Healthcare Transformation Collaboratives Cover Sheet

1. Collaboration Name: West Cook Coalition (WCC)

2. Name of Lead Entity: Loyola University Health System

3. List All Collaboration Members:
Loyola University Health System DBA Loyola Medicine
Loyola University Medical Center
Macneal Hospital
Gottlieb Memorial Hospital
Pillars Community Health
CareAdvisors
Healthcare Alternative Systems
Housing Forward
Ann and Robert H. Lurie Children's Hospital of Chicago
Proviso Leyden Council for Community Action, Inc.
Real Foods Collective
Suburban Primary Health Care Council / DBA: Access to Care
West Cook YMCA
AgeOptions
Beds Plus Care
Beyond Hunger
Catholic Charities of the Archdiocese of Chicago
Family Focus
Quinn Center of St. Eulalia
Maywood Medical-Legal Partnership (Loyola University Chicago School of Law)
Pav YMCA

4. Proposed Coverage Area:
The WCC's targeted service area includes 18 communities located in west Cook County, Illinois.

5. Area of Focus:
Bellwood, zip code 60104
Berkeley, zip code 60163
Berwyn/Stickney, zip code 60402
Broadview, zip code 60155
Brookfield, zip code 60513
Cicero, zip code 60804
Forest Park, zip code 60130
Franklin Park, zip code 60131
Hillside, zip code 60162
Lyons, zip code 60534
Maywood, zip code 60153
Melrose Park, zip code 60160
North Lake, zip code 60164
North Riverside, zip code 60546

River Grove, zip code 60171
Stone Park, zip code 60165
Summit, zip code 60501
Westchester, zip code 60154

6. Total Budget Requested: $50,865,024.00

FORM 0. PROJECT DESCRIPTION

Eligibility Screen

Note that applications cannot qualify for funding which:

1. fail to include multiple external entities within their collaborative (i.e. entities not within the same organization); or,
2. fail to include one Medicaid-eligible biller.

Does your collaboration include multiple, external, entities?
Yes

Can any of the entities in your collaboration bill Medicaid?
Yes

FORM 1. PARTICIPATING ENTITIES.

Contact Information for Collaborating Entities

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

Loyola University Medical Center

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

Partner Name	Primary Contact	Position	Secondary Contact Name	Secondary Contact Position
Loyola University Health System DBA Loyola Medicine	Keith Veselik	Vice President/Chief Medical Officer, Population Health	Ellyn Chin	Regional VP of Population Health and Contracting
Loyola University Medical Center	Christin Zollicoffer	Regional Director, Diversity and Inclusion, Trinity Health Midwest; Vice President, Community Health and Well-being, Loyola Medicine	Venoncia M. Baté-Ambrus, PhD	Regional Director of Community Health & Well-Being
Macneal Hospital	Ellyn Chin	Regional VP of Population Health and Contracting	Keith Veselik	Vice President/Chief Medical Officer, Population Health
Gottlieb Memorial Hospital	Ellyn Chin	Regional VP of Population Health and Contracting	Keith Veselik	Vice President/Chief Medical Officer, Population Health
Pillars Community Health	Angela Curran	President and CEO	Helen Stewart	Senior Executive Vice President
CareAdvisors	Chris Gay	CEO	Dawn Gay, MBA-HCM	Executive Director
Healthcare Alternative Systems	Millie M. Adan	COO/Corporate Compliance Office	Marco Jacome	CEO
Housing Forward	Erik Johnson	Chief Development Officer	Lynda Schueler	Executive Director
Ann and Robert H. Lurie Children's Hospital of Chicago	Mathew Davis	EVP Community Health Transformation	Stephanie Pelligra, MPH	Senior Director, Department of Pediatrics
Proviso Leyden Council for Community Action, Inc.	Bishop Dr. Claude Porter	President and CEO	Claudette Harrell	Executive Vice President
Real Foods Collective	Mary Mora	Co-Founder	Sarah Lira	Board of Directors Member
Suburban Primary Health Care Council / DBA: Access to Care	Gayle Deja-Schultz	Director of Development	Kim Mertz	Chief Operating Officer

West Cook YMCA	Philip Jiminez	President and CEO	Luis Lazaro-Carrasco	Director of Finance
AgeOptions	Diane Slezak	President and CEO	Robert Mapes	Director of Program and Community Support
Beds Plus Care	Tina Rounds	Executive Director	Julie Daraska	Director, Grants & Contracts
Beyond Hunger	Michele Zurakowski	CEO	Teri Miller	Director of Development
Catholic Charities of the Archdiocese of Chicago	Sarah Ogle	Executive Vice President	Michael Waters	Regional Director, West Cook Region
Family Focus	Sherneron Hilliard	Senior Vice President of Programs and Impact	Griselda Zuluaga	Early Childhood Program Specialist
Quinn Center of St. Eulalia	Kristen Mighty, Phd, MPH	Executive Director	Elizabeth Young	Development Coordinator
Maywood Medical-Legal Partnership (Loyola University Chicago School of Law)	Maya Watson	Director	L. Kate Mitchell	Director of Health Justice Project, Loyola University Chicago School of Law
Pav YMCA	Jamie Kucera	Executive Director/CEO	Raj Waller	Healthy Living/Program Director

3. Please confirm that you have entered the required information for each entity in the table above, including secondary contact information and Tax ID #.
I confirm.

4. Please upload the most recent IRS Form 990 (including Schedule H, if applicable) for all participants in the collaboration.
WCC 990 Forms

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

1A. Please enter the names of entities that provide primary or preventative care in your collaborative.
- Loyola Medicine (Gottlieb Memorial Hospital, Loyola Physician Partners, MacNeal Hospital)
- Pillars Community Health
- Ann and Robert H. Lurie Children's Hospital of Chicago (Lurie Children's Hospital)
- Suburban Primary Health Care Council DBA: Access to Care

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

2A. Please enter the names of entities that provide specialty care in your collaborative.
- Loyola Medicine (Gottlieb Memorial Hospital, Loyola Physician Partners, MacNeal Hospital)

- Lurie Children's Hospital

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

Note: HFS is seeking to know in which MCO networks each hospital in your collaborative participates. See questions below.
3A. Please enter the name of the <u>first</u> entity that provides hospital services in your collaborative.
Loyola University Medical Center

3B. Which MCO networks does <u>Loyola University Medical Center</u> participate in?
- YouthCare
- Blue Cross Blue Shield Community Health Plan
- IlliniCare Health
- Meridian Health Plan (Former Youth in Care Only)
- Molina Healthcare

3C. Are there any other hospital providers in your collaborative? Yes/No toggle
Yes

3D. Please give the name of your <u>second</u> hospital provider here.
MacNeal Hospital

3E. Which MCO networks does <u>MacNeal Hospital</u> participate in?
- YouthCare
- Blue Cross Blue Shield Community Health Plan
- CountyCare Health Plan (Cook County only)
- IlliniCare Health
- Meridian Health Plan (Former Youth in Care Only)
- Molina Healthcare

3F. Are there any other hospital providers in your collaborative? Yes/No toggle
Yes

3G. Please give the name of your <u>third</u> hospital provider here.
Gottlieb Memorial Hospital

3H. Which MCO networks does <u>Gottlieb Memorial Hospital</u> participate in?
- YouthCare
- Blue Cross Blue Shield Community Health Plan
- IlliniCare Health
- Meridian Health Plan (Former Youth in Care Only)
- Molina Healthcare

3I. Are there any other hospital providers in your collaborative? Yes/No toggle
Yes

3J. Please give the name of your fourth hospital provider here.
Ann and Robert H. Lurie Children's Hospital of Chicago

3K. Which MCO networks does Lurie Children's Hospital of Chicago participate in?

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

4. Are there any mental health providers in your collaborative? Yes/No toggle
Yes

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

- Loyola Medicine (Gottlieb Memorial Hospital, Loyola Physician Partners, MacNeal Hospital)
- Pillars Community Health (Co-Chair, Behavioral Health Lead)
- Lurie Children's Hospital
- Healthcare Alternative Systems
- Proviso Leyden Council for Community Action, Inc.

5. Are there any substance use disorder services providers in your collaborative? Yes/No toggle
Yes

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

- Loyola Medicine (Gottlieb Memorial Hospital, Loyola Physician Partners, MacNeal Hospital)
- Pillars Community Health (Co-Chair, Behavioral Health Lead)
- Healthcare Alternative Systems
- Proviso Leyden Council for Community Action, Inc.

6. Are there any social determinants of health services providers in your collaborative? Yes/No
Yes

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

- Loyola Medicine (Gottlieb Memorial Hospital, Loyola Physician Partners, MacNeal Hospital)
- Pillars Community Health
- CareAdvisors
- AgeOptions
- Lurie Children's Hospital
- Beds Plus Care
- Beyond Hunger
- Catholic Charities of the Archdiocese of Chicago (Catholic Charities)
- Family Focus

- Healthcare Alternative Systems
- Housing Forward
- Maywood Medical-Legal Partnership, Loyola University Chicago School of Law
- Young Men's Christian Association of Berwyn-Cicero (Pav YMCA)
- Proviso-Leyden Council for Community Action, Inc.
- Quinn Center of St. Eulalia
- Real Foods Collective
- Suburban Primary Health Care Council DBA: Access to Care
- West Cook YMCA

7. Are there any safety net or critical access hospitals in your collaborative? Yes/No toggle
Yes

7A. Please list the names of the safety net and/or critical access hospitals in your collaborative.
Ann and Robert H. Lurie Children's Hospital of Chicago

8. Are there any entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that are majorly controlled and managed by minorities? Yes/No toggle
Yes

8A. Please list the names of the entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that are majorly controlled and managed by minorities.
CareAdvisors
Family Focus
Healthcare Alternative Systems
Maywood Medical-Legal Partnership
Proviso Leyden Council for Community Action, Inc.
Quinn Center of St. Eulalia
Real Foods Collective
West Cook YMCA

9. Please list the Medicaid-eligible billers (firms that can bill Medicaid for services) in your collaborative, <u>and the Medicaid ID for each</u>. (REDACTED)
Ann and Robert H. Lurie Children's Hospital of Chicago:
Gottlieb Hospital:
Healthcare Alternative Systems: Broadview, Medicaid ID: Substance Use Disorder; Medicaid ID: Mental Health. Melrose Medicaid ID: SUD; Medicaid ID: MH
Loyola University Medical Center:
Loyola University Health System DBA Loyola Medicine:
Macneal Hospital:
Pillars Community Health:
Proviso-Leyden Council for Community Action, Inc.:

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

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

10A. If you checked, "Other," provide additional explanation here.
Not applicable

[10A. 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.)
Care Group Table of Participating Entities

FORM 2. PROJECT DESCRIPTION.

Brief Project Description
1. 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.
West Cook Coalition (WCC)

2. Provide a one to two-sentence summary of your collaboration's overall goals.
The goal of the West Cook Coalition is to increase health equity and improve the health outcomes, quality of life, and overall well-being of members of the west Cook County community.

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. (REDACTED)
The West Cook Coalition (WCC) is a group of collaborative entities dedicated to the health and well-being of the communities we serve led by Loyola University Medical Center, Pillars Community Health, and CareAdvisors, Inc. Our purpose is to address the social vulnerabilities that impact the health inequities and poor health outcomes identified by Healthcare Transformation Collaborative (HFS) for 18 zip codes and communities in west Cook County. To accomplish our mission, we seek three years of HFS funding.

We will use this funding to implement an enhanced care management model that supports high-risk, hard-to-reach, and rising risk Medicaid recipients and uninsured adults residing in west Cook County.

Our Coalition model is built upon six key interconnected Core Strategies designed to collectively provide transformational impact:

- Core Strategy 1: One-Stop Access to Multiple Care Systems via a Community Navigation Hub
- Core Strategy 2: Disease Management Programs for Members with Chronic Conditions
- Core Strategy 3: Improved Care Coordination through an Equity Internet Exchange (EIEx)
- Core Strategy 4: Clinically Integrated Social Care Management for Hard-to-Reach Members
- Core Strategy 5: Increased Community Access to Behavioral Health Services
- Core Strategy 6: Community-Based Services for Vulnerable Populations

We provide a detailed overview of each WCC Core Strategy below.

PROJECT GOALS
The WCC will:

- Increase engagement and access to care for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area through the Community Navigation Hub (Core Strategy 1).
- Connect more members with disease management programs available through coalition organizations or Medicaid Managed Care Organizations (MCOs), with a reduction in avoidable complications (Core Strategy 2).
- Improve the creation and use of holistic healthcare records for attributed members through information technology, care management platforms, screenings, and principles of interoperability (Core Strategy 3).
- Connect members with critical social determinants of health interventions and resources, with a focus on housing stability and food security (Core Strategy 4).
- Increase the access of members to behavioral health services by expanding existing and launching new behavioral health programs, investing HFS funds in capital projects designed to expand capacity and reach, and reduce ongoing staff turnover and unfilled high-need positions through enhanced reimbursement for high-risk patients (Core Strategy 5).
- Equip members with the knowledge and support to achieve positive health outcomes and improve their well-being through home-visiting programs (Core Strategy 6).

TRANSFORMATIONAL IMPACT OF PROPOSED PROJECT
The WCC's model will provide transformational impact by:

- Implementing a seamless ecosystem approach to addressing whole health needs of members.
- Leveraging the expertise of a variety of care providers that are already embedded within the community, are known to individuals we seek to serve, and have a proven track record of meeting broad SDoH needs.
- Engaging collaborating entities and developing interventions through a racial equity lens.
- Utilizing extensive community input from community members and leaders to identify the unique health needs of the community and potential solutions for healthy inequities
- Developing a replicable model to impact a broader subset of the local community and other areas of need through improved member health outcomes and cost-of-care savings.

TARGETED SERVICE AREA AND POPULATION

The WCC's targeted service area includes 18 communities located in west Cook County, Illinois:

- Bellwood, zip code 60104
- Berkeley, zip code 60163
- Berwyn/Stickney, zip code 60402
- Broadview, zip code 60155
- Brookfield, zip code 60513
- Cicero, zip code 60804
- Forest Park, zip code 60130
- Franklin Park, zip code 60131
- Hillside, zip code 60162
- Lyons, zip code 60534
- Maywood, zip code 60153
- Melrose Park, zip code 60160
- North Lake, zip code 60164
- North Riverside, zip code 60546
- River Grove, zip code 60171
- Stone Park, zip code 60165
- Summit, zip code 60501
- Westchester, zip code 60154

The population composition for the west Cook County service area is 55% Latinx, 25% non-Latinx white, 17% non-Latinx African American/Black, 2% non-Latinx Asian, and 1% two or more races. One in five residents are foreign-born, with the largest percentage coming from Mexico (38.2%). Racial and ethnic minority populations experience higher rates of poverty than non-Latinx whites throughout our service area. Poverty rates continue to climb in west Cook County, with childhood poverty growing from 10.8% to 18.2% between 2000 and 2013.[1]

The WCC will utilize risk stratification to identify Medicaid members residing in these service areas to target for participation in the project. Criteria in risk stratifications will coincide with established best practices for identifying hard-to-reach Medicaid populations. Data sources may include screening results, clinical data, information exchange data, and claims data received through collaboration with managed care organizations (MCO). Target groups include:

- High-Risk Medicaid members that are not engaged by care management at the health plan level.
- Rising-Risk Medicaid members that are not engaged by care management at the health plan level.
- Hard-to-Reach Medicaid members (high-risk and rising risk) that are not engaged by care management at the health plan level

The Navigation Hub (Core Strategy 1) will also support uninsured individuals for care coordination.

The WCC will also facilitate support for Medicaid members who reside outside of our service area by referring them to the resources to suit their unique needs.

[1] Voices for Illinois Children. (2015). *Child poverty in metropolitan Chicago.* https://www.voices4kids.org/wpcontent/uploads/2015/03/VOICES_2015KC_report_02metro_FINAL.pdf

HEALTHCARE CHALLENGES ADDRESSED

The service area's communities face a nexus of disparities in care delivery and health outcomes for racial and ethnic minorities and other vulnerable populations:

- In Cook County, 11% of the population is uninsured overall. By contrast, rates in many of the WCC's service area communities are higher, including Cicero (20%), Melrose Park (16.3%), Stone Park (26%), and Summit (18%).[2]
- The average life expectancy in predominantly white neighborhoods in the Chicago metro area averages 90 years. In contrast, west Cook County communities have an average life span of just 78.5 years,[3] with especially low life expectancy rates include Broadview (age 72), Bellwood (age 73), Berkeley (age 75), Hillside (age 75), Maywood (age 75), and Melrose Park (age 75).[4]
- Chronic disease mortality rates underscore the same disparity patterns: In both west Chicago and west Cook County, African American/Black individuals have the highest rates of mortality for cardiovascular disease, cancer, diabetes, and stroke compared to other race/ethnic groups in the region.[5]
- Just 9.8% of patients in Chicago and 15.4% of patients in west Cook County who were hospitalized for a chronic disease were receiving outpatient care prior to their hospital admission. After discharge from the hospital, only 14.5% of patients in Chicago and 23% of patients in west Cook County received outpatient care to manage their conditions.[6]
- Our target service area has experienced "disproportionately higher numbers of COVID-19 infections, hospitalizations, and deaths relative to other communities in Illinois." Although Latinx tended to have the highest COVID-19 infection rates, African American/Black people have the highest death rates. While African American/Black Chicagoans make up 30% of the population, they accounted for 70 of the first 100 local COVID-19 deaths.[7]
- Medicaid recipients living in west Cook County are admitted to the hospital at double the national rate for ages 19-64, and the rate is 26% higher than the national rate for ages 65 and older.[8]
- Infant mortality rates also vary substantially by race/ethnicity. African American/Black infants are more than four times as likely as white infants to die before their first birthday in Chicago and almost three times as likely in west Cook County.[9]

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[2] United States Census Bureau. (2019). *QuickFacts: Melrose Park village, Illinois.* Retrieved September 14, 2021, from https://www.census.gov/quickfacts/melroseparkvillageillinois

[3] Basu, S., Flax-Hatch, J., Freeman, V. L., Gao, Y., Hershow, R., Kauth, A., Musick, H., Schneiderman, J., & Wang, H. (2021). *Transformation data & community needs report: Chicago–West side.* University of Illinois at Chicago School of Public Health. https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportWestChicagoDigitalCMP.pdf

[4] Loyola Medicine. (2019). *Community health needs assessment.* https://www.loyolamedicine.org/assets/documents/2019_chna_report_gottlieb.pdf

[5] Cook County Department of Public Health. (2018). *Ten leading causes of death tables 2012-2016.* Community Epidemiology and Health Planning Unit. https://cookcountypublichealth.org/wp-content/uploads/2020/02/Leading-Causes-2012-2016.pdf

[6] Basu, S., Flax-Hatch, J., Freeman, V. L., Gao, Y., Hershow, R., Kauth, A., Musick, H., Schneiderman, J., & Wang, H. (2021). *Transformation data & community needs report: Chicago–West side.* University of Illinois at Chicago School of Public Health. https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportWestChicagoDigitalCMP.pdf

[7] Brandt, K. S. (2020, September 10). *The great unequalizer: Health inequities - Chicago Health.* Chicago Health. https://chicagohealthonline.com/the-great-unequalizer

[8] Basu, S., Flax-Hatch, J., Freeman, V. L., Gao, Y., Hershow, R., Kauth, A., Musick, H., Schneiderman, J., & Wang, H. (2021). *Transformation data & community needs report: Chicago–West side.* University of Illinois at Chicago School of Public Health. https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportWestChicagoDigitalCMP.pdf

[9] Chicago Department of Public Health. (2016). *Healthy Chicago 2.0: Partnering to improve health equity 2016 – 2020.* https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy%20Chicago/HC2.0Upd4152016.pdf

- Of all hospitalizations in west Cook County, 4% are for psychoactive substance use disorder (SUD) (including 48.5% alcohol-related, 44.4% opioid-related, and 7% other).[10]
- ED utilization rates show that racial and ethnic minority populations are more likely to visit than white individuals to visit hospitals for their chronic and behavioral health conditions. Bellwood, Cicero, Maywood, Melrose Park, and Stone Park are some of the communities in west Cook County with the highest rates of emergency department (ED) visits for behavioral health.[11]
- In addition, emergency department visit rates for diabetes are highest in Maywood (51.2 per 10,000 visits) and Melrose Park (22.9 per 10,000 visits).[12]
- As previously noted, childhood poverty grew from 10.8% to 18.2% between 2000 and 2013 in west Cook County, contributing to a number of social and health disparities. Within the service area, ambulatory Care-Sensitive Conditions (ACSCs) including asthma and diabetes are "highly associated with young children."[13] Within the city of Chicago, Black/African American children and adolescents are five times more likely to visit an ED for asthma-related incidents than their White counterparts.[14] Lurie Children's *2019 Community Health Needs Assessment* found that while 15-20% of youth have a serious behavioral health condition, only half receive the mental healthcare they need.[15]

While these persistent inequities stem in part from healthcare system inadequacies, social and structural forces greatly shape everyday living conditions, i.e., the social determinants of health (SDoH), may play an even greater role. The lack of affordable housing and housing insecurity in our service area puts residents at risk for negative health impacts stemming from unhealthy living conditions, stress, social isolation, and limited resources to manage their healthcare conditions. In our service area, housing cost burden (defined by HUD as families whose pay is more than 30% of their income for housing) affects households in every community, with rates ranging from 40-68%.[16] In addition, many west Cook County communities are at risk for food insecurity and have difficulty accessing healthy foods, heightening the population's risk for poor diets and chronic disease. Within the service area, food insecurity rates range from 18-39%, often higher than the rates of 13.6% in suburban Cook County and 19.2% in Chicago.[17]

For all the reasons listed above, we have chosen to focus our efforts on Medicaid members and the uninsured residing in 18 communities in west Cook County. This targeted population is largely comprised of racial and ethnic minorities (Blacks/African Americans and Latinx), low income individuals, at-risk and

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[10] Basu, S., Flax-Hatch, J., Freeman, V. L., Gao, Y., Hershow, R., Kauth, A., Musick, H., Schneiderman, J., & Wang, H. (2021). *Transformation data & community needs report: Chicago–West side.* University of Illinois at Chicago School of Public Health. https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportWestChicagoDigitalCMP.pdf

[11] Loyola Medicine. (2019). *Community health needs assessment.* https://www.loyolamedicine.org/assets/documents/2019_chna_report_gottlieb.pdf

[12] Loyola Medicine. (2019). *Community health needs assessment.* https://www.loyolamedicine.org/assets/documents/2019_chna_report_gottlieb.pdf

[13] Basu, S., Flax-Hatch, J., Freeman, V. L., Gao, Y., Hershow, R., Kauth, A., Musick, H., Schneiderman, J., & Wang, H. (2021). *Transformation data & community needs report: Chicago–West side.* University of Illinois at Chicago School of Public Health. https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportWestChicagoDigitalCMP.pdf

[14] Loyola Medicine. (2019). *Community health needs assessment.* https://www.loyolamedicine.org/assets/documents/2019_chna_report_gottlieb.pdf

[15] Ann and Robert H. Lurie Children's Hospital of Chicago (2019). *Community health needs assessment.* https://www.luriechildrens.org/globalassets/documents/luriechildrens.org/community/community-health-needs-assessment/chna-2019.pdf

[16] Housing Action Illinois. (2020). *Making rent affordable.* https://housingactionil.org/what-we-do/advocacy/rental-affordability

[17] Greater Chicago Food Depository. (2016). *Cook County food access plan.* https://www.chicagosfoodbank.org/wp-content/uploads/2016/10/Cook_County_Food_Access_Plan.pdf

high-need mothers and children, people with chronic conditions, and individuals negatively impacted by SDoH, with a particular focus on those facing food insecurity or housing instability.

PARTICIPATING ORGANIZATIONS

The WCC includes collaborating entities that are established and trusted service providers in our targeted service area:

WCC Co-Chairs:

- Loyola Medicine (Gottlieb Memorial Hospital, Loyola Physician Partners, MacNeal Hospital) (Clinical Lead)
- Pillars Community Health (Co-Chair, Behavioral Health Lead)
- Care Advisors, Inc. (Co-Chair, Social Care Management Lead)

WCC Foundational Partners:

- AgeOptions
- Ann and Robert H. Lurie Children's Hospital of Chicago (Lurie Children's)
- Beds Plus Care
- Beyond Hunger
- Catholic Charities of the Archdiocese of Chicago
- Family Focus
- Healthcare Alternative Systems
- Housing Forward
- Maywood Medical-Legal Partnership, Loyola University Chicago School of Law
- Pav YMCA (Young Men's Christian Association of Berwyn-Cicero)
- Proviso-Leyden Council for Community Action, Inc.
- Quinn Center of St. Eulalia
- Real Foods Collective
- Suburban Primary Health Care Council DBA: Access to Care
- West Cook YMCA

We have included letters of commitment to this HFS Transformation coalition from each co-chair and foundational partner within Section 2 Supporting Documents, Exhibit 2A.

In addition to our Co-Chairs and Foundational Partners, we will leverage the collective impact and reach of additional local organizations ("Coalition Affiliates") to improve service gaps and better meet community SDoH needs. Our Coalition Affiliates include JourneyCare, Casa Esperanza, Youth Outreach Services, Leyden Family Services, Community Support Services, Leyden Family Services, and workforce development affiliates such as the Chicago Cook Workforce Partnership. Criteria used to identify and select Coalition Affiliates includes health mission alignment, targeted service areas, and current capacities.

We will facilitate rigorous data sharing among Co-Chairs and Foundational Partners, and Coalition Affiliates, which will help local providers shape their policies and programs, and how they manage Medicaid member care. Our integrated model of care will promote interoperability and information sharing among autonomous entities. We will also use data to create reports to inform the programs and policies of other funders and further collaboration among WCC participating organizations.

WCC will establish agreements with adjacent HFS Transformation coalitions and individual providers that serve as primary care medical homes to support the care coordination of members who reside in our region but are attributed to providers within other HFS Transformation collaborations or otherwise have a provider not currently in our networks. Our collaborative agreements will include appropriate data sharing and care coordination with members' medical homes or primary care providers. This will allow the WCC to facilitate social care management of these members and educate them on how to access these resources from their medical homes. These collaborations will include convening stakeholder groups to share best practices for our care model and improve member care coordination.

STRATEGIES TO ACHIEVE GOALS

Core Strategy 1: One-Stop Access to Multiple Care Systems via a Community Navigation Hub

Goal: Increase engagement and access to care for high-risk, high-need Medicaid recipients and uninsured adults who reside in the WCC service area through the Community Navigation Hub.

Based on our analysis of clinical treatment data and direct member feedback, we know that service area Medicaid members experience significant delays in treatment due to several factors. These factors include mistrust of the healthcare system due to historical institutional inequity, an inability to navigate the healthcare system, and the financial and emotional stress of managing chronic care with limited caregiver support.

To address these factors, the WCC will establish a Community Navigation Hub that includes three integrated resources:

- Key Staff - Community Health Worker/Social Work Care Manager (CHW/SWCM) teams who will connect members with clinically integrated staff and help manage "social care" challenges for members.
- In-Field Member Support - CHW/SWCM teams will serve members within the community through work with each WCC Co-Chair and Foundational Partner organization.
- Integrated Software – a toolkit of screening and e-referral tools that WCC Co-Chairs and Foundational Partners will use to screen members for SDoH.

Social care encompasses the 25 SDoH:[18]

▪ Access to Services	▪ Housing	▪ Mental Health
▪ Career Resiliency/Training	▪ Income (Self-Sufficiency Standards)	▪ Parenting
▪ Childcare	▪ Income (Area Median Income)	▪ Physical Health
▪ Clothing	▪ Income (Federal Poverty Level)	▪ Safety
▪ Education	▪ Legal	▪ Substance Use
▪ Employment Stability	▪ Life Skills (Household Management)	▪ Support System
▪ English Language Skills	▪ Life Skills (Human Relations)	▪ Transportation
▪ Food	▪ Life Skills (Financial Matters)	
▪ Functional Ability	▪ Life Skills (Setting Goals and Resourcefulness	

[18] Artiga, S., & Hinton, E. (2018, May 10). *Beyond health care: The role of social determinants in promoting health and health equity. Kaiser Family Foundation.* https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Key Staff

Numerous community-based organizations (CBOs), healthcare providers, and participants within the WCC report a lack of a local CHW pipeline. Loyola currently has a team of seven CHWs that connect members with clinically integrated staff and help manage social care challenges for members. The WCC will build on Loyola's network of CHWs by hiring an additional 25 CHWs and 20 Social Worker Care Managers over the next three years to assist member needs through the Hub. Collaborating entities within the WCC will recruit CHWs with a preference given to individuals residing in our service area. We will focus on hiring CHWs based on shared life experiences and cultural, linguistic, and socioeconomic backgrounds with the communities they will serve.

As trusted community members, CHWs have a deep understanding of the communities they serve. This allows CHWs to serve as a liaison between healthcare and social services providers, and the community, to facilitate access to services, as well as improve the quality and cultural competence of service delivery. Through the Hub, CHWs will partner with SWCMs to build trust-based relationships with members and address the barriers which may impede members seeking care including navigating the complexities of the healthcare system or linkages to social service resources. Integration of CHWs into the local health delivery system will also build individual and community capacity by increasing health knowledge and self-sufficiency through a variety of activities that include outreach, community education, informal counseling, social support, and advocacy.

Through the Hub, CHW/SWCM teams will collaborate with an extended care team of primary care physicians, specialists, behavioral health specialists, medical homes, nurse care coordinators, pharmacists, lab specialists, dentists, respiratory therapists, benefits and eligibility staff, outreach staff, case managers, patient navigators, and other care resources to coordinate solutions for members. Additionally, CHW/SWCM teams will utilize the electronic resource directory Aunt Bertha to refer members to community resources for housing, medical respite, food security, transportation, and other social care needs.

Through their work within the Hub, CHW/SWCM teams will:

- Help to bridge the gap between clinical care and social (community) care.
- Promote wellness by providing culturally appropriate health information to members and providers
- Assist members in self-management of chronic illnesses and medication adherence.
- Provide individual social and healthcare support.
- Organize and/or facilitate support groups.
- Refer and link members to preventive services through health screenings and healthcare information.
- Conduct health-related screenings and connect members with community resources.
- Coordinate care for high acuity members
- Participate in coordinated intake and psychosocial assessments with partner agency staff.
- Work with trained and certified patient navigators within Co-Chair organizations, Foundational Partners, and Coalition Affiliates.
- Support and expedite the completion of member Medicaid paperwork.
- Advocate for the medical and social care needs of members.

In addition to the responsibilities outlined above, CHW/SWCM teams will help members explore disease management options available through WCC collaborating entities (see Core Strategy 2). The CHW/SWCM team will also help members access behavioral health services (see Core Strategy 5) and community-based services (see Core Strategy 6).

Collaborating entities within the WCC will recruit CHWs with a preference given to individuals residing in our service area (see Jobs section). We will focus on hiring CHWs based on shared life experiences and cultural, linguistic, and socioeconomic backgrounds with the communities they will serve.

The WCC will design and implement a training program for WCC CHWs. This training will promote standardized career readiness, employee retention, and a more consistent experience for members served. Training will include:

- How to utilize electronic health record (EHR) systems to improve health outcomes.
- A deep dive into the referral process (both from the perspective of the member experience and from receiving MCOs)
- Coordinated intake for behavioral health
- Motivational interview training for listening, communication, and response skills.

The WCC is following the progress of state Senate Bill 336 (part of the spring 2021 House Bill 158).[19] If passed, the bill includes a state certification program for CHWs. The WCC will revise our CHW training program if such legislation passes.

Based on feedback from community leaders, the training may also include cross-training in recovery support, addressing co-morbidity issues such as SUD, end-of-life care, and caregiver support. The WCC is also exploring including "continuum of care" training as many members with serious/chronic health conditions have never had a culturally appropriate "goals of care" conversation with a health professional. CHWs will receive a certificate upon completing the training. The WCC will invite MCOs in the area to collaborate on and participate in the training for CHWs.

Increasing the number of CHWs through recruitment and career readiness training is critical to public health and equal access to medical care. Through these efforts, the WCC will increase the breadth and quality of the local CHW workforce and form the foundation for an intentional network of CHWs and organizations looking to employ CHWs.

Caseloads for each CHW will intentionally be kept small to ensure that each member's needs are fully addressed. At any given time, each CHW will maintain a caseload of 25-30 members. Caseloads will contain a mix of high, medium, and low-intensity members. Collaborating entities within the WCC will take travel and visiting times into consideration when assigning caseloads. CHWs will participate in case reviews and conferences with other care team members to enable them to contribute their observations and to continually grow their expertise.

In-Field Member Support

[19] Illinois General Assembly. (n.d.). *Bill status of SB0336.* https://www.ilga.gov/legislation/billstatus.asp?DocNum=336&GAID=16&GA=102&DocTypeID=SB&LegID=131711&SessionID=110

CHW/SWCM teams will engage and support members in their own communities. Service sites may include schools, churches, and community events, and the client service locations of WCC Co-Chairs, Foundational Partners, and Coalition Affiliates, among others.

Integrated Software

Utilization of technology tools can help identify and address SDoH, which often serve as access barriers to care. CHW/SWCM teams will utilize screening and e-referral tools that WCC Co-Chairs and Foundational Partners use to screen members. To improve coordination of care across sectors, the WCC will build an Equity Information Exchange (EIEx) platform on top of the existing data infrastructure to create an integrated and interoperable technology platform that merges data from multiple sources to deliver closed loop referrals and enhanced care coordination. This platform will connect all software within the Hub (see Core Strategy 3) and enables CHW/SWCM teams to create a plan of care and refer members to appropriate community-based resources.

Please refer to within Section 2 Supporting Documents, Exhibit 2B for a CHW/SWCM team workflow.

Pediatric Navigation Hub

The Community Navigation Hub will feature navigation capabilities for pediatric specialties that have long wait times and lack sufficient capacity within the WCC's targeted service area. Areas of focus include behavioral health, pediatric rheumatology, and weight management. These areas of focus may be revised or expanded upon based on findings from the steering committee and community needs. Six staff including a nurse practitioner, two registered nurse care coordinators, and three patient navigators will facilitate member access to specialty resources at Lurie Children's location in Westchester via telehealth. The Pediatric Navigation Hub will facilitate member transportation to other Lurie Children's locations as needed.

Collaboration with Adjacent HFS Transformation Coalitions and Providers

Our targeted service area has a total of 100,000 individuals who are either Medicaid beneficiaries or individuals who are Medicaid-eligible but not enrolled. The majority of the additional 42,000 individuals are largely attributed to either Loyola Medicine or PCH. The remaining 58,000 individuals are attributed to either the CountyCare Health Plan or the Meridian Health Plan and will have providers outside of Loyola Medicine and PCH.

WCC will establish agreements with adjacent HFS Transformation coalitions and individual providers that serve as primary care medical homes to support the care coordination of members who reside in our region but are attributed to providers within other HFS Transformation collaborations or otherwise have a provider not currently in our networks. Our collaborative agreements will include appropriate data sharing and care coordination with members' medical homes or primary care providers. This will allow the WCC to facilitate social care management of these members and educate them on how to access these resources from their medical homes. These collaborations will include convening stakeholder groups to share best practices for our care model and improve member care coordination.

Core Strategy 2: Disease Management Programs for Members with Chronic Conditions

Goal: Connect more members with disease management programs available through coalition organizations or Medicaid MCOs, with a reduction in avoidable complications.

In the traditional medical model, there is often a disconnect between the plan of care from healthcare providers and the self-management activities that individuals are able and willing to do. Many Medicaid members face physical, psychological, cognitive, economic, and social/cultural barriers that hinder their ability to self-manage their chronic health conditions actively and effectively. Data show that African American/Black and Latinx individuals suffer significantly more complications and severity of conditions than their white counterparts.[20]

Engaging individuals with chronic disease in disease management programs is shown to prevent complications, slow disease progression, and limit disease severity. Disease management programs also inform staff training processes, allow for consistent and comprehensive member education materials, and detail effective steps for member engagement in managing their chronic health issues. The WCC will connect members with disease management programs that address their chronic conditions, such as diabetes and hypertension. We leveraged data, community input, evidence-based self-management education and support disease management programming information from our Co-Chairs and Foundational Partners to design our second Core Strategy.

Examples of disease management programs currently available through entities participating in the WCC include:

- Home Care Connect (Loyola) is an integrated virtual care program that empowers patients with Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) to achieve their health goals at home. Participants (and their caregivers) receive a smart tablet and a wireless scale, pulse oximeter, and blood pressure cuff. The visiting nurse or therapist trains the patient and caregivers on how to use each item. Every day, the patient follows the tablet's voice and text instructions and devices to self-report vital health information. The patient also completes a condition-specific education module and answers questions to increase knowledge. Patient vitals including blood pressure, weight, health symptoms, etc., stream securely to the Virtual Care Center. The platform also allows for instant two-way virtual video visits with the patient and his or her care center nurse; physicians and patient caregivers can also be added to the video conversation. These real-time assessments enable patients and the care team to address health changes that, if left undetected, could lead to ER visits or hospitalizations.
- PCH and the other behavioral health partners in the WCC offer a number of disease management interventions within their Community Mental Health and Substance Use Services. PCH offers office-based, home-based, telehealth, and community-based counseling for children and adults, including individual and group counseling, community support (individual and team), employment services, mobile crisis response teams, and grief support. Services also include comprehensive assessment and treatment planning for Substance Use Disorder Services, individual and group counseling, DUI (driving under the influence) risk education, and intensive outpatient treatment for adolescents and adults, including telehealth services where appropriate.
- Take Charge of Your Health (Loyola, West Cook YMCA) is an interactive six-to-eight week workshop series led by trained facilitators who have personal experience with ongoing health conditions. Each weekly session provides older adults and their caregivers with information and self-management skills for managing chronic disease. Take Charge of Your Health is the Illinois-branded name for the Stanford Patient Education Research Center Chronic Disease and Diabetes Self-Management programs.

[20] National Academies of Sciences, Engineering, and Medicine. (2017b). *The state of health disparities in the United States.* In *Communities in action: Pathways to health equity.* National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK425844

The WCC will expand this programming by purchasing additional licenses to expand upon our existing portfolio of disease management programs. These additions will enable WCC collaborating entities to serve a greater number of community members and engage directly with them to connect them with the appropriate community-based disease management programs and social supports. Participants in disease management programs may also self-refer or be referred by providers or WCC Co-Chairs, Foundational Partners, and Coalition Affiliates. Additionally, we will expand access to disease management programs via telehealth, web-based education, hospital-based groups, one-on-one education, and community-based programs. The participation of members in our disease management programs will be tracked through the EIEx (see Core Strategy 3).

In addition to connecting members to disease management programs, CHW/SWCM teams will provide supplementary support for members designed to lower rehospitalizations and ED utilization rates. Examples of supplementary support will include follow-up and engagement after member hospitalizations, case management, and referrals to alternative therapeutic services, among others.

The WCC's disease management programs will encompass asthma, behavioral health, cardiovascular disease, chronic kidney disease, COPD, diabetes/prediabetes, and hypertension. We have chosen to focus on these specific chronic conditions and diseases as they demonstrate a high utilization of inpatient and emergency care and/or high readmission rates and are prevalent across the population to be served.

- Asthma/COPD: As of 2019, more than 25 million Americans were living with asthma including over 5 million children under the age of 18. In 2018, there were 1,629,469 ED visits and 178,530 hospital inpatient stays in which asthma was the primary diagnosis.[21] According to research published in 2018, asthma costs the U.S. economy more than $80 billion per year in medical expenses, missed work and school days, and deaths. The annual per-person medical cost of asthma was $3,266. Of that, $1,830 was for prescriptions, $640 for office visits, $529 for hospitalizations, $176 for hospital outpatient visits and $105 for emergency room care.[22] COPD affects nearly 16 million Americans, or about 6% of the U.S. population. As of 2018, it was the fourth leading cause of death in the U.S. More than 50% of adults with low pulmonary function were not aware that they had COPD, so the actual number of individuals with COPD may be higher.[23] In the City of Chicago, non-Hispanic African American/Black children and adolescents are five times more likely to visit the emergency department for an asthma-related condition than white children and adolescents.[24]
- Behavioral Health: In 2019, an estimated 1 in 5 (51.5 million) adults in the U.S. were living with a mental illness. Only 44.8% (23 million) of adults living with a mental illness received behavioral health services in the past year.[25] Further, the ongoing COVID-19 pandemic and the resulting economic recession have negatively affected many people's mental health. In particular, "the pandemic has disproportionately affected the health of communities of color. Non-Latinx Black adults (48%) and Latinx or Latino adults (46%) are more likely to report symptoms of anxiety

[21] Centers for Disease Control and Prevention. (2021a, March 30). *Most recent national asthma data.* Retrieved September 8, 2021, from https://www.cdc.gov/asthma/most_recent_national_asthma_data.htm

[22] American Thoracic Society. (2018). *Asthma costs the U.S. economy more than $80 billion per year.* https://www.thoracic.org/about/newsroom/press-releases/journal/2018/asthma-costs-the-us-economy-more-than-80-billion-per-year.php

[23] Centers for Disease Control and Prevention. (2021b, June 9). *Basics about COPD.* https://www.cdc.gov/copd/basics-about.html

[24] Loyola Medicine. (2019). *Community health needs assessment.* https://www.loyolamedicine.org/assets/documents/2019_chna_report_gottlieb.pdf

[25] National Institute of Mental Health. (n.d.). *Mental illness.* https://www.nimh.nih.gov/health/statistics/mental-illness

and/or depressive disorder than Non-Latinx white adults (41%). Historically, these communities of color have faced challenges accessing behavioral healthcare."[26] Within the west Cook service area, the topmost frequent and resource-intensive hospitalization (defined as the rate of readmission for the disease block) included a mood affective disorder (i.e., bipolar, depression) followed by schizophrenia and schizotypal disorders.[27] The HFS also found that out of all hospitalizations in west Cook County, 4% are for psychoactive SUD (including 48.5% alcohol-related, 44.4% opioid-related, and 7% other).

- Cardiovascular Disease: Cardiovascular disease remains the leading cause of death in the United States. Heart disease and stroke claim over 868,000 American lives each year, or one-third of all deaths. Each year, cardiovascular disease costs the healthcare system $214 billion and causes $138 billion in lost productivity on the job. HTC data found that, within west Cook County, A) the congestive heart failure hospital admission rate was nearly triple the national rate for patients 19-64 years old and 20% higher for patients 65 years and older, B) the age-adjusted hospitalization rate due to heart failure per 10,000 population aged 18 years and older was 72.9 compared to 61.5 for the state of Illinois, and C) the percentage of Medicare members who were treated for stroke totaled 4.3% compared to 3.8% for both Illinois and nationally.[28] Additionally, data from the 2019 Loyola CHNA found that 25% of more than 650 local respondents identified heart disease among the most important health problems in their community.[29]
- Chronic Kidney Disease: In the U.S., more than 1 in 7 adults (37 million) are estimated to have chronic kidney disease. As many as 90% are not aware of their health condition. Nearly 80 million adults in the U.S. (1 in 3) are at risk for developing the condition. Adults with other serious chronic medical conditions often also have chronic kidney disease. In fact, research finds that as many as 1 in 5 adults with diabetes and 1 in 5 adults with hypertension in the U.S. may also have kidney disease.[30]
- Diabetes/Prediabetes: Approximately 10% of adults in the U.S. (34.2 million) have diabetes. This statistic includes 26.9 million people who are diagnosed and an additional 7.3 million people who are undiagnosed. Another 88 million Americans (34.5% of the adult population) have prediabetes. In 2017, the direct and indirect estimated costs of diagnosed diabetes in the U.S. totaled $327 billion.[31] HTC data found that within west Cook County, 28.8% of Medicare members were treated for diabetes (compared to 27.1% statewide and 27% nationally), and the diabetes hospital admission rate was more than double the national rate for patients 19-64 years old and 65 years and older.[32] Data from the *2019 Loyola Community Health Needs Assessment* (CHNA) found that 46% of more than 650 local respondents identified diabetes among the most important health

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[26] Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R., Hamel, L., & Chidambaram, P. (2021, February 10). *The implications of COVID-19 for mental health and substance use.* Kaiser Family Foundation. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use

[27] Basu, S., Flax-Hatch, J., Freeman, V. L., Gao, Y., Hershow, R., Kauth, A., Musick, H., Schneiderman, J., & Wang, H. (2021). *Transformation data & community needs report: Chicago–West side.* University of Illinois at Chicago School of Public Health. https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportWestChicagoDigitalCMP.pdf

[28] Community Memorial Foundation. (2020). *Age-adjusted hospitalization rate due to hypertension - County: Cook.* Retrieved October 2, 2021, from https://cmfdn.thehcn.net/indicators/index/view?indicatorId=2344&localeId=662

[29] Loyola Medicine. (2019). *Community health needs assessment.* https://www.loyolamedicine.org/assets/documents/2019_chna_report_gottlieb.pdf

[30] National Kidney Foundation. (2021). Kidney disease: The basics. https://www.kidney.org/news/newsroom/fsindex

[31] Centers for Disease Control and Prevention. (2020, August 28). *National diabetes statistics report, 2020.* https://www.cdc.gov/diabetes/data/statistics-report/index.html

[32] Community Memorial Foundation. (2020). *Age-adjusted hospitalization rate due to hypertension - County: Cook.* Retrieved October 2, 2021, from https://cmfdn.thehcn.net/indicators/index/view?indicatorId=2344&localeId=662

problems in their community. Community residents living with diabetes reported that difficulty accessing healthy foods and a high prevalence of fast-food options made it more difficult for them to manage their conditions.[33]

- Hypertension: National statistics from the 2017 hypertension guidelines estimate that 46% of U.S. adults (103 million) have high blood pressure. However, only half of individuals with high blood pressure have their condition under control, whether through medication, lifestyle changes, or through a combination. Nationally, annual healthcare costs for the U.S. population with high blood pressure are estimated to be $131 billion higher compared to those without the disease.[34] Within Cook County, the age-adjusted hospitalization rate due to hypertension, or high blood pressure, per 10,000 population aged 18 years and older was 10.3 compared to 8.1 for the state of Illinois.[35]

Core Strategy 3: Improved Care Coordination through an Equity Information Exchange (EIEx)

Goal: Improve the creation and use of holistic healthcare records for attributed members through information technology, care management platforms, screenings, and principles of interoperability.

There are significant care coordination gaps in west Cook County due to the fragmentation of patient data among disparate EHRs and case management systems. This makes it difficult for clinicians and case managers to adequately address the needs of members. Additional obstacles to holistic patient care include the lack of information transfer, systems to monitor patients, and tools to support patients' self-management goals, and tools to link patients and their caregivers with community resources. There are also limited tools that facilitate interoperability with legacy case management software.

CBOs participating in WCC-hosted community input sessions (see Community Input section) highlighted these gaps and resulting concerns. Participants noted that ensuring coordinated care for at-risk individuals, particularly those with limited or no technology access, continues to be a challenge. Under the existing data infrastructure, users must pull clinical and social care data from different systems. While large hospitals' EHR systems are interoperable with thousands of other systems nationwide, smaller safety net providers (including many community health centers) often lack connectivity and are unable to transfer data with other providers. Feedback pointed to the value that a shared information exchange platform would have if developed and utilized across collaborative member-care-focused organizations.

To improve coordination of care across sectors, the WCC will leverage CareAdvisors' web-based EIEx platform to create an interoperable bi-directional data exchange with all EHR systems as well as legacy community resource directory tools and case management software at CBOs. The platform will combine data sets to provide both healthcare and social care providers with a holistic view of community members' health and social needs to better address broad disparities. Using this information, care providers will be able to determine individual risk profiles, make informed and strategic decisions about matching clients with community resources, and attain closed loop referrals.

Functionality

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[33] Loyola Medicine. (2019). Community health needs assessment. https://www.loyolamedicine.org/assets/documents/2019_chna_report_gottlieb.pdf

[34] Kirkland, E. B. (2018, May 30). *Adults with high blood pressure face higher healthcare costs.* American Heart Association. https://newsroom.heart.org/news/adults-with-high-blood-pressure-face-higher-healthcare-costs

[35] Community Memorial Foundation. (2020). *Age-adjusted hospitalization rate due to hypertension - County: Cook.* Retrieved October 2, 2021, from https://cmfdn.thehcn.net/indicators/index/view?indicatorId=2344&localeId=662

Referrals can be generated in three ways: auto-referral, assisted referral from a service integration user, a care provider, or self-referral. To ensure that a robust data set can be exchanged efficiently and compliantly with multiple stakeholders across the network, information will be shared under a consent module that allows the individual to indicate consent to share their data, and with whom, and to revoke consent at any time.

Ease of administration for platform users is crucial to users, all while providing the best reporting at the right time. For example, an operations manager at a food pantry will be able to access data reporting to view referral volume for the previous month, identify utilization spikes, and review those high utilization days by demographic information to gain a better understanding for utilization increase and export the data in the best-suited format. A robust self-service analytics dashboard will provide standard analyses of data and allow users to create custom visualizations and conduct powerful reporting without needing any technical knowledge or additional applications. Reports can be customized to show or hide sensitive information and be shared with users across the network.

Through the EIEx, CBOs will also be able to view aggregated, anonymized community level data for benchmarking and trend analysis to adjust or design practices, programs, and policies to better meet their clients' health and service needs. In addition, they will be able to chart population level changes in care coordination, such as reduced hospital stays and ED use among ethnic and racial minorities, as reflected in service patterns and other reporting metrics generated by the EIEx. These reporting metrics can be used to a) create or refine social care policies, programs, and practices to improve service and outcomes; and b) inform legislative briefings with government stakeholders about health disparities.

Workshop training will be the main approach for helping community stakeholders to determine their data needs and to understand and use data to inform development of policies, programs, and practices to address health disparities among racial and ethnic minority populations. These sessions provide an overview of data and social care management, the existing data set and reporting metrics so that the organizations can use, understand, and apply data to better meet their clients' needs.

Secure Data Management
Information on the EIEx platform will be shared in a secure manner in compliance with HealthChoice Illinois ADT, appropriate federal and state regulations such as HIPAA and FERPA, Illinois' medical privacy laws, 42 C.F.R. Part 2, and other regulatory requirements.

Please refer to within Section 2 Supporting Documents, Exhibit 2C for a workflow of the EIEx platform.

Core Strategy 4: Clinically Integrated Social Care Management for Hard-to-Reach Members
Connect members with critical social determinants of health interventions and resources, with a focus on housing stability and food security.

Many individuals in WCC's service area face inequalities across SDoH that negatively impact their health outcomes. Individuals with chronic conditions experiencing housing instability and food insecurity typically experience more severe complications and higher utilization of healthcare services.[36] Connecting these individuals with targeted community-based resources can help address SDoH disparities and achieve better health. Nonclinical social care barriers can include lack of childcare, limited time off from

[36] Cunningham, P. J. (2018, September 27). *Low income neighborhood.* The Commonwealth Fund. https://www.commonwealthfund.org/blog/2018/healthy-low-income-people-greater-health-risks

work, or language barriers, among others. Members face numerous barriers to addressing social care needs, including knowing how to navigate complex benefit application requirements, cultural or language differences, and concerns about divulging sensitive information such as immigration status. Engaging hard-to-reach community Medicaid recipients beyond their healthcare needs is critical to addressing health disparities.

Utilizing the EIEx platform, CHW/SWCM teams will conduct social needs screening assessments and seamlessly connect members with critical resources to address SDoH needs. Conducting social needs screening assessments is an integral part of effective care coordination. These assessments incorporate local needs specific to medical, behavioral health, social, environmental, and educational factors and help shape interventions to improve health and reduce inequities. Our social care management model assesses patients across the 25 social determinants of health domains and provides linkages and follow-up connections to community resources. We will share assessments with the members' MCOs to avoid duplication of services.

Within the platform, there are multiple screening tools that risk-stratify members, enabling care providers to allocate appropriate resources for their care. A self-sufficiency matrix scores results across all 25 SDoH domains, with scores ranging from 1 to 5: 1-In Crisis, 2-Vulnerable, 3-Safe, 4-Building Capacity, and 5-Empowerment. Based on the score, the platform then generates a "Social Care Plan" that matches members with the right resources for them. Social care plans include recommended interventions based on the established standard of care and matched to the appropriate community resources capable of providing the intervention. As a member's care team enters supplemental information into the platform, the system adjusts the member's matrix score and suggested care plan accordingly.

The platform will provide three tiers of social care management for the community served:

- Tier 1: High Complexity SDoH. Members with high social care needs will require crisis care such as housing and/or food stability interventions. Care management assistance will be managed in collaboration with the member's family and can be provided through several proven patient communication strategies including face-to-face clinic encounters and home-based visits, among others.
- Tier 2: Moderate Complexity SDoH. Members with moderate social care needs are identified as those engaged in their care but are having difficulty accessing services. Moderate complexity SDoH cases often experience language barriers that can inhibit them from accessing the necessary services. Communication with a care coordinator is typically provided over the phone and occasionally in person. Hub and network partner referrals will be coordinated as necessary and monitored and tracked within the CareAdvisors platform.
- Tier 3: Low Complexity SDoH. Members with low social care needs typically require telephonic services and are fully engaged in their care but are experiencing a resource gap. These members are typically managed via phone.

The platform will track Hub and network partner referrals for coordination of care. Platform data can be shared seamlessly and bi-directionally with multiple EHRs and existing referral directory software, ensuring that all collaborating entities within the WCC have access to data.

Core Strategy 5: Increased Community Access to Behavioral Health Services

Goal: Increase the access of members to behavioral health services by expanding existing and launching new behavioral health programs, investing HFS funds in capital projects designed to expand capacity and

reach, and reduce ongoing staff turnover and unfilled high-need positions through enhanced reimbursement for high-risk patients.

Research shows that living in a low-income household increases the risk for developing behavioral health issues in both children and adults.[37] Despite having a high need for behavioral healthcare and intervention, individuals living in poverty are often the least likely to receive high-quality behavioral healthcare. Critical contributing factors often include the lack of a systemic approach to early intervention, the stigma of behavioral health treatment, lack of awareness, and insufficient access to culturally competent behavioral health services and substance use treatment programs, among others.

Prior to COVID-19, a majority of the west Cook County population lived in households with income at or below the federal poverty level. Since the beginning of the pandemic, many families living just above the poverty threshold have been pulled into poverty due to loss of employment. Our service area has seen a tremendous increase in the need for behavioral health services since the COVID-19 pandemic began. Young people and teens are experiencing some of the worst forms of psychological distress. Between April and October 2020, the number of behavioral health-related ED visits among children ages 12 to 17 increased by 30% when compared to the same period in 2019.[38]

Nationally, and especially in low-income urban areas, there is a continuing shortage of healthcare professionals, particularly among primary care providers and behavioral health professionals.[39] These workforce shortages serve as an additional barrier for residents of west Cook County to obtain the behavioral healthcare they need. Part of the issue is compensation. Locally, data indicate that there is a 20% gap (average of $15,000 in salary) between current compensation levels and market rates for licensed clinicians, further jeopardizing the sustainability of the local behavioral health workforce. Ongoing staff turnover and unfilled high-need positions make it more difficult to connect community members facing behavioral health crises with the help they need. Pillars Community Health (PCH) reports that the average number of days between patient intake and case assignment has increased rapidly over the last five quarters (FY21Q1: 24 days, FY21Q2: 28 days, FY21Q3: 44 days, FY21Q4: 50 days, and FY22Q1: 83 days). Longer wait times to begin treatment appear to correlate with decreased patient engagement rates (defined as the ratio of patients completing intake to patients completing at least one initial assessment or treatment planning session). In FY21Q1, PCH had a patient engagement rate of 90%. As of FY22Q1, this rate has fallen to 70%.

The WCC convened several coalition members to plan and implement our fifth core strategy, which seeks to increase the access of members to behavioral health services in west Cook County. Each participating organization serves as a leader in the local behavioral health sector and is committed to meeting the health and social needs of west Cook County residents. PCH (a WCC co-chair and the lead behavioral health provider of the WCC) is a FQHC and state-licensed Community Mental Health Center and a Substance Use (SUPR) provider that utilizes the Screening, Brief Intervention, Referral for Treatment (SBIRT) model to provide community mental health and substance use services including behavioral

[37] Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2016). Improving mental health access for low-income children and families in the primary care setting. *Pediatrics*, 139(1), e20151175. https://doi.org/10.1542/peds.2015-1175

[38] Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. *Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020.* MMWR Morb Mortal Wkly Rep 2020;69:1675–1680.

[39] Mongelli, F., Georgakopoulos, P., & Pato, M. T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus*, 18(1), 16-24. https://doi.org/10.1176/appi.focus.20190028

health screenings, mental health assessments, brief therapy, and connection to more intensive behavioral healthcare. WCC Foundational Partners participating in the development and launch of this core strategy include Healthcare Alternative Systems, Proviso-Leyden Council for Community Action, and Real Foods Collective.

Within the WCC's fifth Core Strategy, we will increase the access of members to behavioral health services by:

- Expanding existing behavioral health programs and making virtual behavioral health support more available to those in need.
- Launching new behavioral health services to more adequately service community needs.
- Investing HFS funds in three capital projects designed to expand the local capacity and reach of BH services.
- Reduce ongoing staff turnover and unfilled high-need positions through enhanced reimbursement for high-risk patients.

Interventions will also include culturally and linguistically appropriate education and outreach efforts across the community to reduce the social stigma around seeking treatment for mental health and educate members on how to access care.

<u>Expand Existing Behavioral Health Programs</u>

The WCC will expand the reach of several existing models of care available through WCC members. A variety of evidence-based practices (EBP) are utilized depending on each member's presenting issue, level of engagement, and identified needs. Some of the EBP include Screening, Brief Intervention and Referral to Treatment (SBIRT), Medication Assistance Recovery (MAR), Cognitive Behavioral Therapy, Motivational Interviewing, and harm reduction approaches, and Solution-Focused Brief Therapy.

Please see Section 2 Supporting Documents, Exhibit 2D for additional details on existing behavioral health intervention models available across WCC collaborating entities.

Exhibit 2D, Section 2 Behavioral Health Intervention Strategies

- Increasing community access to behavioral health resources by expanding the capacity of provider organizations, funding the addition of new providers, implementing several new mental health and substance use treatment programs to expand the continuum of BH services and making virtual behavioral health support programs more broadly available. In addition, our strategies will align with and complement the state's expansion of Mobile Crisis Services through its 590 grants and the state's other initiatives such as Pathways To Success and other similar care coordination strategies for targeted Medicaid populations.
- Integration of the SBIRT model into primary care, outpatient care, and community-based settings to enhance early identification, education, and intervention for mental health and substance use issues, including through individual and group therapies.
- The WCC will leverage PCH's current Mobile Crisis Response (MCR) services available to all Medicaid recipients in collaboration with the existing CARES crisis line to address the unmet needs of individuals facing a mental health crisis. In 2022, the phone number 988 will go live nationwide as a three-digit mental crisis hotline number, similar to how 911 serves as an emergency number. PCH and Proviso Leyden Council for Community Action, Inc. received grants to expand the capacity of crisis services, specifically mobile crisis response, to support the implementation of

the 988 behavioral health crisis hotline statewide next year. MCR services will be available to the entire community and will now include a team approach and recovery support specialists (peers) as appropriate.

- Pillars and Healthcare Alternative Systems partner with NAMI Metro Suburban, a west Cook County-based affiliate of the National Alliance on Mental Illness, to provide crisis evaluations and CMHC support at NAMI's "Living Rooms" in LaGrange and Broadview. Living Rooms offer a no-cost alternative to the emergency room for adults ages 18 and older seeking help in a mental health crisis. Unlike hospital EDs, Living Rooms have the resources to provide timely, effective support services. In addition, trained Recovery Support Specialists use their personal experiences to help individuals identify obstacles, develop wellness action plans, find and maintain recovery, and identify ongoing support and education through CBOs.
- PCH also intends to apply to participate in the HFS Pathways to Success program. As a CCSO in the program, Pillars will be the primary behavioral health crisis resource for children and families across west Cook County.
- Several collaborating entities participating in the WCC provide Medication Assistance Recovery (MAR) services. Pillars launched MAR services in 2020 and serves the communities of Berwyn, Cicero, Stickney, Summit, Lyons, and Riverside. Through planned outreach and education to the community, these MAR programs offer harm reduction strategies and service connections to individuals and families who need additional support. These MAR sites also include Hepatitis C and HIV testing, Naloxone training and distribution partnerships, and Narcan distribution and Transtheoretical Model of Behavior Change. MAR services are provided in conjunction with local area police departments, hospitals, schools, community treatment providers, and other community stakeholders. PCH's MAR program will be led by experienced MAR providers and will be housed at its new Riverside facility. It will be supported by Pillars' SUPR outpatient and intensive outpatient services. PCH will also partner with area agencies to provide a fuller complement of SUPR services, including partial hospitalization and residential services.
- Community Support Services at Pillars include Community Support for Individuals (CSI) and Community Support Teams (CST). These services help people with severe mental illness develop recovery and resiliency-oriented skills and decrease the risk of hospitalizations and crisis episodes, all while increasing functioning for clients. Through outreach, education, and prevention services, CST also identifies and addresses social determinants of health that contribute to substance use, create barriers to engaging in ongoing services within the community and contribute to long-term adverse health outcomes. These community support teams will coordinate with the WCC CHWs to serve members through the Hub. In addition, the WCC will explore the expansion of CST to address substance use disorder.
- The Pritzker Department of Psychiatry and Behavioral Health at Lurie Children's is staffed and equipped to manage the complex care of children with concurrent medical and psychiatric treatment needs. Treatment spans anxiety disorders, psychoses, behavior problems, school problems, affective disorders, post-traumatic stress disorder, developmental delay, intellectual disabilities, and a range of adjustment problems. Each year, Lurie provides mental health evaluation and care through more than 22,000 outpatient visits, 490 inpatient psychiatric admissions, 254 children served in the Partial Hospitalization Program and 500 consultations each in its ED and through the hospital's inpatient pediatric and surgical services.
- PCH will expand our integrated medical/BH model through the FQHC capital project in Riverside. This capital project also enables PCH to expand its SUPR licensed outpatient and intensive outpatient services (already licensed at PCH's Berwyn location; other locations can be added as needed).

Launch New Behavioral Health Services

In addition to expanding existing behavioral health programs, the WCC will implement Solution-Focused Brief Therapy (SFBT) services at PCH to provide targeted communities with additional evidence-based therapeutic interventions. SFBT is a short-term goal-focused evidence-based therapeutic approach that helps clients progress towards change by constructing solutions rather than focusing on problems. Historically, PCH found that less than 40% of clients who undergo brief intervention demonstrate a need to engage with higher levels of behavioral health services.

PCH will provide SFBT services to 112 new clients each month by hiring four full-time therapists. Eligible members include those who score as a LOCUS Level 1 or 2. Clients who score at higher levels, or who are seeking other types of service, will be connected with other behavioral health interventions. Currently, PCH's outpatient program receives approximately 85 new referrals each month. Four additional therapists focused on providing SFBT services will help meet current demand, allow for WCC participating organizations to refer additional members for care, and reduce the average number of days between patient intake and case assignment. Members participating in SFBT will benefit from Community Navigation Hub services to assist with social determinants of health needs as well as in navigating other services and potential entitlements.

The WCC will also launch the following value-based behavioral health pilot programs through PCH:

- Utilize PCH's SBIRT model as a platform to provide interventional services among WCC partners including through early identification, education and prevention (for those at risk of a substance use disorder), and referral for related treatments.
- Develop currently non-reimbursable substance use services like "find and engage," outreach, education, and prevention services for members. The WCC is considering PCH's CST (Community Support Team) services model as a starting point for these services, with plans to adapt the model into a more defined SUD-CST and/or ACT model.
- Launch a Medication Assistance Treatment (MAT) program within PCH's psychiatry program at its Riverside location (please see below). MAT will be supported by an expansion of PCH's SUPR licensed outpatient and intensive outpatient services.

Feedback from community input sessions highlighted the critical need for children's mental health interventions within our service area. Common mental disorders that begin in childhood include anxiety disorders, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, depression, and other mood disorders, eating disorders, and post-traumatic stress disorder (PTSD).[40] Parental mental illness can also negatively impact children. As Mental Health America notes, "Children whose parents have a mental illness are at risk for developing social, emotional and/or behavioral problems. An inconsistent and unpredictable family environment, often found in families in which a parent has mental illness, contributes to a child's risk" as does poverty, substance abuse disorder, and living in single-parent households.[41] The WCC will utilize the best practice recommendations and requirements of the state's forthcoming Pathways to Success (launch planned for early 2022) to adapt our behavioral health

[40] National Institute of Mental Health. (2021). *Children and mental health: Is this just a stage?* https://www.nimh.nih.gov/health/publications/children-and-mental-health

[41] Mental Health America. (n.d.). Parenting with a mental health condition. https://mhanational.org/parenting

interventions for the unique behavioral health needs of the children in our west Cook County service areas.

Capital Investments to support BH

The WCC will invest a portion of HFS Transformation funds to open a new Federally Qualified Healthcare Center in Riverside. PCH has completed the purchase of the land and onsite 15,000 square foot building. The site includes 45 parking spots and is also accessible through suburban PACE bus lines and the Berwyn Metra stop.

Once repurposing renovations on the existing building are completed, building uses are projected to include:

- Integrated medical and behavioral health services including SBIRT (Screening Brief Intervention and Referral to Treatment)
- Psychiatry and the launch of Medication Assistance Treatment program
- Oral Health services
- Community and group rooms to be used for care coordination, benefits and eligibility assistance, employment services, specialty mental health services, and domestic and sexual violence services

PCH projects that this site will annually serve approximately 6,500 unduplicated patients; of these, approximately 80% (or 5,200 individuals) will be Medicaid eligible based on current eligibility rules and our payer mix. PCH will self-fund a portion of capital costs to open the Riverside facility. Additional secured funds include private donations and monies from local, state, and federal agencies. PCH will work towards NCQA PCMH designation for this site once it is fully operational.

The WCC will also invest a portion of HFS Transformation funds to expand the existing BH facility of a WCC Foundation Partner, Healthcare Alternative Systems. This expansion will greatly improve the existing facility and expand its capacity to provide SUD treatment within the community.

Finally, the WCC will utilize Transformation funds to renovate an existing 1,250 square foot BH office space of one of our Foundational Partners, the Quinn Center of St. Eulalia.

Rapid Access to Mental Health Services for High-Risk Patients (RAMP) Program

Through this program, the WCC will also provide enhanced reimbursement for high-risk patients with a behavioral health diagnosis, which will expand staffing capacity for local behavioral health staff. Behavioral health providers in the WCC have identified an estimated 125 clinical staff in the service area that would be enrolled in the program which would directly expand capacity to serve high-risk mental health patients. The HFS Transformation proposal will include $ in an enhanced reimbursement for PCH to provide outpatient mental health treatment to approximately 1,685 high-risk members for $ per member per month. This enhanced reimbursement provides an estimated $ per behavioral health clinical staff member to support an improved workforce development strategy.

Core Strategy 6: Community-Based Services for Vulnerable Populations

Goal: Equip members with the knowledge and support to achieve positive health outcomes and improve their well-being through home-visiting programs.

Maternal and Child Health

Medical and social support during pregnancy, birth, and postpartum periods increase the likelihood of patients adhering to medical guidance, attending aftercare visits, increasing the inter-conception period (time between pregnancies), and adhering to immunization schedules and child wellness visits. Medical and social support services can also assist with transportation and parent/child bonding and facilitate improved outcomes and safety for children.

Peer-reviewed evidence supports the positive impact that evidence-based home-visiting programs have on maternal and child health outcomes. Data show that participating members are:[42]

- 4 times less likely to have a low birth weight (LBW) baby.
- 2 times less likely to experience a birth complication for themselves or the baby.
- Significantly more likely to initiate breastfeeding.
- More likely to engage in safe sleep practices for their newborn.
- More likely to use car seats.

Utilizing WCC's robust data capabilities to identify high-risk mothers and young children (ages 0-3), care teams within the Community Navigation Hub (Core Strategy 1) will integrate maternal and child health into its services for members. CHW/SWCM teams will engage members and help to connect them with medical providers, community resources, and/or state and federal aid programs most suited for their needs. Community resources may span housing, food security, behavioral health, transportation, and other social care needs through the lens of cultural responsiveness. We will also partner with MCOs to facilitate a referral and enrollment pipeline into their programs.

Care teams within the Hub will also facilitate the coordinated intake of appropriate mothers or expectant individuals into evidence-based home visiting programs, maximizing the evidence-based interventions that the State already significantly funds through the Illinois Department of Human Services (IDHS). Federal and state assistance programs may include the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Family Case Management, and Better Birth Outcomes/Great Start, among others. The WCC will leverage these funding streams to augment care for hard-to-reach members and remove some of the barriers to care coordination. WCC Foundational Partners can also provide doula home-visiting services and other culturally appropriate prenatal and postnatal resources for participants.

Older Adults

Data from the CDC show that more than 85% of older adults (age 65 and over) have one or more chronic health conditions, 56% have at least two chronic conditions, and 23% have three or more chronic conditions.[43] Common conditions in older adults include asthma, cardiovascular disease, diabetes/prediabetes, and hypertension, among others. Research shows that incorporating home-based interventions in the care of older adults with chronic conditions results in numerous benefits for patients. Home healthcare promotes aging in place for older adults, reduces the likelihood of infections acquired at medical facilities, and is typically more cost-effective than provider-based care for both patients and

[42] National Home Visiting Resource Center. (n.d.). *Homepage.* https://nhvrc.org

[43] Centers for Disease Control and Prevention. (2021, November 6). *Health policy data requests - Percent of U.S. adults 55 and over with chronic conditions.* https://www.cdc.gov/nchs/health_policy/adult_chronic_conditions.htm

healthcare plans.[44] Numerous observational studies found that home-based care promoted a higher continuity of care, which is frequently associated with fewer ED visits and hospitalizations.[45]

The WCC will use HFS Transformation funds to expand several successful Loyola programs designed to help Medicaid-eligible older adults manage their health conditions at home, remain outside of acute care and skilled nursing facilities, reduce ED utilization and hospitalization rates, and gain convenient, affordable at-home care. Within our project, the WCC will identify additional participants eligible for participation in these three programs, which include:

- House Call Interventions: The WCC will expand Loyola's successful home visiting program, designed to meet the needs of older adults that are disabled or homebound and eligible for both Medicare and Medicaid. Teams of physicians, medical residents, nurse practitioners, and care coordinators will facilitate house calls to address participants' chronic conditions and reduce their emergency department usage. The goal is to reduce readmission, improve specific chronic disease metrics such as A1c, and facilitate medication and treatment adherence through integration of home and community-based social support into the member's clinical care plan. The program works to expand member social networks over the course of at-home healing by introducing participating older adults to classes, social clubs, and activities.
- Chronic Care Management: Another Loyola program provides remote patient monitoring for older adults with two or more chronic health conditions such as heart failure, diabetes, and hypertension, among others. Participants work with their care providers to develop a care plan that includes ongoing self-management activities and monthly one-on-one telehealth-based coaching sessions.
- Remote Patient Management: Another third Loyola program equips members with the equipment and training needed to monitor their vitals and conditions at home rather than visiting a hospital or primary care provider. Depending on their unique needs, participants may receive smart tablets, wireless scales, pulse oximeters, and blood pressure cuffs to use at home. Each member follows a protocol to check their vitals on a regular basis. The equipment transmits the data to the member's EHR, and the member's care team receives updated readings. The WCC's Hub model will identify candidates that qualify for this program and enroll them as early as possible. Participation enables members and their care teams to utilize real-time assessment to detect health changes that could lead to emergency room (ER) visits, hospitalizations, or placement in skilled nursing and acute care. Participation also results in reduced cost for members and improved convenience of care.

Adults with Intellectual/Developmental Disabilities (IDD)

Individuals with IDD face a great number of health disparities compared to neurotypical individuals and individuals with non-intellectual and developmental disabilities.[46] They are also more likely to face SDoH barriers to accessing care.[47] Research published in 2020 found that "for every one unit increase in the

[44] Mitzner, T. L., Beer, J. M., McBride, S. E., Rogers, W. A., & Fisk, A. D. (2009). Older adults' needs for home health care and the potential for human factors interventions. *Proceedings of the Human Factors and Ergonomics Society Annual Meeting, 53*(11), 718–722. https://doi.org/10.1177/154193120905301118

[45] Health Quality Ontario. (2013). Continuity of care to optimize chronic disease management in the community setting: An evidence-based analysis. *Ontario Health Technology Assessment Series, 13*(6), 1–41. https://pubmed.ncbi.nlm.nih.gov/24167540

[46] World Health Organization. (2001). Healthy ageing – adults with intellectual disabilities: Summative report. *Journal of Applied Research in Intellectual Disabilities, 14*(3), 256–275. https://doi.org/10.1046/j.1468-3148.2001.00071.x

[47] Friedman, C. (2021). Social determinants of health, emergency department utilization, and people with intellectual and developmental disabilities. *Disability and Health Journal, 14*(1), 100964. https://doi.org/10.1016/j.dhjo.2020.100964

number of social determinant outcomes present, there was a 7.97% decrease in emergency department visits" for adults with IDD.Home and community-based health resources can improve the health outcomes of individuals with IDD while enabling them to remain in the community and outside of acute care settings.[48]

The WCC will work with Community Support Services, one of our Coalition Affiliates, to expand existing home-based support services available for adults with IDD in our targeted service area that are enrolled in the Children's and Adult Waivers through IDHS and The Division of Developmental Disabilities (DDD). Depending on the member's unique needs identified during the development of their personal plan, services may include:

- Providing self-directed assistance
- Skills training for caretakers
- Assisting with recruiting, hirigin, and managing Personal Support Workers
- Assisting with monthly budgeting and funding allocations
- Advocating and recommending additional support services
- Other services to address additional member needs

PROJECT TIMEFRAME

As our approach is built on a sustainable model of care, the WCC requests HFS Transformation funding for 3.5 years. Transformation funding plays a significant role in the project budget during Years 1-3. During Years 4 and 5, we will transition to operating through value-based payment funding through MCOs, based on the impact on shared cost savings. Additional details are available in the Milestones section.

CAPITAL INVESTMENTS IN PROJECT

1) New FQHC in Riverside (Partner: PCH): A new Federally Qualified Healthcare Center location at 7234 Ogden Avenue in Riverside, Illinois, owned and operated by PCH. The site includes a 15,000 square foot building and 45 parking spaces.
Total Costs:
HFC Transformation Funds:

2) Expanded Facility for Substance Use Treatment (Partner: Healthcare Alternative Systems): Improve existing facility to expand SUD treatment capacity.
Total Costs:
HFC Transformation Funds:

3) Permanent Supportive Housing Project in Broadview (Partner: Housing Forward): New 16-unit Permanent Supportive Housing development for 30% AMI or below individuals and families who are homeless and have a documented long-term disabling condition, including Transition-Aged Youth, young adults aged 18-24 years who have aged out of the foster care system and are at high risk of becoming homeless, and veterans. Each floor will have eight residential units, for a total of four two-bedroom units for families and 12 one-bedroom units for individuals, with additional common space for tenants. Twenty percent (4) of the units will be handicapped accessible and one will be designed to accommodate sensory, hearing, and visually impaired individuals.

[48] Friedman, C. (2020). The impact of home and community based settings (HCBS) final settings rule outcomes on health and safety. *Intellectual and Developmental Disabilities, 58*(6), 486–498. https://doi.org/10.1352/1934-9556-58.6.486

Total Costs:
HFC Transformation Funds:

4) New Food Pantry in Summit (Partner: Catholic Charities): New community center located at 7437-7439 W. Archer Avenue in Summit, Illinois. Catholic Charities will serve as the entry point and food pantry anchor at this multi-service site. $ will be used to purchase equipment for the food pantry and congregate dining area such as refrigerators, freezers, walk-in cooler, shelving units, desks, chairs, commercial stove and oven, prep table, sanitation station, tables and chairs, and other items necessary to outfit the new space.
Total Costs:
HFC Transformation Funds:

5) Build out of BH Office (Partner: Quinn Center of St. Eulalia): Renovations for BH office space (1,250 SQF) in an existing community center facility location. Renovation costs are estimated at $ per square foot including supplies, labor, and architecture.
Total Costs:
HFC Transformation Funds:

5 Total Capital Projects:
HFS Transformation Funds Requested:
Existing Funding:

[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.)
Section 2 Supporting Documentation

FORM 3. GOVERNANCE STRUCTURE.

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

The governance structure of the WCC includes a Steering Committee, Advisory Board, Standing Committees, and Ad Hoc Committees. Please refer to Section 3 Supporting Documents, Exhibit 3A for a graphic of the WCC's governance structure.

The WCC will evaluate the performance of the steering committee, advisory board, standing committees, and ad hoc committees as part of ongoing monthly convenings. Groups will convene for additional work sessions as needed throughout each month of the project.

Steering Committee

The WCC Steering Committee includes three committee Co-Chairs and committee members. Participants include primary care and specialty physicians, behavioral health providers, social service providers, diversity and inclusion leaders, and a community consumer advocate. The Steering Committee will make decisions including but not limited to the following:

- Assessing data from Foundational Partners, Coalition Affiliates, standing committees to gauge and hone the project's impact on local racial and health disparities
- Review trends in metrics when needed to ensure course corrections are implemented
- Assure coalition performance and compliance as set forth in terms of the agreement with HFS.
- Approve budget and allocation of funds
- Evaluate and invite additional partners that share the WCC's commitment to advancing racial and health equities in west Cook County

Advisory Board

The WCC Advisory Board includes one representative from each WCC foundational partner. It is designed to promote collaboration and inclusive decision making and augment the knowledge of the Steering Committee. The Advisory Board will have input for the training, staffing structure, targeted populations, targeted health and service agencies, and community outreach activities.

Standing Committees

The WCC's governance structure includes several Standing Committees. Each committee will make recommendations within their specific area of focus. Membership will vary based on each committee's focus, but may include representatives from WCC Co-Chairs, Foundational Partners, and Coalition Affiliates organizations as well as elected officials, community leaders, faith leaders, west Cook County residents, and representatives of MCOs, among other stakeholders. The WCC's Standing Committees will include*:*

- Finance and Compliance Committee: These committee members will act as liaisons between the Steering Committee and all Foundational partners regarding finance and compliance related updates. This committee includes one or more Co-Chairs from the steering committee.
- Community Input and Engagement Committee: This committee will provide a formal channel for community engagement and input into the direction of the WCC's Core Strategies. Most participants will be independent community members and local leaders who provide input and direction for project activities, along with select elected officials. The committee will also include a WCC Community Consumer Advocate role, a paid position (via stipend) for one to three individuals not directly linked to any entity participating in the WCC collaboration. We envision that this role will provide deep knowledge and representation of our targeted services areas and populations, and support decision making consistent with community input and established community values. The committee will gather input from Foundational Partners and the broader community and bring its findings back to the Steering Committee.
- Racial and Health Equity Committee: The WCC designed this project through a lens of racial equity including community engagement, transformational strategies, and collaborating entities. This

committee will assess and support the WCC's intent to incorporate racial equity across its policies, programs, practices, and partnerships.

- Clinical and Quality Committee: This committee will ensure that all systems are in place to implement and maintain an effective quality assurance and quality improvement process for the project. This will include (but is not limited to) overseeing and ensuring the quality of care coordination, patient safety, quality metrics for core strategies, and quality assurance and improvement.
- MCO Collaboration Committee: This committee will closely interface with a broad group of Medicaid MCOs. It will serve as the liaison between this project and MCOs and will implement a number of strategic initiatives with MCOs including data sharing coordination for engagement of hard-to-reach members, coordinating care management services to avoid duplications of support, and developing a sustainable payment model.

Ad Hoc Committees
The WCC will form Ad hoc committees on an as-needed basis to accomplish specific purposes not addressed by other committees within our governance structure. Ad hoc committees will include one co-chair from the Steering Committee. Like Standing Committees, Ad Hoc Committees may include representatives from WCC Co-Chairs, Foundational Partners, and Coalition Affiliates organizations as well as elected officials, community leaders, faith leaders, west Cook County residents, and representatives of MCOs, among other stakeholders.

The WCC will continue to leverage data gathered from its community input sessions and work to gather additional community input to inform and guide our policies and priorities moving forward. We will vet potential strategies and related activities across our steering committee, advisory board, and standing committees.

[1. 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.)
Section 3 Supporting Documents, Exhibit 3A

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?
WCC collaborating entities are required to execute a contractual partnership agreement that outlines compliance expectations with policies and strategies of the coalition. Contracts will require data sharing, coordination with CHW/SWCM teams, monthly/quarterly reports, participation in a biannual analysis of the strengths and weaknesses of the project along with recommendations for improvement, optional shared records, and necessary business associate agreements.

Additionally, WCC collaborating entities will be required to execute a contract stipulating the participation rights and responsibilities for being a participant in our Community Navigation Hub. These requirements will guide the responsibilities for adhering to patient care metrics, reporting, and pathways that are coordinated through the Advisory Board.

The WCC will implement a monitoring and auditing program that include policies and procedures for routine internal monitoring as well as oversight auditing activities. These activities will confirm our compliance with HFS Medicaid managed care requirements, regulatory guidance, contractual agreements, program integrity compliance risks, and applicable federal and state laws, as well as internal policies and procedures to protect against non-compliance and potential fraud, waste, abuse, mismanagement and misconduct. Additionally, we will conduct regular audits of Subcontractors and Providers to ensure compliance with contractual and regulatory requirements.

[2. 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.)

New Legal Entity
3. Will a new umbrella legal entity be created as a result of your collaboration?
No

[3A. 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.)

Payments and Administration of Funds
4. How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's intended purpose? If the plan is to use a fiscal intermediary, please specify.
Loyola will serve as the fiscal agent and centrally track the disbursement of Transformation funds. All participating entities will be required to submit expense tracking and subsequent reports in order to ensure funds continue to be spent as appropriate for the purposes of this Transformation. Within our contractual partnership agreements, collaborating entities participating in the WCC must attest to only use funds as agreed upon in our transformation project documentation. Our policies and procedures will comply with HFS Medicaid managed care requirements, regulatory guidance, contractual agreements, program integrity compliance risks, and applicable federal and state laws, as well as internal policies and procedures to protect against non-compliance and potential fraud, waste, abuse, mismanagement, and misconduct.

[4. 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.)

FORM 4. RACIAL EQUITY.

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

The WCC designed this project through a lens of racial equity including community engagement, transformational strategies, and collaborating entities.

Meaningful Community Engagement

To develop our proposal, the WCC leveraged the expertise of a diverse group of stakeholders that represent the vibrancy and diversity of west Cook County. We deeply engaged local healthcare providers, CBOs, local businesses, schools, and residents living in or serving our community service area through our intensive community input process. Community members played a critical role in identifying local inequities, validating data-driven assumptions, and exploring and selecting equity-driven solutions that meet the needs of the community. We will continue to work with diverse community members and stakeholders to further identify barriers to accessing social, physical, and behavioral healthcare, as well as to identify the most effective culturally competent and equitable means of addressing these gaps.

WCC Strategies

Our model incorporates and promotes racial equity by reducing the fragmentation of care delivery services and systems. Each strategy embeds equity, cultural competence, and health literacy in its efforts to serve community members. Our strategies address uninsured individuals' and Medicaid members' SDoH, a key component of racial equity. Staff hired for this project will include a diverse mix of individuals from various racial and ethnic backgrounds reflective of west Cook County. Preference will be given to individuals with similar linguistic, cultural, and socioeconomic backgrounds to the communities they will serve.

WCC Participants

Medical care is just one factor in ensuring health outcomes for a community. Our coalition leverages the collective impact of traditional healthcare providers, CBOs, and local stakeholders to drive solutions that improve health outcomes and decrease disparities within west Cook communities. The WCC intentionally includes organizations with longstanding experience in advancing health equity for the predominantly racially and ethnically diverse populations of west Cook County. Our Co-Chairs, Foundational Partners, and Coalition Affiliates are established and trusted service providers in the service area and already employ or are open to hiring or training culturally competent healthcare and social care workers to provide services in accordance with the cultural and linguistic needs of individuals in the community.

[High Level Narrative - 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.)

Racial Equity Impact Assessment Questions

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

Across the service area of the WCC, racial and ethnic minority populations experience higher rates of poverty than non-Latinx whites and face persistent and stark social disparities. These populations fare worse on a host of SDoH indicators including educational attainment, access to health insurance, housing stability, and food security, among others. These SDoH disparities translate into marked health inequities.

The racial/ethnic groups most affected by and concerned with the issues addressed by this proposal (and the proposed strategies to address them) include African American/Black and Latinx populations. The WCC will track the number of individuals within these populations that are impacted by the project as well as the project's impact on participants' social disparities and health inequities. For further details, please see the Quality Metrics section.

[1 - 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.)

2. Have stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities — been informed, meaningfully involved, and authentically represented in the development of this proposal? Who's missing and how can they be engaged?
Community involvement in solution development is a foundational element of our strategy. We have conducted multiple listening sessions with community members and representatives of care coordination programs to better understand local barriers to equity, available resources, and potential solutions. Stakeholders from all racial/ethnic groups, ranging from residents to community leaders to elected officials, meaningfully contributed to these conversations. Our proposal resulted from this deep community engagement. Please see the Community Input section for further details.

The collaborating entities of the WCC conduct community-based initiatives and activities that engage local stakeholders from different racial/ethnic groups. Experiences from these activities (and the subsequent engagement with different stakeholder groups) also informed the WCC's development of this proposal. Examples include:

- Workforce development initiatives
- Multilingual community engagement across social media channels
- Sharing resources with care providers and elected officials serving vulnerable populations
- Organizing in community focus groups and completing community health needs assessments
- Developing community-wide, culturally relevant COVID-19 information and resource initiatives for diverse communities with high vulnerability indices in the targeted service area
- Through outreach, engaging with CBOs and schools to raise awareness of services available and gather additional information to tailor our services to community needs
- Offering culturally competent behavioral health services
- Working with American Hospital Association Institute for Diversity and Health Equity (AHA IFDHE) BCBS Health Equity Grant to address Perinatal Mental Health disparities (Loyola)
- Completing organization-wide restorative justice training (Foundational Partners), and working with the Health and Medicine Policy Research Group-IL ACES Collaborative and The Morten Group to enhance the organizational cultural humility, diversity, racial equity and inclusion, and capacity to be a trauma-informed organization (PCH)
- Examining current diversity and inclusion statements and policies and expanding them to fully reflect an organizational commitment to fostering, cultivating, and preserving a culture of diversity, equity, and inclusion.

The WCC will continue to engage diverse stakeholders in real and meaningful involvement in the implementation of the proposal's activities. As detailed in the Governance section, the Community Engagement Committee will identify and implement opportunities for the WCC to engage with local

stakeholders to jointly develop equity-oriented solutions to the disparities that racial and ethnic minorities face in west Cook County.

The WCC also will engage local faith-based organizations and congregations. Many of these ministries may have internal health initiatives that can inform and enhance the reach of the WCC. Additionally, faith leaders can play a critical role in influencing the health behaviors of congregation members. Opportunities for engagement may include focus group and community listening sessions with ministry leaders and members of congregations as well as providing direct services to individuals affiliated with various ministries.

[2 - 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.)

3. Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?
Historically, African American/Black and Latinx Medicaid individuals face greater health and social inequities compared to other groups. These groups include white populations, populations with higher education attainment, populations with higher incomes, and populations that are commercially insured, among others. They typically experience better access to care (primary and specialty), higher health literacy, and receive a greater proportion of routine preventive services known to improve quantity and quality of life. In addition, they do not suffer from the same SDoH challenges as vulnerable populations, and frequently have more social support systems than those in vulnerable subpopulations.

While this project is open to all members, we will focus on serving African American and Latinx members who are most often disadvantaged by racial, health, and social inequities. Quantitative evidence for these inequities includes data from the University of Illinois at the Chicago School of Public Health and the Institute for Healthcare Delivery Design for the Illinois Department of Healthcare and Family Services. As the report notes, "lack of access is driven by both resource gaps and by social, economic, and other 'social determinants of health' barriers that people face in achieving health (for example, lack of access to transportation; lack of access to affordable, healthy food; unemployment; community violence; etc.)"[49] The WCC also utilized Loyola's *2019 CHNA* as a key source of evidence of inequalities. Primary data for the *CHNA* was collected through four methods including community input surveys, community resident focus groups and learning map sessions, healthcare and social service provider focus groups, and two stakeholder assessments.

Data assessed by the WCC provides sufficient evidence of the needs addressed within our proposal.

[3 - 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.)

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

[49] Basu, S., Flax-Hatch, J., Freeman, V. L., Gao, Y., Hershow, R., Kauth, A., Musick, H., Schneiderman, J., & Wang, H. (2021). *Transformation data & community needs report: Chicago–West side.* University of Illinois at Chicago School of Public Health. https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportWestChicagoDigitalCMP.pdf

Historically, disinvestment from the communities within our focus area, job loss, redlining, and the displacement/disruption of communities have and continue to perpetuate racial inequities. One significant contributing factor to racial inequities is the lack of sufficient resources to address unmet social needs that impact healthcare. For example, we often see more severe complications for patients with diabetes within the homeless population.

While behaviors, genetics, and medical care influence an individual's well-being, these factors alone do not determine health outcomes. Contributing factors include SDoH as well as "the historic and ongoing interplay of structures, policies, and norms that shape lives."[50] In other words, the root causes of racial inequities addressed by this proposal stem from access to and affordability of the healthcare system.

This proposal addresses these root causes through its goals and related strategies:

- Increase engagement and access to care for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area through the Community Navigation Hub (Core Strategy 1).
- Connect more members with disease management programs available through coalition organizations or Medicaid MCOs, with a reduction in avoidable complications (Core Strategy 2).
- Improve the creation and use of holistic healthcare records for attributed members through information technology, care management platforms, screenings, and principles of interoperability (Core Strategy 3).
- Connect members with critical social determinants of health interventions and resources, with a focus on housing stability and food security (Core Strategy 4).
- Increase the access of members to behavioral health services by expanding existing and launching new behavioral health programs, investing HFS funds in capital projects designed to expand capacity and reach, and reducing ongoing staff turnover and unfilled high-need positions through enhanced reimbursement for high-risk patients (Core Strategy 5).
- Equip members with the knowledge and support to achieve positive health outcomes and improve their well-being through home-visiting programs (Core Strategy 6).

[4 - 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.)

5. What does the proposal seek to accomplish? Will it reduce disparities or discrimination?
This proposal seeks to increase health equity and improve the health outcomes, quality of life, and overall well-being of participating members in west Cook County. Our strategies will reduce disparities by improving access to care and offering sustainable interventions to address SDoH for the Medicaid population and uninsured within the communities we serve.

Beyond our Core Strategies, the WCC will address disparities, both across our coalition's collaborating entities and within the west Cook County community. WCC Partners will leverage existing internal initiatives to provide training modules that span implicit bias, trauma-informed care, and cultural humility. As one example, PCH is working with the Health and Medicine Policy Research Group (Illinois ACEs Response Collaborative) and The Morten Group to expand the organization's understanding of trauma and adverse childhood experiences (ACEs) and the resulting impact on the health and well-being of Illinois children, families, communities, and systems. The WCC plans to develop an action plan to encourage

[50] National Academies of Sciences, Engineering, and Medicine. (2017a). *Communities in action: Pathways to health equity.* National Academies Press. https://doi.org/10.17226/24624

Foundational Partners and Coalition Affiliates to participate in these training sessions to broaden community-wide capacity to respond to critical local issues.

Similarly, the Community Navigation Hub will not just impact the members it serves. Hub activities will also have an impact on the primary care physicians, specialists, behavioral health specialists, medical homes, nurse care coordinators, pharmacists, lab specialists, dentists, respiratory therapists, benefits and eligibility staff, outreach staff, case managers, patient navigators, and other care resources that CHW/SWCM teams work with, broadening systemwide abilities to coordinate solutions for members.

[5 - 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.)

6. What are negative or unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized?
The WCC has identified the following risks within our proposal:

- Target populations may still lack the resources needed to access the services, resources, and supports proposed across our Core Strategies due to SDoH-related barriers. Examples of such barriers include limited transportation options, the inability to take time off work to attend appointments, lack of childcare, and limited access to technology for telehealth engagements. The WCC will work closely with Co-Chairs, Foundational Partners, and Coalition Affiliates to ensure that these obstacles are identified and addressed in a culturally appropriate manner to ensure access for members.
- Our proposed staffing plan may be a challenge, particularly in a time of ongoing nationwide labor shortages. These challenges may become particularly acute for specialized roles that suffer from salary disparities or require bilingual or multicultural candidates. Through our workforce development efforts, the WCC will collaborate with organizations such as the Latino Social Workers Organization and the National Black Nurses Association to mitigate these challenges. Collaborative work will go beyond the dissemination of job opportunities to include an exploration of the expectations of diverse, qualified candidates that supports job readiness.
- Our target populations have heard before that “change is coming” from other initiatives or programs. Unfortunately, many projects designed to address ongoing, pervasive inequities lack the sustainability to truly make a lasting change in communities in need. Broken promises have resulted in community distrust in or fear of new change-focused initiatives. The WCC has worked to create community trust and inclusion throughout our planning process and has developed a sustainability strategy designed to create long-term value for west Cook County. Please see the Sustainability section for additional information.
- We may encounter more members than anticipated, particularly from underserved individuals who reside outside our service area seeking to participate in our programs. To circumvent this potential risk, the WCC will formulate a plan to share best practices with other regions through a replicable model designed to be customized to the unique needs of other communities.

These situations would generate solutions that provide positive impacts to our target service area.

[6 - 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.)

7. Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?
The WCC believes that "Instead of trying to change some people to fit the organization, we must focus on transforming our organizations to fit all people."[51] We know that socioeconomic status and structural racism are major, if not the dominant, predictors of individual and population health. We have constructed this project from concept to model through a "health equity in all decision making," lens by taking into consideration the lived experiences and perspectives of the racially diverse communities we intend to serve.

[7 - 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.)

8. Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?
Our proposal is realistic and adequately funded, and we have put in place the right mechanisms to ensure success. Many of the WCC's collaborating entities have had success serving communities in need through a collaborative model similar to our model. Our unified network provides an extraordinary opportunity to manage social and clinical interactions that are often overlooked in these communities. The Coalition's Steering Committee has established provisions to ensure ongoing data collection, public reporting, stakeholder participation, and public transparency that can be utilized for public impact reporting.

[8 - 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.)

9. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?
Many of our success indicators and progress benchmarks are based on Healthcare Effectiveness Data and Information Set (HEDIS) measures spanning chronic conditions, access, and utilization (see Quality Metrics section). We will also utilize a health disparity ratio comparing racial/ethnic minorities to other members of the communities we serve to measure progress.

The Coalition's Steering Committee has established guidelines for tracking and evaluating health disparities by high-risk member status and health conditions. We will provide a Health Disparity Report Card to document the impact of the programs on members.

Community input played and will continue to play a critical role in shaping the WCC's strategies to improve the overall health and health outcomes of participating members in west Cook County. We leveraged our partnership expertise to convene existing and new constituents from across healthcare providers, CBOs, local businesses, schools, and residents living in or serving our community service area in west Cook County. We will continue to work with diverse community members and stakeholders to further identify barriers to accessing social, physical, and behavioral healthcare, as well as to identify the most effective culturally competent and equitable means of addressing these gaps. We will assess the ongoing engagement of stakeholders by setting milestones for level, diversity, and quality through our overall evaluation process.

[51] Hecht, B. (2020, June 16). Moving beyond diversity toward racial equity. *Harvard Business Review.* https://hbr.org/2020/06/moving-beyond-diversity-toward-racial-equity

[9 - 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.)
Works Cited for Racial Equity_Section 4

FORM 5. COMMUNITY INPUT.

Service Area of the Proposed Intervention
1. Identify your service area in general terms (e.g., "West Chicago", "East St. Louis Metro Area", "Southeastern Illinois").
West Cook County

2. Please select all Illinois counties that are in your service area. (NOTE: Selecting a county does not mean that your intervention must service the entire county.)
(Hold CTRL+click on a PC or command+click on a Mac to select multiple counties).
Cook County

3. Please list all zip codes in your service area, separated by commas.
60104, 60130, 60131, 60153, 60154, 60155, 60160, 60162, 60163, 60164, 60165, 60171, 60402, 60501, 60513, 60534, 60546, 60804

NOTE ON THE IMPORTANCE OF COMMUNITY IMPACT: 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.

Community Input
1. Describe the process you have followed to seek input from your community and what community needs it highlighted.
Community input played and will continue to play a critical role in shaping the WCC's strategies to improve the overall health and health outcomes of participating members in west Cook County. We leveraged our partnership expertise to convene existing and new constituents from across healthcare providers, CBOs, local businesses, schools, and residents living in or serving our community service area in west Cook County. We then implemented a two-phase process to establish the needs of our community service area:

- Phase 1: Conceptualization. We collected and analyzed data to identify key community needs and develop initial concept interventions. See the next section ("Data") for a complete overview of the Phase 1 process.

- Phase 2: Validation. We collected diverse and direct community input to test assumptions of community needs and provide a more informed framework for developing and implementing our six Core Strategies.

Across both phases of community input development, the WCC conducted focus groups, virtual town halls, individual surveys, one-on-one interviews, community roundtable meetings, and direct engagement with elected officials which included one-on-one briefings as well as an elected official roundtable

meeting. Throughout this process, the WCC engaged over 200 stakeholders and community leaders for comprehensive feedback throughout the proposal development process.

The Collaborative implemented various community engagement strategies to gain insights into the range of issues that constituents face in our service area. Please refer to Section 5 Supporting Documents, Exhibit 5A for a listing of our community engagement strategies, framework, targeted audiences, and attendance documenting our engagement with the community, local leaders, and elected officials.

Summary of Community Input Findings

Food Insecurity

The COVID-19 pandemic has significantly increased local food insecurity rates in west Cook County, pushing food pantries beyond capacity. Local food pantries are struggling to keep up with demand and face food quality issues due to increased demand and intermittent supply chain disruptions. In addition, households that can afford food often face inequitable access within their own neighborhoods when compared to more affluent areas. As one example, Oak Park, a more affluent village just beyond the community service area, has six grocery stores while Maywood (zip code 60153) has none.

Community input also found that residents also need education to increase their knowledge of nutrition and to promote healthy eating. In addition, there is a need for a stronger interconnected network of interventions that go beyond just food pantries, such as fresh food delivery programs that target high-risk populations, which are shown to make a dramatic difference in their health outcomes. Hospitals in underserved communities have worked to address the food needs of the community by hosting “Food Farmacies.” Outpatient clinics, particularly those serving oncology patients, have established relationships with food banks where they can obtain food boxes for patients to pick up during appointments. Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs) noted seeing a similar community need and are working with food pantries to help connect their patients with food. However, there is still more need for access to healthy foods and nutrition services.

Housing Instability

The community service area suffers from a growing shortage of safe, affordable housing. Substandard living conditions such as pests, mold, and chronic dampness can lead to chronic conditions such as asthma. Many renters who do locate available housing in good condition struggle to pay the security deposits required before move-in. Existing rental assistance programs are often challenging to navigate for those they are meant to benefit. Applicants may have trouble navigating the paperwork process or finding landlords willing to participate in assistance programs. Landlords, on the other hand, may struggle with their own expenses while waiting on delayed third-party rental payments. While housing stability is the number one issue for medically fragile populations, collaborative efforts around housing interventions remain limited between local health systems and CBOs. If patients do not find stable housing, they are more likely to return to the hospital and incur longer lengths of stay and frequent readmissions.

Each of these factors contribute to the growing number of individuals and families experiencing homelessness, which are beginning to outpace the supply of available emergency shelter through local CBOs. During community engagement sessions, participants noted that housing instability is one of the most common reasons that a patient is referred to a social worker. 311 is another common housing resource but tends to not have the bandwidth of providing immediate assistance. Due to high caseloads, social workers, care coordinators, and other clinical and CBO staff lack the capacity to complete

comprehensive research on appropriate housing for their cases. Many times, they can only give individuals a listing of shelters in the area. Individuals experiencing homelessness that have high needs are often referred to housing case managers, shelters, or even systems like CareAdvisors to manage housing crisis needs. Despite the value of these resources, many individuals end up on housing waitlists through these referrals. They can wait anywhere from six months to two years to find permanent housing.

Coordination of Social Care

Community residents struggle with navigating the complex landscape of healthcare and accessing community-based resources. These challenges are only compounded by a chokepoint that multiple stakeholders stressed: lack of interoperability. Myriad social care platforms including EHRs, case management programs, and resource hubs do not interface with each other. As one example provided during a community input session, there are three unique Aunt Bertha platforms operating in west Cook County, but none of them connect with any of the others. This lack of connectivity slows down care coordination and impedes closed loop referral management. Integrating social care platform interoperability and streamlining resources coordination into a "holy grail" tool can more effectively meet community needs. These interventions can also promote an inclusive participation of all communities and townships within the service area.

Behavioral Health

COVID-19 continues to negatively affect behavioral health in communities that already face cultural stigma around behavioral health interventions. Infant, early childhood, and adolescent behavioral health needs often go unmet. Reports of child neglect and abuse increase when in-person school is in session. Since the pandemic began, there has been a significant local increase in both adult and adolescent substance use rates. Feedback provided during community engagement sessions noted that "infant, early childhood, adolescent, and adult mental health needs abound" locally. Police who serve as first responders in health emergencies are not well prepared to handle behavioral health crises. Improving their response preparation and training is a key priority for the community.

Additional feedback of note gathered during our community engagement sessions includes:

- Healthcare provider needs: Like many other areas across the country, west Cook County suffers from a growing shortage of healthcare workers, particularly workers with similar cultural, linguistic, and socioeconomic experiences as the communities served.
- Digital and transportation access inequities: Interventions need to be inclusive of the many community members that still lack in-home phone and internet access or access to reliable transportation.
- "Build where you live, live where you build": Young adults ages 18-24 seek employment and healthcare benefits like their older counterparts. Yet local unemployment rates remain high for young adults, a group that was particularly hard hit from the fallout of the COVID-19 economy. This group (and others like it) is an underutilized resource in the community, one that can be leveraged to promote local workforce development efforts.
- Latinx populations and palliative care: Latinx residents lack culturally competent hospice care within their own communities, and utilize available palliative care at lower rates than other populations.
- Service gaps for older populations: A number of local older adults must travel outside their community to receive the care they need due to a distinct and widening gap of in-area services. The aging population should also be more broadly factored into community-focused interventions.

- Unidentified Diversity: While the 2020 Census illustrates a diversifying population, it does not fully capture the ethnic and racial complexities of west Cook County.

2. Please upload any documentation of your community input process or findings here. (Note: if you wish to include multiple files, you must combine them into a single document.)

Section 5 Supporting Documents, Exhibit 5A

Input from Elected Officials
1. Did your collaborative consult elected officials as you developed your proposal? Yes/No toggle
Yes

1A. If you consulted Illinois federal or state legislators, please select all legislators whom you consulted. (Hold CTRL+click on a PC or command+click on a Mac to select multiple legislators).

Davis, D. - U.S. Representative - 7th Congressional District, Duckworth, T. - U.S. Senator - Illinois, Durbin, R. - U.S. Senator - Illinois, Ford, L. - Ill. Representative - 8th State Representative District, García, J. - U.S. Representative - 4th Congressional District, Gonzalez Jr., E. - Ill. Representative - 21st State Representative District, Harmon, D. - Ill. Senator - 39th State Senate District, Hernandez, E. - Ill. Representative - 24th State Representative District, Lightford, K. - Ill. Senator - 4th State Senate District, Lilly, C. - Ill. Representative - 78th State Representative District, Villanueva, C. - Ill. Senator - 11th State Senate District, Welch, E. - Ill. Representative - 7th State Representative District, Willis, K. - Ill. Representative - 77th State Representative District

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

The WCC facilitated two in-person breakfast gatherings for local civic, business, healthcare, and nonprofit leaders and one virtual event for elected officials. Local leaders in attendance included:

- Cecilia Salinas, Community Relations Director representing Cook County Commissioner Frank Aguilar's office
- Ruth Siaba-Green, Berwyn City Administrator
- Sergio Rodriguez, Summit Village President
- Jacqueline Pereda, Berwyn Township Assessor
- Maribel Zapata , Berwyn Township Trustee
- David Avila, Berwyn Public Health President
- Katrina Thompson, Mayor of Broadview
- Andre Harvey, Mayor of Bellwood
- Sergio Rodriguez, Mayor of the Village of Summit
- Barrett F. Pedersen, Mayor, Franklin Park
- Peter Silvestri, Cook County Commissioner
- Mayor Rory Hoskins, Mayor, Forest park
- Brandon Johnson, 1st District Cook County Commissioner

[Input from Elected Officials - Optional] Please upload any documentation of support from or consultation with elected officials. (Note: if you wish to include multiple files, you must combine them into a single document.)

Section 5 Supporting Documents, Exhibit 5A

FORM 6. DATA SUPPORT.

It is imperative that applicants use data to design the proposed work. HFS is seeking applications that are "data-first." 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.

1. Describe the data used to design your proposal and the methodology of collection.
The WCC analyzed and synthesized data from several sources to identify and prioritize the areas of greatest need across our service area, assess local health disparities and racial inequities, and design suitable project interventions. Key data sources utilized include but are not limited to:

- Community input sessions including town halls, council meetings, virtual events, listening sessions, frontline caregiver surveys, and one-on-one meetings (as outlined in the Community Input section).
- HFS Transformation Resources (ex. Transformation Data and Community Needs Report: Chicago-West Side, Racial Equity Impact Assessment Guide
- Racial equity impact resources (ex. Race Forward From Seed to Harvest Toolkit, GARE Racial Equity Toolkit)
- Loyola's 2019 Community Health Needs Assessment
- Population health data (ex. Cook County Public Health Department, Cook County Health and Hospital System Strategic Plan)
- Patient-level data (ex. EHR clinical data, claims data)
- Demographic data (ex. U.S. Census, Data.usa)
- Social needs data (ex. CDC Social Vulnerability Index, CareAdvisors data)
- Published research (ex. *Pediatrics*, National Academies of Sciences, Engineering, and Medicine)
- Data from WCC Co-Chairs, Foundational Partners, Coalition Affiliates, and community advocates (ex. Housing Forward client data, Chicago Health Atlas)

2. Attach the results of the data analyses used to design the project and any other relevant documentation. (Note: if you wish to include multiple files, you must combine them into a single document.)
Please refer to Section 6 Supporting Documents, Exhibit 6A for results of the WCC data analyses by Core Strategy.

Exhibit 6A. Section 6. Data Support

The WCC's model is built upon six key interconnected Core Strategies designed to collectively create transformational impact:

- Core Strategy 1: One-Stop Access to Multiple Care Systems via a Community Navigation Hub
- Core Strategy 2: Disease Management Programs for Members with Chronic Conditions
- Core Strategy 3: Improved Care Coordination through an Equity Internet Exchange (EIEx)
- Core Strategy 4: Clinically Integrated Social Care Management for Hard-to-Reach Members

- Core Strategy 5: Increased Community Access to Behavioral Health Services
- Core Strategy 6: Community-Based Services for Vulnerable Populations

Primary data utilized to build each of these strategies include the following:

Core Strategy 1: One-Stop Access to Multiple Care Systems via a Community Navigation Hub
The WCC chose to focus on 18 communities in west Cook County:

- Bellwood, zip code 60104
- Berkeley, zip code 60163
- Berwyn/Stickney, zip code 60402
- Broadview, zip code 60155
- Brookfield, zip code 60513
- Cicero, zip code 60804
- Forest Park, zip code 60130
- Franklin Park, zip code 60131
- Hillside, zip code 60162
- Lyons, zip code 60534
- Maywood, zip code 60153
- Melrose Park, zip code 60160
- North Lake, zip code 60164
- North Riverside, zip code 60546
- River Grove, zip code 60171
- Stone Park, zip code 60165
- Summit, zip code 60501
- Westchester, zip code 60154

The population composition for the west Cook County service area is 4% non-Latinx white, 24% non-Latinx African American/Black; 8% non-Latinx Asian; 26% Latinx, and 2% two or more races. About 21% of residents are foreign born, with the largest percentage coming from Mexico (38.2%). Racial and ethnic minority populations experience higher rates of poverty than non-Latinx whites throughout our service area. Poverty rates continue to climb in west Cook County, with childhood poverty growing from 10.8% to 18.2% (a 69% jump) between 2000 and 2013.

The service area's communities face a nexus of disparities in care delivery and health outcomes for racial and ethnic minorities and other vulnerable populations:

- In Cook County, 11% of the population is uninsured overall. By contrast, rates in many of the WCC's service area communities are higher including Cicero (20%), Melrose Park (16.3%), Stone Park (26%), and Summit (18%).
- The average life expectancy in predominantly White neighborhoods in the Chicago metro area averages 90 years. In contrast, west Cook County communities average 78.5 years, with especially low life expectancy rates include Broadview (age 72), Bellwood (age 73), Berkeley (age 75), Hillside (age 75), Maywood (age 75), and Melrose Park (age 75).
- Chronic disease mortality rates underscore the same disparity patterns: In both west Chicago and west Cook County, African American/Black individuals have the highest rates of mortality for cardiovascular disease, cancer, diabetes, and stroke compared to other race/ethnic groups in the region.

- Just 9.8% of patients in Chicago and 15.4% of patients in west Cook County who were hospitalized for a chronic disease were receiving outpatient care prior to their hospital admission. After discharge from the hospital, only 14.5% of patients in Chicago and 23% of patients in west Cook County received outpatient care to manage their conditions.
- Our target service area is one that has experienced "disproportionately higher numbers of COVID-19 infections, hospitalizations, and deaths relative to other communities in Illinois." Although Latinx tended to have the highest COVID-19 infection rates, African American/Black people have the highest death rates. While African American/Black Chicagoans make up 30% of the population, they accounted for 70 of the first 100 local COVID-19 deaths.
- Medicaid recipients living in west Cook County are admitted to the hospital at double the national rate for ages 19-64, and the rate is 26% higher than the national rate for ages 65 and older.
- Infant mortality rates also vary substantially by race/ethnicity. African American/Black infants are more than four times as likely as White infants to die before their first birthday in Chicago and almost three times as likely in west Cook County.
- Of all hospitalizations in west Cook County, 4% are for psychoactive substance use disorder (SUD) (including 48.5% alcohol-related, 44.4% opioid-related, and 7% other).
- ED utilization rates show that racial and ethnic minority populations are more likely to visit than White individuals to visit hospitals for their chronic and behavioral health conditions. Bellwood, Cicero, Maywood, Melrose Park, and Stone Park are some of the communities in west Cook County with the highest rates of emergency department (ED) visits for behavioral health.
- In addition, emergency department visit rates for diabetes are highest in Maywood (51.2 per 10,000 visits) and Melrose Park (22.9 per 10,000 visits).

While these persistent inequities stem in part from healthcare system inadequacies, social and structural forces greatly shape everyday living conditions, i.e., the social determinants of health (SDoH), may play an even greater role. The lack of affordable housing and housing insecurity in our service area puts residents at risk for negative health impacts stemming from unhealthy living conditions, stress, social isolation, and limited resources to manage their healthcare conditions. In our service area, housing cost burden (defined by HUD as families whose pay is more than 30% of their income for housing) affects households in every community, with rates ranging from 40-68%. In addition, many west Cook County communities are at risk for food insecurity and have difficulty accessing healthy foods, heightening the population's risk for poor diets and chronic disease. Within the service area, food insecurity rates range from 18-39%, often higher than the rates of 13.6% in suburban Cook County and 19.2% in Chicago.

This targeted population is largely comprised of low income individuals, at-risk and high-need mothers and children, people with chronic conditions, and individuals negatively impacted by SDoH, with a particular focus on those facing food insecurity or housing instability.

Core Strategy 2: Disease Management Programs for Members with Chronic Conditions

Data show that African American/Black and Latinx individuals suffer significantly more complications and severity of conditions than their White counterparts. Engaging individuals with chronic disease in disease management programs is shown to prevent complications, slow disease progression, and limit disease severity. Disease management programs also inform staff training processes, allow for consistent and comprehensive member education materials, and detail effective steps for member engagement in managing their chronic health issues. The WCC will connect members with disease management programs that address their chronic conditions, such as diabetes and hypertension. We leveraged data, community

input, evidence-based self-management education and support disease management programming information from our Co-Chairs and Foundational Partners to design our second Core Strategy.

Our disease management programs will encompass asthma, behavioral health, cardiovascular disease, chronic kidney disease, COPD, diabetes/prediabetes, and hypertension. We have chosen to focus on these specific chronic conditions and diseases as they demonstrate a high utilization of inpatient and emergency care and/or high readmission rates, and are prevalent across the population to be served.

- Asthma/COPD: As of 2019, more than 25 million Americans were living with asthma including over 5 million children under the age of 18. In 2018, there were 1,629,469 ED visits and 178,530 hospital inpatient stays in which asthma was the primary diagnosis. According to research published in 2018, asthma costs the U.S. economy more than $80 billion per year in medical expenses, missed work and school days, and deaths. The annual per-person medical cost of asthma was $3,266. Of that, $1,830 was for prescriptions, $640 for office visits, $529 for hospitalizations, $176 for hospital outpatient visits and $105 for emergency room care. COPD affects nearly 16 million Americans, or about 6% of the U.S. population. As of 2018, it was the fourth leading cause of death in the U.S. More than 50% of adults with low pulmonary function were not aware that they had COPD, so the actual number of individuals with COPD may be higher. In the City of Chicago, non-Hispanic African American/Black children and adolescents are five times more likely to visit the emergency department for an asthma-related condition than White children and adolescents.
- Behavioral Health: In 2019, an estimated 1 in 5 (51.5 million) adults in the U.S. were living with a mental illness. Only 44.8% (23 million) of adults living with a mental illness received behavioral health services in the past year. Further, the ongoing COVID-19 pandemic and the resulting economic recession have negatively affected many people's mental health. In particular, "the pandemic has disproportionately affected the health of communities of color. Non-Latinx Black adults (48%) and Latinx or Latino adults (46%) are more likely to report symptoms of anxiety and/or depressive disorder than Non-Latinx White adults (41%). Historically, these communities of color have faced challenges accessing behavioral healthcare." Within the west Cook service area, the topmost frequent and resource-intensive hospitalization (defined as the rate of readmission for the disease block) included a mood affective disorder (i.e., bipolar, depression) followed by schizophrenia and schizotypal disorders. The HFS also found that out of all hospitalizations in west Cook County, 4% are for psychoactive SUD (including 48.5% alcohol-related, 44.4% opioid-related, and 7% other).
- Cardiovascular Disease: Cardiovascular disease remains the leading cause of death in the United States. Heart disease and stroke claim over 868,000 American lives each year, or one-third of all deaths. Each year, cardiovascular disease costs the healthcare system $214 billion and causes $138 billion in lost productivity on the job. HTC data found that, within west Cook County, A) the congestive heart failure hospital admission rate was nearly triple the national rate for patients 19-64 years old and 20% higher for patients 65 years and older, B) the age-adjusted hospitalization rate due to heart failure per 10,000 population aged 18 years and older was 72.9 compared to 61.5 for the state of Illinois, and C) the percentage of Medicare members who were treated for stroke totaled 4.3% compared to 3.8% for both Illinois and nationally. Additionally, data from the 2019 Loyola CHNA found that 25% of more than 650 local respondents identified heart disease among the most important health problems in their community.

Core Strategy 3: Improved Care Coordination through an Equity Internet Exchange (EIEx)
There are significant care coordination gaps in west Cook County due to the fragmentation of patient data among disparate EHRs and case management systems. This makes it difficult for clinicians and case managers to adequately address the needs of members. Additional obstacles to holistic patient care include the lack of information transfer, systems to monitor patients, and tools to support patients' self-management goals, and tools to link patients and their caregivers with community resources. There are also limited tools that facilitate interoperability with legacy case management software.

CBOs participating in WCC-hosted community input sessions (see Community Input section) highlighted these gaps and resulting concerns. Participants noted that ensuring coordinated care for at-risk individuals, particularly those with limited or no technology access, continues to be a challenge. Under the existing data infrastructure, users must pull clinical and social care data from different systems. While large hospitals' EHR systems are interoperable with thousands of other systems nationwide, smaller safety net providers (including many community health centers) often lack connectivity and are unable to transfer data with other providers. Feedback pointed to the value that a shared information exchange platform would have if developed and utilized across collaborative member-care-focused organizations.

Our EIEx (Equity Information Exchange) platform (Core Strategy 3) combines real-time clinical data and social care data from healthcare providers and social care providers in the community service area to address the data challenges of care coordination. CBOs and hospitals will easily be able to access longitudinal records of racial and ethnic minorities and other vulnerable patients to determine individual risk profiles, make informed and strategic decisions about matching clients with community resources and attain closed loop referrals. In addition, they will be able to chart population level changes in care coordination, such as reduced hospital stays and ED use among ethnic and racial minorities, as reflected in service patterns and other reporting metrics generated by the EIEx.

Core Strategy 4: Clinically Integrated Social Care Management for Hard-to-Reach Members
Data informed the WCC's decision to focus on the following disparities in west Cook County:

Chronic Conditions: Based on WCC's review of the population health and individual member-level data, African American/Black and Latinx community members in the service area suffer significantly more complications and severity of chronic conditions than their White counterparts. For example, we found that 1) the congestive heart failure hospital admission rate was nearly triple the national rate for patients 19-64 years old and 20% higher for patients 65 years and older; 2) the age-adjusted hospitalization rate due to heart failure per 10,000 population aged 18 years and older was 72.9 compared to 61.5 for the state of Illinois; and 3) the percentage of Medicare members who were treated for stroke totaled 4.3% compared to 3.8% for both Illinois and nationally. After discharge from the hospital, less than 1 in 4 patients in west Cook County received outpatient care to manage their conditions. Contributing factors include mistrust of the healthcare system, inability to navigate the healthcare system, and the financial and emotional stress of managing chronic care with limited caregiver support.

Behavioral Health: The community service area is classified as a mental health shortage area by the Health Resources and Services Administration (HRSA) with scores between 17 and 20 (26 is the maximum score), indicating high unmet need. While most racial/ethnic minority groups have similar rates of behavioral health disorders than white counterparts, they are more likely to suffer from poor health outcomes due to "inaccessibility of high-quality mental healthcare services, cultural stigma surrounding mental healthcare, discrimination, and overall lack of awareness about mental health." The shortage of

behavioral health providers in the west Cook County area contributes to community members' limited access to appropriate care. This shortage is in part due to insufficient wages. PCH reports that there is a 20% gap between current compensation levels and market rates for licensed clinicians. Due to these barriers to care, many individuals go without treatment entirely, which can have devastating effects on the health and stability of their households. The risks of untreated behavioral health issues in these communities include higher incidence rates of unemployment, SUD and overdose, and suicide when compared to White communities. Other individuals may delay care until they hit a crisis point.

Maternal and Child Health: Research shows that women of color face a greater risk of being uninsured prior to pregnancy. A lack of insurance may impact an individual's prenatal care and result in poor health outcomes for babies. Women of color also experience higher rates of complications during pregnancy, labor, and delivery. Compared to White women, Latinx women are roughly two times more likely to die from pregnancy-related causes while African American/Black women are six times more likely to die from pregnancy-related causes. Many complications are associated with chronic conditions including diabetes and obesity, which occur at higher rates among low-income, racially/ethnically diverse communities. Infant mortality rates are also divided along race/ethnic lines. In west Cook County, African American/Black infants are almost three times as likely as White infants to die before their first birthday.

Access to Care: Medicaid members face a variety of challenges to achieving timely access to care. In west Cook County, significant care coordination gaps exist as member data is fragmented and siloed in disparate EHRs and case management systems, making it difficult for clinicians and case managers to adequately address member needs. Additional gaps of note include information transfer, systems to monitor patients, tools to support patients' self-management goals, and tools to link patients and their caregivers with community resources. There are also few tools that provide interoperability with legacy case management software for community resources which are defined as any service.

Nonclinical social care barriers can include lack of childcare, limited time off from work, or language barriers, among others. As one example, research released earlier this year found that 1 in 3 Medicaid recipients faces transportation insecurity that affects their access to care. Patients face numerous barriers to addressing social care needs, including knowing how to navigate complex benefit application requirements, cultural or language differences, and concerns about divulging sensitive information such as immigration status. On a more systemic level, patients may have difficulty finding specialty physicians due to low Medicaid acceptance rates and provider shortages, resulting in longer wait times to get appointments. Medicaid patients may ultimately choose not to pursue seeing a specialist, which can put them at risk for adverse health outcomes.

These disparities can be directly attributed to SDoH. Many individuals in WCC's service area face inequalities across SDoH that negatively impact their health outcomes. Connecting these individuals with targeted community-based resources can help address SDoH disparities and achieve better health outcomes. The WCC's model assesses patients for all SDoH and provides appropriate linkages and follow-up to community resources.

Core Strategy 5: Increased Community Access to Behavioral Health Services

Nationally, and especially in low-income urban areas, there is a continuing shortage of healthcare professionals, particularly among primary care providers and behavioral health professionals. These workforce shortages serve as an additional barrier for residents of west Cook County to obtain the behavioral healthcare they need. Part of the issue is compensation. Locally, data indicate that there is a 20% gap (average of $15,000 in salary) between current compensation levels and market rates for licensed clinicians, further jeopardizing the sustainability of the local behavioral health workforce. Ongoing staff turnover and unfilled high-need positions make it more difficult to connect community members facing behavioral health crises with the help they need. PCH reports that the average number of days between patient intake and case assignment has increased rapidly over the last five quarters (FY21Q1: 24 days, FY21Q2: 28 days, FY21Q3: 44 days, FY21Q4: 50 days, and FY22Q1: 83 days). Longer wait times to begin treatment appear to correlate with decreased patient engagement rates (defined as the ratio of patients completing intake to patients completing at least one initial assessment or treatment planning session). In FY21Q1, PCH had a patient engagement rate of 90%. As of FY22Q1, this rate has fallen to 70%.

Research shows that living in a low-income household increases the risk for developing behavioral health issues in both children and adults. Despite having a high need for behavioral healthcare and intervention, individuals living in poverty are often the least likely to receive high-quality behavioral healthcare. Critical contributing factors often include the lack of a systemic approach to early intervention, the stigma of behavioral health treatment, lack of awareness, and insufficient access to culturally competent behavioral health services and substance use treatment programs, among others. Members may have difficulty accessing behavioral health services due to low Medicaid acceptance rates and ongoing provider shortages, resulting in longer wait times to get appointments. Medicaid patients may ultimately choose not to pursue seeing a specialist, which can put them at risk for adverse behavioral health outcomes.

Feedback from community input sessions highlighted the critical need for children's mental health interventions within our service area. Common mental disorders that begin in childhood include anxiety disorders, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, depression, and other mood disorders, eating disorders, and post-traumatic stress disorder (PTSD). Parental mental illness can also negatively impact children. As Mental Health America notes, "Children whose parents have a mental illness are at risk for developing social, emotional and/or behavioral problems. An inconsistent and unpredictable family environment, often found in families in which a parent has mental illness, contributes to a child's risk" as does poverty, substance abuse disorder, and living in single-parent households.

Core Strategy 6: Community-Based Services for Vulnerable Populations

Maternal and Child Health

Medical and social support during pregnancy, birth, and postpartum periods increase the likelihood of patients adhering to medical guidance, attending aftercare visits, increasing the inter-conception period (time between pregnancies), and adhering to immunization schedules and child wellness visits. Medical and social support services can also assist with transportation and parent/child bonding and facilitate improved outcomes and safety for children.

Peer-reviewed evidence supports the positive impact that evidence-based home-visiting programs have on maternal and child health outcomes. Data show that participating members are:

- 4 times less likely to have a low birth weight (LBW) baby.
- 2 times less likely to experience a birth complication for themselves or the baby.

- Significantly more likely to initiate breastfeeding.
- More likely to engage in safe sleep practices for their newborn.
- More likely to use car seats.

Older Adults
Data from the CDC show that more than 85% of older adults (age 65 and over) have one or more chronic health conditions, 56% have at least two chronic conditions, and 23% have three or more chronic conditions. Common conditions in older adults include asthma, cardiovascular disease, diabetes/prediabetes, and hypertension, among others. Research shows that incorporating home-based interventions in the care of older adults with chronic conditions results in numerous benefits for patients. Home healthcare promotes aging in place for older adults, reduces the likelihood of infections acquired at medical facilities, and is typically more cost-effective than provider-based care for both patients and healthcare plans. Numerous observational studies found that home-based care promoted a higher continuity of care, which is frequently associated with fewer ED visits and hospitalizations.

Adults with Intellectual/Developmental Disabilities (IDD)
Individuals with IDD face a great number of health disparities compared to neurotypical individuals and individuals with non-intellectual and developmental disabilities. They are also more likely to face SDoH barriers to accessing care. Research published in 2020 found that "for every one unit increase in the number of social determinant outcomes present, there was a 7.97% decrease in emergency department visits" for adults with IDD.Home and community-based health resources can improve the health outcomes of individuals with IDD while enabling them to remain in the community and outside of acute care settings.

FORM 7. HEALTH EQUITY AND OUTCOMES.

1. Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes.
West Cook County faces a nexus of disparities in care delivery and health outcomes for racial and ethnic minorities and other vulnerable populations. Based on findings from community listening sessions, CHNAs, and other sources described within the Data section, the WCC has chosen to focus on the following health disparities to improve health equity and well-being in west Cook County:

Chronic Conditions: Based on WCC's review of the population health and individual member-level data, African American/Black and Latinx community members in the service area suffer significantly more complications and severity of chronic conditions than their white counterparts. For example, we found that 1) the congestive heart failure hospital admission rate was nearly triple the national rate for patients 19-64 years old and 20% higher for patients 65 years and older; 2) the age-adjusted hospitalization rate due to heart failure per 10,000 population aged 18 years and older was 72.9 compared to 61.5 for the state of Illinois; and 3) the percentage of Medicare members who were treated for stroke totaled 4.3% compared to 3.8% for both Illinois and nationally.[52] After discharge from the hospital, less than 1 in 4

[52] Community Memorial Foundation. (2021b). *Stroke: Medicare population - County: Cook.* Retrieved October 29, 2021, from https://cmfdn.thehcn.net/indicators/index/view?indicatorId=2067&localeId=662

patients in west Cook County received outpatient care to manage their conditions.[53] Contributing factors include mistrust of the healthcare system, inability to navigate the healthcare system, and the financial and emotional stress of managing chronic care with limited caregiver support.

Behavioral Health: The community service area is classified as a mental health shortage area by the Health Resources and Services Administration (HRSA) with scores between 17 and 20 (26 is the maximum score), indicating high unmet need.[54] While most racial/ethnic minority groups have similar rates of behavioral health disorders than their white counterparts, they are more likely to suffer from poor health outcomes due to "inaccessibility of high-quality mental healthcare services, cultural stigma surrounding mental healthcare, discrimination, and overall lack of awareness about mental health."[55] The shortage of behavioral health providers in the west Cook County area contributes to community members' limited access to appropriate care. This shortage is in part due to insufficient wages. PCH reports that there is a 20% gap between current compensation levels and market rates for licensed clinicians. Due to these barriers to care, many individuals go without treatment entirely, which can have devastating effects on the health and stability of their households. The risks of untreated behavioral health issues in these communities include higher incidence rates of unemployment, SUD and overdose, and suicide when compared to white communities. Other individuals may delay care until they hit a crisis point.

Maternal and Child Health: Research shows that women of color face a greater risk of being uninsured prior to pregnancy. A lack of insurance may impact an individual's prenatal care and result in poor health outcomes for babies.[56] Women of color also experience higher rates of complications during pregnancy, labor, and delivery. Compared to white women, Latinx women are roughly two times more likely to die from pregnancy-related causes while African American/Black women are six times more likely to die from pregnancy-related causes. Many complications are associated with chronic conditions including diabetes and obesity, which occur at higher rates among low-income, racially/ethnically diverse communities.[57] Infant mortality rates are also divided along race/ethnic lines. In west Cook County, African American/Black infants are almost three times as likely as white infants to die before their first birthday.[58]

Access to Care: Medicaid members face a variety of challenges to achieving timely access to care. In west Cook County, significant care coordination gaps exist as member data is fragmented and siloed in disparate EHRs and case management systems, making it difficult for clinicians and case managers to adequately address member needs. Additional gaps of note include information transfer, systems to monitor patients, tools to support patients' self-management goals, and tools to link patients and their caregivers with community resources. There are also few tools that provide interoperability with legacy case management software for community resources which are defined as any service.

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[53] Basu, S., Flax-Hatch, J., Freeman, V. L., Gao, Y., Hershow, R., Kauth, A., Musick, H., Schneiderman, J., & Wang, H. (2021). *Transformation data & community needs report: Chicago–West side.* University of Illinois at Chicago School of Public Health. https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportWestChicagoDigitalCMP.pdf

[54] Health Professional Shortage Area. (n.d.). *HPSA find.* Retrieved November 14, 2021, from https://data.hrsa.gov/tools/shortage-area/hpsa-find

[55] American Psychiatric Association. (n.d.). *Mental health disparities: Diverse populations.* https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts

[56] Artiga, S., Pham, O., Orgera, K., & Ranji, U. (2020). *Racial disparities in maternal and infant health: An overview.* Kaiser Family Foundation. https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief

[57] Loyola Medicine. (2019). *Community health needs assessment.* https://www.loyolamedicine.org/assets/documents/2019_chna_report_gottlieb.pdf

[58] Chicago Department of Public Health. (2016). *Healthy Chicago 2.0: Partnering to improve health equity 2016 – 2020.* https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy%20Chicago/HC2.0Upd4152016.pdf

Nonclinical social care barriers can include lack of childcare, limited time off from work, or language barriers, among others. As one example, research released earlier this year found that 1 in 3 Medicaid recipients faces transportation insecurity that affects their access to care.[59] Patients face numerous barriers to addressing social care needs, including knowing how to navigate complex benefit application requirements, cultural or language differences, and concerns about divulging sensitive information such as immigration status. On a more systemic level, patients may have difficulty finding specialty physicians due to low Medicaid acceptance rates and provider shortages, resulting in longer wait times to get appointments. Medicaid patients may ultimately choose not to pursue seeing a specialist, which can put them at risk for adverse health outcomes.

These disparities can be directly attributed to SDoH. Many individuals in WCC's service area face inequalities across SDoH that negatively impact their health outcomes. Connecting these individuals with targeted community-based resources can help address SDoH disparities and achieve better health outcomes. The WCC's model assesses patients for all SDoH and provides appropriate linkages and follow-up to community resources.

We chose to address the causes of these disparities because the members of our targeted services area are disproportionately affected by very poor health outcomes in these conditions, reflecting the scale of change needed across the local healthcare and social service delivery ecosystem.

[1 - 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.)

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?
The WCC has developed interconnected, clinically-integrated strategies that target these barriers to increase patient access to preventive, primary or specialty care in our service area:

Core Strategy 1: Community Navigation Hub for One-Stop Access to Multiple Care Systems
The WCC has committed to increasing the capacity across all providers, expanding access to preventive, primary or specialty care, as well as access to social services. The group has implemented a CHW/SWCM-driven care management model aimed at supporting hard-to-reach Medicaid recipients residing in west Cook County. Through a field-based model, CHW/SWCM teams will facilitate enrollment member engagement with social care supports and provide case consultation for additional maternal and child healthcare access.

Core Strategy 2: Disease Management Programs for Members with Chronic Conditions
Members may delay care if they lack sufficient financial resources, which may lead to serious health complications. This Core Strategy will provide members with self-management education and support with managing chronic conditions such as diabetes and hypertension by connecting members with the appropriate community-based disease management programs and social supports. Access is made easier

[59] Evidation. (2021, February 16). *One third of Medicare and Medicaid beneficiaries face transportation insecurity that affects access to healthcare and essential medications.* https://evidation.com/news/one-third-of-medicare-and-medicaid-beneficiaries-face-transportation-insecurity-that-affects-access-to-healthcare-and-essential-medications

with the expanded options of telehealth, web-based, hospital-based groups, one-on-one education, and community-based programs.

Core Strategy 3: Improved Care Coordination Through Our EIEx

Our EIEx strategy combines real-time clinical data and social care data from healthcare providers and social care providers in the community service area to address the data challenges of care coordination. Through our EIEx, CBOs and hospitals will easily be able to access longitudinal records of uninsured individuals, Medicaid members, and other vulnerable patients to determine individual risk profiles, make informed and strategic decisions about matching clients with community resources and attain closed loop referrals. In addition, they will be able to chart population level changes in care coordination, such as reduced hospital stays and ED use among ethnic and racial minorities, as reflected in service patterns and other reporting metrics generated by the EIE.

Core Strategy 4: Clinically Integrated Social Care Management for Hard-to-Reach Members

West Cook County faces a nexus of disparities in care delivery and health outcomes for racial and ethnic minorities and other vulnerable populations. These enduring inequities are greatly impacted by SDoH. The WCC will launch a clinically integrated social care management network that provides
end-to-end intervention for hard-to-reach patients in our service area. The network tracks each step in the standard of care starting from registration and first contact through completion. Universal SDoH screenings will identify barriers that members may face when attempting to successfully complete planned interventions. The system then matches members to the appropriate community resources to help reduce barriers to accessing care.

The WCC will evaluate our social care management model based on activities, and quality through the following metrics:

Care Plan Completion

- Urgent Case Completion Rate within 24-48 hours
- Expedited Case Completion Rate within 7-10 business days

Programs and Services

- Percent of patients eligible for programs/services
  - o Enrolled in services
  - o Utilizing ancillary services as part of benefit (i.e., using Medicaid MCO-provided transportation)

Resource Management

- Number of unique individuals provided with resources
- Number of resources provided
- Number of closed loops referrals

Aggregated Closed Loop Referrals in Key Social Domains

- Housing
- Food Insecurity
- Behavioral Health

Core Strategy 5: Increased Community Access to Behavioral Health Services

Working with leaders in the local behavioral health sector, the WCC will leverage several existing evidence-based models of care available through WCC members to address outstanding mental health and substance use needs in west Cook County. Through this strategy, we will implement new mental health and substance use treatment programs and make virtual behavioral health support more available to those in need. Interventions will also include culturally and linguistically appropriate education and

outreach efforts across the community to reduce the social stigma around seeking treatment for mental health and how to access care. We will also provide enhanced reimbursement for high-risk patients, which will provide market rate compensation for 80 licensed behavioral health staff. This will reduce ongoing staff turnover and unfilled high-need positions, enabling community members facing behavioral health crises to get the help they need in a timelier manner.

Core Strategy 6: Community-Based Services for Vulnerable Populations
Care teams within the Hub will facilitate the coordinated intake of appropriate mothers or expectant individuals into evidence-based home visiting programs, maximizing the evidence-based interventions that the State already significantly funds through the IDHS. The WCC will leverage these funding streams to augment care for hard-to-reach members and remove some of the barriers to care coordination. WCC Foundational Partners can also provide doula home-visiting services and other culturally appropriate prenatal and postnatal resources for participants. To serve additional populations, the WCC will screen members to identify those that can benefit from other area home-visiting programs including individuals with an intellectual or developmental disability or individuals 65 and over that are eligible for both Medicare and Medicaid.

Through this work, we expect to see the following impact within the communities:

- Increase in access to primary care through culturally competent outreach
- Referrals and coordinated services
- Education on the knowledge and skills needed to obtain care
- Facilitation of continuity of care by providing follow-up
- Members linked to and informed of available community resources
- Decrease in heart failure-related emergency department (ED) visits
- Reduced adverse outcomes (pre-term birth and low birth weight) among high-risk pregnancies
- Improved HbA1c control, blood pressure, diabetes knowledge, and perceived competence in managing diabetes

Additionally, the WCC will immediately impact the following measurable metrics:

- Annual visit/primary care physician relationship
- Completed and on-schedule immunizations
- Completed well-child and well-adolescent visits
- Completed screenings
- Follow up on abnormal screenings
- 28-day appointment follow-up
- Primary care connection after ED visits
- 7- and 30-day follow-up post ED visits for mental illness
- 7-day follow-up post hospitalization
- Rate of ED use
- Timeliness of care
- Social Care Referrals:
    - Partner Scorecard: Monthly number of "Social Care encounters" defined as any engagement between a Partner and a member to identify and address clinical and social care needs.
    - Health outcomes: Identify correlations between social needs resolution and health outcomes.

- Trend identification: Analyze Community Resource Directory search and referral data to identify common patient needs, gaps in existing community resources, needs for advocacy or partner capacity-building. Monitor referral activity, identification of referrals, and tracking of key trends (CBOs and internal partners engaged in referrals, types of referrals, and member needs).
- Other key metrics: Monthly target(Number of Encounters by Food, Housing and Access to Care, and Open Referrals).

[2 - 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.)

3. Why will the activities you propose lead to the impact you intend to have?
The WCC synthesized numerous data sources to pinpoint the most serious disparities that impact our service area as well as the root causes behind them. Our interconnected Core Strategies will have near-term, mid-term, and long-term impact on these root causes, enabling members to access the care and social support services they need to thrive.

[3 - 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.)
Works Cited for Health Equity and Outcomes_Section 7

FORM 8. 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.
The service area's communities face a nexus of disparities in care delivery and health outcomes for racial and ethnic minorities and other vulnerable populations:

- In Cook County, 11% of the population is uninsured overall. By contrast, rates in many of the WCC's service area communities are higher including Cicero (20%), Melrose Park (16.3%), Stone Park (26%), and Summit (18%).[60]
- The average life expectancy in predominantly white neighborhoods in the Chicago metro area averages 90 years. In contrast, west Cook County communities with especially low life expectancy rates include Broadview (age 72), Bellwood (age 73), Berkeley (age 75), Hillside (age 75), Maywood (age 75), and Melrose Park (age 75).[61]
- Chronic disease mortality rates underscore the same disparity patterns: In both West Chicago and west Cook County, African American/Blacks have the highest rates of mortality for cardiovascular disease, cancer, diabetes, and stroke compared to other race/ethnic groups in the region.[62]
- Our target service area is one that has experienced "disproportionately higher numbers of COVID-19 infections, hospitalizations, and deaths relative to other communities in Illinois." Although Latinx tended to have the highest COVID-19 infection rates, African American/Black people have

[60] United States Census Bureau. (2019). *QuickFacts: Melrose Park Village, Illinois.* Retrieved September 14, 2021, from https://www.census.gov/quickfacts/melroseparkvillageillinois
[61] Loyola Medicine. (2019). *Community health needs assessment.* https://www.loyolamedicine.org/assets/documents/2019_chna_report_gottlieb.pdf
[62] Cook County Department of Public Health. (2018). *Ten leading causes of death tables 2012-2016.* Community Epidemiology and Health Planning Unit. https://cookcountypublichealth.org/wp-content/uploads/2020/02/Leading-Causes-2012-2016.pdf

the highest death rates. While African American/Black Chicagoans make up 30% of the population, they accounted for 70 of the first 100 local COVID-19 deaths.[63]

- Medicaid recipients living in west Cook County are admitted to the hospital at double the national rate for ages 19-64, and the rate is 26% higher than the national rate for ages 65 and older.[64]
- Infant mortality rates also vary substantially by race/ethnicity. African American/Black infants are more than four times as likely as white infants to die before their first birthday in Chicago and almost three times as likely in west Cook County.[65]
- Of all hospitalizations in west Cook County, 4% are for psychoactive SUDs (including 48.5% alcohol-related, 44.4% opioid-related, and 7% other).[66]
- Just 9.8% of patients in Chicago and 15.4% of patients in west Cook County who were hospitalized for a chronic disease were receiving outpatient care prior to their hospital admission. After discharge from the hospital, only 14.5% of patients in Chicago and 23% of patients in west Cook County received outpatient care to manage their conditions.[67]
- ED utilization rates show that racial and ethnic minority populations are more likely to visit than white individuals to visit hospitals for their chronic and behavioral health conditions. Bellwood, Cicero, Maywood, Melrose Park, and Stone Park are some of the communities in west Cook County with the highest rates of ED visits for behavioral health.[68]
- In addition, emergency department visit rates for diabetes are highest in Maywood (51.2 per 10,000 visits) and Melrose Park (22.9 per 10,000 visits).[69]
- As previously noted, childhood poverty grew from 10.8% to 18.2% between 2000 and 2013 in west Cook County, contributing to a number of social and health disparities. Within the service area, ambulatory Care-Sensitive Conditions (ACSCs) including asthma and diabetes are "highly associated with young children."[70] Within the city of Chicago, Black/African American children and adolescents are five times more likely to visit an ED for asthma-related incidents than their White counterparts.[71] Lurie Children's *2019 Community Health Needs Assessment* found that while 15-

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63 Brandt, K. S. (2020, September 10). *The great unequalizer: Health inequities - Chicago Health.* Chicago Health. https://chicagohealthonline.com/the-great-unequalizer

64 Basu, S., Flax-Hatch, J., Freeman, V. L., Gao, Y., Hershow, R., Kauth, A., Musick, H., Schneiderman, J., & Wang, H. (2021). *Transformation data & community needs report: Chicago–West side.* University of Illinois at Chicago School of Public Health. https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportWestChicagoDigitalCMP.pdf

65 Chicago Department of Public Health. (2016). *Healthy Chicago 2.0: Partnering to improve health equity 2016 – 2020.* https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy%20Chicago/HC2.0Upd4152016.pdf

66 Basu, S., Flax-Hatch, J., Freeman, V. L., Gao, Y., Hershow, R., Kauth, A., Musick, H., Schneiderman, J., & Wang, H. (2021). *Transformation data & community needs report: Chicago–West side.* University of Illinois at Chicago School of Public Health. https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportWestChicagoDigitalCMP.pdf

67 Basu, S., Flax-Hatch, J., Freeman, V. L., Gao, Y., Hershow, R., Kauth, A., Musick, H., Schneiderman, J., & Wang, H. (2021). *Transformation data & community needs report: Chicago–West side.* University of Illinois at Chicago School of Public Health. https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportWestChicagoDigitalCMP.pdf

68 Loyola Medicine. (2019). *Community health needs assessment.* https://www.loyolamedicine.org/assets/documents/2019_chna_report_gottlieb.pdf

69 Loyola Medicine. (2019). *Community health needs assessment.* https://www.loyolamedicine.org/assets/documents/2019_chna_report_gottlieb.pdf

70 Basu, S., Flax-Hatch, J., Freeman, V. L., Gao, Y., Hershow, R., Kauth, A., Musick, H., Schneiderman, J., & Wang, H. (2021). *Transformation data & community needs report: Chicago–West side.* University of Illinois at Chicago School of Public Health. https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportWestChicagoDigitalCMP.pdf

71 Loyola Medicine. (2019). *Community health needs assessment.* https://www.loyolamedicine.org/assets/documents/2019_chna_report_gottlieb.pdf

20% of youth have a serious behavioral health condition, only half receive the mental healthcare they need.[72]

While these enduring inequities stem from healthcare system inadequacies, they are even more greatly impacted by SDoH, the social and structural forces that shape everyday living conditions. One of the major crises in our service area is lack of affordable housing and housing insecurity, which puts populations at risk for negative health impacts stemming from unhealthy living conditions, stress, social isolation, and limited resources to manage healthcare conditions. In our service area, housing cost burden (defined by HUD as families whose pay is more than 30% of their income for housing) affects households in every community, with rates ranging from 40-68%.[73] In turn, the area has seen increasing numbers of individuals and families experiencing homelessness.

In addition, many communities are at risk for food insecurity and have difficulty accessing healthy foods, heightening the population's risk for poor diets and chronic disease. Within the service area, food insecurity rates range from 18-39%, largely higher than the rates of 13.6% in suburban Cook County and 19.2% in Chicago.[74]

For all the reasons listed above, we have chosen to focus our efforts on communities with racial/ethnic minority populations and low-income people, at-risk and high-need mothers and children, people with chronic disease, and the homeless population.

[1 - 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.)

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

The WCC has developed interconnected, clinically-integrated strategies that address health inequities by increasing the access of members to preventive, primary or specialty care in our service area:

Core Strategy 1: Community Navigation Hub for One-Stop Access to Multiple Care Systems

To increase access to care, the WCC has committed to increasing the capacity across all providers, expanding access to preventive, primary or specialty care, as well as access to social services. We will implement a CHW/SWCM-driven care management model aimed at supporting hard-to-reach Medicaid recipients residing in west Cook. CHW/SWCM teams will improve access to care by facilitating in-field member engagement with health and social care support, as well as improve the quality and cultural competence of service delivery.

Core Strategy 2: Disease Management Programs for Members with Chronic Conditions

To reduce avoidable chronic disease complications, the WCC will provide members with self-management education and support for conditions such as diabetes and hypertension by connecting them with the

[72] Ann and Robert H. Lurie Children's Hospital of Chicago (2019). *Community health needs assessment.* https://www.luriechildrens.org/globalassets/documents/luriechildrens.org/community/community-health-needs-assessment/chna-2019.pdf

[73] Housing Action Illinois. (2020). *Making rent affordable.* https://housingactionil.org/what-we-do/advocacy/rental-affordability

[74] Greater Chicago Food Depository. (2016). *Cook County food access plan.* https://www.chicagosfoodbank.org/wp-content/uploads/2016/10/Cook_County_Food_Access_Plan.pdf

appropriate community-based disease management programs and social supports. The expanded options of telehealth, web-based, hospital-based groups, one-on-one education, and community-based programs will reduce disparities by improving member access to care.

Core Strategy 3: Improved Care Coordination through an Equity Internet Exchange (EIEx)
To improve coordination of care across sectors, the WCC will leverage CareAdvisors' web-based EIEx platform to create an interoperable bi-directional data exchange with all EHR systems as well as legacy community resource directory tools and case management software at CBOs. The platform will combine data sets to provide both healthcare and social care providers with a holistic view of community members' health and social needs to better address broad disparities. Using this information, care providers will be able to determine individual risk profiles, make informed and strategic decisions about matching clients with community resources, and attain closed loop referrals.

Core Strategy 4: Clinically Integrated Social Care Management for Hard-to-Reach Members
To connect members with critical SDoH interventions and resources, the WCC will launch a clinically integrated social care management network that provides end-to-end intervention for hard-to-reach patients in our service area. The network tracks each step in the standard of care starting from registration and first contact through completion. Universal SDoH screenings will identify barriers that members may face when attempting to successfully complete planned interventions. The system will then match members to the appropriate community resources to help reduce barriers to accessing care.

Core Strategy 5: Increased Community Access to Behavioral Health Services
To increase the access of members to behavioral health services, the WCC will expand existing behavioral health programs and make virtual behavioral health support more available to those in need and launch new behavioral health services to more adequately service community needs. Interventions will also include culturally and linguistically appropriate education and outreach efforts across the community to reduce the social stigma around seeking treatment for mental health and how to access care. The WCC will also invest HFS funds in three capital projects designed to expand the reach and capacity of BH services in the service area, and reduce ongoing staff turnover and unfilled high-need positions through enhanced reimbursement for high-risk patients.

Core Strategy 6: Community-Based Services for Vulnerable Populations
To remove some of the barriers to care coordination for home-based members and equip them with the knowledge and support to achieve positive health outcomes and improve their well-being, the WCC will facilitate the coordinated intake of expectant individuals and mothers and infants into evidence-based home visiting programs. WCC Foundational Partners can also provide doula home-visiting services and other culturally appropriate prenatal and postnatal resources for participants. To serve additional populations, the WCC will screen members to identify those that can benefit from other area home-visiting programs including individuals with an intellectual or developmental disability or individuals 65 and over that are eligible for both Medicare and Medicaid.

The WCC designed each of its six interconnected core strategies to facilitate access to quality, culturally competent care. From an impact standpoint, our model will provide measurable transformational impact by:

- Implementing a seamless ecosystem approach to addressing whole health needs of members.

- Leveraging the expertise of a variety of care providers that are already embedded within the community, are known to individuals we seek to serve, and that have a proven track record of meeting broad SDoH needs.
- Engaging collaborating entities and developing interventions through a racial equity lens.
- Utilizing extensive community input from community members and leaders to identify the unique health needs of the community and potential solutions for healthy inequities
- Developing a replicable model to impact a broader subset of the local community and other areas of need through improved member health outcomes and cost-of-care savings.

[2 - 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.)

3. Why will the activities you propose lead to the impact you intend to have?
Our six Core Strategies work together to provide solutions to the healthcare disparities most prevalent in west Cook County. Our model is member-driven and community informed and is designed to address these disparities and the causes behind them. The activities described will impact the following barriers:

- Gaps in social care services leading to lack of affordable housing, economic instability, and food insecurity
- Delays in accessing care for high-risk patients
- Multiple barriers to patient chronic condition self-management
- Inability of providers and social service agencies to share data
- Insufficient behavioral health and substance use treatment providers

The WCC has developed a clinically-integrated proposal that targets these barriers to resolve the issue of access to preventive, primary or specialty care. Each of the core strategies of support identified as our approach to meeting the program goals place a significant emphasis on increased access to care

The WCC CHW/SWCM-driven care management model supports increased access to primary care and specialty care for high-risk, hard-to-reach members through culturally competent outreach and education by encouraging members to utilize the services that are accessible to them. The WCC proposal addresses access to mental health, behavioral health and substance use treatment specialists by funding the addition of new providers, new mental health and substance use treatment programs and making psychiatric telehealth support available to those in need. The WCC also contracts with community-based organizations in the service delivery area to deliver social services to moderate and high-risk patients to address SDoH factors that limit access to care. The enhanced data interoperability in the WCC proposal will also facilitate timely care coordination to available primary care and specialty care resources by streamlining communication gaps and data silos that serve as a barrier to access.

[3 - 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.)
Works Cited for Access to Care_Section 8

FORM 9. SOCIAL DETERMINANTS OF HEALTH.

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

Based on the WCC's review of data and extensive community input, we identified Food Insecurity and Housing Instability as two significant contributing factors to health disparities for underserved members in the Service Area.

Target SDoH 1: Food Insecurity

Research finds that food insecure adults experience higher rates of chronic health issues including hypertension, diabetes, heart disease, and obesity.[75] Low-income households may be forced to choose between affording treatment for these conditions and food, which can lead to debilitating health complications. Food insecurity also has serious negative impacts on children. Youth facing hunger are at higher risk for developmental problems, problems in school, and obesity.[76] These impacts of food insecurity put individuals facing food insecurity at a higher risk for developing behavioral health issues and decreased employability, among other impacts. The COVID-19 pandemic has only worsened local food insecurity rates. Food pantries are struggling to keep up with demand and face food quality issues due to increased demand and intermittent supply chain disruptions.

Social care management data available through CareAdvisors demonstrates a widespread need for food and housing interventions across Cook County. CareAdvisors received 731 unique patient referrals from six local hospitals over the last 12 months. Of these patients, 72.8% were referred to CareAdvisors for assistance with accessing government benefits (Medicaid, SNAP, TANF, SSI/SSDI, and/or WIC) and 27.2% were referred for assistance with accessing community resources. Of the individuals referred to CareAdvisors to access community resources, 16.9% screened positive for food insecurity.[77] PCH and other safety net providers saw the food insecurity of patients and clients sky-rocket during the pandemic. PCH uses the "Two Item Food Insecurity Screen" derived from the US Department of Agriculture Household Food Security Scale in its health center and collects food security data through client IM+CANS screenings, and develops food security interventions with patients and clients through food pantries, WIC applications and other services. PCH applied for and used tens of thousands of dollars of COVID-19 related supplemental funds to provide gift cards to patients and clients to help with food and housing needs during the pandemic.

Access to healthy food is another important factor needed to support chronic disease prevention for west Cook County residents. When surveyed as part of LUMC's *2019 CHNA*, 29% of survey respondents chose "access to healthy food" as one of the most important factors in their community.[78] In 2018, Loyola University Health System (LUHS) Family Medicine Department found that 40.2% of patients screened were assessed as food insecure. Baseline data suggests community residents experience significant barriers and challenges accessing fresh fruits and vegetables. 82% of survey participants screened positive for FI, 71% ate less than two cups of fruit per day, and 40% of survey participants felt that it was hard or

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75 Feeding America. (n.d.). *Importance of nutrition on health in America.* https://www.feedingamerica.org/hunger-in-america/impact-of-hunger/hunger-and-nutrition

76 U.S. Department of Health and Human Services. (n.d.a). *Food insecurity.* https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/food-insecurity

77 CareAdvisors. (n.d.). *Home*. Retrieved September 4, 2021, from https://care-advisors.com

78 Loyola Medicine. (2019). *Community health needs assessment.* https://www.loyolamedicine.org/assets/documents/2019_chna_report_gottlieb.pdf

extremely hard to access fresh fruits and vegetables in their community.[79] Portions of our service area including Maywood lack full-service grocery stores. Instead, residents must rely on local fast food restaurants and convenience stores where it is difficult to purchase or afford nutritious food.

Community input also found that residents also need education to increase their knowledge of nutrition and to promote healthy eating. In addition, there is a need for a stronger interconnected network of interventions that go beyond just food pantries, such as fresh food delivery programs that target high-risk populations, which are shown to make a dramatic difference in their health outcomes. Hospitals in underserved communities have worked to address the food needs of the community by hosting "Food Farmacies." Outpatient clinics, particularly those serving oncology patients, have established relationships with food banks where they can obtain food boxes for patients to pick up during appointments. FQHCs and Community Mental Health Centers (CMHCs) noted seeing a similar community need and are working with food pantries to help connect their patients with food. However, there is still more need for access to healthy foods and nutrition services.

Target SDoH 2: Housing Instability

Housing instability encompasses one or more of the following characteristics: spending 50% or more of household income on housing, living in substandard or overcrowded conditions, moving frequently, staying with friends and relatives to avoid being unsheltered, and/or having difficulty paying for housing.[80] Similarly, homelessness is typically considered across chronic, transitional, and episodic categories, with chronic homelessness being the most common type.[81] Individuals facing housing instability or homelessness are more likely to experience poor health outcomes when compared to individuals who are stably housed. Research finds that the "stability, quality safety, and affordability" of housing can directly impact health outcomes, as can the physical and social characteristics of the communities in which we live.[82]

Within the WCC's target service area in West Cook County:

- Based on available social care management data, more than 200 Medicaid recipients with a high-risk health condition will face a housing crisis each year.[83]
- CareAdvisors received 731 unique patient referrals from six local hospitals over the last 12 months. Of these patients, 72.8% were referred to CareAdvisors for assistance with accessing government benefits (Medicaid, SNAP, TANF, SSI/SSDI, and/or WIC) and 27.2% were referred for assistance with accessing community resources. Of the individuals referred to CareAdvisors to access community resources, 30.4% screened positive for housing instability.
- Housing Forward served a total of 701 individuals from the WCC's targeted zip codes from July 2020 through July 2021. Of these individuals, 52% were considered at risk for housing instability,

[79] American Academy of Family Physicians. (2020). *2020 Global Health Summit.*

[80] U.S. Department of Health and Human Services. (n.d.b). *Housing instability.* https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/housing-instability

[81] National Coalition for the Homeless. (n.d.). *Homelessness in America.* https://nationalhomeless.org/about-homelessness

[82] Taylor, L. (2018). *Housing and health: an overview of the literature* (Health Affairs Health Policy Brief). Health Policy Brief. https://doi.org/10.1377/hpb20180313.396577

[83] CareAdvisors. (n.d.). *Home*. Retrieved September 4, 2021, from https://care-advisors.com

20% were experiencing homelessness, and 28% were housed through Housing Forward's permanent supportive housing, rapid rehousing, or veteran housing.

During community engagement sessions, participants noted that housing instability is one of the most common reasons that a patient is referred to a social worker. 311 is another common housing resource but tends to not have the bandwidth of providing immediate assistance. Due to high caseloads, social workers, care coordinators, and other clinical and CBO staff lack the capacity to complete comprehensive research on appropriate housing for their cases. Many times, they can only give individuals a listing of shelters in the area. Individuals experiencing homelessness that have high needs are often referred to housing case managers, shelters, or even systems like CareAdvisors to manage housing crisis needs. Despite the value of these resources, many individuals end up on housing waitlists through these referrals. They can wait anywhere from six months to two years to find permanent housing.

Addressed Causes of SDoH of Focus and Process for Selecting SDoH of Focus

Low-income households often have to prioritize their spending, even on basic needs like food, housing, and electricity, and running water. Food insecurity is defined by the USDA as a lack of consistent access to enough food for an active, healthy life.[84] It can range from reduced quality or variety of diet to limited food intake and disrupted eating patterns. When facing food insecurity, individuals often turn to unhealthy coping mechanisms, which may include purchasing cheaper but less nutritious food. These behaviors increase the risk of negative health outcomes and disparities. As an individual's health deteriorates, their employability decreases. This, in turn, further reduces the individual's household income.

In our service area, housing cost burden (defined by HUD as families whose pay is more than 30% of their income for housing) affects households in every community, with rates ranging from 40-68%.[85] Housing cost-burdened households have fewer resources to afford other basic needs such as clothing, basic utilities, and healthcare. The uncertainty and stress created by forced moves, moving frequently, staying with relatives or friends, living in overcrowding situations, and homelessness can contribute to negative health outcomes. Research finds that note that chronic disease is more common among people facing housing instability than among the general population,[86] and that adults facing housing insecurity have reduced access to primary and preventive care.[87]

The WCC conducted a comprehensive analysis of service area needs to identify the most significant factors for health disparities. Sources for our analysis included:

- Community input sessions including town halls, council meetings, virtual events, listening sessions, frontline caregiver surveys, and one-on-one meetings (as outlined in the Community Input section).
- Social service data and published research.
- Data from WCC partners.

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84 U.S. Department of Agriculture. (2021, September 8). *Definitions of food security.* https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx

85 Housing Action Illinois. (2020). *Making rent affordable.* https://housingactionil.org/what-we-do/advocacy/rental-affordability

86 Stahre, M., VanEenwyk, J., Siegel, P., & Njai, R. (2015). *Housing insecurity and the association with health outcomes and unhealthy behaviors*, Washington State, 2011. Preventing Chronic Disease, 12. https://doi.org/10.5888/pcd12.140511

87 Martin, P., Liaw, W., Bazemore, A., Jetty, A., Petterson, S., & Kushel, M. (2019). Adults with housing insecurity have worse access to primary and preventive care. *The Journal of the American Board of Family Medicine*, 32(4), 521–530. https://doi.org/10.3122/jabfm.2019.04.180374

- Elected officials and legislators

As food insecurity and housing instability are often highly correlated, the WCC determined through our analysis that addressing both factors can help achieve better health outcomes for our target service area.

In addition to food insecurity and housing stability, the WCC Social Care Management and Navigation Hub facilitates linkages to 23 other social needs domains including the ones listed here:

- Access to Services
- Career Resiliency/Training
- Childcare
- Clothing
- Education
- Employment Stability
- English Language Skills
- Income (Self-Sufficiency Standards)
- Income (Area Median Income)
- Income (Federal Poverty Level)
- Legal
- Life Skills (Household Management)
- Life Skills (Human Relations)
- Mental Health
- Parenting
- Physical Health
- Safety
- Substance Use
- Support System
- Transportation

[1 - 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.)

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

WCC's collaborative six Core Strategy model assesses each participant's unique SDoH and addresses corresponding needs through partners and community resources. First, member screenings will assess all 25 SDoH including socioeconomic needs, environmental impacts, and health-related factors that collectively influence health outcomes. The platform provides the interoperability capacity to integrate the wide range of tools that WCC partners and affiliates utilize for SDoH patient screenings. The platform includes a number of already embedded standard-based screening tools. Screening results will be available in a dynamic/standardized format ensuring that they can be utilized by third party EHRs, case management systems, and other vehicles of care.

In regards to food insecurity, the WCC includes partnership with three food pantry providers and an older adult meal delivery program. Based on our analysis and community input, the WCC estimates approximately 1,895 high-risk members will experience food insecurity in the service area. To address this social need, the WCC through its food security partners will support expanded access to food pantry, and

mobile food pantry resources throughout the service area. The WCC will also support healthy food delivery for households as well as a medically tailored meal program for older adults.

These programs provide access to free produce, healthy foods and medically tailored meals to residents throughout the service area available for in-person pick-up or delivery. Programs also incorporate interactive nutrition education and facilitate community engagement contributing to improved health outcomes, lower stress, and reduced barriers to access healthy food.

Housing

In regards to housing, the WCC includes partnership with two direct housing providers and the local housing continuum of care. Based on our analysis and community input, the WCC estimates approximately 420 high-risk members will experience housing insecurity in the service area. To address this social need, the WCC through its housing partners will support expanded access to a homelessness prevention program, rapid re-housing program and outreach and diversion program throughout the service area.

Rapid Re-Housing (RRH). Rapid Re-housing is an intervention for individuals and families who are homeless (using the HUD definition) and can become quickly re-housed with limited rental assistance, case management and support to help a household become and remain stably housed. Rapid Re-Housing minimizes the trauma of homelessness by moving individuals and families into stable, permanent housing as quickly as possible through short-to medium-term rental support and supportive services.

Homeless Prevention program helps individuals and families at imminent risk of homelessness to remain in their current housing and classified as high-risk members due to health and social needs stratification. The Homeless Prevention line item will include funding to forestall eviction or near eviction by funding documented past-due rent expenses and, in some cases, security deposits. Homeless prevention program includes client assessment and case management.

Outreach and Diversion: Street Outreach identifies those who are unsheltered and living on the street. Outreach specialists work in the community to identify and build relationships with homeless individuals, working to transition them from street survival. Diversion services address the needs of individuals and families who are imminently homeless. Diversion case management helps households rely on their strengths and support network and identify alternatives to homelessness. Flex Fund distributions help remove barriers by paying one-time or ongoing expenses that will result in an alternative to homelessness.

Our project includes two capital investments designed to help address the food and health disparities identified within our target service area:

- Permanent Supportive Housing Project in Broadview (Partner: Housing Forward): New 16-unit Permanent Supportive Housing development for 30% AMI or below individuals and families who are homeless and have a documented long-term disabling condition, including Transition-Aged Youth, young adults aged 18-24 years who have aged out of the foster care system and are at high risk of becoming homeless, and veterans. Each floor will have eight residential units, for a total of four two-bedroom units for families and 12 one-bedroom units for individuals, with additional common space for tenants. Twenty percent (4) of the units will be handicapped accessible and one will be designed to accommodate sensory, hearing, and visually impaired individuals.
- New Food Pantry in Summit (Partner: Catholic Charities): New community center located at 7437-7439 W. Archer Avenue in Summit, Illinois. Catholic Charities will serve as the entry point and food

pantry anchor at this multi-service site. Funds will be used to purchase equipment for the food pantry and congregate dining area such as refrigerators, freezers, walk-in cooler, shelving units, desks, chairs, commercial stove and oven, prep table, sanitation station, tables and chairs, and other items necessary to outfit the new space.

To improve upon local disparities, the WCC will review baselines of our agreed upon metrics, then set milestones for impact that gauge our ability to influence health outcomes within the targeted populations. The WCC will evaluate our social care management model based on activities, and quality through the following metrics:

Care Plan Completion

- Urgent Case Completion Rate within 24-48 hours
- Expedited Case Completion Rate within 7-10 business days

Programs and Services

- Percent of patients eligible for programs/services
  o Enrolled in services
  o Utilizing ancillary services as part of benefit (i.e., using Medicaid MCO-provided transportation)

Resource Management

- Number of unique individuals provided with resources
- Number of resources provided
- Number of closed loops referrals

Aggregated Closed Loop Referrals in Key Areas

- Housing
- Food Insecurity
- Behavioral Health

[2 - 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.)

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

The disparities identified within our service area can be directly attributed to SDoH. Many individuals in WCC's service area face inequalities across SDoH that negatively impact their health outcomes. Based on the analysis of population health data and patient-level clinical data, as well as demographic and social needs data, the WCC has identified several major contributing factors to health inequity in the community service area related to SDoH.

Root Causes of Health Disparities in the Community Service Area:

- Limited social service resources and challenges navigating the social care system
- Delays in treatment due to poor ability to navigate the complex healthcare system and barriers from SDoH factors
- Poor coordination of care amongst clinical providers and community-based organizations

The WCC's model screens members for all 25 SDoH domains including food and housing, and seamlessly connects them to the supports they need. The WCC's model assesses patients for all SDoH and provides appropriate linkages and follow-up to community resources. Furthermore, the WCC model expands capacity for food and housing security for high-risk members to enhance access for members and improve collaboration between healthcare organizations and community-based organizations. Our data reflect that connecting these individuals with targeted community-based resources can help members address SDoH disparities and achieve better health outcomes.

The WCC synthesized numerous data sources to pinpoint the most serious disparities that impact our service area as well as the root causes behind them. Our interconnected Core Strategies will have near-term, mid-term, and long-term impact on these root causes, enabling members to access the care and social support services they need to thrive.

[3 - 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.)

Works Cited for Social Determinants of Health_Section 9

FORM 10. CARE INTEGRATION AND COORDINATION.

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

Our proposal addresses several key barriers to achieving optimal care integration and coordination in west Cook County:

- Information Fragmentation. Technological barriers limit the data flow of essential information about individual Medicaid members among care providers. This lack of interoperability makes it challenging for providers to cultivate and coordinate comprehensive care among each member's extended care team which may include PCPs and specialists, behavioral health providers, MCOs, nurse care coordinators, pharmacists, lab specialists, and respiratory therapists, among others.
- Care Fragmentation. Patients benefit most when a single touchpoint achieves access to all of the resources they need including MCOs, CBOs, and public benefits. Unfortunately, "one stop" access remains fragmented, increasing the risk that high-risk/hard-to-reach patients receive some services and never engage with multiple delivery systems for others.
- Lack of Holistic Member View. Healthcare plans struggle to achieve 360-degree holistic member views with hard-to-reach members due a lack of coordinated data. Asking clinicians to engage in coordinating a clearinghouse-like consolidation of information would be disruptive within the existing healthcare ecosystem's workflow.
- Limited Time Allocation in Healthcare Visit. Busy medical offices rely on brief appointment slots to accommodate a greater number of patients. Standard visits lack time for a provider to delve into a patient's more complex issues such as SDoH, and educate the patient about the relevant resources available to mitigate SDoH needs.

The WCC's interconnected strategies are designed to overcome these barriers:

- Through our Community Navigation Hub, CHW/SWCM teams will serve as critical advocates for patients, helping them navigate clinical care, social care, and other resource systems through a "one stop" access point with care teams. CHW/SWCM teams will also coordinate with other members of the patient's care team and care managers embedded in our partner organizations

to provide a seamless continuum of care for the member. This model will reduce the typical complexity of processes that patients typically undergo when attempting to access resources; reduce the risk of patients disengaging before receiving full care; and build individual and community capacity by increasing health knowledge and self-sufficiency through a variety of activities that include outreach, community education, informal counseling, social support, and advocacy.

- MCOs play a critical role in the delivery of healthcare to Medicaid patients. Nationally and statewide, over two-thirds of Medicaid members are enrolled in comprehensive managed care plans.[88] The Community Navigation Hub will enable MCOs to make the most of limited interactions with hard-to-reach populations by addressing a broader array of SDoH issues per patient. These efforts will promote collaboration and actionable data sharing between the WCC and health plans, enabling plans to obtain a richer, comprehensive patient view for traditionally hard-to-reach populations and assist members in meeting their healthcare needs.
- The CHW/SWCM training for the Community Navigation Hub will include a deep dive into the referral process for members. This will help CHWs/SWCM teams gain a full understanding of the process from both a member and health plan perspective. Educating CHWs and SWs on clinical and MCO referral workflows will support the flow of supportive data, and provide CHWs and SWs with insight into MCO workflows.
- The WCC Steering Committee includes primary care and specialty physicians, behavioral health providers, social service providers, and local diversity and inclusion leaders, among other key stakeholders. The committee structure will facilitate strategic collaboration to improve care coordination and integration by leveraging partnerships to identify and implement best practices and proven approaches to increased care coordination and integration. Please see the Governance section for a full listing of additional committees.

[1 - 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.)

2. Do you plan to hire community health workers or care coordinators as part of your intervention? Yes/No toggle
Yes

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

Case Management Case Loads
Complex Case Management (15% of total member panel): 16,702
High-Risk Caseload per Care Coordination Staff: 25

Screening and Basic Case Management (50% of total member panel): 55,673
Moderate-Risk Caseload per Care Coordination Staff: 70

$ per member / per month cost

[88] Kaiser Family Foundation. (n.d.). Total Medicaid MCO enrollment – Timeframe 2018. https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[2A - 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.)

3. Are there any managed care organizations in your collaborative? Yes/No toggle
No

3A. If yes, please list the names of the managed care organizations in your collaborative.
N/A

3B. Please describe your collaborative's plans to work with managed care organizations.
Through its governance structure, the WCC will form a MCO Collaboration Committee designed to closely interface with a broader group of Medicaid MCOs. This committee will serve as the liaison between this project and MCOs and will implement a number of strategic initiatives with MCOs including data sharing coordination for engagement of hard-to-reach members, coordinating care management services to avoid duplications of support, and developing payment models. Additionally, Loyola meets with Molina Healthcare on a regular, ongoing basis. In the summer of 2021, we shared our initial project plans with Molina Healthcare to inform our MCO collaboration strategy.

[3 - 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.)

FORM 11. MINORITY PARTICIPATION.

Note on BEP partners/vendors: If one of the members of your collaboration already contracts with a BEP-certified firm or a not-for-profit entity that is majorly controlled and managed by minorities, only include the services of the firm that will be used on this project. To be included, these services must increase the entity's volume of work above the level of services already provided to the collaborating member.

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

Illinois BEP and/or not-for-profits majorly controlled and managed by minorities within the WCC include:
CareAdvisors
Family Focus
Healthcare Alternative Systems
Maywood Medical-Legal Partnership
Proviso Leyden Council for Community Action, Inc.
Quinn Center of St. Eulalia
Real Foods Collective
West Cook YMCA

While we have already identified and included a significant percentage of minority participation, we are committed to furthering BEP initiatives. We have executed and attached commitments as Section 11 Supporting Documents Exhibit 11A to target 20% of HFS Transformational Funding to be paid to BEP vendors.

2. Please describe the respective role of each of the entities listed above, and specify whether they will have a role only during the implementation of your proposal or if they will have a role in the ongoing operation of your transformed delivery system.
CareAdvisors acts as the WCC social care management co-chair. Family Focus, Healthcare Alternative Systems, Maywood Medical-Legal Partnership, Proviso-Leyden Council for Community Action, Quinn Center of St. Eulalia, Real Foods Collective, and the West Cook YMCA are all Foundational Partners within the WCC. As such, each entity will be a part of our governance, have a role in ongoing operation of the project, and receive funding based on services provided. Each entity provides social services including housing, food, counseling, and assistance accessing government available resources. These organizations will assist with training and evaluating our care management team to ensure staff are equipped with knowledge and tools to best meet the needs of the communities within our targeted service area.

[2 - 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.)
Attached: Section 11 Supporting Documentation Exhibit 11A

FORM 12. JOBS.

Existing Employees
1. For collaborating providers, please provide data on the number of existing employees delineated by job category, including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these job levels.
Loyola has approximately 9,000 employees including 1,922 employees within the target service area as reflected in the chart below. The WCC's Foundational Partners and other co-chairs employ approximately 462 staff in our target service area. Our Foundational Partners do not maintain delineated data on employees as requested. All partners have a long-term commitment to hiring locally in diverse underserved communities to help serve their population. Through the WCC's HFS Transformation funding, we plan to hire 60 new staff in the community service area.

Employees by Zip code in the Service Area

Zip Code	Town	Employees
60155	Broadview	64
60153	Maywood	135
60160 60164 60165	Melrose Park	77
60131	Franklin Park	59
60165	Stone Park	16
60104	Bellwood	99
60154	Westchester	137
60162	Hillside	38
60163	Berkeley	25
60171	River Grove	55
60513	Brookfield	145
60804	Cicero	245

60402	Berwyn/ Stickney	469
60130	Forest Park	133
60534	Lyons	67
60546	North Riverside	158

[1 - 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.)

New Employment Opportunities

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

60

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

This project includes the following employment opportunities:

- CHWs (Core Strategy 1): Collaborating entities within the WCC will recruit CHWs with a preference given to individuals residing in our service area. We will focus on hiring CHWs based on shared life experiences and cultural, linguistic, and socioeconomic backgrounds with the communities they will serve.
- Enhanced Behavioral Health Provider Retention - As a part of Core Strategy 5, this project will reduce ongoing local behavioral health staff turnover and unfilled high-need positions through enhanced reimbursement for high-risk patients and add new behavioral health job opportunities in the targeted community.

[3 - 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.)

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

Service Area-Focused Job Placement System

Employment is a key social determinant of health that impacts health outcomes. Thus, the WCC proposes three interconnected strategies to promote workforce development and increase employment opportunities for members served within our targeted service area:

- **Work with local businesses and workforce groups to develop a service area-focused job placement system.** Employment opportunities will include roles needed for the WCC's transformation project as well as community-based roles needed by local businesses. WCC entities will work to cross-promote job opportunities among members served.
- **Identify members with employment disparities and enroll them in the job placement system.** The WCC's social care management model assesses patients across the 25 social determinants of health domains including Employment. Screenings will identify members that are unemployed, underemployed, poverty-wage employed, insecurely employed, or who are seeking new employment opportunities. We will leverage our interoperability network to automate the collection of documents and information typically required during a job search. Depending on each job opportunity, the data collection may include an individual's social security information and work history.

- **Match members with "right fit" job openings and streamline the job placement process.** Our interoperability network will integrate predictive screening to gauge each member's skill sets and unique needs to determine "right fit" employment opportunities. The WCC's EIEx platform will seamlessly deliver candidate data to workforce development partners, ensuring an easier job recruitment process for both employers and applicants.

Employment opportunities embedded within the WCC's project include:

- **Community Health Workers:** The WCC will hire 25 CHWs and 20 SWCMs over the next three years to assist member needs through the Hub. Collaborating entities within the WCC will recruit CHWs with a preference given to individuals residing in our service area. We will focus on hiring CHWs based on shared life experiences and cultural, linguistic, and socioeconomic backgrounds with the communities they will serve.
- **Reduce ongoing local behavioral health staff turnover and unfilled high-need positions through enhanced reimbursement for high-risk patients:** Workforce shortages serve as an additional barrier for residents of west Cook County to obtain the behavioral healthcare they need. Behavioral health organizations participating in the WCC report that locally, there is a 20% gap between current compensation levels and market rates for licensed clinicians. As part of Core Strategy 5, the WCC will provide enhanced reimbursement for high-risk patients, which will provide market rate compensation for 80 licensed behavioral health staff. This will reduce ongoing staff turnover and unfilled high-need positions.
- **Community Consumer Advocates:** Community Consumer Advocates will participate in the WCC's Community Input and Engagement Committee. We envision that this role will provide deep knowledge and representation of our targeted services areas and populations, and support decision-making consistent with community input and established community values. This is a stipend-paid role for one to three individuals not directly linked to any entity participating in the WCC.

[4 - 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.)

FORM 13. QUALITY METRICS.

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

Our proposal aligns with all five Pillars of Improvement included in HFS's Comprehensive Medical Programs Quality Strategy. Although many of our Core Strategies are intentionally designed to impact multiple quality strategy pillars, their primary alignment with HFS's pillars are as follows:

Illinois HFS Quality Strategy Pillar 1: Adult Behavioral Health/
Illinois HFS Quality Strategy Pillar 2: Child Behavioral Health

The WCC's fifth Core Strategy (Increased Community Access to Behavioral Health Services) increases community access to mental health, behavioral health, and SUD specialists by funding the addition of new providers, implementing new mental health and substance use treatment programs for both adults and children, and expanding the use of virtual behavioral health support. The WCC will utilize the best practice recommendations and requirements of the State's forthcoming Pathways to Success (launch planned for early 2022) to adapt our behavioral health interventions for the unique behavioral health needs of the children in our west Cook County service areas.

Our work will also include culturally and linguistically appropriate education and outreach efforts across the community to reduce the social stigma around seeking treatment for mental health and how to access care.

We will also provide enhanced reimbursement for high-risk patients, which will provide enhanced workforce development investment for 125 licensed behavioral health staff. This will reduce ongoing staff turnover and unfilled high-need positions, enabling community members facing behavioral health crises to get the help they need in a timelier manner.

Illinois HFS Quality Strategy Pillar 3: Maternal and Child Health

Utilizing WCC's robust data capabilities to identify high-risk mothers and young children ages 0-3, care teams within the Community Navigation Hub (WCC Core Strategy 1) will engage members and help to connect them with medical providers, community social needs resources, and/or State and federal aid programs through the lens of cultural responsiveness. We will also partner with MCOs to facilitate a referral and enrollment pipeline into MCO programs (e.g., well maternity and child programs, disease management programs, etc.). Finally, we will also facilitate the enrollment of expectant individuals into evidence-based home visiting programs, maximizing the evidence-based interventions that the State already significantly funds through the IDHS. More details about maternal and child health home-visiting programs can be found below under Illinois HFS Quality Strategy Pillar 5: Improving Community Placement.

Illinois HFS Quality Strategy Pillar 4: Equity

WCC's collaborative sixth Core Strategy model will assess the unique SDoH needs of each participating uninsured individual and Medicaid member and address these needs by connecting participants with partners and community resources (WCC Core Strategy 4). We will conduct member screenings that assess all 25 SDoH including socioeconomic needs, environmental impacts, and health-related factors that collectively influence health outcomes. We will leverage CareAdvisors' social care management platform to screen members for 25 SDoH. We will then make screening results available in a dynamic/standardized format so that data can be utilized by third party Electronic Health Records (EHRs), case management systems, and other IT systems. WCC CHW/SWCM teams will then connect members with critical SDoH interventions and resources, with a focus on housing stability and food security.

WCC activities will also increase health equity throughout our targeted service area for members with chronic conditions including asthma, behavioral health, cardiovascular disease, chronic kidney disease, COPD, diabetes/prediabetes, and hypertension. Our coordinated disease management programs (Core Strategy 2) will reduce inequities in healthcare delivery by increasing the quality of and member engagement in outpatient care, potentially leading to a reduction in hospitalizations for vulnerable populations.

Our EIEx (Equity Information Exchange) platform (Core Strategy 3) combines real-time clinical data and social care data from healthcare providers and social care providers in the community service area to address the data challenges of care coordination. CBOs and hospitals will easily be able to access longitudinal records of racial and ethnic minorities and other vulnerable patients to determine individual risk profiles, make informed and strategic decisions about matching clients with community resources and attain closed loop referrals. In addition, they will be able to chart population level changes in care

coordination, such as reduced hospital stays and ED use among ethnic and racial minorities, as reflected in service patterns and other reporting metrics generated by the EIEx.

Illinois HFS Quality Strategy Pillar 5: Improving Community Placement
Care teams within the Hub will also facilitate the coordinated intake of expectant individuals into evidence-based home visiting programs (Core Strategy 6), maximizing the evidence-based interventions that the State already significantly funds through the IDHS. Federal and State assistance programs may include the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Family Case Management, and Better Birth Outcomes/Great Start, among others. The WCC will leverage these funding streams to augment care for hard-to-reach members and remove some of the barriers to care coordination. WCC Foundational Partners can also provide doula home-visiting services and other culturally appropriate prenatal and postnatal resources for participants. To serve additional populations, the WCC will screen members to identify individuals that can benefit from other area home-visiting programs. As one example, Loyola has a home-visiting program designed to meet the needs of individuals 65 and over that are eligible for both Medicare and Medicaid. The program seeks to reduce social isolation via a home visiting program for post hospital discharge, facilitating social interaction during healing. The program works to expand social networks over the course of at-home healing through leisure classes, social clubs, and activities. The goal is to reduce readmission, improve specific chronic disease metrics such as A1c, and facilitate medication and treatment adherence through integration of home and community-based social support into the patient's clinical care plan.

As mentioned above, many of the WCC's six Core Strategies within this proposal intentionally impact more than one of the quality strategy pillars. These complementary strategies collectively support our goal to increase health equity and improve the health outcomes, quality of life, and overall well-being of participating members in west Cook County by implementing a seamless ecosystem approach to addressing whole patient needs.

Proposed Measurable Quality Metrics
The WCC has identified quality metrics that are fundamental to benchmarking our progress towards reducing health disparities, improving care in targeted communities, and implementing sustainable interventions to address needed social supports. All performance metrics will be monitored across race and ethnicity to determine the grant's impact on disparities in service use, hospital stays and visits and referrals, impacts that contribute to the health and wellbeing of at risk, expectant mothers, and infants, people with chronic disease, and people facing housing instability and/or food insecurity. Please see the next sections for our selected metrics by HFS pillars.

[1 - 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.)

2. Does your proposal align with any of the following Pillars of Improvement?
2A. Maternal and Child Health? Yes/No toggle
Yes

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

- Prenatal and Postpartum Care

- Timeliness of Prenatal Care
- C-Section Rate for Low-Risk Women With No Prior Births

Young Children
- Childhood Immunization Status (Combo 3 and Combo 10)
- Well-Child Visits in the First 30 Months of Life
- Child and Adolescent Well-Care Visits

[Maternal and Child Heath - 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.)

2B. Adult Behavioral Health? Yes/No toggle
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.
Follow-up after hospitalization for mental illness
- 7-day
- 30-day

Follow-up after Emergency Department visit for alcohol or other substance use
- 7-day
- 30-day

Follow-Up After High-Intensity Care for Substance Use Disorder
- 7-Day
- 30-Day

[Adult Behavioral Health - 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.)

2C. Child Behavioral Health? Yes/No toggle
Yes

Child Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.
Follow-Up After Hospitalization for Mental Illness—6–17 years of age stratification
- 7-Day
- 30-Day

Follow-Up After Emergency Department Visit for Mental Illness—6–17 years of age stratification
- 7-Day
- 30-Day

- Mobile Crisis Response Services That Result in Hospitalization

- Visits to the Emergency Department Visit for Behavioral Health Services That Result in Hospitalization
- Overall Number and Length of Behavioral Health Hospitalizations
- Number of Repeat Behavioral Health Hospitalizations

[Child Behavioral Health - 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.)

2D. Equity? Yes/No toggle
Yes

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

- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Controlling High Blood Pressure (CBP)
- Adults' Access to Preventive/Ambulatory Health Services (AAP)

[Equity - 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.)

2E. Community-Based Services and Supports? Yes/No toggle
Yes

[Community-Based Services and Supports - 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.)

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.

- Long Term Services and Supports Comprehensive Care Plan and Update
- Successful Transition after Long-Term Care Stay

3. Will you be using any metrics not found in the quality strategy? Yes/No toggle
Yes

3A. If yes, please propose metrics you'll be accountable for improving and a method for tracking these metrics.
Member satisfaction

[3A - 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.)

FORM 14. MILESTONES.

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

Please refer to the Section 14 Supporting Document, Exhibit 14 Milestones included with this application.

[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.)

Attached: Section 14 Supporting Document, Exhibit 14

FORM 15. BUDGET.

1. ((Budget template upload))

2. Individuals Served Each Year. Please project the number of individuals that will be served in each year of funding.
(Numerical fields)
Year 1: 41,750
Year 2: 55,673
Year 3: 55,673
Year 4: 55,673
Year 5: 55,673
Year 6: 55,673

3. Alternative Payment Methodologies. Outline any alternative payment methodologies that your proposal might utilize for receiving reimbursement for services from MCOs.
There are several models for outcomes-based contracts. Under the CMS advanced payment models for Medicare, the allocation of the percentage of the shared savings to the contracting entity is based on the level of risk assumed by the contracting entity. If the contracting entity is willing to accept downside risk, the contracting entity is allocated up to 80% of the upside or downside. Another model is for HFS and/or MCOs to pay a flat Per Member Per Month (PMPM) care management fee and then the shared savings or loss is split 50/50 with the contracting entity.

[Alternative Payment Methodologies - 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.)

FORM 16. SUSTAINABILITY.

Include a narrative that describes how your budget will decrease reliance on Transformation funding over time and how reimbursements for services and other funding sources will increase and establish sustainability over time. (i.e. how will your project continue to operate without HTC funding?) In particular, include how services that address social determinants of health will be funded on an ongoing basis (for example, through existing payment models, alternative payment methodologies for Medicaid services, or through other funding sources). In your narrative, highlight any key assumptions that are critical to making your project sustainable.

Our approach is built on a sustainable model of care. Transformation funding plays a significant role in the project budget during Years 1-3. During Years 4 and 5, we will transition to operating through value-based payment funding through MCOs, based on the impact on shared cost savings.

We chose this sustainability strategy based on our Co-Chair's successful experiences in managing patients under a sustainable value-based payment and shared savings pool model. Loyola currently participates in a number of value-based contracts for commercial, Medicaid, and Medicare Advantage plans. Each agreement's levels of risk and reward vary based on market needs, system capabilities, provider and network preferences, and cost savings. These agreements target strategies for proactive member outreach, delivery of high value care to minimize gaps in member care, and continuity of care. Each contract also identifies sources of low-value care that may represent opportunities for cost containment and reductions in avoidable or unnecessary member care. Providers agree to share a portion of cost savings with us to create a shared savings pool. This pool provides for Loyola's ongoing programming costs and provides a platform for investing in outreach, infrastructure, and expansion. Through this sustainability model, Loyola has saved payers millions of dollars in medical costs while maintaining and improving on its quality metrics.

Based on these successes, the WCC will utilize value-based care coordination contracting to promote sustainability over the course of this project.

Sustainability of SDoH Interventions
The WCC's interventions for Food Insecurity and Housing Instability will continue after this project through a combination of alternative payment methods and private support. As an example, Housing Forward will coordinate with the primary care medical home of each member living in permanent supportive housing in Broadview. Shared cost savings will be categorized as medical loss ratio expenses. Private support (such as donations and foundation grants) will provide additional funds to support these types of interventions for our communities, the uninsured and other interventions such as advancing Medical-Legal Partnerships which addresses the social and legal health-harming needs of vulnerable populations after the project.

Sustainability of Workforce Development Efforts
Revenue from large employers seeking to hire staff in the service area will support the WCC's virtual job placement system, enabling it to provide vital connections between local job-seeking members and employers after the conclusion of this project.

[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.)

West Cook Coalition (WCC)
November 2021 HFS Healthcare Transformation Application
Exhibit 2A, Section 2. Letters of Commitment

LOYOLA MEDICINE

November 11, 2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, Loyola Medicine is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

Zip Code	Service Area
60104	Bellwood
60130	Forest Park
60131	Franklin Park
60153	Maywood
60154	Westchester
60155	Broadview

Zip Code	Service Area
60160	Melrose Park
60163	Berkeley
60162	Hillside
60164	Northlake
60165	Stone Park
60171	River Grove

Zip Code	Service Area
60402	Berwyn/Stickney
60501	Summit
60513	Brookfield
60534	Lyons
60546	North Riverside
60804	Cicero

The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.

LOYOLA
MEDICINE

4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

Loyola Medicine is a healthcare system (Nonprofit) serving the target area and population of the WCC. Our mission is to provide comprehensive healthcare to all with emphasis on the poor and vulnerable.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in the western suburbs of Chicago.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

Loyola Medicine agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Richard K. Freeman, MD, MBA, FACS
Executive Vice President and Regional Chief Clinical Officer
Professor of Surgery
Loyola Medicine
[redacted]

Pillars Community Health

Healing. Caring. Educating.

October 21, 2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, Pillars Communty Health is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

Zip Code	Service Area
60104	Bellwood
60130	Forest Park
60131	Franklin Park
60153	Maywood
60154	Westchester
60155	Broadview

Zip Code	Service Area
60160	Melrose Park
60163	Berkeley
60162	Hillside
60164	Northlake
60165	Stone Park
60171	River Grove

Zip Code	Service Area
60402	Berwyn/Stickney
60501	Summit
60513	Brookfield
60534	Lyons
60546	North Riverside
60804	Cicero

The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,

5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

Pillars Community Health is a nonprofit organization that has served part of the target area and the target population of the WCC for 100 years. Pillars Community Health is an FQHC and licensed Community Mental Health Center and SUPR provider. We provide physical, oral, and behavioral health services to approximately 10,000 individuals annually. We also partner with the Illinois Coalition Against Domestic Violence and Illinois Coalition Against Sexual Assault to provide crisis support and advocacy, emergency shelter and therapy services to survivors as well as prevention education and awareness. Our mission is to improve the health or our communities and empower individuals through compassionate, whole-person care.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness. Although patients and clients from all areas access our services, our primary service areas are the Townships of Lyons, Proviso, Berwyn, Riverside, Cicero, Stickney, and southeast DuPage County.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

Pillars Community Health agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Angela Curran
President and CEO
333 North LaGrange Road
LaGrange Park, Illinois 60525
[redacted]
acurran@pchcares.org

CareAdvisors

November 16, 2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, CareAdvisors is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

CareAdvisors is a minority-owned, digital healthcare company that offers software and support to build community ecosystems for social care management. We provide the only open-source software for the equitable exchange of clinical and human services data. Additionally, through our software, clients can access social care resources, automation tools for government benefits enrollment and management of value-based contracting.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in throughout Chicagoland.

The target population to be served by the WCC includes:

Zip Code	Service Area
60104	Bellwood
60130	Forest Park
60131	Franklin Park
60153	Maywood
60154	Westchester
60155	Broadview

Zip Code	Service Area
60160	Melrose Park
60163	Berkeley
60162	Hillside
60164	Northlake
60165	Stone Park
60171	River Grove

Zip Code	Service Area
60402	Berwyn/Stickney
60501	Summit
60513	Brookfield
60534	Lyons
60546	North Riverside
60804	Cicero

The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.

CareAdvisors

3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

CareAdvisors agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

Chris Gay
Chief Executive Officer
515 N. State Street, Suite 1025
[redacted]
chris@care-advisors.com

AGEOPTIONS

Connecting Older Adults with Community-based Resources and Options

October 20, 2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, AgeOptions is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition and AgeOptions receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

Zip Code	Service Area
60104	Bellwood
60130	Forest Park
60131	Franklin Park
60153	Maywood
60154	Westchester
60155	Broadview

Zip Code	Service Area
60160	Melrose Park
60163	Berkeley
60162	Hillside
60164	Northlake
60165	Stone Park
60171	River Grove

Zip Code	Service Area
60402	Berwyn/Stickney
60501	Summit
60513	Brookfield
60534	Lyons
60546	North Riverside
60804	Cicero

The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention,

1048 Lake Street, Suite 300
Oak Park, Illinois 60301-1102
phone (800)699-9043
(708)383-0258
fax (708)524-0870
TTY (708)524-1653
www.ageoptions.org

peer support, care coordination and expansion of evidence-based treatments and interventions.

AgeOptions is a nonprofit organization serving the target area and population of the WCC. AgeOptions is the Area Agency on Aging of suburban Cook County. Our mission is to innovate, partner, and advocate to improve systems and services in order to strengthen communities so people thrive as they age.

We serve vulnerable populations with a particular focus on serving older adults who are low-income, minority individuals, many of whom face health disparities. AgeOptions operates the statewide network hub for health promotion programming for older adults in Illinois—Illinois Pathways to Health.. We also have the Avisery program which trains professionals in Medicare and Medicaid so that their clients can best make their healthcare affordable. AgeOptions also oversees a network of agencies provided meals to older adults. With funding, AgeOptions will leverage these programs and more for the success of WCC.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

AgeOptions agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Diane Slezak
President & CEO
1048 Lake Street, Suite 300
Oak Park, IL 60301
[redacted]
diane.slezak@ageoptions.org

BEDS PLUS

SHELTER | PREVENTION | HOUSING

September 30, 2021

Brielle Osting
Sr. Community Engagement Manager
CareAdvisors
515 N. State Street
Suite 1025
Chicago, IL 60654

Dear Ms. Osting:

Through this letter of commitment, BEDS Plus Care is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

Zip Code	Service Area
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60155	Broadview

Zip Code	Service Area
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60164	Northlake
60165	Stone Park
60171	River Grove

Zip Code	Service Area
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60513	Brookfield
60534	Lyons
60546	North Riverside
60804	Cicero

The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.

4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

BEDS Plus Care is a homeless services organization (Nonprofit) serving the target area and population of the WCC. Our mission is to stabilize vulnerable individuals through housing and supportive services.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in the west and southwest suburbs of Cook County.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

BEDS Plus Care agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Tina Rounds
Executive Director

BEDS Plus Care
9601 Ogden Avenue
La Grange, IL 60525

[redacted]

rounds@beds-plus.org

BEYOND HUNGER

10/15/2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, Beyond Hunger is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

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The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

BEYOND HUNGER

Beyond Hunger is a hunger relief agency (Nonprofit) serving the target area and population of the WCC. Our mission is to harness the power of communities to end hunger.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing hunger in 13 zip codes across Cook County, including portions of Chicago and its near-west Suburbs.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

Beyond Hunger agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Michele Zurakowski
CEO
Beyond Hunger
848 Lake Street, Oak Park, IL 60301
[redacted]
michele@gobeyondhunger.org

CATHOLIC CHARITIES
ARCHDIOCESE OF CHICAGO

10/21/2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, Catholic Charities of the Archdiocese of Chicago ("Catholic Charities") is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

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Zip Code	Service Area
60402	Berwyn/Stickney
60501	Summit
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60546	North Riverside
60804	Cicero

The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

CATHOLIC CHARITIES
ARCHDIOCESE OF CHICAGO

Catholic Charities is a 501(c)(3) (Nonprofit) serving the target area and population of the WCC. The Agency fulfills the Church's role in the mission of charity to anyone in need by providing compassionate, competent, and professional services that strengthen and support individuals, families, and communities based on the value and dignity of human life.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness across Cook and Lake Counties.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

Catholic Charities agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Elida Hernandez
Chief Financial and Administrative Officer
721 N. LaSalle Chicago, IL 60654
[redacted]
ehernand@catholiccharities.net

October 15, 2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, Housing Helpers, Inc. is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

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60162	Hillside
60164	Northlake
60165	Stone Park
60171	River Grove

Zip Code	Service Area
60402	Berwyn/Stickney
60501	Summit
60513	Brookfield
60534	Lyons
60546	North Riverside
60804	Cicero

The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention,

peer support, care coordination and expansion of evidence-based treatments and interventions.

Housing Helpers, Inc. is a nonprofit housing rehabilitation and advocacy organization serving the target area and population of the WCC. Our mission is to redevelop distressed and vacant homes as affordable housing for first-time home owners.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in the Village of Maywood.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

Housing Helpers, Inc. agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Sarah Lira
Executive Director
602 N 3rd Ave
Maywood, IL 60153
[redacted]
housinghelpersinc@gmail.com

[redacted]
dotloop verified
10/15/21 1:04 PM EDT
ZUNG-VEW2-NBCN-BDE1

Wayne Beals
President
408 N 5th Ave
Maywood, IL 50153
[redacted]

housing FORWARD
ending homelessness

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, Housing Forward is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

Zip Code	Service Area	Zip Code	Service Area	Zip Code	Service Area
60104	Bellwood	60160	Melrose Park	60402	Berwyn/Stickney
60130	Forest Park	60163	Berkeley	60501	Summit
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60155	Broadview	60171	River Grove	60804	Cicero

The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

Housing Forward is a human services nonprofit serving the target area and population of the WCC. Our mission is to is to transition people from housing crisis to housing stability. We offer a full range of programs and services that are participant-centered, integrated, modeled using best practices and designed to reduce the length of time and impact of trauma associated with homelessness and housing instability.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in 24 communities in west suburban Cook County.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

Housing Forward agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

Lynda Schueler
Executive Director

lschueler@housingforward.org

Ann & Robert H. Lurie
Children's Hospital of Chicago®

Matthew M. Davis, MD, MAPP
Chair, Department of Pediatrics
Founders' Board Centennial
Professor in Pediatrics
Executive Vice-President and Chief,
Community Health Transformation
-- Patrick M. Magoon Institute for
Healthy Communities
Ann & Robert H. Lurie Children's
Hospital of Chicago
Professor of Pediatrics, Medicine,
Medical Social Sciences, and
Preventive Medicine
Northwestern University Feinberg
School of Medicine
mmdavis@luriechildrens.org

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, Ann & Robert H. Lurie Children's Hospital is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

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The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area.
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security.

Ann & Robert H. Lurie
Children's Hospital of Chicago®

5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

Ann & Robert H. Lurie Children's Hospital is an Illinois not-for-profit corporation serving the target area and population of the WCC. Our mission is to serve the health needs of any child who needs medical care, at our hospital and through our network of pediatric generalists and subspecialists, and informed by the latest research in children's health care.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness and other social stressors such as food insecurity in the Chicagoland area, including West Cook County, by partnering with community-based service organizations to address the social needs of children and their families.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

Ann & Robert H. Lurie Children's Hospital agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

11/5/2021

Matthew M. Davis, M.D., M.A.P.P.
Ann & Robert H. Lurie Children's Hospital of Chicago
Executive VP and Chief of Community Health Transformation
[redacted]
Email: mmdavis@luriechildrens.org

LOYOLA UNIVERSITY CHICAGO
SCHOOL of LAW

Office of the Dean
Water Tower Campus
Philip H. Corboy Law Center
25 E. Pearson Street | Chicago, Illinois 60611
Phone 312.915.7120 | Fax 312.915.6911| LUC.edu/law

November 1, 2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, the Maywood Medical-Legal Partnership, which is an interdisciplinary partnership of Loyola University Chicago School of Law's Health Justice Project with Loyola Medicine and Loyola University Chicago Stritch School of Medicine, is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

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The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

The Maywood Medical-Legal Partnership, is an interdisciplinary collaboration of Loyola University Chicago School of Law's Health Justice Project with Loyola Medicine and Loyola University Chicago Stritch School of Medicine (Nonprofit) serving the target area and population of the WCC. The mission of the Maywood MLP is to address the health harming legal needs of vulnerable patients of Loyola Medicine health facilities in western Cook County, most of whom also face the ongoing burdens of generational and systemic oppression and negative social determinants of health.

The Maywood MLP serves vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in the western Cook County suburbs that serve as locations for Loyola Medicine health care facilities.

The Maywood MLP and Loyola University Chicago School of Law commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

The Maywood Medical-Legal Partnership agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that

can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

Zelda B. Harris
Interim Dean
Loyola University Chicago School of Law
25 E. Pearson Street
Chicago, IL 60611
[redacted]
zharris@luc.edu

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

October 29, 2021

Director Theresa Eagleson
IDHFS
Prescott Bloom Building
201 South Second Street
Springfield, IL 62763

Letter of Commitment to participate in the Illinois Department of Health and Family Services Healthcare Transformation Collaborative

Dear Director Eagleson,

For over 50 years the Pav YMCA has played a part in strengthening communities. The Y is the leading nonprofit committed to strengthening community by connecting all people to their potential, purpose and each other. Working locally, we focus on empowering young people, improving health and well-being and inspiring action in and across communities

We serve vulnerable populations including low-income individuals, ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in the communities of Berwyn, Cicero, Stickney, Forest View, Riverside and North Riverside.

We commit to participating in the West Cook Coalition program activities in their efforts to transform healthcare in the West Cook area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

The Pav YMCA agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the Program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Jamie Kucera
Executive Director/CEO
Pav YMCA
2947 S. Oak Park Ave
Berwyn, IL 60402
[redacted]
jkucera@pavymca.org

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

October 29, 2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, The Pav YMCA is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

Zip Code	Service Area
60104	Bellwood
60130	Forest Park
60131	Franklin Park
60153	Maywood
60154	Westchester
60155	Broadview

Zip Code	Service Area
60160	Melrose Park
60163	Berkeley
60162	Hillside
60164	Northlake
60165	Stone Park
60171	River Grove

Zip Code	Service Area
60402	Berwyn/Stickney
60501	Summit
60513	Brookfield
60534	Lyons
60546	North Riverside
60804	Cicero

The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

The Pav YMCA is a Nonprofit Community organization serving the target area and population of the WCC. Our mission is to strengthen community by connecting all people to their potential, purpose and each other. Working locally, we focus on empowering young people, improving health and well-being for all and inspiring action in and across communities

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in the communities of Berwyn, Cicero, Stickney, Forest View, Riverside and North Riverside.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

The Pav YMCA agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Jamie Kucera
Executive Director, Pav YMCA
2947 S. Oak Park Ave.
Berwyn, IL 60402
[redacted]
jkucera@pavymca.org

PROVISO PARTNERS FOR HEALTH

October 15, 2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, Proviso Partners for Health is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

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60165	Stone Park
60171	River Grove

Zip Code	Service Area
60402	Berwyn/Stickney
60501	Summit
60513	Brookfield
60534	Lyons
60546	North Riverside
60804	Cicero

The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention,

peer support, care coordination and expansion of evidence-based treatments and interventions.

Proviso Partners for Health is a community-driven multi-sector coalition serving the target area and population of the WCC. Our mission is to build capacity to address racial, health, and economic inequities through partnerships while leveraging community assets and wisdom.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in Proviso Township.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

Proviso Partners for Health agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Dr Lena Hatchett
Executive Team Leader
2160 S 1st Ave
Maywood, IL 60153
[redacted]
lhatchett@luc.edu

[redacted]

Sarah Lira
Executive Team Member
602 N 3rd Ave
Maywood, IL 60153
[redacted]

QUINN CENTER
OF SAINT EULALIA

November 17, 2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, THE QUINN CENTER OF ST. EULALIA is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

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Zip Code	Service Area
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The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

QUINN CENTER
OF SAINT EULALIA

QUINN CENTER OF ST. EULALIA is a NON-PROFIT ORGANIZATION serving the target area and population of the WCC. Our mission is to partner with the people of Proviso to build an inclusive culture of justice, health and peace.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in all villages that comprise the Proviso Township.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

THE QUINN CENTER OF ST. EULALIA agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Kristen K. Mighty, PhD, MPH
Executive Director
815 Lexington Street, Maywood, IL 60153
[redacted]
director@quinncenter.org

REAL FOODS COLLECTIVE

October 15, 2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, Real Foods Collective is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

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60164	Northlake
60165	Stone Park
60171	River Grove

Zip Code	Service Area
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60501	Summit
60513	Brookfield
60534	Lyons
60546	North Riverside
60804	Cicero

The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,

REAL
FOODS
COLLECTIVE

5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

Real Foods Collective is a non-profit organization serving the target area and population of the WCC. Our mission is to create economic opportunity by mobilizing the power of food, community, and connection.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in the Proviso Township, specifically Maywood, Broadview, Bellwood, Melrose Park and Stone Park, as well as in the Austin community.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

Real Foods Collective agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Mary Mora, MS, RDN, CDCES
Co-Founder Real Foods Collective
33 Legion Street
Maywood, IL 60513
[redacted]
Realfoodscollective@gmail.com

Proviso Leyden Council for Community Action, Inc.

October 12, 2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, Proviso Leyden Council for Community Action, Inc. is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

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Zip Code	Service Area
60402	Berwyn/Stickney
60501	Summit
60513	Brookfield
60534	Lyons
60546	North Riverside
60804	Cicero

411 W. Madison Street
P. O Box 950
Maywood, IL 60153
(708) 450-3500 Office (708) 236-5184 Fax

The goals of the WCC are:

1. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
2. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.
3. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
4. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
5. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.

Proviso Leyden Council for Community Action, Inc. is an Illinois not for profit corporation serving the target area and population of the WCC. Our mission is to advocate for social change by promoting community development and empowering people through education, training and supportive services.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in the Proviso and Leyden townships and the west side of Chicago.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

Proviso Leyden Council for Community Action, Inc. agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Bishop Dr. Claude Porter
President and CEO
bishopporter@plcca.org

Access to Care
FILLING THE GAP FOR THE UNINSURED

2225 Enterprise Drive
Suite 2507
Westchester, IL 60154

T 708.531.0680
F 708.531.0686
www.accesstocare.org

October 6, 2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, Suburban Primary Health Care Council (DBA: Access to Care) is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

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60171	River Grove

Zip Code	Service Area
60402	Berwyn/Stickney
60501	Summit
60513	Brookfield
60534	Lyons
60546	North Riverside
60804	Cicero

The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention,

Access to Care
FILLING THE GAP FOR THE UNINSURED

2225 Enterprise Drive
Suite 2507
Westchester, IL 60154

T 708.531.0680
F 708.531.0686
www.accesstocare.org

peer support, care coordination and expansion of evidence-based treatments and interventions.

Suburban Primary Health Care Council (DBA: Access to Care) is a 501(c)(3) (Nonprofit) serving the target area and population of the WCC. The Council's mission is to facilitate access to primary health care services to residents of suburban Cook County and northwest Chicago who lack such access because of financial barriers. It has successfully fulfilled this mission since 1988 through its **Access to Care** (ATC) program. Over 130,000 unduplicated individuals have been provided medical services because of Access to Care, many of them for several years.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in suburban Cook County and northwest Chicago.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

Suburban Primary Health Care Council (DBA: Access to Care) agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Kathryn Franklin
President and CEO

Suburban Primary Health Care Council
2225 Enterprise Drive, Suite 2507
Westchester, IL 60154
[redacted] | E: kathif@accesstocare.org

Healthcare Alternative Systems, Inc.

Providing a continuum of multicultural and bilingual (English/Spanish) behavioral care and social services that empower individuals, families and communities

www.hascares.org

CHICAGO LOCATIONS

Main Office
2755 W. Armitage Ave.
Chicago, Illinois 60647
Tel. (773) 252-3100
Fax (773) 252-8945

4534 S. Western Ave.
Chicago, Illinois 60609
Tel. (773) 254-5141
Fax (773) 254-5753

1949 N. Humboldt Blvd.
(Men's Residence)
Chicago, Illinois 60647
Tel. (773) 252-2666
Fax (773) 252-0527

1866 N. Milwaukee Ave.
(Transitional Housing)
Chicago, Illinois 60647
Tel. (773) 782-4734
Fax (773) 782-8160

5001 W. Fullerton Ave
Chicago, IL 60639
Tel. (773) 235-5100
Fax (773) 692-1011

5005 W. Fullerton Ave.
Chicago, Illinois 60639
Tel. (773) 745-7107
Fax (773) 745-9902

210 N. Ashland Ave.
(Medication Assisted Recovery)
Chicago, Illinois 60607
Tel. (312) 948-0200
Fax (312) 948-0600

SUBURBAN LOCATIONS

373 S. County Farm Rd.
Wheaton, Illinois 60187
Tel. (630) 344-0001
Fax (630) 344-0206

1115 N. 23rd Avenue
Melrose Park, Illinois 60160
Tel. (708) 345-3632
Fax (844) 616-2536

1915-17 W. Roosevelt Rd.
Broadview, Illinois 60155
Tel. (708) 498-0200
Fax (844) 616-2536

2644 Dempster St.
Suite 115
Park Ridge, IL 60068
Tel. (847) 824 – 17000
Fax (847) 886 – 1005

10/06/2021

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, Healthcare Alternative Systems, Inc. is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

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Zip Code	Service Area
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60804	Cicero

The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

Healthcare Alternative Systems, Inc. is a 501(c)3 Nonprofit organization serving the target area and population of the WCC. Our mission is to provide a continuum of multicultural and bilingual (English/Spanish) behavioral care and social services that empower individuals, families and communities.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in Chicagoland and West Suburbs.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

Healthcare Alternative Systems, Inc. agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Marco E. Jacome, MA, LPC, CAADC, CEAP
Chief Executive Officer
2755 W. Armitage Ave.
Chicago, IL 60647
[redacted]
mjacome@hascares.org

INSERT ORGANIZATION LETTERHEAD

DATE

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, The West Cook YMCA is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

The target population to be served by the WCC includes:

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The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,
5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

INSERT ORGANIZATION LETTERHEAD

The West Cook YMCA is a Health and Wellness (Nonprofit) serving the target area and population of the WCC. Our mission, rooted in Judeo-Christian tradition, is dedicated to developing the spirit, mind, and body of all persons through quality leadership, programs and services, in cooperation with community groups for the common good.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in primarily the following villages: Oak Park, River Forest, Forest Park, Maywood, Melrose, Franklyn Park, Bellwood, Broadview,

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

The West Cook YMCA agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,
Signature of AR

[redacted]

Philip Jiménez
President & CEO
The West Cook YMCA
255 S. Marion Street
Oak Park, IL 60302
[redacted]
Phillip@westcookymca.org

FAMILY FOCUS
Nurturing Children • Strengthening Families

10/08/21

Letter of Commitment to participate in the West Cook Coalition for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative

Through this letter of commitment, Family Focus is expressing its intention to participate in the West Cook Coalition, as detailed below, should that coalition receive the funding support of the Department of Healthcare and Family Services Health Care Transformation Collaboratives.

The West Cook Coalition ("WCC") is a collaborative being led by Loyola Medicine, Pillars Community Health and CareAdvisors, Inc. to address the social vulnerability to health inequities and poor health outcomes identified by HFS for several zip codes and communities in west suburban Cook County.

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The goals of the WCC are:

1. Enhanced engagement and access to care, for high-risk, high need Medicaid recipients and uninsured adults who reside in the WCC service area
2. Enhanced connection of WCC attributed members to medical homes and disease management programs available through our coalition partners or Medicaid MCOs, with a reduction in avoidable complications through self-care practices and community health worker engagement.
3. Through information technology, care management platforms, screenings and principles of interoperability, improve creation and use of holistic health care records for attributed members, including medical, behavioral and social elements.
4. Develop CHW model to help connect members with critical SDoH interventions and resources, focusing on housing and food security,

5. Address limited access to BH resources for attributed members and expand access to mental health and substance use disorder services through expanded early intervention, peer support, care coordination and expansion of evidence-based treatments and interventions.

Family Focus is a nonprofit serving the target area and population of the WCC. Our mission is to invests in strengthening families and their children in Chicago and NE Illinois so they build social capital and achieve upward economic mobility through high-quality innovative programs and services, grounded in anti-racism and social justice.

We serve vulnerable populations including low-income individuals, racial and ethnic minorities facing health disparities, patients with multiple chronic conditions and individuals experiencing homelessness in the 60804, 60153, 60160, 60164, 60165, 60402, 60501 zipcodes.

We commit to participating in the WCC program activities in its efforts to transform healthcare in the West Cook County area. We recognize the many regional benefits of this project, and the innovative approach taken to create meaningful partnership that is more likely to serve individuals at high risk. The proposed investment will strengthen our communities by reducing health disparities, improving access to care and offering sustainable solutions in bridging clinical, social and behavioral care to underserved communities in the western Cook County areas.

Family Focus agrees to work collaboratively with WCC partners and other organizations in our community to ensure our goals are in alignment with the goals of the program that can demonstrate a measurable outcome, while expanding available solutions through the sharing of promising and sustainable practices with other jurisdictions.

Sincerely,

[redacted]

Sherneron Hilliard
Senior Vice President of Programs and Impact
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[redacted]
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West Cook Coalition (WCC)
November 2021 HFS Healthcare Transformation Application
Exhibit 5A, Section 5. Community Engagement Strategies for Direct Community Input

Strategy	**Framework**	**Audience/s**	**Reach**	**Total Participants***
Focus groups with community leaders	In person breakfast gatherings of individuals that have a broad understanding of community identity, resources, and needs	Local civic, business, healthcare, and nonprofit leaders	2 in-person events: ● Berwyn, Cicero, and Summit focus ● Proviso and Leyden townships focus	24 Participants
Virtual town halls open to the public	Facilitated 60-minute discussions providing opportunity for broad local input	Participants included local CSWs, community and behavioral health specialists, CBOs, State and local agencies, hospital and health system leaders and public health advocates	2 online events: ● Proviso and Leyden townships focus ● Berwyn and Cicero focus	56 Participants
Survey	34-question online survey spanning local social service needs, utilization of resources, and effectiveness of interventions	CSWs and behavioral health specialists with an emphasis on the west Cook County service area	Distributed January-November 2020	83 Respondents
1:1 Interviews	In-depth 60-minute discussions with key constituents not engaged through other strategies	Community leaders unable to attend two community breakfasts; other leaders, frontline caregivers based in service area	Conducted January-September 2021	17 Interviewees (Includes 6 community leaders and 11 CHWs)
Legislative Convening	Facilitated 60-minute discussion introducing the WCC, soliciting feedback on communities and model	Federal and state senators, federal and state representatives within the region targeted, city township mayors, and county commissioners	1 event engaging political leaders representing Cicero, Summit, Leyden, and Proviso	26 participants

West Cook Coalition (WCC)
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Exhibit 14, Section 14. Milestones

The following list includes milestones and activities for Year 1, Year 2, and Year 3 of the WCC. Year 1 includes a calendar of milestones by month in three parts – Planning, Staffing and Infrastructure, and Program Launch. Milestones for Years 2 and 3 are calendared quarterly.

Year 1

Planning and Implementation	Year 1 Months from Contract											
Task and Milestones	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Planning												
Project Kick off Meeting	X											
Launch weekly Steering Committee meetings; complete detailed work plan and task timeline by quarter including detailed description of budget items requiring Steering Committee approval	X											
Finalize Governing Board and bylaws; begin convening meetings	X											
Finalize resource allocations and measurable quality metrics with HFS, and establish quarterly meetings		X										
Inventory existing technology across partners and affiliates; begin technology pre-implementation design to align patient panel for each partner; identify key use cases and gather requirements.	X	X	X									
Establish working structure for the WCC's model spanning all participants including WCC members, CBOs, provider groups, and additional partners and vendors	X	X	X									
Identify overlaps in coverage within the partner network; determine placement of CHW/SW teams and identify CBO partners for SDoH interventions	X	X	X									
Establish data sharing agreements among new WCC partners and with affiliate organizations; negotiate and/or revise and execute updated agreements with existing WCC partners and consultants		X	X	X	X	X	X	X	X	X	X	X
Begin conducting semi-annual review of community health needs						X						
Establish quality assurance and performance standards				X						X		

Planning and Implementation	Year 1 Months from Contract											
Task and Milestones	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Establish care coordination pathway workflows to support referrals among PCPs, other institutions, and specialists; identify opportunity areas and care coordination gaps			X	X	X							
Create subcommittees for all targeted interventions, establishing leads and best practices for each intervention area			X	X	X							
Quarterly Update local government agencies												
Staffing and Infrastructure												
Select key vendors in accordance with local hiring goals		X										
Finalize hiring plan		X										
Develop detailed milestones for active member engagement throughout Year 1		X										
Begin development of Capital Investment Projects			X									
Develop/adapt curriculum for CHW training		X	X									
New staff training and onboarding				X	X	X						
Complete program related hiring						X						
Intervention specialist training							X	X	X			
Program Launch												
Register all WCC partners and affiliates for Equity Information Exchange (EIEx)									X			
Conduct pre-implementation design of care coordination and related interventions based on target population segments	X	X	X									
Initiate interventions around food security						X						
Initiate interventions around homelessness						X						
Launch new behavioral health programing										X		
16-unit Permanent Supportive Housing Available												X
Refine survey of food and housing security needs							X	X	X	X	X	X
Individual needs assessment							X	X	X	X	X	X

Planning and Implementation	Year 1 Months from Contract											
Task and Milestones	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Begin member and patient engagement and program enrollment							X	X	X	X	X	X
Conduct ongoing targeted outreach to different stakeholders							X	X	X	X	X	X
Conduct community engagement campaigns for CHWs and CBOs							X	X	X	X	X	X

Year 2

Implementation and Expansion	Year 2			
Task and Milestones	**Q1**	**Q2**	**Q3**	**Q4**
Enhance social care activities by reviewing the impact and intervention models through community meetings with participants and providing insights to Steering Committee for changes	X			
Case study development on impact across programs	X			
Begin impact analysis	X			
Assess active engagement milestone based on number of members successfully engaged quarterly	X			
Launch SUD investment-based impact assessments		X		
Review quarterly quality metrics at Steering Committee level across interventions	X	X	X	X
Track the number of activated new partners within the different targets	X	X	X	X
Prepare monthly Steering Committee Meetings on Finance Models	X	X	X	X
Begin sustainability analysis in collaboration with health plans, identifying prospective cost savings to support program sustainability	X	X	X	X

Year 3

Sustainability	Year 3			
Task and Milestones	**Q1**	**Q2**	**Q3**	**Q4**
Network development activities	X	X	X	X
Social care enhancement activities	X			
Case study development on impact across programs	X			
Prep Steering Committee on Finance Models	X	X	X	X
Complete sustainability analysis	X			
Complete impact analysis	X			