Illinois Department of Healthcare Transformation Collaboratives

West Side Health Equity Collaborative

Application for Submission (April 9, 2021)

Participating Entities Cover Sheet

The following participating entities will be collaborating as part of the West Side Health Equity Collaborative. Entities are comprised of two hospital providers and six community-based organizations that address the social determinants of health. Copy of each entities' most recent IRS 990 Form are provided in **Attachment A**.

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Executive Summary

The West Side Health Equity Collaborative ("Collaborative") will improve the health status of Medicaid-insured and medically uninsured residents of Chicago's West Side. For decades, hospitals, specialists, primary care providers, behavioral health providers, community-based social service agencies, community advocates and residents have shared that aim. Despite that, significant health inequities and disparities persist as highlighted in the recent release of the Transformation Data and Community Needs Report: Chicago West Side. Those inequities and disparities are the focus of recent "Four Pillars" legislation by the Illinois Legislative Black Caucus. Funding for the Healthcare Transformation Collaboratives is intended to transform the healthcare delivery system, not just supplement funding of the status quo.

With that charge, the stakeholders listed above have deliberated and are pleased to present this proposal for a transformed healthcare system on Chicago's West Side. It represents a heightened degree of communication and collaboration around a common model of care with aligned objectives for all stakeholders. The model is distinguished from current practice:

- It addresses the realization that the health care system creates dependency for some and alienates others rather than empowering individuals and their families to self-monitor and proactively manage their health.
- It recognizes that there is a unique and too often overlooked role for community health workers and other "non-billable" members of the care team who have unique ability to relate and effectively communicate with patients.
- It is based on a federated architecture allowing interoperability and information sharing between autonomous entities within an integrated model of care.
- It does not passively wait for individuals to arrive for care but proactively seeks those who could benefit from services.
- It goes beyond the realization that social determinates of health create barriers to self-care and compliance with treatment plans to systematically screening for and addressing those factors and objectively measuring the success in resolving those barriers.
- It recognizes that it often takes warm handoffs rather than simply referrals to help patients navigate the health care system.
- It realizes that care coordination and care management are most effective when delivered in-person and leverages individuals with learned similar experience.
- It creates employment opportunities for residents of the community being served to enhance economic recovery.

Project Description and Goals

General health status is suboptimal on Chicago's West Side, with disparities particularly experienced by Black and Latinx individuals with low incomes in part due to inadequacies of the health care system and how it is funded. However, it is also driven to an even greater degree by structural inequalities across race, gender, class, sexual orientation, immigration status, and multiple socioeconomic drivers that often remain undetected and under-addressed at the community and individual resident levels.

As health and social service providers with a long history of providing care for this community, the West Side Health Equity Collaborative ("Collaborative") banded together when presented with the opportunity to address health and racial inequities through this transformative effort. Transforming healthcare for the Collaborative includes increasing convenient access to culturally responsive healthcare, supporting the unique and changing socio-economic needs of individuals and families, and developing a model with evidence-based best practices that link and align the efforts of community-based organizations and healthcare providers.

The task of completely remedying this is beyond the plausible scope of the proposed Collaborative's project. Still, funding can support these efforts by focusing on Chicago-West Side residents who have one or more project-targeted conditions that account for some of the greatest disparities in health outcomes.[1]

Upon review and discussion of the *Transformation Data and Community Needs Report: Chicago-West Side* prepared for the Illinois Department of Healthcare and Family Services (HFS) by the University of Illinois at Chicago School of Public Health and Institute for Healthcare Delivery Design released in February 2021, the Collaborative will focus on Medicaid insured and medically uninsured individuals residing in one of the eight Chicago West Side zip codes with one or more of the following conditions:

1. Severe mental illness (SMI)
2. Substance use disorder (SUD)
3. Mild to moderate depression
4. Adverse childhood experience
5. Hypertension (HTN)
6. Diabetes Mellitus (DM)

Subpopulation-specific metrics and performance goals are described in the Quality Metric section of this response. Overarching project goals include:

1. Improving collaboration, communication, and timely sharing of information among health care providers serving individuals with Medicaid coverage and the medically uninsured on Chicago's West Side.
2. Alleviating barriers that make it difficult for individuals with these chronic conditions to follow their treatment plans with a special focus on addressing social determinates of health (SDoH) and previously undetected depression
3. Improving the appropriateness and effectiveness of care from a cultural perspective by integrating community health workers (CHWs) into the care teams.
4. Improving patient self-management and clinical control of the chronic conditions of focus.
5. Improving access to care in the most convenient fashion for patients within the context of clinical appropriateness.
6. Enhancing the care team's full use, not just the "billable" members of the care team.
7. Reduce potentially avoidable, low-value utilization and cost of health care services while increasing appropriate utilization of ambulatory primary care, behavioral health, specialty, diagnostic and therapeutic services, including medication adherence.
8. Reduce health inequities for the target population on Chicago's West Side.

The Collaborative's General Approach

The Collaborative will use an integrated care approach to improving health outcomes. According to the Agency for Healthcare Research and Quality (AHRQ), integrated care consists of "a practice team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population." [2] The Bipartisan Policy Center's Behavioral Health Integration Advisory Group released a 120-page report, "Tackling America's

[1] Transformation Data and Community Needs Report: Chicago-West Side

[2] Reference Peek, C. J., & The National Integration Academy Council. (2013). Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. Agency for Healthcare Research and Quality.

Mental Health and Addiction Crisis Through Primary Care Integration," in March 2021.[3] The Collaborative's project approach to integrated care for each of the chronic conditions follows that recommended by this policy group with some additions:

1. Systematic screening for the targeted health conditions, and referral for complex patients.
2. Ongoing care management inclusive of patient, family, and provider members of the care team.
3. Multidisciplinary team-based care between behavioral health and primary care providers and other specialists.
4. Improved access to and communication with specialty providers to support primary care providers.
5. Measurement-based care, using evidence-based tools, to monitor health symptoms and key objective measure of condition control to guide treatment adjustments as needed.
6. Culturally adapted self-management of health conditions.
7. Tracking and exchanging patient information among providers.
8. Assessing social needs and providing links to services supported by bidirectional electronic communication; repeated assessments after a 6–12-month period to determine the project's effectiveness to successfully addressing those risk factors.
9. Systematic quality improvement using established quality metrics that align with those identified by HFS in its 2021-2024 Quality Strategy and that Medicaid MCOs are required to report.
10. Payment reform initially through enhanced payments within the existing structure but offering an option to transition to a new capitated value-based payment structure no longer built on a fee-for-service chassis. Rather, employing a structure that engages the whole team and more convenient service delivery for patients and incentivizes improved population health outcomes.

Individuals with chronic conditions that make them eligible for the program will be identified and enrolled by navigators staffing West Side hospital emergency departments (ED), primary care, behavioral health, or specialists providing ambulatory care services, and community-based organizations (CBO's).

Condition-Specific Strategy

Behavioral Health: SUD and SMI

The Collaborative will address the complex needs of patients going to the hospital with severe mental illness and substance use disorders. It will implement the following Collaborative Care Model (CoCM) to improve outcomes for West Side Chicago residents with a recent hospitalization or emergency department visit at a West Side Chicago hospital for a primary diagnosis of SUD, or a condition qualifying as an SMI. Using project funding, the hospitals will employ care navigators that staff the emergency room (ER) during high-volume times. Care navigators (navigators) will identify individuals who are eligible (see project descriptions below for additional condition eligibility criteria), introduce them to the program, gain consent to participate, and notify the on-call behavioral health care manager to meet with the patient.

Using this process provides an opportunity to:

- establish a trusting relationship
- perform a health risk screening that includes a common set of SDoH factors and BH conditions
- address immediate needs where possible
- document contact information
- schedule a place and time for a follow-up visit to perform a comprehensive assessment and create a care plan

[3] https://bipartisanpolicy.org/event/tackling-americas-mental-health-and-addiction-crisis-through-primary-care-integration/).

Evidence-based screening tools will be used to identify physical, behavioral, and social needs for individuals with Alcohol and other Substance Use Disorders (CAGE, AUDIT, DAST) or Domestic Violence with (HITS and HARK). SBIRT (Screening, Brief Intervention, and Referral to Treatment) will be used to provide brief interventions to increase motivation to change a related behavior. ASAM criteria will guide the selection of treatment for individuals with SUD. If hospitalized, the care manager will visit with the patient in the hospital, and if possible, meet them at time of discharge. The project care manager will attend outpatient appointments if necessary to facilitate ambulatory follow-up.

With a population health approach, the project behavioral health care manager becomes an extension of the medical home and facilitates engagement with traditionally unreachable patients. The project care manager will provide higher-touch intensive services in the community and coordinate referrals with relationship continuity. The goal is to increase behavioral health and physical health treatment and appointments post-hospitalization or emergency department visits, improve medication adherence, initiate treatment for SUD, and mobilize community resources such as transitional housing, job training, and transportation - ultimately reducing emergency department visits and hospitalizations.

Behavioral health care managers are the “boots-on-the-ground” member of the care team anchored by the primary care manager. The latter will be a primary care or behavioral health provider employed care manager for individuals insured by Medicaid when that provider entity is delegated by the Medicaid health plan for care management. Otherwise, it will be the MCO care manager. The project behavioral health care manager will collaborate with a medical home-based care manager for the medically uninsured when one exists. Care navigators and project care managers will communicate via a web-based care management platform that allows permissioned use by the interdisciplinary care team (primary care provider, behavioral health provider, project care manager, primary care manager, others as indicated). Outcomes as described in the Quality Section below will be used to monitor success and make mid-course adjustments to this and the other models described below.

Behavioral health care managers will team up with Peer Recovery Support Team as part of this transformation initiative. Their support is essential to ensuring that patients who are touched by safety net hospitals and who are discharged into the community receive continuity of care. Typically, individuals with SMI and Co-Occurring conditions are left to navigate the system(s) of care on their own which more that often results in failed appointment for both behavioral health and medical conditions. These individuals are identified as high utilizers of ED services, unnecessary inpatient psychiatric hospitalization, or are incarcerated at Cook County Jail for misdemeanor offences (i.e., trespassing, and petty theft) which are often the result of homelessness and food insecurity. The Peer Recovery Support model utilizes Persons with Lived Experience (PWLE) as navigators and care coordinators to ensure that the service needs of Members are met. The PRS Team manages a caseload of approximately 10 to 15 individuals. They will monitor individual Member’s program needs as established in the Member’s Individual Treatment Plan and ensure warm hand-off to identified services. The PRS staff also help guide the Member throughout his/her treatment, utilize their lived experience to reduce treatment resistance and stigma, and assist Members in developing their own Wellness Recovery Action Plan (WRAP). The PRS staff manages the Member and the system to ensure access and sustainability of treatment engagement. In other words, they will assist Members in identifying resources to address Social Determinants of Health, assist them in keeping appointment for primary care, psychiatry, therapy/counseling, provide community support individual to support and/or enhance independent living skills, etc. Individuals who are referred to BEW for services will have access to the following array of treatment and service program

Behavioral Health: Mild to Moderate Depression

The Collaborative will implement the collaborative care model (CoCM) to improve care for West Side Chicago residents with mild to moderate depression. CoCM is an evidence-based approach for integrating physical and behavioral health (IBH) services that can be implemented within a primary care-based medical home or a behavioral health home.

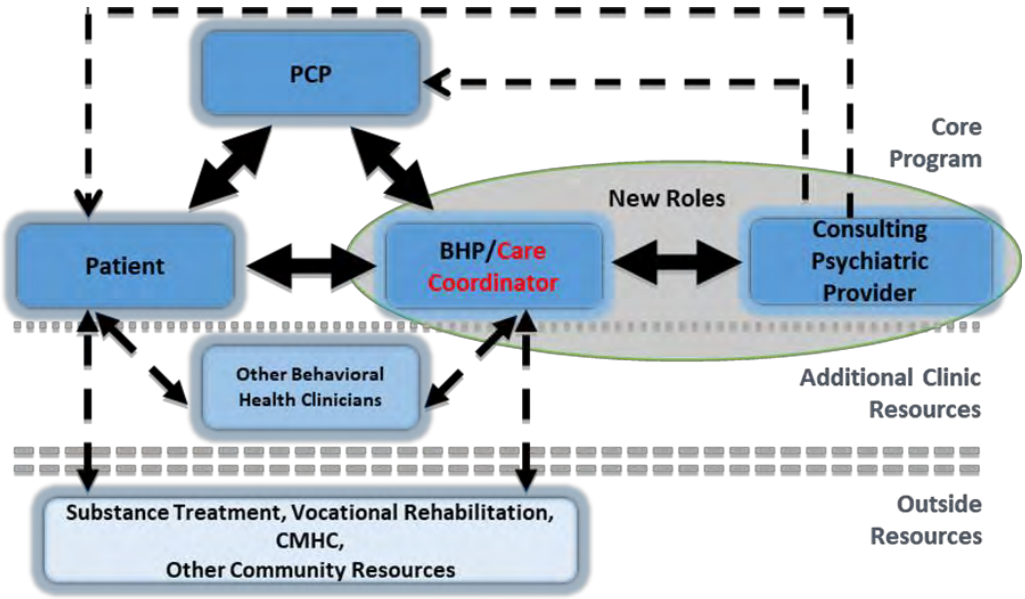
CoCM includes:

- care coordination and care management,
- regular/proactive monitoring,
- treatment to target using validated clinical rating scales (PHQ9 for depression),
- regular systematic caseload reviews by a behavioral health clinician, and
- consultation for patients who do not show clinical improvement.

Intervention techniques include motivational interviewing, behavior activation, goal setting, problem solving therapy, and cognitive behavior therapy principals.

CoCM has many benefits. It promotes a robust model of integrated behavioral health in care management and primary care. It also provides invaluable support to care teams by ensuring the medical homes have a fabric of support to address a high percentage of patients with depression or anxiety.

Primary care, behavioral health, hospital-based providers and to the extent feasible, social service agency providers will be encouraged to annually screen their clients for depression using the PHQ-2 screening tool that triggers a full PHQ-9 screening when abnormal. Individuals with a PHQ-9 score of ten or above will be referred to their primary care or behavioral health provider for verification of depression and referral to CoCM. The Collaborative will use provider-employed community health workers (CHWs) trained in the model as the primary contacts for these individuals. The CHW is part of the care team comprised of the primary care provider (PCP) and practice-based behavioral health (BH) provider with psychiatry back-up via eConsult as needed. The CHW screens potentially eligible individuals for SDoH and makes referrals to resources to address identified issues.



The CoCM for depression is an evidence-based model promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a best practice. Although originally designed to use a clinically licensed behavioral health professional as the primary patient contact, Medical Home Network has enrolled 4,212 patients with depression, many of them residing on Chicago's West Side, in an evidence-based approach using CHW-supported CoCM over the past four years with the outcomes listed below.[4]

- 88% of patients were screened for SDOH
- 62.2% had five or more screened SDOH
- 55% of patients actively engaged in the program demonstrated a 50% reduction in depression symptoms, and
- 34% reached full remission from depression

The Collaborative will incent program implementation by reimbursing on a fee-for-service basis using the methodology that CMS uses for Medicare covered individuals. The Collaborative will monitor the portion of enrolled members with at least a 50% reduction in the PHQ-9 and the portion who achieve remission by a PHQ-9 decrease to less than five. It will also follow the success in resolving SDoH risk factors as demonstrated on rescreening after six to twelve months.

Hypertension
The Collaborative will offer enrollment of Medicaid-insured and medically uninsured individuals residing in one of the Chicago West Side zip codes with hypertension into the self-monitoring program. It will apply the CoCM team approach using practice employed CHWs, nurses and PCPs. As with the CoCM model for depression, funding will be used for virtual support by a care team member up to once a month and to purchase blood pressure monitors for the medically uninsured.

Program impact will be determined using the Healthcare Effectiveness Data and Information Set (HEDIS) Controlling High Blood Pressure metric that HFS includes as part of its premium withhold pay-for-performance program with Medicaid MCOs. The Illinois Medicaid program is currently performing at less than the 25th percentile nationally on this metric.

Diabetes
Using a similar approach to that taken with hypertension, individuals with diabetes whom their PCP is recommending self-monitoring with a glucometer will be offered participation in the CoCM. Each enrollee will be screened for SDoH upon enrollment and six to twelve months later.

Program impact will be measured by the portion of enrollees with a HbA1c of >9.0 and those with a value of <8.0.

Specialty Consultation
The primary care team (CHW, PCP, nurse, social worker or BH provider) can manage most individuals enrolled in the CoCM for mild to moderate depression, hypertension and/or diabetes. There are some cases, however, that will require specialty consultation when the patient is not improving. For these conditions, that is usually advice for changing medications once the PCP has exhausted options that he or she feels comfortable with. There is an inadequate supply of endocrinologists and psychiatrists willing to serve the Medicaid and medically uninsured populations on Chicago's West Side so wait times are long.

[4] Karen J. Coleman, Ph.D. et al. "The COMPASS initiative: description of a nationwide collaborative approach to the care of patients with depression and diabetes and/or cardiovascular disease." General Hosp Psychiatry Jan-Feb 2017;44:69-76

Usually, the necessary advice can be provided through eConsult (secure electronic messaging between the PCP and the specialist). This is further described in the Access section of this response.
Although a cost-effective method for providing specialty care and reimbursed by CMS for Medicare-covered individuals, it is not a reimbursable service under Illinois Medicaid. This project will purchase time from a full-time equivalent group of adult psychiatrists, pediatric psychiatrists and adult endocrinologists to respond to eConsults and phone queries from primary care providers.

Hub-and-Spoke Referral Specialists

The model will include a team of four Referral Specialists (to ensure sufficient capacity for the 12,500 enrollees) who will serve as a hub for the Collaborative, to oversee requests that originate from CHWs, ED providers, and primary care providers for subspecialty visits for the program enrollees, targeted for providers at all the participating hospitals. This team will be very familiar with the referral process to reach subspecialists at all the participating hospitals, enabling them to engage and problem-solve to secure timely referrals for all enrollees, as well as to confirm follow-up with primary care providers after the enrollees' subspecialty visits (an essential part of the Collaborative Care Model). Of note, the Collaborative will ensure that the Hub-and-Spoke Referral Specialists will have special training in the typical subspecialty-level needs of enrollees regarding the target conditions for the collaborative: depression, substance use disorder, serious mental illness, hypertension, and diabetes mellitus. They will also have training in adverse childhood experiences (ACEs) and the behavioral and cardiometabolic risks during adolescence and adulthood of ACEs.

Collaboration Participants

A diverse group of healthcare providers in Chicago's West Side are partnering to address health equity through the newly formed Collaborative. Members are listed below and include public and private hospitals, federally qualified health centers, and community-based organizations.

- Access Community Health Network
- Ann & Robert H. Lurie Children's Hospital of Chicago
- Bobby E. Wright Comprehensive Behavioral Health Center, Inc.
- Cook County Health
- Habilitative Systems, Inc.
- Humboldt Park Health
- The Loretto Hospital
- Medical Home Network (MHN) with its twelve federally qualified health centers
- Rush University Medical Center
- Sinai Chicago
- West Side United

Community Service Area

The Collaborative's community service area includes the zip codes listed below and the following neighborhoods on Chicago's West Side: Austin, Belmont Cragin, Douglas Park, East Garfield, Homan Square, Humboldt Park, Little Village, Pilsen, South, and North Lawndale, and West Garfield.

West Chicago Zip Codes				
60608	60622	60624	60639	60644
60612	60623	60634	60642	60651

Project Timeframe

Months 1-6

The expected project timeframe begins with three months of additional planning and infrastructure building. Months four to six include escalated provider education, community outreach, marketing, recruitment, and training of patient-facing staff, and the implementation of IT solutions. In month six, the Collaborative will submit a midyear report to HFS and request ongoing quarterly meetings to review project outcomes and progress.

Months 7-12

In January 2022, the program will launch and begin to serve the targeted population. The collaborative's employees and workgroups will begin monthly collection and analysis of baseline quality metrics and standardized SDoH screening tool results.

Years 2 and 3

After a year of implementation, the Collaborative will identify areas for improvement based on data and feedback from program participants, plan to add additional chronic conditions to the model based on available resources and project success and establish an MCO Planning Committee to develop value-based payment strategies for long-term sustainability.

Community Input

Identify the community service area by zip code or county of your collaborative and the process you have followed or intend to follow to establish the needs of your community including the process for direct community input. Also describe how you have included elected officials at all relevant levels ofgovernment in your service area in discussions as you developed your proposal.

Effectively addressing the unique health disparities in Chicago's West Side requires rallying community involvement, public awareness, and consensus-building to combine diverse groups' common interests with different needs. This Collaborative's strength includes the ability to connect people to resources and opportunities and strengthen partnerships across sectors and public/private partnerships, including faith-based organizations, local businesses, and schools.

Community Service Area

The Collaborative's community service area includes the zip codes listed below and the following neighborhoods on Chicago's West Side: Austin, Belmont Cragin, Douglas Park, East Garfield, Homan Square, Humboldt Park, Little Village, Pilsen, South, and North Lawndale, and West Garfield.

West Chicago Zip Codes				
60608	60622	60624	60639	60644
60612	60623	60634	60642	60651

Establishing Community Needs

The Collaborative has and will continue to employ various community engagement strategies to establish the needs of the communities it is serving. These strategies will be carefully conducted, so they are meaningful and inclusive, as outlined in each of the following planning phases:

- Phase I: HFS Healthcare Transformation Conceptualization
- Phase II: Application Comment Period Responsiveness
- Phase III: Community Advisory Committee
- Phase IV: Program Development
- Phase V: Advocacy and Outreach

More than 20,000 adults residing in one of these ten zip codes that are current members of CountyCare and assigned to an MHN PCP had a health risk assessment to identify barriers to optimal health outcomes including several SDoH. Similarly, a pediatric version of the health risk screening was completed for more than 20,000 children by them or their parent or guardian for MHN-assigned members living in these ten zip codes. The screening completion rate exceeded 90 percent. Subgroups of members with the project-focused conditions were then separately analyzed. The analysis demonstrates a high number of needs for SDoH, high incidence of co-morbidities, and low self-assessment of health status, as illustrated in the charts that follow. Those interviews informed this project design and selection of subgroups by condition. The health risk assessments were analyzed for each subgroup as follows:

West Side Adult Members with an elevated PHQ-9 by systematic health risk assessment screening

The percentage and number of current adult members with an elevated PHQ-9 and frequency of each of the other risk factors we screen for in the HRA

	Number of MHN WS Adults	% of Total Adults	Number of WSC Adults	% of Adults w Elevated PHQ-9
Total adult members in MHN ACO based on March 2021 Membership	**22,344**		**126118**	
Total adult members with at least one HRA reporting feeling down and depressed (regardless of whether they are in treatment or not)	**3,466**	**15.51%**	**19563**	
Total adult members with at least one PHQ-9 > 9	**1,559**	**6.98%**	**8800**	
At risk of homelessness or experiencing homelessness	165	0.74%	931	10.58%
Need help with making appointments	484	2.17%	2732	31.05%
Having issues with transportation	772	3.46%	4357	49.52%
Need help with other essentials or are experiencing food insecurity	756	3.38%	4267	48.49%
Need help paying for meds	369	1.65%	2083	23.67%
Reported health as fair or poor	1,003	4.49%	5661	64.34%
Report not feeling safe at home	212	0.95%	1197	13.60%
Report feeling they should cut down on drinking alcohol	315	1.41%	1778	20.21%
Report smoking AND not interested in cessation program	486	2.18%	2743	31.17%
Report not having no one who could take care of them for a few days	614	2.75%	3466	39.38%

West Side Adult Members with Hypertension by Claims

The percentage and number of current adult members with Hypertension and frequency of each of the other risk factors we screen for in latest HRA

	Number of MHN WS Adults	% of Total Adults	Number of WSC Adults	% of Adults w Condition
Total West Side adult members in MHN ACO	**22,344**		**126118**	
Hypertension (by claims)	**5,515**	**24.68%**	**31129**	
Hypertension with any of the following SDOH on their latest HRA	**3,327**	**14.89%**	**18779**	**60.33%**
Report feeling down and depressed	906	4.05%	5114	16.43%
At risk of homelessness or experiencing homelessness	222	0.99%	1253	4.03%
Need help with making appointments	513	2.30%	2896	9.30%
Having issues with transportation	860	3.85%	4854	15.59%
Need help with other essentials or are experiencing food insecurity	562	2.52%	3172	10.19%
Need help paying for meds	324	1.45%	1829	5.87%
Reported health as fair or poor	1,561	6.99%	8811	28.30%
Report not feeling safe at home	177	0.79%	999	3.21%
Report feeling they should cut down on drinking alcohol	328	1.47%	1851	5.95%
Report smoking AND not interested in cessation program	866	3.88%	4888	15.70%
Report not having no one who could take care of them for a few days	880	3.94%	4967	15.96%

West Side Adult Members with Diabetes by Claims

The percentage and number of current adult members with Diabetes and frequency of each of the other risk factors we screen for in latest HRA

	Number of MHN WS Adults	% of Total Adults	Number of WSC Adults	% of Adults w Condition
Total adult members in MHN ACO based on March 2021 Membership	**22,344**		**126118**	
Total adult population with Diabetes	**2,633**	**11.78%**	**14862**	
Total adult population with Diabetes reporting any of the following SDOH on their latest HRA	**1,643**	**7.35%**	**9274**	**62.40%**
Report feeling down and depressed	456	2.04%	2574	17.32%
At risk of homelessness or experiencing homelessness	109	0.49%	615	4.14%
Need help with making appointments	244	1.09%	1377	9.27%
Having issues with transportation	410	1.83%	2314	15.57%
Need help with other essentials or are experiencing food insecurity	281	1.26%	1586	10.67%
Need help paying for meds	153	0.68%	864	5.81%
Reported health as fair or poor	814	3.64%	4595	30.92%
Report not feeling safe at home	81	0.36%	457	3.08%
Report feeling they should cut down on drinking alcohol	101	0.45%	570	3.84%
Report smoking AND not interested in cessation program	344	1.54%	1942	13.06%
Report not having no one who could take care of them for a few days	445	1.99%	2512	16.90%

West Side Adult Members with Diabetes & Hypertension by Claims

The percentage and number of current adult members with both Hypertension and Diabetes and frequency of each of the other risk factors we screen for in latest HRA

	Number of MHN WS Adults	% of Total Adults	Number of WSC Adults	% of Adults w Condition
Total adult members in MHN ACO based on March 2021 Membership	**22,344**		**126118**	
Total adult population with both Diabetes and Hypertension	**1,525**	**6.83%**	**8608**	
Total adult population with both Hypertension and Diabetes reporting any of the following SDOH on their latest HRA	**986**	**4.41%**	**5565**	**64.66%**
Report feeling down and depressed	264	1.18%	1490	17.31%
At risk of homelessness or experiencing homelessness	60	0.27%	339	3.93%
Need help with making appointments	154	0.69%	869	10.10%
Having issues with transportation	253	1.13%	1428	16.59%
Need help with other essentials or are experiencing food insecurity	160	0.72%	903	10.49%
Need help paying for meds	89	0.40%	502	5.84%
Reported health as fair or poor	500	2.24%	2822	32.79%
Report not feeling safe at home	43	0.19%	243	2.82%
Report feeling they should cut down on drinking alcohol	57	0.26%	322	3.74%
Report smoking AND not interested in cessation program	202	0.90%	1140	13.25%
Report not having no one who could take care of them for a few days	250	1.12%	1411	16.39%

West Side Children with a Mental Health Diagnosis by Claims

The percentage and number of current pediatric members with a mental health diagnosis and frequency of each of the other risk factors we screen for in latest HRA

	Number of MHN WS Peds	% of Total Peds	Number of WSC Peds	% of Peds w Condition
Total pediatric population in MHN ACO based on March 2021 Membership	**21,510**		**108368**	
Total pediatric population with Mental Health diagnosis	**4,963**	**23.07%**	**25004**	
Mental health diagnosis reporting any of the following SDOH on their latest HRA	**1,842**	**8.56%**	**9280**	**37.11%**
At risk of homelessness or experiencing homelessness	28	0.13%	141	0.56%
Having issues with transportation	479	2.23%	2413	9.65%
Need help with other essentials or are experiencing food insecurity	396	1.84%	1995	7.98%
Need help paying for meds	265	1.23%	1335	5.34%
Reported health as fair or poor	280	1.30%	1411	5.64%
Missing more than 10 days of school	166	0.77%	836	3.34%
Living in a house with chipping or peeling paint	129	0.60%	650	2.60%
Smoker in the household	351	1.63%	1768	7.07%
Prescribed daily medications	615	2.86%	3098	12.39%
Seeing a specialist	135	0.63%	680	2.72%
Care giver concerns about child's behavior/development	35	0.16%	176	0.71%
Reported receiving treatment for behavioral or emotional problems	37	0.17%	186	0.75%
Reported concerns regarding drug or alcohol use	4	0.02%	20	0.08%
Reported caregiver has concerns about their own health and wellness	12	0.06%	60	0.24%

West Side Children with a SUD Diagnosis by Claims

The percentage and number of current pediatric members with a substance use diagnosis and frequency of each of the other risk factors we screen for in latest HRA

	Number of MHN WS Peds	% of Total Peds	Number of WSC Peds	% of Peds w Condition
Total pediatric population in MHN ACO based on March 2021 Membership	**21,510**		**108368**	
Total pediatric population with substance use diagnosis	**142**	**0.66%**	**715**	
Total pediatric population with a substance use diagnosis reporting any of the following SDOH	**73**	**0.34%**	**368**	**51.41%**
At risk of homelessness or experiencing homelessness	3	**0.01%**	15	**2.11%**
Having issues with transportation	23	**0.11%**	116	**16.20%**
Need help with other essentials or are experiencing food insecurity	16	**0.07%**	81	**11.27%**
Need help paying for meds	12	**0.06%**	60	**8.45%**
Reported health as fair or poor	15	**0.07%**	76	**10.56%**
Reported missing more than 10 days of school	12	**0.06%**	60	**8.45%**
Reported living in a house with chipping or peeling paint	5	**0.02%**	25	**3.52%**
Reported a smoker in the household	16	**0.07%**	81	**11.27%**
Reported using daily medications	18	**0.08%**	91	**12.68%**
Reported seeing a specialist	2	**0.01%**	10	**1.41%**
Caregiver reported concerns about child's behavior/development	3	**0.01%**	15	**2.11%**
Receiving treatment for behavioral or emotional problems	6	**0.03%**	30	**4.23%**
Reported concerns regarding drug or alcohol use	3	**0.01%**	15	**2.11%**
Caregiver has concerns about their own health and wellness	2	**0.01%**	10	**1.41%**

Community Engagement and Outreach

The Healthcare Transformation Collaborative is a tremendous opportunity for institutions to ban together to address the health and social inequities on Chicago's Westside. As a community connector and convenor, West Side United (WSU) believes that the Healthcare Transformation Collaborative can help enhance the capabilities of residents, community organizations, and healthcare providers to improve the socio-economic status of individuals and families.

The focus of the engagement strategy will be to create partnerships with residents, health care institutions, community leaders, and organizations scaling the impact of existing initiatives, developing new programs, and providing coordinated support to existing neighborhood networks of CBO's. As a partner of the Collaborative, WSU would serve as the lead organization for community engagement with the help of partner organizations Habilitative Services, INC., Bobby E. Wright Comprehensive Behavioral Health Center, and Sinai Chicago.

The Collaborative's community engagement goals include:

- Establishing relationships and improve communication between the community and providers
- Engaging individuals who are not accessing the health care system even though they have one of targeted conditions and enrolling them into care and this program
- Uncovering new ideas and expertise to inform the Collaborative's initiatives
- Gaining community awareness and understanding about the impacts of health inequities they experience in communities and the Collaborative
- Garnering community buy-in, support, and ownership
- Building consensus and reducing potential conflicts within or among stakeholder groups, as individuals and communities hear and understand various points of view
- Establishing a mechanism for continuous feedback and evaluation of planning decisions
- Developing a shared understanding of potential planning approaches

WSU will organize community anchor institutions to use residents as experts to understand families' impact with health inequities. WSU will administer training sessions to CBO's provide resources for individuals and families in need. After establishing the mechanism for continuous feedback and evaluation with the other community engagement partners, WSU with Sinai Chicago's support, will create an evaluation tool to report findings.

Phase I: HFS Healthcare Transformation Conceptualization

HFS

From its inception, the Collaborative engaged HFS to learn about their health priorities, goals, and strategies to determine the Collaborative's priority population, goals, and approach. Jim Parker, HFS advisor, attended meetings held by the Collaborative to share information regarding the State's transformation funding opportunity and its goals. Members of the Collaborative presented the project and received feedback.

Legislative Medicaid Workgroup

On Dec. 16, 2020, the Collaborative presented its plan to the Legislative Medicaid Workgroup. Also, CCH and UIHHSS are government-owned hospitals that are members of the Collaborative. Collectively they offer a perspective that underscores overarching public health goals.

Members of the Collaborative
Members who are already community leaders and advocates held critical roles in developing program concepts, priorities, goals, strategies, objectives, outcomes for each stakeholder through workgroup sessions.

Local Health Disparities Data and Research
Members of the Collaborative have a long history of working in and engaging with west Chicago communities. Member organizations have received meaningful input from community stakeholders through multiple forums about their health and wellness needs over the past two years, conducted assessments to identify priority areas of highest need, and relied heavily on that input in the development of program concepts, priorities, goals, strategies, objectives, and outcomes. This includes:

- Eight Hospital Community Needs Assessments (Access Community Health Network, AMITA Health Saints Mary and Elizabeth Medical Center, Humboldt Park Health, The Loretto Hospital, Lurie Children's Hospital, Rush University Medical Center, Sinai Chicago, and University of Chicago – Illinois)
- Alliance for Health Equity Community Health Assessment 2019
- AMITA Health Humboldt Park Healing Illinois Grant on COVID-19 Equity
- Cook County Health & Hospital System Strategic Plan
- Sinai Urban Health Institute Sinai Survey 2.0
- West Side United Strategic Plan, listening sessions, and Community Advisory Council

Additionally, this project is heavily informed by highly respected efforts led by other community leaders and advocates, including:

- Austin Coming Together Quality of Life Plan 2018
- Belmont Cragin Quality of Life Plan 2016
- Chicago Health Atlas
- Counting on Chicago Coalition Key Performance Indicators
- COVID Urgent Needs Data from Chicago Anchor Organizations
- Healthy Chicago 2025
- Hermosa/Logan Square Logan Square Square Neighborhood Association Quality of Life Plan 2018
- HFS Comprehensive Medical Programs Quality Strategy
- Kedzie Avenue Corridor Preliminary Study
- Near North LaSalle Street Church Quality of Life Plan 2015
- North Lawndale Community Coordinating Council Quality of Life Plan 2018

Legislation
Illinois Legislative Black Caucus Health Reform Legislation (2021)

Sen. Sims discussed Criminal Justice Reform, Violence Reduction and Police Accountability
Bill Number: HB 163 SFA 2
https://ilga.gov/legislation/101/HB/PDF/10100HB0163sam002.pdf

Sen. Lightford and Rep. Ammons discussed Education and Workforce Development
Bill Number: HB 2170 SFA 1
https://ilga.gov/legislation/101/HB/PDF/10100HB2170sam001.pdf

Sen. Van Pelt and Rep. Harper discussed Economic Access, Opportunity & Equity
Bill Number: HB 2685 SFA 3
https://ilga.gov/legislation/101/HB/PDF/10100HB2685sam003.pdf

Rep. Lilly discussed Healthcare and Human Services
Bill Number: HB 3840 SFA 1
https://ilga.gov/legislation/101/HB/PDF/10100HB3840sam001.pdf

Phase II: Application Comment Period Responsiveness

The Collaborative will document and respond to all feedback and questions submitted to HFS during the public comment period regarding the Collaborative's application. These responses will be summarized by major themes resulting from input and posted on the Collaborative's website to ensure transparency and accountability. All comments will be considered, either individually or collectively, to:

- Help the Collaborative make informed decisions
- Identify common concerns or major concerns expressed in the comments
  Consider new suggestions and recommendations

Liaisons of the Collaborative will also share results, next steps, or other relevant information, including closing the loop with stakeholders to encourage future participation and build trust (what was heard, what will be done in the short-term and long-term, and why).

Phase III: Community Advisory Committee

The Collaborative will form a Community Advisory Committee comprised of community stakeholders representing the designated HFS neighborhoods of Chicago's West Side and a Collaborative Member. Community stakeholders should reflect the diverse interests, concerns, organizations, issues, and populations of Chicago's West Side. The CAC is a link between the community-at-large. It supports community awareness about the Collaborative and its services, advises on issues of importance in the community where the Collaborative may have an impact, encourages community involvement in the Collaborative's activities, and ensures that the programming reflects and meets the needs of the community.

Phase IV: Program Development

The Collaborative will employ a continuous evaluation of outcomes to confirm the intended stakeholders are reached. It will identify common themes and perspectives that inform planning priorities and inform future engagement strategies.

Virtual Listening Sessions
Virtual listening sessions for various stakeholders will be hosted at multiple junctures of the initiative's planning and implementation phases to receive diverse ideas and feedback from the community about the Collaborative's services and programs.

Phase V: Advocacy and Outreach

The Collaborative will analyze the local context that will affect the engagement process and the different stakeholders and community groups interested in the Plan. This analysis will include identifying stakeholders and community groups such as Chicago Prize Winner Quality of Life community groups, the Mayor's Racial Equity Rapid Response Team, anchor community organizations in each neighborhood, social services agencies, and grassroots organizations. After the stakeholders have been identified, the Collaborative will explore what issues are of interest to them, how individuals and groups might be affected, and what methods we will use to engage, communicate, and build relationships.

For this phase, we will conduct a relevant and appropriate engagement process that includes:

- Ensuring participants have a complete understanding of the background information and historical context of the Collaborative
- Focusing on the best interests of each community
- Using approaches that are inclusive and meet a community's particular needs
- Providing timely, accurate, easy-to-understand, and accessible information
- Transparency about decision-making
- Using a wide range of communication tools (online, social media, etc.)

Members will share results, next steps, or other relevant information with stakeholders to encourage future participation and build trust (what will be done in the short-term and long-term, and why).

Data

Across Chicago's West Side, there is currently inadequate sharing of health care information among health plans, health care providers, and community-based social service agencies (CBOs). This is driven partly by a lack of health information technology (Health IT) systems that support enhanced communication and data sharing to facilitate integrated care plan development and track health outcomes and quality metrics. There is neither a Medicaid claims data repository at the State level nor a mandate for health plans to share claims data with providers in advanced alternative payment method (APM) arrangements. Care plans are duplicative, services are unnecessarily repeated, and medical errors are compounded. The Health Information Exchange is underdeveloped, information is not shared via web-based platforms that CBOs can access, and the electronic health record (EHR) systems used by some health care providers are outdated. Interoperability between EHRs remains more aspirational than reality. Despite this, there are examples where this has been overcome, allowing for the following information to be collected to inform planning for this project as did HFS and national statistics outlined below.

Behavioral Health: SMI and SUD

During 2013–2016, eight percent of American adults aged 20 and over had depression in any given two-week period. Major depression was most prevalent among Hispanics (10.8 %), followed by African Americans (8.9%) and Whites (7.8%). In 2019, about one in five adults in the United States had a mental health condition (51.5 million Americans).[5] During the same year, 19.3 million adults experienced a SUD, and 9.5 million faced a co-occurrence of both substance use and mental health conditions.[6] By the middle of 2020, during the pandemic, a survey by the Centers for Disease Control and Prevention reported that two in five adults struggled with mental health or substance use problems. Although overall rates of mental health conditions in Black and Latino communities are lower than the general population in some studies,[7] disparities in access to behavioral health treatment exist. According to the SAMHSA, approximately 66% of Latino and 67% of Black Americans did not receive treatment for mental health conditions in 2019, compared to 55% of the general population.[8] Indeed, the *Transformation Data and Community Needs Report: Chicago-West Side* showed the odds ratio for depression in the five regions of focus, including Chicago's West Side, was lower for Blacks than Whites. Our experience caring for this population points to underscreening of low income individuals and a significant lack of behavioral health provider capacity to treat.

In adolescents, depression can also result in serious long-term morbidities such as generalized anxiety disorder and panic disorder or lead to engagement in risky behaviors such as substance use. Adolescent-onset depression increases the risk of attempted suicide five-fold in comparison with nondepressed adolescents. Rates of depression for pregnant or postpartum women range from 12%-15%, with postpartum depression rates in some U.S. areas are estimated to be as high as 20 percent. Women with untreated depression during pregnancy are at risk of developing severe postpartum depression and suicidality and delivering premature or low birth-weight infants. Postpartum depression hinders important caregiving activities and infant attachment and bonding, leading to developmental disorders that last into adolescence.[9]

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[5] Substance Abuse and Mental health Services Administration, Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health, 2019

[6] Substance Abuse and Mental Health Services Administration, Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health, September 2020

[7] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019, Table 8.1A – Any Mental Illness in Past Year among Persons Aged 18 or Older, by Gender and Detailed Age Category: Number in Thousands, 2018 and 2019.

[8] Substance Abuse and Mental Health Services Administration, "2019 National Survey of Drug Use and Health (NSDUH) Releases"

[9] https://www.ncqa.org/hedis/measures/depression-screening-and-follow-up-for-adolescents-and-adults/

While the utilization of behavioral health services has generally increased over time, many who need services do not receive treatment. A variety of barriers persist, including an insufficient network of providers to triage and treat mental health and SUD. In 2019 nearly 90 percent of people with a substance use disorder did not receive treatment. In 2020, 57.2 percent of adults with a mental illness went untreated, and nearly 60 percent of youth with major depression did not receive treatment. According to CMS, more than half of the Medicaid enrollees in the top five percent of expenditures with asthma or diabetes also had a behavioral health condition. Individuals with a severe mental illness die 10 to 20 years earlier than the general population, mostly from preventable physical diseases.[10] The Transformation Data and Community Needs Report showed that behavioral health conditions are leading causes of hospitalization and rehospitalization for Chicago West Side residents insured by Medicaid. The hospitalized individuals received outpatient behavioral care less than 25 percent of the three months before hospitalization. Less than half received those services in the three months post-discharge.

OUTPATIENT CARE AMONG PATIENTS HOSPITALIZED (3 MONTHS PRIOR, 3 MONTHS AFTER)

	Prior	**After**
Mental disorder	9.8%	14.5%
Substances use disorder	25.1%	42.5%
Ambulatory Care Sensitive Conditions	21.1%	36.6%

Medical Home Network Accountable Care Organization (MHN ACO), an integrated delivery system comprised of twelve Chicago-area Federally Qualified Health Centers (FQHCs) and three health systems, assessed 703 of its Medicaid-insured members that were hospitalized at a hospital on Chicago's West Side in 2018 for a behavioral health condition. Using claims data and a health risk assessment tool queried for several SDoH, analysis revealed the following:

- 28% needed help making appointments
- 5% reported being homeless or living in a shelter
- 33% needed help with essentials such as food and clothing
- 13% couldn't afford medication copayments,
- 28% needed help making an appointment
- 36% cited a lack of transportation to medical appointments

[10] Marc De Hert, Christoph U. Correll, Julio Bobes, et. al., "Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care," World Psychiatry, 10(1): 52–77, February 2011.

This group of patients had a readmission rate of 29.65%, a hospitalization rate of 2,282 admits per 1,000/year, and an emergency department visit rate of 5,575 per 1,000/year after initial hospitalization at the following West Chicago hospitals:

MHN ACO HOSPITALIZATIONS FOR A BH CONDITION 2018		
HOSPITAL	**# ADMISSIONS**	**% ADMISSIONS**
Amita	232	33.0%
Hartgrove	104	14.8%
Humbold Park	72	10.2%
Loretto	80	11.4%
Mt. Sinai	58	8.3%
Riveredge	92	13.1%
St. Anthony	65	9.2%
TOTAL	**703**	

These individuals accessed ambulatory behavioral health (BH) services in any of the six months leading up to the hospitalization between 30 to 37% of the time. That increased to 64% the month following hospitalization before falling to 45% in any given month over the next five months. Ambulatory primary care services in any given month leading up to the hospitalization occured 30 to 37% of the time. It was still only 40% in the month following that hospitalization and then fell to an average of 27% in any given month over the next five months.

The average total cost of care for this group of individuals was $2,298 in the first month post-hospitalization and an average of at least $1,772 in any given month for the next five months. Adherence to behavioral health medications in the six months following discharge was especially low.

Drug Category	Members with ≤2 fills	Members with 2+ fills	
	% of Total	% of Total	% Adherent*
Antidepressants	52.5%	48.1%	**19.0%**
Antipsychotics	61.9%	38.6%	**25.9%**

Fifty-five percent of patients lost eligibility with the health plan within 12 months of hospitalization, often due to failure to complete the Medicaid eligibility redetermination process.

Hypertension

Nearly half of American adults have high blood pressure. Of the 75 million Americans who have hypertension, almost half do not have the condition under control.[11] About 11 million do not know their blood pressure is too high and are not receiving treatment to control it. Only about one in four adults with hypertension have their condition under control (below 130/80 mm Hg). Most of the time, there are no obvious symptoms. There are significant differences in the prevalence of hypertension by race (White 50.2%, Black 43.0%, Hispanic 57.0%) but also a disparity in the percentage of those treated with medication who have poorly controlled hypertension equal to or greater than 140/90 (White 57.2%, Black 66.5%, Hispanic 60.1%).

For Medicaid beneficiaries, the usual way to know if your blood pressure is high is to have your healthcare provider check it regularly, although public screening machines are available in some pharmacies. In the 2019 UDS report, the six FQHCs predominantly serving Chicago's West Side reported that blood pressure control to less than 140/90 mmHg ranged between 60 and 81%.[12]

Untreated or ineffectively treated hypertension leads to increased cardiovascular morbidity and mortality and increased consumption of health care resources, thus levying high human and financial costs to society. Hypertension is an important modifiable risk factor for coronary artery disease, stroke, peripheral vascular disease, congestive heart failure, and chronic kidney disease.

Strong scientific evidence shows that self-measured blood pressure monitoring (SMBP), also known as home blood pressure monitoring, plus clinical support helps people with hypertension lower their blood pressure.[13] A systematic review in the American Journal of Preventive Medicine (Am J Prev Med 2017;53(3):e105–e113) concluded that SMBP monitoring interventions with additional support or within team-based care are cost-effective. SMBP requires the patient to measure blood pressure at different times using a home measurement device. Clinical support includes regular one-on-one counseling, web-based or telephonic support tools, and educational classes. Only the former is a reimbursable service and then only delivered by a "billable" member of the care team. Before the current pandemic emergency period, even that was not reimbursable unless provided in-person at the clinician's office.

The American Heart Association recommends home monitoring for all people with high blood pressure to help the healthcare provider determine whether treatments are working. Home blood pressure monitoring is beneficial for anyone diagnosed with high blood pressure (HBP or hypertension) but especially:

- Individuals starting high blood pressure treatment to determine its effectiveness
- People requiring closer monitoring, especially individuals with risk factors for high blood pressure and/or conditions related to high blood pressure
- Pregnant women experiencing pregnancy-induced hypertension and/or preeclampsia
- Evaluating potentially false readings, like:
    - People who only have high readings at the doctor's office ("white coat" hypertension)
    - People who only have high readings at home but not at the doctor's office ("masked" hypertension).

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[11] American Heart Association web site https://www.heart.org/en/health-topics/high-blood-pressure/high-blood-pressure-toolkit-resources

[1212] https://data.hrsa.gov/tools/data-reporting/program-data

[13] American Heart Association web site https://www.heart.org/en/health-topics/high-blood-pressure/high-blood-pressure-toolkit-resources

Diabetes

Diabetes is a chronic disease affecting approximately 34.2 million people in the United States.[14] Its prevalence higher in Blacks (16.4%) and Hispanics (14.7%) than it is in Whites (11.9%). [15]

While no cure exists, the disease can be managed with a multi-pronged approach that includes diet, exercise, and medications. People with diabetes often have other chronic conditions such as hypertension or hypercholesterolemia. Untreated or inadequately managed diabetes and these other conditions can lead to complications such as heart attack, stroke, limb amputation, kidney failure, and hyperglycemic or hypoglycemic emergencies.

Ongoing management of diabetes, hypertension, and hypercholesterolemia can decrease or delay the disease complications. The average medical cost of treating patients with diabetes in 2017 was $16,752 per year - $9,601 attributed directly to diabetes.[16]

The six FQHCs predominantly serving Chicago's West Side reported in 2019 that between 25 and 36% of their diabetic patients were poorly controlled Hemoglobin A1c (HbA1c > 9%) or had no test during the year.[17] The 2020 National Diabetes Statistics Report does not break out diabetic control by race, but nationally, 14.6% of Diabetics have HbA1c of >9%.

The Transformation Data and Community Needs Report: Chicago-West Side found a composite diabetes-related hospital admission rate per 100,000 Medicaid recipients aged 19-64 at 496 per 100,000, more than triple the national rate of 158. It was two and a half times higher (673 vs. 274) for Medicaid recipients age 65 and older. The discrepancy from national averages was even more significant for hospitalizations for long-term complications of diabetes.

[14] National Diabetes Statistics Report, U.S. Department of Health and Human Services, Center for Disease Control
[15] The 2020 National Diabetes Statistics Report, a periodic publication of the Centers for Disease Control and Prevention (CDC)
[16] Economic Costs of Diabetes in the U.S. in 2017, Commissioned by the American Diabetes Association
[17] https://data.hrsa.gov/tools/data-reporting/program-data

Health Equity and Outcomes

The Collaborative will improve outcomes and reduced disparities through the innovative, transformative and aligned model of care described above that is inclusive of all major stakeholders: residents, community organizers, social service agencies, behavioral health and primary care providers, specialists, hospitals and payers. The model is distinguished from current practice:

- It addresses the realization that the health care system creates dependency for some and alienates others rather than empowering individuals and their families to self-monitor and proactively manage their health.
- It recognizes that there is a unique and too often overlooked role for community health workers and other "non-billable" members of the care team who have unique ability to relate and effectively communicate with patients.
- It is based on a federated architecture allowing interoperability and information sharing between autonomous entities within an integrated model of care.
- It does not passively wait for individuals to arrive for care but proactively seeks those who could benefit from services.
- It goes beyond the realization that social determinates of health create barriers to self-care and compliance with treatment plans to systematically screening for and addressing those factors and objectively measuring the success in resolving those barriers.
- It recognizes that it often takes warm handoffs rather than simply referrals to help patients navigate the health care system.
- It realizes that care coordination and care management are most effective when delivered in-person and leverages individuals with learned similar experience.
- It creates employment opportunities for residents of the community being served to enhance economic recovery.

It focuses on the health disparities identified by the Transformation Data and Community Needs Report: Chicago-West Side which align with the experience of stakeholders involved in this planning process. The specific conditions of focus are:

SMI and SUD

According to the SAMHSA, approximately 66% of Latino and 67% of Black Americans did not receive treatment for mental health conditions in 2019, compared to 55% of the general population. Per the Transformation Data and Community Needs Report: Chicago-West Side, the odds ratios for African Americans over age 40 living on Chicago's West Side to have an opioid addiction is 2.84 compared to 1.16 for Whites. Unfortunately, the report does not separate LatinX ethnicity from other Whites.
The COVID-19 pandemic has significantly impacted suicide, and opioid mortality rates over the past year and continue to have a disproportionate impact on Chicago's Black community. Clearly, mental health experts are concerned that the stress and isolation resulting from COVID-19 is strongly contributing to mental health challenges and substance use disorders. Recently, the Chicago Tribune reported that 51 Black residents died by suicide in Chicago, primarily on the South and West sides. This statistic represents a 106% change from 2019 to 2020. Suicide rates for White and Hispanic persons decreased during this same period (October 2020). In the August 2020 report of Morbidity and Mortality, specific attention was given to Mental Health, Substance Abuse and Suicidal Ideation during COVID-19. This report concluded, "Periodic assessment of mental health, substance use, and suicidal ideation should evaluate the prevalence of psychological distress over time. Addressing mental health disparities and preparing support systems to mitigate mental health consequences as the pandemic evolves and will continue to be needed urgently."

Mild to Moderate Depression

During 2013–2016, eight percent of American adults aged 20 and over had depression in any given two-week period. Major depression was most prevalent among Hispanics (10.8 %), followed by African Americans (8.9%) and Whites (7.8%). The medical cost of treating several common medical conditions increases between 40% to more than double when there is superimposed anxiety and/or depression.

Hypertension

There are significant differences in the prevalence of hypertension by race (White 50.2%, Black 43.0%, Hispanic 57.0%) but also a disparity in the percentage of those treated with medication who have poorly controlled hypertension equal to or greater than 140/90 (White 57.2%, Black 66.5%, Hispanic 60.1%). In the 2019 UDS report, the six FQHCs predominantly serving Chicago's West Side reported that blood pressure control to less than 140/90 mmHg ranged between 60 and 81%. Although hospitalization for uncontrolled hypertension, it is a main contributor to the leading causes of hospitalization and death in the United States: coronary artery disease, congestive heart failure, peripheral vascular disease, stroke and renal failure. Per the *Transformation Data and Community Needs Report: Chicago-West Side*, the odds ratio for a chronic ambulatory sensitive condition for African Americans of all adult ages was 1.52 verses Whites. These are associated with frequent ED visits and hospitalizations on the West Side.

Diabetes

Diabetes is a chronic disease affecting approximately 34.2 million people in the United States. Its prevalence higher in Blacks (16.4%) and Hispanics (14.7%) than it is in Whites (11.9%). The six FQHCs predominantly serving Chicago's West Side reported in 2019 that between 25 and 36% of their diabetic patients were poorly controlled Hemoglobin A1c (HbA1c > 9%) or had no test during the year. The 2020 National Diabetes Statistics Report does not break out diabetic control by race, but nationally, 14.6% of Diabetics have HbA1c of >9% in comparison. Per the *Transformation Data and Community Needs Report: Chicago-West Side*, the odds ratio for hospitalization for short term complications of diabetes of all age groups is 1.20 and uncontrolled diabetes 1.31 versus the White population.

Adverse Childhood Experience

Pediatricians from Lurie, Rush, Northwestern, Stroger and University of Illinois collaborated on a study published in 2018 that demonstrated that 6% of 2,569 families seen in their clinics over a 6-month period, had a least one adverse childhood experience, a risk factor for toxic stress (stress that is strong, frequent, and/or prolonged without sufficient protective factors). 47% had a least one unmet social need. Higher rates were associated with African American race (P<.05) and Hispanic ethnicity (P<.05).[18]

[18] Selvaraj et al. Screening for risk factors at well child visits Jour Pediatrics_2019

Quality Metrics

HFS has made significant progress in this area as outlined in their 2021-2024 Comprehensive Medical Programs Quality Strategy. Greater emphasis is made on metrics that measure prevention treatment and management of behavioral health conditions and promote better service integration. The Collaborative will use the condition-specific metrics that HFS requires Medicaid MCOs to report.

The Collaborative will not take a randomized controlled trial approach to study the impact of program intervention. By choosing HFS required metrics, the Collaborative will compare outcomes for Medicaid-insured individuals residing in Chicago's West Side with a comparable group living elsewhere. The change in the control group provides an estimate of the change caused by regression to the mean and any placebo effect. Any statistically significant extra improvement or decline in the West Side group compared to the control group can be attributed to the program's effectiveness or treatment. HFS can determine whether an external evaluator wishes to include the medically uninsured in the final evaluation.

HFS Quality Metrics

The Collaborative will use the following quality metrics that HFS includes for Medicaid MCOs to earn back their premium withhold.

Adult Behavioral Health

1. Follow-Up After Hospitalization for Mental Illness (7-Day and 30-Day): Statewide, the Illinois Medicaid Program performs at less than the 25th Percentile nationally with an absolute score of 27.78% for 7-Day and 47.76% for 30-Day.
2. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7-Day and 30-Day)

Child Behavioral Health

1. Follow-Up After Hospitalization for Mental Illness —6–17 years of age stratification (7-Day and 30-Day)
2. Follow-Up After Emergency Department Visit for Mental Illness —6–17 years of age stratification (7-Day and 30-Day)

HFS Reporting Metrics

The Collaborative will use the following HFS reporting metrics.

Adult Behavioral Health

1. Follow-Up After High-Intensity Care for Substance Use Disorder (7-Day and 30-Day)
2. Pharmacotherapy for Opioid Use Disorder (POD)

Child Behavioral Health

1. Mobile Crisis Response Services That Result in Hospitalization
2. Visits to the Emergency Department for BH Services that Result in Hospitalization
3. Overall Number and Length of Behavioral Health Hospitalizations
4. Number of Repeat Behavioral Health Hospitalizations

In addition, the Collaborative will monitor the impact of the CoCM for depression on PHQ-9 scores by measuring the percentage of members 12 years of age and older enrolled for depression who experience at least a 50 percent decrease in their initial PHQ-9 score and the percentage who achieve a PHQ-9 score of less than five.

Hypertension

1. Controlling high blood pressure: adults 18–85 years of age diagnosed with hypertension and adequately controlled blood pressure (<140/90 mm Hg). Statewide, the Illinois Medicaid Program performs at less than the 25th Percentile nationally with an absolute score of 47.83%. (2019 HEDIS for Medicaid mean of 60.8%)

Diabetes

HFS has included these diabetic measures as part of the Medicaid MCO pay-for-performance program in the past but dropped them for 2021. The Collaborative requests that it requires Medicaid MCOs to report this information to the Members of the Collaborative. If that is not possible, the Collaborative will report the number of diabetics enrolled in this project. Our target performance is the 50th percentile nationally.

Adults 18–75 years of age with diabetes (type 1 and type 2) who had the following:

1. HbA1c poor control (>9.0%) (2019 HEDIS for Medicaid mean of 40.4%)
2. Eye exam (retinal) performed (2019 HEDIS for Medicaid mean of 57.2%)

CAHPS

If HFS can work isolate Medicaid-covered individuals residing in one of the ten zip code areas on Chicago's West Side, the Collaborative would like to achieve at least the 50th percentile nationally on the following CAHPS survey results. Currently, the Illinois Medicaid Program performs between the 25th and 49th percentiles on each.

Adult and Child Aggregate Results

- Getting Care Quickly
- Getting Needed Care

SDoH

We will follow the success in resolving SDoH risk factors as demonstrated on rescreening at six-month intervals.

Utilization Efficiency and Cost

We will monitor program impact on ambulatory, emergency department, and inpatient utilization and cost.

Care Integration and Coordination

Our current care delivery system, health insurance coverage, payment for service rather than outcomes, workforce training, and health information exchange does not adequately support the integration of primary, specialty, behavioral health care, inpatient care, and social services addressing health. Care coordination and care management continue to be under-funded in Medicaid premium rates and, with rare exceptions, siloed within Medicaid health plans.

Completing key care management performance indicators and reducing potentially preventable ED visits, hospitalizations for ambulatory sensitive conditions, and unplanned readmissions on a risk-adjusted basis for people with Medicaid in Chicago are improved when care management is delegated to providers that pass HSAG reviews and participate in advanced APMs. However, most Medicaid health plans refuse to delegate care management to those same providers. Social service agencies that serve individuals who remain unengaged in primary care are mostly isolated from the care coordination effort.

The Collaborative will improve care integration and coordination through the following:

1. It will use a cloud-based care management platform to share care coordination information across the entire care team (PCPs, BH, specialists, hospitals, social service agencies, and Medicaid MCO care managers) securely
2. Individuals eligible for the program can be identified in West Side emergency rooms, in the community by social service agencies, or by ambulatory providers. As patients are screened for depression, SDoH, and hypertension, the information is entered into the platform
3. Patients are then referred to CHWs working at the assigned primary care provider or the appropriate behavioral health provider. EHRs can connect directly to the portal
4. As SDoH are identified the portal gives access to NowPow for referrals to the most geographically proximal and appropriate social service agency; NowPow is an electronic registry of community-based resources that help individuals address their SDoH.
5. Since social service agencies do not use EHRs, bidirectional communication will occur through the portal's secure messaging feature
6. It will integrate medical and behavioral health services using the CoCM
7. There will be direct communication between the primary care team and specialist using eConsult.
8. The portal will connect to MHN's direct ADT feeds from over 30 hospitals serving Cook County and the statewide health information exchange established by HFS when available

Access to Care

Most commonly, access to care is measured by network adequacy with agreed-upon ratios of health plan-participating health care clinician to population ratios by provider type. HFS sets minimum ratio standards for Medicaid MCOs, but these can be misleading. They do not consider wait times, providers who are not taking on new patients, and whether providers listed in the network have even submitted recent claims for health plan members. These ratios also do not measure the availability of culturally and linguistically competent providers. Payment rules sideline non-clinician members of the care team who have the competencies necessary to identify issues and encourage individuals to continue their care.

Access is further hampered by limiting payment to face-to-face encounters with "billable" health care providers. Before the pandemic, reimbursement for telehealth services was minimal. It remains to be determined how reimbursement rules will be revised after this emergency period. It appears unlikely that payments for audio-only telehealth visits will continue to be provided. Since low-income populations are less likely to have access to high-speed internet, devices, and data plans required for visual with audio telehealth, this likely will contribute to further health disparity. Even relaxed telehealth payment rules are a barrier to optimizing the use of non-billable care team members as clinically and culturally appropriate despite recognition that the workforce shortage of medical and behavioral health providers negatively affects efforts to improve population outcomes.

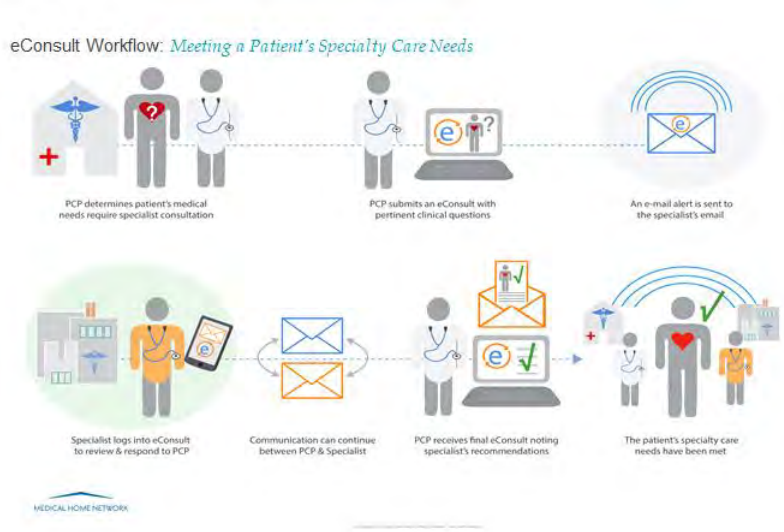
Increasing Access to Preventative and Primary Care

The project will address these access issues in several ways:

1. Participating providers will be encouraged to recruit community health workers (CHWs) and emergency department navigators who live on Chicago's West Side or who grew up on the West Side with a cultural competency and language capability required to effectively engage and communicate with the targeted populations.
2. Although it will be important to build a trusting relationship between patients and care teams, much of the follow-up care can be handled virtually by "non-billable" team members over the phone and at a time convenient for patients.
3. As CHW visits replace some of the current in-person visits, it will free up primary care and behavioral health providers to see other patients in-person or by billable telehealth visits as clinically indicated.

Increasing Access to Specialty Care: eConsults

Access to psychiatrists and endocrinologists for complex patients who are not improving with usual care supported by the CoCM will provide consultation via eConsult. eConsult is secure electronic messaging between a referring provider and the specialists. This is a more efficient use of their time (100% "show rate" and more clarity for the referral) and more convenient for patients.



MHN implemented eConsult to serve its CountyCare members three years ago using the Cook County Health System specialists. Approximately half of consultations are resolved without requiring an in-person visit. In-person visits, when required, are more efficient as pre-visit testing recommended by the specialist is usually completed and communicated. The specialist indicates the time frame for patient appointments based on clinical urgency.

- The average specialist response time is less than one day
- 90% appointments scheduled within Specialist's recommendation
- 97% of visit notes uploaded to eConsult, on average within eight days post-appointment

Social Determinants of Health

Medical care is only one of the five major interconnected determinants of health. Genetics, behavior, environmental and physical influences, and social factors are the others. SDoH encompass economic and social conditions that influence the health of people and communities. These conditions are shaped by socioeconomic position, which is the amount of money, power, and resources people have, all influenced by socioeconomic and political factors (e.g., policies, culture, and societal values). Residents living in under-resourced communities on Chicago's West Side often lack access to community-based organizations and resources that can help them address these socio-economic risk factors.

SDoH can create barriers to access health care services, and even for individuals who do access care, to follow their individualized care plans. Individuals are not routinely screened for these needs and, even when they are, may not be referred to accessible resources. Community-based social service agencies responding to those needs are under-resourced, providing the excuse of "why screen if nothing can be done to remedy the situation." For the most part, screening, healthcare utilization, cost, and outcomes data are not linked and analyzed at the individual patient level and then aggregated at the population level. This hampers informed decisions on allocating limited resources to support health care and social services aimed at improving health.

Addressing SDoH

The hospitals will employ emergency department care navigators to work shifts with a high volume of patients. They will identify eligible individuals, introduce them to the program, gain consent to enroll and then connect them to the appropriate CHW if the qualifying condition is mild to moderate depression, hypertension, or diabetes. The CHW will perform a health risk assessment using the universal screening tool and refer the individual to the appropriate resource to address identified SDoH.

If the individual is in the ED for a SMI or SUD diagnosis, the ED navigator will notify the on-call behavioral health (BH) care manager to meet with the patient. The BH care manager will establish a trusting relationship with the enrollee, perform the health risk screening, address immediate needs where possible, and establish contact information and a place and time for a follow-up visit to perform a comprehensive assessment to create a care plan.

Other individuals with depression, hypertension, and diabetes will be offered participation in the collaborative care program by their ambulatory care provider or a social service agency. Each patient will be connected with the appropriate CHW who will complete the screening.

Universal Screening Tool

The Collaborative will screen all project-enrolled adults for the following SDoH upon enrollment to the program. Progress in successfully addressing any identified barriers will be monitored in periodic repeat screenings by the CHW at least every six months. The Collaborative aims to resolve at least one-third of these barriers over the first year of the project. The screening tool queries for the following risk factors:

Adults

1. At risk of experiencing homelessness
2. Need help with making appointments
3. Having issues with transportation
4. Need help with other essentials or are experiencing food insecurity
5. Need help paying for meds
6. Reported health as fair or poor
7. Report not feeling safe at home
8. Report feeling they should cut down on drinking alcohol

9. Report smoking AND not interested in cessation program
10. Report having no one who could take care of them for a few days
11. Employment status
12. Insurance as factor for access
13. Financial strain (utilities, rent, etc.)
14. Childcare/Caregiving Needs
15. Report not having time or resources for exercise/physical activity

Children

1. At risk of experiencing homelessness
2. Having issues with transportation
3. Need help with other essentials or are experiencing food insecurity
4. Need help paying for meds
5. Reported health as fair or poor
6. Missing more than 10 days of school
7. Living in a house with chipping or peeling paint
8. Smoker in the household
9. Prescribed daily medications
10. Seeing a specialist
11. Caregiver concerns about child's behavior/development
12. Reported receiving treatment for behavioral or emotional problems
13. Reported concerns regarding drug or alcohol use
14. Reported caregiver has concerns about their health and wellness

It also will follow the success in resolving SDoH risk factors as demonstrated on rescreening after six months and monitor the impact on ambulatory, emergency department, and inpatient utilization and cost.

Budget

Budget Template

The Collaborative's utilized HFS's budget template to develop its budget, which is included as **Attachment B**. The total budget request is $68,800,768.

Column F. Revenues

Revenues were not included in the spreadsheet. Year one requires planning and a ramp up period, revenue diversification is unlikely to occur with potential funders during that time. However, thousands of dollars will be donated with in-kind contributions such as executive, clinical, and administrative staff time who will serve on the board and workgroups. Sustainability will remain a key priority for the Collaborative and intends to work with its Executive Director to develop a detailed roadmap that includes long-term cost savings from patient outcome improvements (lower utilization), MCO's, foundations, and philanthropic support.

Budget Justification

Emergency Room Navigators

Each of the seven participating hospitals on Chicago's West Side will staff navigators in their emergency rooms during peak hours seven days a week. They will identify individuals eligible for enrollment in the program, educate those individuals about the program, obtain consent for participation and refer to the behavioral health care manager (if qualifying for an SMI or SUD diagnosis) or CHW (for a condition qualifying for the CoCM). The non-clinically licensed navigators are budgeted for an annual $50,000 in salary and benefits, the same as the CHWs.

FTEs: 14

In Year One, this expense is prorated from $700,000 to $466,667 as the staff is hired and trained in months five and six and provides direct service beginning in month seven.

Collaborative Staffing Expense

Per the *Transformation Data and Community Needs Report: Chicago West Side,* 590,175 individuals live in the ten targeted zip codes. The Collaborative tabulated the number of individuals residing in the 10 Chicago West Side zip codes covered by Medicaid on June 30, 2020, reported on the HFS website at 234,476 or 39.7% of the population. Data was not available to determine the percentage of medically uninsured adults in these zip codes. Zip codes with higher Latinx populations will have a higher rate than those with a predominantly Black population. For budgeting purposes, an average of 20% of adults are assumed to be medically uninsured.

Zip Code	Children	Disabled Adults	ACA Adults	Other Adults	Seniors	TOTAL
60608	10270	1596	3631	3631	2481	
60612	5842	1790	2359	2359	1482	
60622	3151	943	2767	1357	1397	
60623	23215	3083	8580	6583	2469	
60624	9783	2869	6424	3762	1569	
60634	8886	1110	3873	3258	1886	
60639	21262	2471	6487	5819	2623	
60642	896	168	749	373	388	
60644	10575	3548	7446	4288	1990	
60651	14488	3371	8154	4922	2052	
TOTAL	108368	20949	50470	36352	18337	234476
Total Population						590175
% Covered by Medicaid						39.7%
Medicaid insured Adults						107771
Total Population Adults						310432
% Adults Covered by Medicaid						34.7%
Estimated Uninsured Adults						20%
Estimated # Uninsured Adults						62086

Based on CMS, states with Health Homes, and MHN in implementing the CoCM for depression for CountyCare members, reimbursement for the CoCM will be on a fee-for-service. When MHN implemented the model four years ago, it estimated the number of members with depression by provider entity, the percentage of members who would enroll in the

program, and the staffing needed. Enrollment was slower than anticipated in the first year, so funding was adjusted to pay a PMPM for each enrolled member. This led to a significant increase in the percentage of eligible individuals enrolled but still not the percentage of enrollees who were served at least once in the month. In the third year, MHN transitioned to paying $61.85 each month per enrollee with at least one monthly qualifying encounter with a repeat PHQ-9 screening. Within two months, there was a dramatic improvement in member contacts. In February 2021, MHN had 1,061 individuals with depression enrolled in the program, 797 (75%) who had a qualifying encounter with a repeat PHQ-9 performed. Since implementing the program in October 2016, MHN has enrolled 4,212 CountyCare members in the program, with 55% achieving at least a 50% reduction in their original PHQ-9 score and 34% achieving remission, defined as reducing the PHQ-9 score to less than five. Based on that experience, the Collaborative will pay on a fee-for-service basis for qualifying encounters.

We then calculated the fee-for-service payment. Staffing assumes that a full-time CHW will have at least one bidirectional communication with an average of 80 unique clients monthly. For individuals with depression who are enrolled, a full-time CHW will require support from a .1 FTE behavioral health clinician for complex patients. A nurse with the same staffing ratio will provide support for patiens with hypertension and/or diabetes

Total staff expense	
1 Care Coordinator salary and benefits	$50,000
.1 BH Clinician salary and benefits	$ 9,375
Annual team expense =	$59,375
Monthly team expense	$4,948
Average number of individuals served per month	80
Reimbursement rate for at least a monthly qualifying contact :	$ 61.85

Total monthly payment to a provider entity (# patients with at least one contact * $61.85)

MHN then calculated the percentage of its roughly 40,000 members living in the ten zip code areas with the following conditions:

Adolescents and adults with depression and an initial PHQ-9 score of 10 or above	7.0%
Adults with a claim with a diagnosis of both hypertension and diabetes	6.8%
Adults with a claim with a diagnosis of diabetes but no claim for hypertension	5.0%
Adults with a claim with a diagnosis of hypertension but no claim for diabetes	17.9%
Children with an adverse childhood experience	6.0%

These percentages estimate the number of potentially eligible individuals residing in the ten zip codes. The Clinical workgroup estimated 15% enrollment of eligible individuals in the program at any one time. They will each be enrolled for six months, longer if they are not at target for their PHQ-9, HbA1c, or blood pressure. The workgroup assumed an enrollee would be contract two-thirds of the months if they just had hypertension and three-quarters of the month for the other conditions. We recognize that some of the enrollees will have depression and diabetes, or hypertension, but we did not have data to calculate. This was factored in when a 15% enrollment was estimated. Based on these calculations, the following amount was budgeted for each CoCMs.

Collaborative Care Model for Depression

The staffing budget of $1,748,123 equates to 29.4 FTE CHWs and 2.9 FTE clinically licensed social workers or clinical psychologists. In Year One, this expense is prorated to $1,165,415 as the staff is hired and trained in months five and six and provides direct service beginning month seven.

Medicaid adolescents	**36123**				
Medicaid adults	**126108**				
Uninsured adults	**62086**				
Total	**224317**				
% Depressed	**7%**				
# Depressed	**15702**				
Encounter Rate		**$61.85**			
Annual Program Cost					
	% Enrolled				
Monthly Encounters	**5%**	**10%**	**15%**	**20%**	**25%**
1	**$48,559**	**$97,118**	**$145,677**	**$194,236**	**$242,795**
2	**$97,118**	**$194,236**	**$291,354**	**$388,472**	**$485,590**
3	**$145,677**	**$291,354**	**$437,031**	**$582,708**	**$728,386**
4	**$194,236**	**$388,472**	**$582,708**	**$776,945**	**$971,181**
5	**$242,795**	**$485,590**	**$728,386**	**$971,181**	**$1,213,976**
6	**$291,354**	**$582,708**	**$874,063**	**$1,165,417**	**$1,456,771**
7	**$339,913**	**$679,827**	**$1,019,740**	**$1,359,653**	**$1,699,566**
8	**$388,472**	**$776,945**	**$1,165,417**	**$1,553,889**	**$1,942,362**
9	**$437,031**	**$874,063**	**$1,311,094**	**$1,748,125**	**$2,185,157**
10	**$485,590**	**$971,181**	**$1,456,771**	**$1,942,362**	**$2,427,952**
11	**$534,149**	**$1,068,299**	**$1,602,448**	**$2,136,598**	**$2,670,747**
12	**$582,708**	**$1,165,417**	**$1,748,125**	**$2,330,834**	**$2,913,542**

Collaborative Care Model for Diabetics with Hypertension

The staffing budget of $1,424,714 equates to 24.0 FTE CHWs and 2.4 FTE clinically licensed social workers or clinical psychologists. In Year One, this expense is prorated to $949,809 as staff is hired and trained in months five and six and provides direct service beginning month seven.

Medicaid adults	**126108**				
Uninsured adults	**62086**				
Total	**188194**				
% DM & HTN	**6.8%**				
# DM & HTN	**12797**				
Encounter Rate		**$61.85**			
Annual Program Cost					
	% Enrolled				
Monthly Encounters	**5%**	**10%**	**15%**	**20%**	**25%**
1	**$39,575**	**$79,151**	**$118,726**	**$158,302**	**$197,877**
2	**$79,151**	**$158,302**	**$237,452**	**$316,603**	**$395,754**
3	**$118,726**	**$237,452**	**$356,179**	**$474,905**	**$593,631**
4	**$158,302**	**$316,603**	**$474,905**	**$633,206**	**$791,508**
5	**$197,877**	**$395,754**	**$593,631**	**$791,508**	**$989,385**
6	**$237,452**	**$474,905**	**$712,357**	**$949,810**	**$1,187,262**
7	**$277,028**	**$554,056**	**$831,083**	**$1,108,111**	**$1,385,139**
8	**$316,603**	**$633,206**	**$949,810**	**$1,266,413**	**$1,583,016**
9	**$356,179**	**$712,357**	**$1,068,536**	**$1,424,714**	**$1,780,893**
10	**$395,754**	**$791,508**	**$1,187,262**	**$1,583,016**	**$1,978,770**
11	**$435,329**	**$870,659**	**$1,305,988**	**$1,741,318**	**$2,176,647**
12	**$474,905**	**$949,810**	**$1,424,714**	**$1,899,619**	**$2,374,524**

Collaborative Care Model for Diabetics without Hypertension

The staffing budget of $1,047,584 equates to 17.1 FTE CHWs and 1.7 FTE clinically licensed social workers or clinical psychologists. In Year One, this expense is prorated to $678,389 as staff is hired and trained in months five and six and provides direct service beginning in month seven.

Medicaid adults	**126108**				
Uninsured adults	**62086**				
Total	**188194**				
% Diabetic	**5.0%**				
# Diabetic	**9410**				
Encounter Rate		**$61.85**			
Annual Program Cost					
	% Enrolled				
Monthly Encounters	**5%**	**10%**	**15%**	**20%**	**25%**
1	**$29,100**	**$58,199**	**$87,299**	**$116,398**	**$145,498**
2	**$58,199**	**$116,398**	**$174,597**	**$232,796**	**$290,996**
3	**$87,299**	**$174,597**	**$261,896**	**$349,195**	**$436,493**
4	**$116,398**	**$232,796**	**$349,195**	**$465,593**	**$581,991**
5	**$145,498**	**$290,996**	**$436,493**	**$581,991**	**$727,489**
6	**$174,597**	**$349,195**	**$523,792**	**$698,389**	**$872,987**
7	**$203,697**	**$407,394**	**$611,091**	**$814,788**	**$1,018,485**
8	**$232,796**	**$465,593**	**$698,389**	**$931,186**	**$1,163,982**
9	**$261,896**	**$523,792**	**$785,688**	**$1,047,584**	**$1,309,480**
10	**$290,996**	**$581,991**	**$872,987**	**$1,163,982**	**$1,454,978**
11	**$320,095**	**$640,190**	**$960,286**	**$1,280,381**	**$1,600,476**
12	**$349,195**	**$698,389**	**$1,047,584**	**$1,396,779**	**$1,745,974**

Collaborative Care Model for Hypertension without Diabetes

The staffing budget of $3,333,646 equates to 56.1 FTE CHWs and 5.6 FTE clinically licensed social workers or clinical psychologists. In Year One, this expense is prorated to $2,222,431 as the staff is hired and trained in months five and six and provides direct service beginning in month seven.

Medicaid adults	**126108**				
Uninsured adults	**62086**				
Total	**188194**				
% HTN no DM	**17.9%**				
# HTN no DM	**33687**				
Encounter Rate		**$61.85**			
Annual Program Cost					
	% Enrolled				
Monthly Encounters	**5%**	**10%**	**15%**	**20%**	**25%**
1	**$104,176**	**$208,353**	**$312,529**	**$416,706**	**$520,882**
2	**$208,353**	**$416,706**	**$625,059**	**$833,411**	**$1,041,764**
3	**$312,529**	**$625,059**	**$937,588**	**$1,250,117**	**$1,562,646**
4	**$416,706**	**$833,411**	**$1,250,117**	**$1,666,823**	**$2,083,529**
5	**$520,882**	**$1,041,764**	**$1,562,646**	**$2,083,529**	**$2,604,411**
6	**$625,059**	**$1,250,117**	**$1,875,176**	**$2,500,234**	**$3,125,293**
7	**$729,235**	**$1,458,470**	**$2,187,705**	**$2,916,940**	**$3,646,175**
8	**$833,411**	**$1,666,823**	**$2,500,234**	**$3,333,646**	**$4,167,057**
9	**$937,588**	**$1,875,176**	**$2,812,764**	**$3,750,351**	**$4,687,939**
10	**$1,041,764**	**$2,083,529**	**$3,125,293**	**$4,167,057**	**$5,208,821**
11	**$1,145,941**	**$2,291,881**	**$3,437,822**	**$4,583,763**	**$5,729,703**
12	**$1,250,117**	**$2,500,234**	**$3,750,351**	**$5,000,469**	**$6,250,586**

Collaborative Care Model for Children with Adverse Childhood Experience

The staffing budget of $482,584 equates to 8.1 FTE CHWs and 0.8 FTE clinically licensed social workers or clinical psychologists. In Year One, this expense is prorated to $321,723 as staff is hired and trained in months 5 and 6 and provide direct service beginning month seven.

Children	**108368**				
% Adverse Exper	**6%**				
# Adverse Exper	**6502**				
Encounter Rate		**$61.85**			
Annual Program Cost					
	% Enrolled				
Monthly Encounters	**5%**	**10%**	**15%**	**20%**	**25%**
1	**$20,108**	**$40,215**	**$60,323**	**$80,431**	**$100,538**
2	**$40,215**	**$80,431**	**$120,646**	**$160,861**	**$201,077**
3	**$60,323**	**$120,646**	**$180,969**	**$241,292**	**$301,615**
4	**$80,431**	**$160,861**	**$241,292**	**$321,723**	**$402,154**
5	**$100,538**	**$201,077**	**$301,615**	**$402,154**	**$502,692**
6	**$120,646**	**$241,292**	**$361,938**	**$482,584**	**$603,230**
7	**$140,754**	**$281,508**	**$422,261**	**$563,015**	**$703,769**
8	**$160,861**	**$321,723**	**$482,584**	**$643,446**	**$804,307**
9	**$180,969**	**$361,938**	**$542,907**	**$723,877**	**$904,846**
10	**$201,077**	**$402,154**	**$603,230**	**$804,307**	**$1,005,384**
11	**$221,185**	**$442,369**	**$663,554**	**$884,738**	**$1,105,923**
12	**$241,292**	**$482,584**	**$723,877**	**$965,169**	**$1,206,461**

eConsult for Specialists and Brief Phone Consultation with Referring Providers

As previously discussed, this project will purchase time from a full-time equivalent of adult psychiatry, pediatric psychiatry, and adult endocrinology to respond to eConsults and phone queries from primary care providers, as this is not a reimbursable service under Illinois Medicaid. We are budgeting 1 FTE child psychiatrist, 1 FTE adult psychiatrist, and 1 FTE endocrinologist, each at $310,000 for annual salary and benefits. This is prorated the first year as services will not begin received consultation until month seven.

Behavioral Care Managers will be available to respond to requests from emergency room navigators during peak hours seven days a week. They will meet the patient in the emergency room and begin to build a trusting relationship. They will serve as a resource to emergency room staff to offer treatment options as clinically appropriate to prevent otherwise avoidable hospitalizations. If the patient requires hospitalization, they will meet with the patient during the hospitalization and, if possible, at the time of discharge. They will continue to be the "boots-on-the-ground" member of the care team, working with clinicians and the Medicaid MCO care manager. These care managers have behavioral health training but have not met the criteria yet to become fully licensed to provide counseling services independently. Their annual salary and benefits are $70,000.

FTEs: 14

In Year One, this expense of $980,000 is prorated to $653,333 as the staff is hired and trained in months five and six and provides direct service beginning in month seven.

Behavioral Health Peer Recovery Support Team

Peer Recovery Support Teams will work with the Behavioral Health Care Managers to assist and support individuals living in recovery using their shared life experience. They will use their own stories in helping others develop hope and improve their lives.

Annual Budget for Peer Recovery Support Team

Peer Recovery Support Specialist Salary @ $35,000.00 x 10 FTE's = $350,000.00
Clinical Supervisor Salary @ $50,000.00
Fringe benefits @ 27% = 108,000.00
Cell Phone stipend @ $35.00 per month x 10 FTE's = $4,200.00
Mileage Reimbursement @ 10 miles per day x .57 = $15,960.00
Indirect cost @ 10% = $50,800.00
Total $578,960.00

In Year One, this expense is prorated to $385,973 as the staff is hired and trained in months five and six and provides direct service beginning in month seven.

Other Direct Costs

Additional direct costs include a series of trainings for evidence-based best practices for providers of the Collaborative that includes First Dose Medication and Medication Assisted Treatment. Funding for Naloxone (NARCAN) training for CHW's and other non-medical professionals on how to recognize the signs of an opioid overdose and administer the opioid overdose reversal drug.

Collaborative members who have not received accreditations for NCQA, PCMH, and Trauma-Informed Care and express interest in attaining one of these accreditations will have an opportunity to undergo a readiness assessment. Subsequent years include funding for accreditations prioritized for organizations with the greatest need.

Finally, funding for an Electronic Medical Record program for a key community-based behavioral health provider, Bobby Wright is included in the budget to ensure interoperability and data sharing requirements for participation in the project.

Consultants

The Collaborative will hire the following consultants to provide subject matter expertise and support for a variety of functions. Consultants have yet to be identified.

- IT Gap Analysis - Identify interoperability gaps and IT needs of members of the Collaborative
- Legal Counsel- develop and finalize Collaborative Charter
- System Redesign/Coordination – Project management, facilitation
- Race Equity Training – for members of the Collaborative and workgroup teams

Subcontractors

The Collaborative will hire Benford and Brown as its BEP fiscal agent. Requests for Proposals will be developed for BEP's that provide marketing and administrative support. Additionally, the Collaborative will contract with West Side United to coordinate community outreach and engagement efforts in the community with other members of the Collaborative.

Milestones

The following is a list of milestones and activities for the first, second, and third year of the Collaborative. Year one includes a calendar of milestones by month in two parts - planning and infrastructure and implementation. Milestones for years two and three are calendared quarterly.

Planning, Infrastructure	Year 1					
	M1	M2	M3	M4	M5	M6
Planning						
Stakeholder Outreach	x					
Establish Collaborative Workgroups / Committees	x	x				
Add MCO's to Collaborative		x	x	x		
Job Descriptions for the Collaborative's Staff		x				
Identify and Recruit CAC Members	x	x	x	x		
Convene CAC					x	
Hire for and Receive Health Equity Training				x	x	x
Community Engagement & Outreach				x	x	x
System Redesign/Coordination Consultant Work				x	x	x
Consultant Performs IT Gap Analysis				x	x	x
Execute eConsults Agreement					x	x
Conduct Assessment for CBO certifications/training		x	x			
Establish Supportive Housing Partner				x	x	x
Identify MAT/First Dose Members that Need Certification, Conduct Certification			x	x	x	x
Hire CADC's				x	x	x
Determine SDoH Funding Pool Distribution Methodology				x	x	x
Sustainability Planning			x	x	x	x
Month Six Report to HFS						x
Establish Quarterly Meetings with HFS						x
Staffing and Infrastructure						
Hire BEP Fiscal Agent	x	x				
Interview for and Hire Executive Director		x	x			
Develop BEP(s) Request for Proposals			x	x		
Interview and Hire BEP's		x	x			
Executive Director Hires Collaborative Staff			x	x		
Interview and Hire Consultants			x	x		
System Redesign/Coordination Consultant				x	x	x
Staff Recruitment and Training				x	x	x
Purchase Care Management Platform						x
Purchase EMRs						x

Project Implementation	Year 1					
	M7	M8	M9	M10	M11	M12
Project Launch	x					
Community Outreach and Engagement	x	x	x	x	x	x
Institute cross-platform IT solution	x					
Begin Monthly Collection of Baseline Quality Metrics and SDoH Information	x					
Purchase Consumer IT/Wearables	x					
Purchase Broadband Supports	x					
Conduct Training (Opioid/Naloxone, Race Equity, and others)	x	x	x	x	x	
Develop and Submit Yearly Report to HFS					x	x

Implementation	Years 2 and 3			
	Q1	Q2	Q3	Q4
Clinical Committee Data-Based Model Refinement	x	x	x	x
Identify Additional Chronic Conditions for the Project (Based on Resources and Project Success)	x		x	
Institute MCO Planning Committee for Value-Based Payment Strategies	x			

Racial Equity

About Chicago's West Side Communities

With a population of nearly 600,000 people, Chicago's West Side is diverse, comprised of a population that is 42.1% Latinx, 41.4% white, 33.2% Black, and 3.6% other races/ethnicities. Life expectancy in the West Side averages only 71.4 years. The mean income is just under $23,000, and almost 13% of the population did not complete high school. Unemployment is nearly 11%, and just over a quarter of the people live at or below the poverty line. Using the Social Vulnerability Index rankings from the Centers for Disease Control and Prevention (CDC), the West Side of Chicago has one of the highest population-weighted social vulnerability percentile scores in Illinois, 83.5. [19]

This area encompasses 11 distinct neighborhoods or communities: Austin, Belmont Cragin, Douglas Park, East Garfield, Homan Square, Humboldt Park, Little Village, Pilsen, South and North Lawndale, and West Garfield. The *Transformation Data & Community Needs Report: Chicago-West Side* study conducted 15 listening sessions with 60 individuals (42 Latinx, 17 Black) from the West Side to gather input about factors that create health inequities, staying healthy, and accessing care.

Inequities in these communities have been building over decades. Numerous policy and economic decisions such as redlining, economic disinvestment, and discriminatory education funding have helped create low employment rates, food deserts, disproportionately high incidences of chronic illnesses, behavioral health conditions, and excess mortality across the West Side. In particular, these issues have disproportionately impacted the Black and Latinx populations in these neighborhoods.

The Collaborative will engage with Black and Latinx groups in these communities and the organizations that serve and support them through multiple efforts over time as our project moves forward as part of the community engagement and outreach efforts as mentioned above. We will build relationships to improve communications between our participating providers and each of the unique areas and populations they serve. By listening to and learning from these organizations and individuals, we will build trust and develop a dialogue that will allow us to build consensus around important ways to support racial equity more broadly in these communities than by addressing targeted health issues among Black and Latinx individuals.

We plan to do this through the Community Advisory Committee, comprised of community stakeholders representing each of the designated HFS neighborhoods of Chicago's West Side. These stakeholders will reflect the diverse interests, concerns, organizations, issues, and populations of their communities and serve to raise awareness of the Collaborative of the important equity issues and challenges faced by these communities, as well as help to disseminate information among their communities about the Collaborative's services and supports. They will be an essential conduit to encouraging community involvement in the Collaborative's activities, and more importantly, ensuring that Collaborative programming reflects and meets the needs of its community as defined by these communities.

In addition to the Community Advisory Committee, we will periodically host virtual listening sessions with stakeholders across the West Side. These will serve as necessary "checkpoints" for our work at various junctures of planning and implementation and allow the Collaborative to gather input and feedback from our communities so we can adjust our approach as needed.

[19] *Transformation Data & Community Needs Report: Chicago-West Side*, February 2021

HFS Racial Equity Impact Assessment Guide by RACE FORWARD

As required, the HFS Racial Equity Impact Assessment Guide by RACE FORWARD can be found as **Attachment C** in this document.

Care Coordination

We believe that the Collaborative's approach to integrated care coordination will, by design, positively impact racial equity because the patients we are targeting are those most likely to experience inequities due to their race/ethnicity. For example, we know there are significant differences in the prevalence of hypertension by race (White 50.2%, Black 43.0%, Latinx 57.0%) in this area. This disparity is exacerbated because there are differences in people with poorly controlled hypertension equal to or greater than 140/90 who get treated with medication (White 57.2%, Black 66.5%, Latinx 60.1%). This pattern of more significant disparities in disease prevalence and greater disparity in access to and actual treatment of those diseases to all of the conditions targeted in this project: SMI, SUD, mild to moderate depression, hypertension, and type 2 diabetes mellitus.

Screening for and Supporting SDoH

Given the significant impact of SDoH on health equity, the Collaborative will include in its care management approach interventions designed to improve access to care and be more effective in linking patients to necessary resources – both healthcare and social service needs. Using a universal screening tool, the Collaborative partners will systematically screen all enrolled patients to understand their specific health and SDoH needs. We will use this information to connect them to resources within our partner systems and those in the community. To further support our patients' SDoH needs, we will create an SDoH funding pool for patients experiencing barriers to accessing care or managing their conditions. These funds allow providers and community partners the flexibility needed to address emergency needs that are typically not covered by healthcare, such as food insecurity, transportation, or housing supports.

Human-Centered Design

Finally, the Collaborative also intends to work with a partner to apply a human-centered design and delivery science approach to our model's development and implementation. Human-centered design engages individuals living with one or more of the target conditions and applies a process to understand their daily experiences, barriers, needs, and preferences to develop interventions to achieve our desired outcomes. Investing in a process that meaningfully includes patients in the design of their care allows us to connect with traditionally hard-to-reach individuals. Employing human-centered design furthers our ability to have a meaningful impact on health equity across the West Side.

Community Health Workers and ED Navigators

An inherent aspect of our integrated care and coordination approach includes CHWs and ED Navigators' use to support clinical care teams. These care team members are critical to the success of our model. We know from experience and research that the most influential support staff such as CHWs and ED Navigators are from the areas they will be serving. We plan to hire CHWs and ED Navigators with lived experience from each of the West Side communities and empower them with the knowledge, skills, and tools needed to address health equity in their neighborhoods effectively. This approach accomplishes two important goals: 1) it helps us to build capable and effective care teams with staff who bring vital

community connections; and 2) it creates job opportunities in communities where this type of employment can make a significant economic impact.

BEPs

An additional commitment we are making to improving racial equity is the strategy to contract with several BEP vendors certified by the State. We will foster an inclusive business environment that supports local businesses through increased capacity and revenue through these business partners. For example, within six months of the project's start, we plan to contract with BB&A as the Collaborative's fiscal administrator to ensure and monitor its financial health. The Collaborative's Executive Committee will oversee BB&A's responsibilities and ensure proper financial compliance. Additionally, we will contract with BEPs to support other essential aspects of the Collaborative's operations, including marketing and communications, administrative supports, and race equity training.

We further will build on current partner efforts to advance equity and inclusion on the West Side through West Side United to advance local hiring, procurement, and community investment. Our Collaborative members have been engaged in implicit bias training and implementing trauma-informed care models as ways to help broadly reduce instances of discrimination and inequities in patient experience and care in their systems.

Minority Participation

Illinois Business Enterprise Program (BEP) Entities of the Collaborative

The Collaborative will contract a variety of Business Enterprise Program (BEP) vendors certified by the State as part of its commitment to foster an inclusive business environment that helps local business increase their capacity and revenue. Contracts for BEP's will be secured at a set monthly rate using a formal Request for Proposal (RFP) process. BEP's will be legally obligated to comply with State requirements.

Benford Brown & Associates, LLC (BB&A)

Within six months of the project, a BB&A will be contracted as the Collaborative's fiscal administrator to ensure and monitor its financial health. The Collaborative's Executive Committee or Executive Director will oversee the BEP's responsibilities and ensure proper financial compliance.

Future BEP Contracting

Additional BEP's will be contracted by the Collaborative within the first six months of the project to provide the following functions:

- Marketing and Communications
- Administrative Supports
- Race Equity Training

Not-for-Profits Majorly Controlled and Managed by Minorities of the Collaborative

Members of the Collaborative are a diverse group of executive leaders representing various communities of Chicago's West Side. The list of members below are not-for-profit providers or community-based organizations that are majorly controlled and managed by minorities. These organizations will participate in the implementation and ongoing operation of the Collaborative's transformed delivery system.

Access Community Health Network

For more than 25 years, ACCESS has been on the frontlines of community-based health care and grown to become one of the largest Federally Qualified Health Clinics in the country. ACCESS provides a continuum of care model that connects patients to health care resources both within and beyond the walls of 35 locations in Cook and DuPage counties. ACCESS' services are designed to address the health of underserved communities in such areas as preventive care, chronic disease management, and support services. To address patients' comprehensive health needs, ACCESS physicians, nurse practitioners, midwives and other providers are teamed with outreach staff, case managers, social workers and substance abuse counselors to advance a continuum of care. ACCESS will serve more than 175,000 individuals and families, including more than 30,000 uninsured patients this year. Last year, ACCESS provided care to 6,329 pregnant women, 26,117 patients with hypertension, 16,923 patients with diabetes and 9,919 asthmatic patients. They also provided primary care, mental health services, and care management for more than 900 men and women with HIV/AIDS.

Bobby E. Wright Comprehensive Behavioral Health Center

The Bobby E. Wright Comprehensive Behavioral Health Center, Inc., is a non-profit that has been providing quality mental health care, addictions treatment, and developmental disability services for more than 42 years. B.E.W. provides support and treatment to youth, adults and families living within Chicago's Westside communities and surrounding areas. They provide a holistic, evidenced-based approach, towards positive mental health in the home, at work and in the community. By partnering with each consumer, they strive towards accomplishing each individual's goals. Services are available to anyone who meets the admission criteria regardless of gender, sexual orientation, race, nationality, religion, or ability to pay.

Habilitative Systems, Inc.
Habilitative Systems, Inc. (HSI) is a nationally recognized human services agency that uses a continuum of care approach to provide much-needed programs to underserved populations and people living with an array of health and human service needs. Headquartered on the west-side of Chicago, HSI has offered supportive programs to Chicago's most disadvantaged and vulnerable residents for 40 years and provides services to over 7,000 people annually in the North Lawndale, West Garfield, Austin and Englewood communities in Chicago. HSI is the only organization on the west-side of Chicago that specializes in providing assistance to individuals with developmental disabilities and has created a unique social enterprise that produces packaging supplies while teaching important life skills and delivering supportive services to program participants. The organization also serves individuals with mental illness and substance abuse challenges, youth and families at risk, veterans, seniors, ex-offenders, the homeless and those who are unemployed. Most recently, in 2020, HSI was chosen to as one of the Regional Intermediaries for the Illinois Department of Human Services Census Initiative. HSI formed the Counting on Chicago Coalition with over 30 organizations, which employed over 250 outreach workers, screening over 45,000 people for social determinants.

Humboldt Park Health
Humboldt Park Health is a 200-bed, acute care facility, accredited by The Joint Commission and has achieved Primary Stroke Certification from the Healthcare Facilities Accreditation Program (HFAP). They provide healthcare treatment that's patient-centered and focused on quality of care, ranging from everyday care to treatment for a patient's most critical needs. Humboldt Park Health has an extensive, talented medical staff, featuring specialists in family practice, pediatrics, obstetrics, general surgery, neurology, behavioral health, emergency medicine, podiatry, gastroenterology, internal medicine, and ophthalmology. This team of experienced medical providers offers specialized services in the Humboldt Park community, alleviating the practical challenges of traveling distances to receive quality medical care. As a community-based hospital, Humboldt Park Health reinvests back into the community through programs to serve the poor and uninsured, manage chronic conditions like diabetes, health education and promote initiatives and outreach for the elderly. They work hard every day to be a place of healing, caring and connection for patients and families in the community they call home.

The Loretto Hospital
As a not-for-profit, community-focused health care provider, The Loretto Hospital offers a unique, patient-centered healthcare delivery system that promotes general wellness and education in the communities they serve. Serving more than 33,000 patients each year, the Loretto Hospital provides quality healthcare services including: primary care, geriatric medicine, vision care, behavioral health services, women's health, podiatric medicine, and dental services. In addition, they are the largest non-governmental employer in the Austin community with more than 600 employees many of whom live in Austin. Through partnerships with physicians, research institutions, area residents and local businesses, they strive daily to be their communities' health care provider of choice, dedicated to improving the health and well-being of the communities they serve.

West Side United
West Side United was established in 2018 to build community health and economic wellness on Chicago's West Side and build healthy, vibrant neighborhoods. Nearly 120 individuals and 50 organizations work together to more systematically identify the obstacles and challenges to health. They have a Planning Committee with neighborhood representatives, government, non-profits, and health care institutions. To address health disparities, West Side United is an incubator and accelerator to scale the impact of existing initiatives, develop new programs, and provide coordinated support to existing neighborhood networks of CBO's.

Jobs

Existing Employees

The Collaborative will not have existing employees upon inception. All Collaborative members serve voluntarily.

Planned Workforce Development

The following are new employment opportunities to implement the project. Individuals hired will be individuals who have either lived or professional experience in the priority areas.

Staffing for The Collaborative

Within two months, through a BEP, the Collaborative will hire an Executive Director. Within 60 days, the Executive Director will employ the staff listed below to manage the program. The Executive Director will report to the Collaborative's co-chairs.

- Administrative Assistant
- Community Liaison
- Director of Finance
- Project Director
- Program Evaluator / Researcher
- Project Manager Care Coordination / Management
- Project Manager Hypertension/Diabetes
- Project Manager IBH
- Data Analyst

Collaborative Care Model Shared Staffing

Direct service staff will be hired and trained in Months Five and Six of Year One and will begin serving individuals in Month Seven.

Emergency Department Navigators: 14 FTEs
Two navigators hired by each of the seven hospitals serving Chicago's West Side.

Behavioral Health Model for individuals with a SMI or SUD diagnosis: 24 FTEs
Fourteen BH Care Managers
Ten Peer Counselors

Payment for the Collaborative Care Model will be on a fee-for-service basis, allowing providers to hire staff appropriate to anticipated caseloads that average 80 individuals served each month.

Collaborative Care Model for Individuals with Depression
CHWs 29.4 FTE
CLSW 2.9 FTE

Collaborative Care Model for Individuals with Adverse Child Experience
CHWs 8.1
CLSWs .8

Collaborative Care Model for Individuals with Hypertension and/or Diabetes
CHWs 97.3 FTE
Nurses 9.7 FTE

Training and Workforce Development

Funding has been allotted for the Collaborative members to ensure the implementation of best practices and the effective, culturally responsive provision of services.

Member Training and Accreditation Opportunities

Funding will be made available to members of the Collaborative who have not received accreditation or certification as bulleted below. The Collaborative will hire a consultant to conduct a readiness assessment based on member organizations' expressed interest. Requests will be prioritized based on the results of the assessment and available funds to ensure equitable distribution.

- Patient-Centered Medical Home Model
- Trauma-Informed Care
- Naloxone First Responder Training for CBO's
- Behavioral health screening for CBO's
- National Committee for Quality Assurance Care Coordination for CBO's

Race Equity Training

In healthcare, race equity is the motivation to see that everyone has a fair and just opportunity to be as healthy as possible. Training in the spirit of this motivation requires exploring why and how specific populations bear a disproportionate burden of disease and mortality and what power structures and institutions generate those inequities to design strategies to eliminate them. This includes understanding the difference between individual and structural racism, identifying the root causes of institutional racism, recognizing implicit bias in one's daily interactions, and learning how to account for such stereotyping. Ultimately, the goal of such training is to begin the discussion of ideas for operationalizing health equity in practice and specifically look at opportunities to expand the definition of health, strategically use data, assess and influence the policy context, and strengthen community capacity to act on health inequities.

Sustainability

Current Healthcare Financing

The way health care services are financed makes it difficult for some residents on Chicago's West Side to access health care services. For some, that is due to a lack of affordable medical insurance. For others, low Medicaid reimbursement rates limit provider willingness to accept Medicaid-insured patients.

Health care services payment rules directly limit access for individuals with Medicaid coverage. Services continue to be paid almost entirely under a fee-for-service system that limits care to face-to-face visits with only certain care team members. Before the pandemic, that was mostly restricted to in-person visits. Although payment rules for telehealth visits have been significantly relaxed during the COVID-19 public health emergency, it is anticipated they will be tightened once the emergency is lifted, including the elimination of payment for audio-only telehealth visits. This has the potential to widen health disparities for those who do not have access to high-speed internet and cannot afford smartphones with unlimited data plans.

Even under currently relaxed telehealth payment rules, payment must be provided by "billable" members of the care team who meet specific licensing requirements even with medical evidence that nurses and CHW yield equally good clinical outcomes. For example, the CoCM was shown in a Centers for Medicare and Medicaid Innovation (CMMI) funded project to successfully improve PHQ-9 scores whether the virtual patient contact was made by a licensed behavioral health clinician or a CHW trained in the model. Although reimbursed by Medicare and some state Medicaid programs, it is not by HFS.

Illinois Medicaid payment for specialists has been stagnant for decades, almost eliminating the option for independent specialists to serve West Side communities with high concentrations of individuals insured by Medicaid. Area hospitals, many of which are already financially strapped, must by necessity employ or find a legally compliant means of supplementing specialist income to meet their staffing needs. Specialists require in-person visits even when e-consult or telehealth is equally productive and convenient for patients but non-reimbursable.

Health care providers typically are not allowed to assume delegated responsibility for care management or offered a shared savings option with a realistic opportunity to achieve meaningful incentive payments even if they improve patient outcomes and reduce the total cost of care. They are rarely held financially accountable for the total cost of care of assigned Medicaid-covered individuals in risk contracts. HFS has yet to follow the example of other state Medicaid agencies by mandating delegated care management to providers meeting care management standards or setting and enforcing health plan quotas for moving providers to advanced (not just pay-for-performance) APMs and the percent of total provider payments derived from incentive payments versus fee-for-service reimbursement. Such quotas with financial consequences could help to level contract negotiations between health plans and providers.

Proposed Sustainability Approach

The Collaborative proposes to use HFS funding to make substantial and sustainable improvements in the system of care.

1. Project leadership staff will facilitate the development of more detailed planning, including workflows that enable integration and model implementation, performance monitoring, and iterative improvement.

2. Funding streams using transformation dollars will be created to support and reimburse for expanded use of emergency department navigators and CHWs on the West Side for:
    a. Screening of uninsured and Medicaid-insured residents for the targeted conditions and a subset of SDOH using a brief, uniform tool for children and another for adults.
    b. Offering a CoCM approach

3. A care management platform that is interoperable with a common EHR and accessible to organizations that do not use an EHR will be employed to promote information exchange among the full care team.

4. eConsult will be implemented for psychiatrists, and endocrinologists, cardiologists to support PCPs in the CoCM focused on project-specific conditions outlined below.

5. As gaps in key social service agency and behavioral health provider capacity are identified, focused investment will be made to implement the model of care.

This plan and additional transformation efforts with future funding can only be self-sustaining with a significant financial restructuring of the care system. The following alternatives are offered as options:

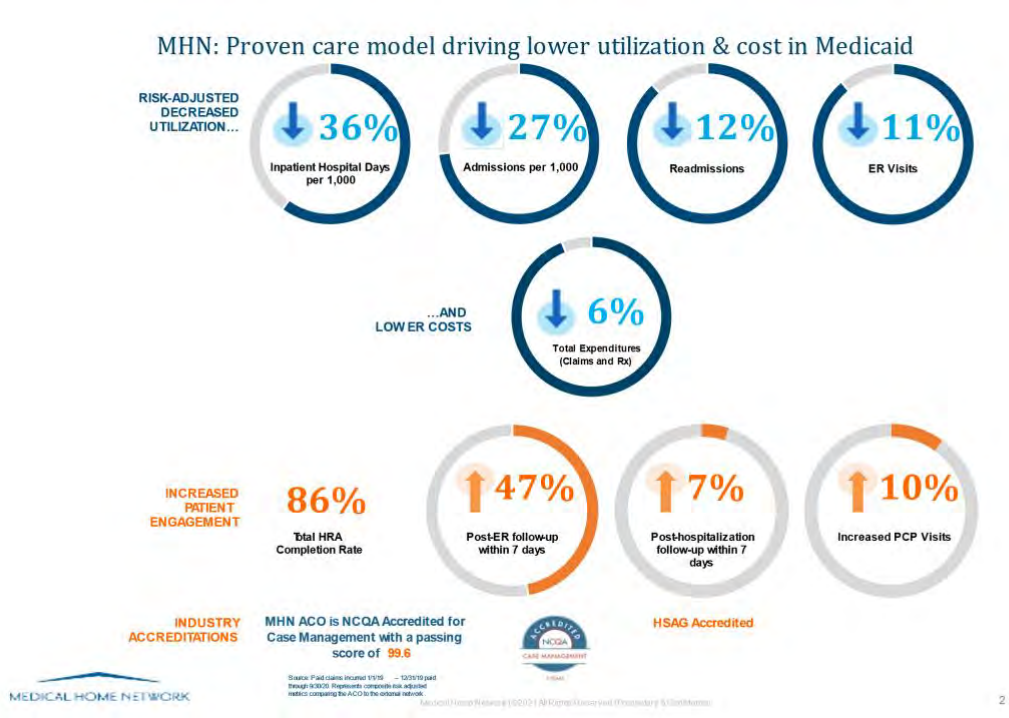
1. Capitation should be offered as an alternative option to FFS for primary care services. For FQHCs, this includes approval of the capitated FQHC APM developed by the Illinois Primary Health Care Association and proposed to HFS. This gives PCPs the ability to optimally use the full care team operating at the top of license in the most efficient care models. It allows them to customize the means of accessing care, whether in-person, face-to-face, video and audio, audio-only, or by virtual means such as electronic visits through the EHR patient portal, texting, or other interactive technology, to meet the needs of the patient. The capitation rates should account for historical primary care revenue under FFS without recalculation as “billable” encounters are replaced by the CoCMs described above, nurse triage, or other member-centric care models.

2. Health systems and other clinically integrated networks should have the three payer options offered by the Massachusetts Medicaid agency to Accountable Care Organizations.
    a. An accountable care partnership plan where a single MCO is integrated with or closely partnered with an ACO provider
    b. A primary care ACO, which contracts directly with the State
    c. An ACO provider organization that contracts directly with multiple MCOs

Patients assigned to PCPs should follow their PCP to a new health plan if contractual arrangements change so that the patient-PCP relationship is preserved unless the patient prefers to stay with the health plan.

Ultimately, this model of care must be supported from total health care cost savings realized by improving patient self-management, better control of chronic conditions, more efficient options for patients to access health care, reduction in social determinant of health barriers and recovery from substance use disorder. Those savings must be plowed back to maintain and expand this model of care. It cannot be diverted solely

to reduce managed care premiums, enhance MCO margins or profit providers. Fortunately, this is already happening to some extent on Chicago's West Side. Collaborative providers have already implemented components of this model of care in isolation. This Healthcare Transformation Collaborative funding opportunity has brought these disparate providers together to share their experience and best practices. They have individually improved outcomes and have reduced avoidable utilization and cost. They are ready to bring it to scale. Just one such example of promising outcomes is illustrated below.



Governance Structure

The Collaborative will engage in a shared governance structure comprised. At a minimum, the Collaborative's Members will include representatives of two health service providers, two non-profit, community-based organizations that address the social determinants of health, and two community members who use services provided by Collaborative member organizations or represent patients, citizens associations, or advocacy groups.

Officers of the Collaborative will include two co-chairs, one representing a hospital and another representing a community-based organization, one treasurer, and one secretary. The Collaborative will use Robert's Rules of Order's parliamentary procedure to conduct business efficiently and predictably. At a minimum, there shall be 12 monthly meetings of the Collaborative annually, but additional Collaborative meetings can be called by the co-chairs upon six (6) members' written request.

The Collaborative will hold five standing committees, which are permanently appointed to serve, including: Executive Committee, Finance Committee, Community Advisory Committee, Governance Committee, and Compliance and Quality Committee. The Collaborative will also have Ad Hoc committees appointed to perform specific tasks outside the scope of the standing committees. Each committee shall consist of two or more Members, which shall have and exercise the Collaborative's authority in its governance.

Directed Payments

Access Community Health Network, Cook County Health, and Rush University Medical Center are the member hospitals (and Medicaid providers as required) designated to receive HFS directed payments on behalf of the Collaborative. Directed payments received by these member hospitals will be directed to the BEP fiscal agent to distribute the funds according to the Plan's specifications. A monthly reporting methodology will be developed by the Collaborative to ensure the fiscal agent's accountability.

Membership Roster, Racial and Ethnic Composition

The following are details of the Collaborative's Board, including its racial and ethnic makeup.

Member Roster

Healthcare Providers		Preventative care	Primary Care	Specialty Care	Hospital Services	Mental Health	Substance Use
1.	Access Community Health Network	X	x	*x		x	x
2.	Ann & Robert H. Lurie Children's Hospital of Chicago	x	x	x	x	x	
3.	Bobby E. Wright Comprehensive Behavioral Health Center					x	x
4.	Cook County Health	x	x	x	x	x	x
5.	Habilitative Systems, Inc.					x	x
6.	Humboldt Park Health	x	x	x	x	x	x
7.	The Loretto Hospital	x	x	x	x	x	x
8.	Rush University Medical Center	x	x	x	x	x	x
9.	Sinai Chicago	x	x	x	x	x	x

Community Based Entities		Food Insecurity	Life Skills	Supported Employment	Health Education	Case Management	Housing Services	Community Engagement
1.	Access Community Health Network	x	x	x	x	x	x	x
2.	Bobby E. Wright Comprehensive Behavioral Health Center		x	x	x	x	x	
3.	Habilitative Systems, Inc.	x	x	x	x	x	x	x
4.	Sinai Community Institute		x		x	x		
5.	Sinai Urban Health Institute		x		x	x		
6.	West Side United			x	x			x

Member	Race	Ethnicity
Access Community Health Network Donna Thompson, CEO	African American	Non-Hispanic
Ann & Robert H. Lurie Children's Hospital of Chicago Matthew M. Davis, Chair, Department of Pediatrics & Executive Vice-President, Chief Community Health Transformation Officer	White	Non-Hispanic
Bobby E. Wright Comprehensive Behavioral Health Center Rashad Saafir, PhD, President and CEO	African American	Non-Hispanic

Cook County Health Israel Rocha, CEO	White	Hispanic
Habilitative Systems, Inc. Donald Dew, President and CEO	African American	Non-Hispanic
Humboldt Park Health José R. Sánchez, President & CEO	White	Hispanic
The Loretto Hospital George Miller, CEO	African American	Non-Hispanic
Rush University Medical Center Omar Lateef, MD, President and CEO	Asian American	Non-Hispanic
Sinai Health Systems Karen Teitelbaum, CEO	White	Non-Hispanic
West Side United LaDarius Curtis, Senior Director of Community Engagement and Health	African American	Non-Hispanic