitment and hiring	█	█	█									
Review/refine clinical workflows to support evidence				█	█	█						
Develop physician alignment and incentive model for value-base care					█	█	█					
Recruit first wave of providers; initiate credentialing and training					█	█	█	█	█	█	█	█
Hire scribes (in-step) with physician and provider hiring					█	█	█	█	█	█		
<i>Fulfill phase one hiring, leasing, coverage arrangements</i>										█		
Community outreach events to build rapport, trust, and awareness									█	█	█	█
Infrastructure												
Planning for demolition of old structure on medical campus		█	█	█								
<i>Demolish old structure (prepare land for beneficial community use)</i>					█	█						
Establish workgroup and plan for GEDA accreditation (Level 3)							█	█	█	█	█	█
Establish workgroup for 12-15 bed SNU conversion										█	█	█
SDoH, Wellness, Coordination Services												
Patient's journey mapping for integrated "Whole-Person "model	█	█	█									
Signed contracts with anchor CBO partners for (SDoH, Wellness, CHWs)				█	█							
Hire ~ 5 experienced CHW (1 manager and 5 staff)					█	█	█					
Co-marketing/community outreach events with CBOs to raise awareness					█	█	█	█	█	█	█	█
<i>Initiate programming for SDoH and Wellness with CBO vendors</i>					█							
Technology & Analytics												
Inventory existing tech and reporting capabilities across partner orgs.		█	█									
Curate and demo technology platforms				█	█	█						
<i>Finalize technology needs and vendor selection</i>							█					
Working with HFS, measure baseline outcomes, set-up quality dashboard						█	█	█	█	█	█	█
Outcome and reporting analysis for year 1 metrics											█	█

TASK	Milestone			
	Year 2	Year 3	Year 4	Year 5
Management & Governance				
Annual BOD Strategic Planning				
<i>Establish sustainability workgroup</i>				
Begin executing sustainability plan (value-based arrangements)				
Clinical Services (Primary and Specialty Care)				
Continue developing pipeline (hiring, recruiting, training)				
<i>Provider capacity at scale</i>				
Plan and launch virtual care services				
Infrastructure				
<i>Apply for GEDA accreditation (Level 3)</i>				
Convert unused hospital unit to 12-15 bed SNU				
Community outreach and engagement to raise awareness regarding GEDA				
Re-develop on cleared land?				
SDoH, Wellness, Coordination Services				
Ramp up pipeline development for CHW				
Expand services and contract with additional CBOs to meet demand				
<i>Launch data and analytics approach to matching needs to service vendors</i>				
Technology & Analytics				
<i>IT / connected care platform fully functional</i>				
Recurring quarterly meetings with HFS				
Annual quality and outcomes reporting to HFS				

15. Budget

Total Budget Requested: \$132,972,8952

Number of Individuals Served

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

- *Year 1 - 6,950*
- *Year 2 - 10,640*
- *Year 3 - 19,606*
- *Year 4 - 36,357*
- *Year 5 - 43,606*
- *Year 6 - 48,120*

Alternative Payment Methodologies

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

16. Sustainability

Provide your narrative here:

The Southside Center of Excellence for Older Adult Health and Wellness will be a scalable project designed to meet the needs of a rapidly aging population of older adults that is disproportionately poor, medically underserved and at risk for high-cost episodes such as hospitalization or nursing home placement. This project is designed to transform Chicago's South Side healthcare delivery landscape for older adults by delivering "whole-person" care that will close longstanding gaps in access, care, and health outcomes. Over a five-year period, the SSCO will work to execute milestones along a path to self-sustainability, which is grounded in the following:

- Improving payer mix to include a larger share of Medicare patients
- Converting unused hospital beds/unit to create a revenue generating SNU beds
- Expanding access to quality ambulatory services to meet the needs of a population that is aging and disproportionately underserved (primary, specialty, etc.)
- Developing a GEDA-certified emergency department that can provide specialized geriatric emergency care that has shown to result in lower healthcare expenditures [35]

By accomplishing these milestones, the Southside will have a sustainable safety-net in St. Bernard hospital (STBH) and a cross-provider ecosystem that can meet the specialized need of older adults and is **positioned to be anchor for older adult care and destination/in-network for all PACE providers** (Program for All Inclusive Care for the Elderly) and other value-based care partners.

17. REFERENCES

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18. Letters of Support

- Senator Mattie Hunter 3rd District
- Representative Sonya Harper 6th District
- Representative Lamont Robinson 5th District
- Beloved Community Family Wellness Center
- Chicago Commons
- Riley Safer Holmes Cancilla
- Loyola Stritch School of Medicine
- Loyola Parkinson School of Health Sciences and Public Health
- Kennedy King College
- Teamwork Englewood
- Victory Centre Country Club Hills
- Victory Centre Park Forest
- Victory Centre Calumet City
- Victory Centre Chicago (60628)
- Victory Centre Chicago (60617)

See attached letters of support (next page)

CAPITOL OFFICE:
619 CAPITOL BUILDING
SPRINGFIELD, ILLINOIS 62706
217-782-5966
FAX: 217-782-1631

STATE OF ILLINOIS



COMMITTEES:
APPROPRIATIONS I
ENERGY & PUBLIC UTILITIES
EXECUTIVE, CHAIR
HUMAN SERVICES
PUBLIC HEALTH
TRANSPORTATION,
VICE CHAIR

DISTRICT OFFICE:
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MATTIE HUNTER
MAJORITY CAUCUS CHAIR
STATE SENATOR - 3RD DISTRICT

November 16, 2021

Director Theresa Eagleson
Illinois Department of Healthcare and Family Services
201 South Second Street, Prescott Bloom Building
Springfield, Illinois 62763

Re: Southside Center for Excellence in Older Adult Health and Wellness

Dear Director Eagleson:

This letter is written in support of St. Bernard Hospital and Health Center's proposal for a Southside Center for Excellence in Older Adult Health and Wellness.

A Center of Excellence in Older Health and Wellness on the Southside would benefit the residents of Englewood and the southside. The Center of Excellence for Older Adult Health will address the needs of an aging population by assisting with closing health gaps and improving health outcomes. The impact of this program in Englewood and the surrounding areas will be significant because it focuses on the unique needs of a community that is medically underserved and disproportionately poor by addressing their health, social/wellness support, and workforce development initiatives to address the scarcity of workers specializing in the care of older adults.

St. Bernard Hospital's financial situation is very bleak, and it is positioned to become the next "Mercy Hospital" and close its doors, which will further reduce access to care on Chicago's Southside for vulnerable populations. While the transformation program is not the immediate "fix" that St. Bernard needs now to remain viable, it will help with the Hospital's long-term sustainability by driving Medicare volume, should the State decide in the next few months that it wants St. Bernard to remain open.

Therefore, I fully support the efforts of St. Bernard Hospital and Health Center as they seek funding to support a Southside Center for Excellence in Older Adult Health and Wellness. Currently there is no other program on the southside that focuses so intently on the health outcomes and social determinants of health of the older adult population.

Sincerely,

A handwritten signature in black ink that reads "Mattie Hunter".

Mattie Hunter
Majority Caucus Chair
Illinois State Senator
3rd Legislative District

DISTRICT OFFICE:
4926 South Ashland
Chicago, IL 60609
Phone: (773) 925-6580

SPRINGFIELD OFFICE:
276-S Stratton Office Building
Springfield, IL 62706
Phone: (217) 782-5971



Sonya M. Harper
STATE REPRESENTATIVE • 6th DISTRICT

November 17, 2021

Director Theresa Eagleson
c/o St. Bernard Transformation Project
Illinois Department of Healthcare and Family Services
201 South Second Street, Prescott Bloom Building
Springfield, IL 62763

Dear Director Eagleson:

Re: Southside Center for Excellence in Older Adult Health and Wellness – Letter of Support

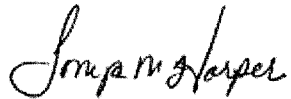
It is with immediate concern and enthusiasm that I write a letter of support of the proposal of St. Bernard Hospital and Health Center in its application for a Southside Center for Excellence in Older Adult Health and Wellness.

As State Representative for the 6th Legislative District, a Center of Excellence in Older Health and Wellness on the Southside would greatly benefit the residents of Englewood and the southside. The Center of Excellence for Older Adult Health will address the needs of an aging population by assisting with closing health gaps and improving health outcomes. The impact of this program in Englewood and the surrounding areas will be significant because it focuses on the unique needs of a community that is medically underserved and disproportionately poor by addressing their health, social/wellness support, and workforce development initiatives to address the scarcity of workers specializing in the care of older adults.

I recently visited St. Bernard Hospital, where I was informed that they will not be able to stay in operation much longer without assistance. They are operating at a \$5 million operating loss in 2021, and in 2022, that will rise to \$6.5 million, even with a plug number of \$1 million for the ARPA safety net hospital funds that are expected. This is not sustainable. We saw the OB unit close when it was not financially viable. The St. Bernard Board is not taking any of these decisions lightly, and it will soon be faced with no other choice than to close the hospital. If we can keep the hospital open until this transformation program begins, it might be able to be sustainable, keeping services and jobs available for residents and taking care of the City's elderly population.

Therefore, I fully support the efforts of St. Bernard Hospital and Health Center as they seek funding to support a Southside Center for Excellence in Older Adult Health and Wellness. Currently there is no other program on the southside that focuses so intently on the health outcomes and social determinants of health of the older adult population.

Sincerely,

A handwritten signature in black ink that reads "Sonya M. Harper". The signature is written in a cursive, flowing style.

State Representative Sonya M. Harper

6th District

ILLINOIS HOUSE OF REPRESENTATIVES

SPRINGFIELD OFFICE:
290-S Stratton Building
Springfield, Illinois 62706
(217) 782-4535 (Office)

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Lamont J. Robinson, Jr.

STATE REPRESENTATIVE
5th DISTRICT

COMMITTEES:

- **Chair:** Cybersecurity, Data Analytics, IT
- **Chair:** Tourism
- **Appropriations:** Human Services
- Healthcare Accessibility & Access
- Public Utilities
- Special Issues (AP) Subcommittee
- Prescription Drug Affordability

November 18, 2021

Director Theresa Eagleson
c/o St Bernard Transformation project
Illinois Department of Healthcare and Family Services
201 South Second Street, Prescott Bloom Building
Springfield, IL 62763

Dear Director Eagleson,

I write to you in support of the transformation proposal of St. Bernard Hospital and Health Center in its application for a Southside Center for Excellence in Older Adult Health and Wellness.

St. Bernard Hospital currently sits just outside my district boundary but will reside in my new district when the recently approved legislative maps become effective. I am very familiar with the hospital and its talented administrative team. As such, I'm also very familiar with the Hospital's financial struggles of the last several years. In addition, as chair of the House Safety Net and Critical Access Task Force, I will be working with St. Bernard and other safety net and critical access hospitals to implement strategies that will ensure the Hospital's sustainability. I believe this transformation proposal can be a key part of the Hospital's longer-term financial viability.

The proposed Center of Excellence in Older Health and Wellness on the Southside will be a key component in addressing the needs of the aging population in Englewood and on the Southside, areas often plagued by a lack of access to specialty care. This medically underserved area deserves our help and state resources to address the unique needs of the community, particularly the most vulnerable of an aging population. For too long the area has been financially overlooked by the State as we have watched services be reduced and eliminated for Englewood citizens and the surrounding community. The health, wellness and social supports, and workforce development initiatives that will address the lack of workers specializing in the care of older adults will bring kidney dialysis, cardiac services, pulmonary specialists, and GI services to the community.

In closing, I respectfully request that strong consideration be given to the St. Bernard Hospital and Health Center application for a Southside Center for Excellence in Older Adult Health and Wellness. If the State wants St. Bernard Hospital to remain financially viable, it must take the steps to support this critical Southside institution that has been serving residents since 1904. The Center will help fill a gap in services for Southside senior residents while also supporting St. Bernard hospital, which is an economic engine and haven of healthcare for a community in need.

ILLINOIS HOUSE OF REPRESENTATIVES

I thank you in advance for your consideration. Please feel free to contact me at lamont@lamontjrobinson.com or via telephone at 773-924-4614 if you should have any questions and/or need additional information.

Sincerely,

A handwritten signature in black ink that reads "Lamont J. Robinson". The signature is stylized, with the first name "Lamont" written in a cursive script and the last name "Robinson" in a more formal, slightly cursive font. The signature is positioned above the printed name.

Lamont J. Robinson
State Representative District 5

November 18, 2021

St. Bernard Transformation Project
Health Transformation Collaboratives
326 W. 64th Street
Chicago, IL 60621

Dear St. Bernard Transformation Project:

Re: Southside Center for Excellence in Older Adult Health and Wellness – Letter of support

It is my pleasure to write a letter of support of the proposal of St. Bernard Hospital and Health Center in their application for a Southside Center for Excellence in Older Adult Health and Wellness.

As President and CEO of Chicago Commons, a Center of Excellence in Older Health and Wellness on the Southside would greatly benefit the residents of Englewood and the southside. The Center of Excellence for Older Adult health will address the needs of an aging population by assisting with closing health gaps and improving health outcomes. The impact of this program in Englewood and the surrounding areas will be significant because it focuses on the unique needs of a community that is medically underserved and disproportionately poor by addressing their health, social/wellness support and workforce development initiatives to address the scarcity of workers specializing in the care of older adults.

Therefore, I fully support the efforts of St. Bernard Hospital and Health Center as they seek funding to support a Southside Center for Excellence in Older Adult Health and Wellness. Currently there is no other program on the southside that focuses so intently on the health outcomes and social determinants of health of the older adult population.

Sincerely,



Edgar Ramirez
President & CEO



Patricia Brown Holmes
(312) 471-8745
pholmes@rshc-law.com

November 18, 2021

St. Bernard Transformation Project
Health Transformation Collaboratives

Re: Southside Center for Excellence in Older Adult Health and Wellness – Letter of Support

Dear St. Bernard Transformation Project:

As managing partner of Riley Safer Holmes & Cancila LLP, it is my pleasure to write in support of the proposal of St. Bernard Hospital and Health Center in their application for a Southside Center for Excellence in Older Adult Health and Wellness. We are a diverse law firm of litigators and business transaction attorneys who provide extensive experience in a variety of areas. We are nationally known for being creative negotiators, counselors, and trusted advisors who craft and implement effective strategies to assist our clients with all of their business needs. We have experience providing legal and regulatory advice and counsel to health care companies and other non-profit organizations as they develop compliance programs, complete memoranda of understanding, procure contracts, manage vendors, and generally remain in compliance with the law. We would be proud to support the Southside Center for Excellence in Older Adult Health and Wellness as they launch a program that would be extremely beneficial to the community it would serve.

As long-time resident of the southside, I truly believe a Center of Excellence in Older Health and Wellness would greatly benefit the residents of Englewood and the greater southside. Addressing the myriad needs of an aging and underserved population by assisting to close health gaps and improve health outcomes is a lofty goal; given the resources and assistance from those who care about the mission, they will undoubtedly succeed. The impact of this program in Englewood and the surrounding areas will be significant because it focuses on the unique needs of a community that is medically underserved and disproportionately minority and poor by addressing their health, mental, social and wellness support as well as workforce development initiatives. This program will also provide opportunities for medical professionals to address the scarcity of workers specializing in the care of older adults.

RSHC has the legal acumen and experience to assist the organization as it formulates a board and compliance programs, procures contracts, and begins the growth and development of a non-profit that will benefit the southside community. Currently there is no other program on the southside that focuses so intentionally on the health outcomes and social determinants of this particular older adult population, and we would be proud to assist.

Warm regards,

A handwritten signature in blue ink that reads "Patricia Brown Holmes". The signature is written in a cursive style with a large initial "P".

Patricia Brown Holmes
Managing Partner



LOYOLA
UNIVERSITY CHICAGO

STRITCH SCHOOL *of* MEDICINE

Sam J. Marzo, MD
Dean and Chief Diversity Officer
Stritch School of Medicine
Loyola University Chicago
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(P) 708.216.3960 smarzo@lumc.edu

November 18, 2021

Health Transformation Collaboratives
c/o St. Bernard Transformation Project
Illinois Department of Healthcare and Family Services
201 South Second Street, Prescott Bloom Building
Springfield, IL 62763

Dear St. Bernard Transformation Project:

Re: Southside Center for Excellence in Older Adult Health and Wellness – Letter of support

It is my pleasure to write a letter of very strong support of the proposal of St. Bernard Hospital and Health Center in their application for a Southside Center for Excellence in Older Adult Health and Wellness.

I am a practicing physician and the Dean of the Loyola University Chicago Stritch School of Medicine in Maywood, Illinois. I firmly believe that a Center of Excellence in Older Health and Wellness on the Southside would greatly benefit the residents of Englewood and the southside. The Center of Excellence for Older Adult health will address the needs of an aging population by assisting with closing health gaps and improving health outcomes. The impact of this program in Englewood and the surrounding areas will be significant because it focuses on the unique needs of a community that is medically underserved and disproportionately poor by addressing their health, social/wellness support and workforce development initiatives to address the scarcity of workers specializing in the care of older adults.

Therefore, I fully support the efforts of St. Bernard Hospital and Health Center as they seek funding to support a Southside Center for Excellence in Older Adult Health and Wellness. Currently there is no other program on the southside that focuses so intently on the health outcomes and social determinants of health of the older adult population.

Loyola Stritch School of Medicine looks forward to collaborating with the South Side Center on opportunities to introduce our graduates to practice options in the St Bernard Service area. We would also be interested in expanding our medical school curriculum to provide opportunities for our students to be a part of this center's evolution and hopefully supporting the build out of the workforce pipeline.

Sincerely,

Sam J. Marzo, MD



PARKINSON

SCHOOL of HEALTH SCIENCES
AND PUBLIC HEALTH

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November 19, 2021

Health Transformation Collaboratives
c/o St. Bernard Transformation Project
Illinois Department of Healthcare and Family Services
201 South Second Street, Prescott Bloom Building
Springfield, IL 62763

Letter of Support: Southside Center for Excellence in Older Adult Health and Wellness

To Whom It May Concern:

I am delighted to offer my utmost support to St. Bernard Hospital and Health Care Center on their Healthcare Transformation Collaborative proposal entitled “Southside Center for Excellence in Older Adult Health and Wellness”.

I am professor and founding dean of the Loyola University Chicago’s Parkinson School of Health Sciences and Public Health. An established leader in health care education with the Loyola University Chicago Stritch School of Medicine and the Marcella Niehoff School of Nursing, the Parkinson School draws on those strengths to address today’s public health challenges and train the next generation of experts in public health, health systems and informatics, healthcare administration, and applied health sciences.

Our mission is to be *persons for others* and answer our calling as a Jesuit Catholic institution to go to the frontiers of education, research, and practice, and help people who live at the margins. We aim to:

- **Understand and impact the health continuum.** A healthy life requires more than clinical encounters or public health promotion alone. Lasting transformation requires a systems approach, synthesizing multiple perspectives across the clinical and translational spectrums.
- **Meet the demands of allyship.** Health disparities have become increasingly evident — and finding solutions more complex. Effective collaboration and meaningful impact require leaders who can listen, reconcile, and build on a broad range of stakeholders needs
- **Translate insight to impact.** The Parkinson School is a community of entrepreneurial problem solvers that fosters innovation and generates knowledge, shining light on humanity’s darkest challenges. The school is driven to take action that effects change and makes an enduring impact, especially for those historically underrepresented or underserved.
- **Learn by continually doing.** Experiential learning is in the DNA of an Ignatian education. Reflecting on such experiences is central to a Parkinson School education.
- **Embrace and promote the Loyola Way.** *Cura personalis*, or care for the whole person, is at the heart of Loyola University’s Jesuit mission. This enduring value of more than 150 years imbues the Parkinson School’s teaching, research, and service mission and shapes the members of its community.

Given my school's mission, you can imagine how excited I was when St. Bernard reached out to share their vision for the Southside Center for Excellence. I applaud the team for its specific aims to transform health outcomes and reduce disparities for the rapidly aging population of older adults on Chicago's Southside. The cross-provider collaboration will deliver "whole-person" care designed to meet the unique needs of a community that is medically underserved and disproportionately poor by addressing clinical needs, social/wellness support, and workforce development initiatives to address the scarcity of workers specializing in the care of older adults.

Loyola University Chicago and the Parkinson School has been actively involved in the Maywood, IL and surrounding community in academic public-private partnership. I have witnessed the power of bringing public health and health expertise (students, faculty, staff) together with community partners to design workable solutions to address health disparities through our Covid Equity Response Collaborative-Loyola (CERC-L).

The Southside Center of Excellence proposes a similar model of cross-provider collaborative which includes an anchor safety net hospital (St. Bernard), a public university (Chicago State University), non-profit community organizations, and local small businesses. Under the advisement of community input and data to drive programmatic decisions, you have proposed implementation of a 5-year transformation that will deliver "whole-person" care designed to meet the unique needs of older adults.

I am excited to see that the team's proposal aligns IL Health and Family Services (HFS) commitment to healthy aging, the Age-Friendly Chicago Plan, and the IL Department of Aging priorities related to 1) supporting older adults' ability to remain independent and in their own homes through the provision of quality home and community-based services with a strong focus on healthy aging and prevention, 2) expanding equitable access to care and programs that address the social determinants of health with a focus on identifying and understanding the needs of underserved and diverse populations, and 3) maximizing federal, state, local, and private resources to sustain and expand services and supports to older adults.

We are committed to partnering with and supporting the Southside Center of Excellence for Healthy Aging & Geriatric Health in addressing its four specific aims:

- 1) Addressing unmet healthcare needs (physical and behavioral) by recruiting and retaining committed physicians, nurse practitioners, specialists, etc.
- 2) Investing in the physical plant at St Bernard Hospital so that it's modernized and responsive to the service needs of older adults
- 3) Improving coordinated access to social determinants of health services
- 4) Implementing evidence-based wellness and prevention programs for healthy aging
- 5) Build a workforce pipeline for fields in the business and practice of care for older adults with Chicago State as an anchor partner

The following summarizes the resources available for us to contribute to the proposed transformative initiative, should it be awarded:

General Academic Medical Campus Expertise

Our Health Sciences Campus, located in suburban Maywood is home to Loyola's Stritch School of Medicine (under which are the Graduate School's biomedical programs), Marcella Niehoff School of Nursing, and the Parkinsons School of Health Sciences & Public Health. Medical students benefit from the University's clinical partnership with the Loyola University Health System and Trinity Health. Loyola is also among a select group of colleges and universities recognized for community service

and engagement by prestigious national organizations like the Carnegie Foundation and the Corporation for National and Community Service. U.S. News & World Report has ranked Loyola University Chicago consistently among the "top national universities" in its annual publications.

Marcella Niehoff School of Nursing: The Marcella Niehoff School of Nursing (MNSON) provides a transformative education in the Jesuit Catholic tradition, preparing leaders in the health professions to enhance the health of persons, communities, and the larger global environment through the discovery, application, and dissemination of knowledge; and service with others. The SON offers undergraduate (BSN), master's (MSN), and doctoral programs (DNP and PhD) for the education of professional nurses. Over 85 percent of SON's full-time faculty have doctoral degrees. Many are certified in their areas of clinical expertise and serve in leadership positions for regional and national nursing organizations. Graduates of the School of Nursing are highly sought for positions in health-care organizations.

Parkinson School of Health Sciences and Public Health: The Parkinson School is the newest school within the Health Sciences Campus of Loyola University Chicago. It was launched in 2019 with an eye to creating new opportunities for transdisciplinary collaboration. The Parkinson School offers programs for undergraduate (BS programs in Exercise Science, Healthcare Administration, and Public Health) and graduate students (MS programs in Clinical Research Methods, Dietetics, Exercise Science, Health Informatics, Medical Laboratory Science, and Public Health (MPH), Implementation Science, and Healthcare Administration (MHA)). The Parkinson School also collaborates with other schools to confer dual degrees that include MPH/MD, Masters in Social Work (MSW)/MPH, BS (in Healthcare Administration)/MPH, and a BS in Environmental Sustainability/MPH). These degree programs offer innovation and accessibility to adult learners along with traditional undergraduates, afforded by online instruction and hybrid learning programs.

Stritch School of Medicine: The Stritch School of Medicine provides outstanding clinical education to its students with the opportunity to participate in research, global health, and service. SSOM's cutting edge facilities are also used to educate multidisciplinary, collaborative health care teams in quality and safety. Programs offered through SSOM include the MD program (and the MD/PhD program), the Bioethics and Health Policy programs (MA, DBE and Certificate programs), and the Biomedical Science MS and PhD programs. Stritch students enjoy an opportunity to personalize their own education experience in order to meet their individual professional goals. Students often personalize their education with a focus on research, public or global health and/or bioethics, which collectively prepare our graduates for a well-rounded approach to their professional careers.

Cardinal Bernardin Cancer Center: The Cardinal Bernardin Cancer Center brings together all aspects of cancer care to one site. Beautifully designed for the comfort and convenience of our patients, the center also promotes optimal collaboration between healthcare providers. Loyola Medicine is nationally recognized for its expert team of specially trained cancer doctors who come from a wide variety of clinical specialties. These multidisciplinary specialists provide the expertise, translational research experience and compassionate care needed to diagnose and treat cancer. They work together, taking a collaborative approach to cancer care.

Clinical Quality Improvement Expertise

Loyola University Chicago is a member of the **Institute of Translational Medicine (ITM-CTSA) Program award**. The ITM is a partnership between the University of Chicago and Rush University in collaboration with Advocate Health Care, the Illinois Institute of Technology (Illinois Tech), Loyola University Chicago, and NorthShore University Health System. I am the Site PI for Loyola's ITM partnership, and the proposed project will provide opportunities to leverage Loyola's experience and scientific environment in both dissemination and implementation science and the development and translation of health informatics solutions.

- **Dissemination and Implementation Science.** Loyola houses the ITM's new Implementation Science Cluster as well as the Evaluation Core for the ITM.

Of particular note, is our Innovation-Corps (I-Corps™) Program - an accelerated bootcamp version of Stanford University's Lean Launchpad entrepreneur training for technology startups developed a decade ago in partnership with the National Science Foundation (NSF) to magnify the societal impact of academically-derived innovation in science and technology.

The success of I-Corps in preparing clinicians, scientists, engineers, and graduate students to extend their focus beyond the academic campus has been lauded by the U.S. Department of Commerce. The National Institutes of Health adapted the NSF program for the life sciences and there is opportunity to apply this design-thinking approach to clinical quality improvement intervention development and implementation.

The Parkinson School is also the academic home for Loyola's Masters in Implementation Science program that has been designed specifically for healthcare systems and quality improvement change.

- **Center for Health Outcomes & Informatics Research (CHOIR):** The Center for Health Outcomes and Informatics Research is a Health Sciences Center-wide center focused on providing research expertise in biomedical informatics to improve health outcomes and reduce health inequities, and on the development of a health informatics-trained workforce. The center provides expertise in machine learning, deep learning, natural language processing and associated computing resources, electronic health record integration, mobile health, and applications to management of chronic conditions, cancer prevention, predictive modeling of cardiac myopathies and events, Parkinson's disease, adverse drug reactions, and drug misuse.

CHOIR hosts faculty members from the Parkinson School of Health Sciences and Public Health, the Stritch School of Medicine, and the Niehoff School of Nursing. This analytic expertise could be contributed to assist the Southside Center for Excellence in its quality improvement efforts.

Health Sciences Library

The Loyola University of Chicago Health Sciences Library facilitates biomedical discovery by connecting the Health Sciences campus with the best knowledge available. We acquire, organize, and disseminate needed information, provide educational outreach, and design and deliver innovative programming for user-focused support of education, research, and patient care.

HSL collections support the teaching/learning, biomedical research and patient care information needs of the health sciences campus and could be brought to bear with the Southside Center for Excellence through access to the thousands of electronic journals and hundreds of electronic books, as well as article and index databases, point-of-care clinical-decision support tools,

In closing, I enthusiastically support the proposed Southside Center for Excellence in Older Adult Health and Wellness program and its proposed aims to address healthcare equity. I look forward to offering the full support of the Parkinson School.

Sincerely,



Elaine H. Morrato, DrPH, MPH
Professor and Founding Dean



November 19, 2021

St. Bernard Transformation Project
Health Transformation Collaboratives

**Re: Southside Center for Excellence in Older Adult Health and Wellness
Letter of support**

Dear St. Bernard Transformation Project:

It is my pleasure to write a letter of support of the proposal of St. Bernard Hospital and Health Center in their application for a Southside Center for Excellence in Older Adult Health and Wellness.

A Center of Excellence in Older Health and Wellness on the Southside would greatly benefit the residents of Englewood. The Center of Excellence for Older Adult Health will address the needs of an aging population by assisting with closing health gaps and improving health outcomes. The impact of this program in Englewood and the surrounding areas will be significant because it focuses on the unique needs of a community that is medically underserved and disproportionately poor by addressing their health, social/wellness support and workforce development initiatives to address the scarcity of workers specializing in the care of older adults.

Therefore, I fully support the efforts of St. Bernard Hospital and Health Center as they seek funding to support a Southside Center for Excellence in Older Adult Health and Wellness. Currently there is no other program on the southside that focuses so intently on the health outcomes and social determinants of health of the older adult population.

Sincerely,

A handwritten signature in black ink, appearing to read 'Gregory Thomas', with a long horizontal flourish extending to the right.

Dr. Gregory Thomas
President



November 15, 2021

Mr. Charles Holland
President and CEO
St. Bernard Hospital and Healthcare Center
326 W. 64th Street
Chicago, IL 60621

Dear Mr. Holland,

Re: Southside Center for Excellence in Older Adult Health and Wellness – Letter of support

It is my pleasure to write a letter of support of the proposal of St. Bernard Hospital and Health Center in their application for a Southside Center for Excellence in Older Adult Health and Wellness.

As CEO of Beloved Community Family Wellness Center (FQHC), a Center of Excellence in Older Health and Wellness on the Southside would greatly benefit the residents of Englewood and the southside. The Center of Excellence for Older Adult health will address the needs of an aging population by assisting with closing health gaps and improving health outcomes. The impact of this program in Englewood and the surrounding areas will be significant because it focuses on the unique needs of a community that is medically underserved and disproportionately poor by addressing their health, social/wellness support and workforce development initiatives to address the scarcity of workers specializing in the care of older adults.

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Sincerely,

Margie N. Johnson, MS
Chief Executive Officer



CONVENE.

CONNECT.

IMPACT.

815 W. 63rd Street, 2nd Floor, Chicago, IL 60621 • Phone: (773) 488-6600 • Fax: (773) 488-6601 •
www.teamworkenglewood.org • www.englewoodportal.org

November 17, 2021

St. Bernard Transformation Project
Health Transformation Collaboratives

Dear St. Bernard Transformation Project:

Re: Southside Center for Excellence in Older Adult Health and Wellness – Letter of support

It is my pleasure to write a letter of support of the proposal of St. Bernard Hospital and Health Center in their application for a Southside Center for Excellence in Older Adult Health and Wellness.

Teamwork Englewood is a community based organization that serves the Greater Englewood community. Our organization provides services that help to improve the quality of life for Englewood residents. A Center of Excellence in Older Health and Wellness on the Southside would greatly benefit the residents of Englewood and the southside.

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Sincerely,



Cecile De Mello



Supportive Living & Senior Apartments
by Pathway to Living

November 17, 2021

St. Bernard Transformation Project
Health Transformation Collaboratives

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Sincerely,

Executive Director

VICTORY CENTRE
of Park Forest

A SUPPORTIVE LIVING & SENIOR APARTMENT COMMUNITY
by Pathway Senior Living, LLC
101 Main Street • Park Forest, IL 60466
708-283-2921 • www.pathwayseniorliving.com

November 17, 2021

St. Bernard Transformation Project
Health Transformation Collaboratives

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Executive Director



Supportive Living & Senior Apartments
by Pathway to Living

November 17, 2021

St. Bernard Transformation Project
Health Transformation Collaboratives

Re: Southside Center for Excellence in Older Adult Health and Wellness – Letter of support

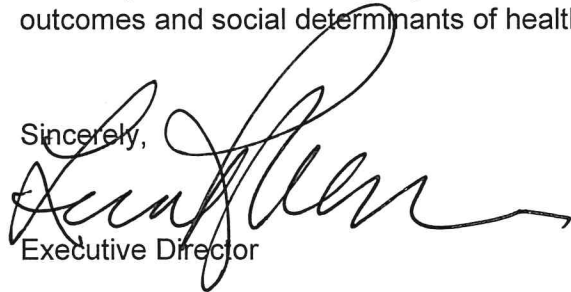
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Sincerely,



Executive Director

November 17, 2021

St. Bernard Transformation Project
Health Transformation Collaboratives

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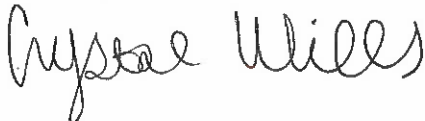
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Sincerely,



Crystal Wills
Executive Director



Supportive Living & Senior Apartments
by Pathway to Living

November 17, 2021

St. Bernard Transformation Project
Health Transformation Collaboratives

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