Healthcare Transformation Collaboratives Cover Sheet

1. Collaboration Name: Austin Collaborative

2. Name of Lead Entity: Presence Alexian Brothers Health System d/b/a AMITA Health Saints Mary and Elizabeth Medical Center

3. List All Collaboration Members:

Presence Alexian Brothers Health System d/b/a AMITA Health Saints Mary and Elizabeth Medical Center
PCC Community Wellness Center
West Suburban Medical Center
The Loretto Hospital

4. Proposed Coverage Area:
Within five-mile radius of PCC Community Wellness Center – i.e., primarily zip codes 60104, 60153, 60160, 60302, 60304, 60402, 60612, 60623, 60624, 60634, 60639, 60641, 60644, 60647, 60651, 60707, 60804

5. Area of Focus:
Health Equity – Specialty Care

6. Total Budget Requested: $10,922,071

Austin Collaborative

Prepared by PRESENCE ALEXIAN BROTHERS HEALTH SYSTEM
for Department of Healthcare and Family Services Healthcare Transformation Collaboratives

Primary Contact: Robert Dahl

Project Description

0. Start Here - Eligibility Screen

Eligibility Screen

Note that applications cannot qualify for funding which:

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

Does your collaboration include multiple, external, entities?
- (●) Yes
- ( ) No

Can any of the entities in your collaboration bill Medicaid?
- (●) Yes
- ( ) No

Based on your responses to the two questions above, your application meets basic eligibility criteria. You may proceed to complete the remainder of the application.

1. Participating Entities

Contact Information for Collaborating Entities

1. What is the name of the lead entity of your collaborative?
Presence Alexian Brothers Health System

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

Entity Name	Tax ID # (xx-xxxxxxx)	Primary Contact	Position	Email	Office Phone	Mobile Phone	Secondary Contact	Secondary Contact Position	Secondary Contact Email
AMITA Health - Saints Mary & Elizabeth Medical Center	36-3260495	Robert Dahl	CEO & President	[redacted]	[redacted]	[redacted]	Dan Liberty	Director, Foundation Relations	[redacted]
West Suburban Medical Center	61-1899386	Barbara Martin	Chief Executive Officer	[redacted]	[redacted]	[redacted]	Vennie Christoff	Chief Quality Officer	[redacted]
PCC Community Wellness Center	36-3828320	Toni Bush	President and CEO	[redacted]	[redacted]	[redacted]	Carla Land	Director of Development	[redacted]
The Loretto Hospital	36-2200248	George Miller	Chief Executive Officer	[redacted]	[redacted]	[redacted]	Nikhila Juvvadi	Chief Clinical Officer	[redacted]

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

4. Please upload the most recent IRS Form 990 (including Schedule H, if applicable) for all participants in the collaboration. (Note: These 990s will all have to be compiled into a single PDF file.)
Collaborative IRS Forms 990

Participating Entities

Please answer the following questions regarding the various entities that would comprise your collaborative.

1. Are there any primary or preventative care providers in your collaborative?
◉ Yes
○ No

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

AMITA Health - Saints Mary & Elizabeth Medical Center

PCC Community Wellness Center

West Suburban Medical Center

The Loretto Hospital

2. Are there any specialty care providers in your collaborative?
◉ Yes
○ No

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

AMITA Health - Saints Mary & Elizabeth Medical Center

West Suburban Medical Center

The Loretto Hospital

3. Are there any hospital services providers in your collaborative?
◉ Yes
○ No

Note: HFS is seeking to know in which MCO networks each hospital in your collaborative participates.

3A. Please enter the name of the first entity that provides hospital services in your collaborative.
AMITA Health - Saints Mary & Elizabeth Medical Center

3B. Which MCO networks does this hospital participate in?
☒ YouthCare
☒ Blue Cross Blue Shield Community Health Plan
☒ CountyCare Health Plan (Cook County only)
☒ IlliniCare Health
☒ Meridian Health Plan (Former Youth in Care Only)
☒ Molina Healthcare

3C. Are there any other hospital providers in your collaborative?
◉ Yes
○ No

3D. Please give the name of your second hospital provider here.
West Suburban Medical Center

3E. Which MCO networks does this hospital participate in?
☐ YouthCare
☒ Blue Cross Blue Shield Community Health Plan
☒ CountyCare Health Plan (Cook County only)
☒ IlliniCare Health
☒ Meridian Health Plan (Former Youth in Care Only)
☒ Molina Healthcare

3F. Are there any other hospital providers in your collaborative?
◉ Yes
○ No

3G. Please give the name of your third hospital provider here.
The Loretto Hospital

3H. Which MCO networks does this hospital participate in?
☒ YouthCare
☒ Blue Cross Blue Shield Community Health Plan
☒ CountyCare Health Plan (Cook County only)
☒ IlliniCare Health
☒ Meridian Health Plan (Former Youth in Care Only)
☒ Molina Healthcare

3I. Are there any other hospital providers in your collaborative?
○ Yes
◉ No

4. Are there any mental health providers in your collaborative?
◉ Yes
○ No

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

AMITA Health - Saints Mary & Elizabeth Medical Center

PCC Community Wellness Center

The Loretto Hospital

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

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

AMITA Health - Saints Mary & Elizabeth Medical Center

PCC Community Wellness Center

The Loretto Hospital

West Suburban Medical Center

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

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

AMITA Health - Saints Mary & Elizabeth Medical Center

PCC Community Wellness Center

The Loretto Hospital

West Suburban Medical Center

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

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

AMITA Health - Saints Mary & Elizabeth Medical Center

The Loretto Hospital

West Suburban Medical Center

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

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

The Loretto Hospital - majorly controlled and managed by minorities

PCC Community Wellness Center - majorly controlled by minorities

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

AMITA Health - Saints Mary & Elizabeth Medical Center: 362235165018

PCC Community Wellness Center: 1871516799

The Loretto Hospital: 362200248-001

West Suburban Medical Center: 611899386-001

10. Below are high-level descriptions of project types that appeared in the Transformation funding statute. Check any that apply to your project; if none apply, please provide a brief description of what kind of entities comprise your collaboration. (This question is informational only and will not affect your eligibility).
☒ Safety Net Hospital Partnerships to Address Health Disparities
☒ Safety Net plus Larger Hospital Partnerships to Increase Specialty Care
☒ Hospital plus Other Provider Partnerships in Distressed Areas to Address Health Disparities (led By Critical Area Hospitals, Safety Net Hospitals or other hospitals in distressed communities)
☐ Critical Access Hospital Partnerships (anchored by Critical Area Hospitals, or with Critical Area Hospitals as significant partners)
☐ Cross-Provider Care Partnerships Led By Minority Providers, Vendors, or Not-For-Profit Organizations
☐ Workforce Development and Diversity Inclusion Collaborations
☐ Other

10A. If you checked, "Other," provide additional explanation here.

[10A. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2. Project Description

Brief Project Description

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

Austin Collaborative

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

The Austin Collaborative will help to achieve health equity on the West Side of Chicago by providing specialty care services and diagnostics, which are typically available only in hospital settings, at PCC Community Wellness Center (PCC), in the heart of the Austin community. By integrating specialty care into a medical home model that includes a) primary, preventative, mental health and dental care, b) new, existing and expanded programs addressing social determinants of health and c) a new fitness and lifestyle center being constructed on the PCC campus, the Austin Collaborative will create a much-improved version of the existing "one stop shop" medical home model by providing care for up to 16 specific specialty care areas associated with severe health disparities in the Austin area. These services will be provided on the first floor of PCC's existing site once its new, adjacent building, the PCC Pavilion, offering additional services described in this proposal, is completed in April, 2023.

Detailed Project Description

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

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

Describe any capital improvements, new interventions, delivery redesign, etc. Your narrative should explain the need for each significant item in your budget, clarifying how each connects to the overall goals and operations of the collaboration.

Provide your narrative here:

Transformational Strategy

The Austin Collaborative addresses intractable health care issues rooted in historical injustice and the often-fragmented nature of healthcare in the United States. Together, these issues place a very high burden of risk on vulnerable populations with often tragic results.

By addressing these issues head-on, the Austin Collaborative will create an innovative vehicle for broad-based change including but not limited to improving health care outcomes. An individual's *entire* quality of life stands to improve when no longer competing for advancement in education, housing and employment while struggling against often lifelong disadvantages in health status ranging from a lack of prenatal care to premature death.

According to the U.S. Health Resources and Services Administration (HRSA), Federally Qualified Health Centers (FQHCs) "are leading the nation in driving quality improvement and reducing health care costs." All FQHCs, including PCC Community Wellness Center, employ the medical home model, integrating and managing primary, preventative, mental health, substance use and dental care in a single location. By doing so, they reduce issues associated with fragmented care and poor patient compliance. The clear gap, in this otherwise successful model of care, is specialty care.

Specialty care requires trained specialists not generally available at FQHCs due to the current Medicaid professional fee structure coupled with inadequate volumes to support the expense in hiring them. Additionally, the Federal Torts Claim Act (the primary insurer for many FQHCs) does not provide malpractice coverage for specialists. Without onsite specialists, there is not a compelling reason for a community-based clinic to invest in the ancillary equipment that specialists rely upon to diagnose and evaluate disease progression.

The absence of integrated specialty care in the communities hardest hit with social and healthcare disparities continues to plague our city's most vulnerable patient populations. Only specialists are trained to diagnose and treat serious heart, lung, brain, metabolic and other acute and chronic conditions – i.e., high acuity diseases that are potentially fatal and chronic diseases that erode quality of life. Currently, patients showing symptoms of such illnesses are referred outside the accessible, trusted, efficacious environment of the medical home – resulting in higher rates of non-compliance with recommended testing and treatment. The challenge, then, is to integrate hospital-provided specialty care within PCC's medical home model as a primary means of significantly improving clinical outcomes and substantially accelerating the achievement of health equity.

The Austin Collaborative provides a laser-focused solution that is both straightforward and evidence-based. In the Collaborative's hub-and-spokes model, PCC is the hub and the three community-based hospitals (AMITA Health Saints Mary and Elizabeth Medical Center, West Suburban Medical Center and The Loretto Hospital) are the spokes. These three hospitals will work together to strategically embed up to 16 types of high need, high-risk specialty care in PCC's growing Austin campus. The Austin Collaborative model will coordinate and integrate high-touch, patient-centered care for diseases and conditions including, but not limited to:

- Diabetes and other metabolic diseases
- Cancers of many types, but especially urological and gynecological
- Diseases of the heart, such as congestive heart failure and arrhythmias
- Pulmonary diseases, such asthma and COPD
- Diseases of the eyes such as retinopathy (from diabetes and hypertension), macular degeneration and cataracts
- Orthopedic conditions such as advanced arthritis
- Podiatric conditions that impair walking in daily activities of life or work requirements

- Dermatological conditions such as skin cancer, psoriasis and presentations unclear to primary care providers (which often indicate systemic disease)
- Neurological conditions including Parkinson's and Alzheimer's Diseases, which can affect movement, coordination, mood, and memory
- Maternal-Fetal Medicine, to assist in the care of complicated or high-risk pregnancies
- Lack of transportation
- Lack of prenatal care
- Access to fitness equipment, fitness education and training
- Access to nutrition education, healthy foods and culturally-competent cooking classes
- Education on conditions to proactively manage comorbidities and improve health care literacy

Three community hospitals working together to embed strategically selected specialty care providers in a trusted, community-based setting at PCC Community Wellness Center is less an act of genius than an act of justice. "Creating a one stop shop" for all forms of care, including specialty care, managed by a dedicated primary care physician and supported by community-based hospitals through shared care coordination processes and electronic medical records, is a commonsense solution to systemic challenges that is capable of producing transformative results.

Service Area and Challenges

The Austin Collaborative's primary service area (PSA) comprises zip code 60644 and extends in a five-mile radius. The PSA starts with the Austin community itself and extends to all or parts of the Humboldt Park, North Lawndale, East Garfield Park and West Garfield Park communities. Its primary zip code is 60644 – though it also serves a significant number of patients in the 60612, 60623, 60624, 60639, 60651 and 60707 zip codes. These seven zip codes account for 67% of PCC Austin's current patient population. Austin is Chicago's second-largest recognized community area (next to Lakeview which enjoys a vastly higher standard of living and health outcomes). PCC Austin's entire service area includes 16 West Side zip codes detailed in the Community Input section of this proposal.

Austin is among Chicago's lowest-scoring communities across a wide range of health disparities documented in the Health Equity and Outcomes section of this proposal including the following examples:

- New York University researchers examining life expectancy data from the Centers for Disease Control and Prevention found that Chicago had the largest neighborhood-to-neighborhood life expectancy gaps in the nation. In downtown Streeterville, for example, residents live to an average age of 90; in low-income West Side neighborhoods, the average plummets to as low as 60.
- Infant mortality rates of 11 per 1,000 births in 2016 compared to 6.5 in Illinois as a whole
- Stroke mortality rates of 52 to 63 per 100,000 from 2013 – 2017 compared to 38.9 in Illinois as a whole

Social determinants issues:

- Poverty: In Austin, 25% of the residents live in poverty, which is defined as living below 100% of the Federal Poverty Level. This is much higher than the U.S. Census Bureau's national rates of 18.8% for Blacks, 15.7% for Hispanics, and 7.3% for Whites in 2019.
- Housing: In Austin, the percentage of households that are "housing cost burdened" (i.e., spending more than 30% of gross income on rent and utilities) is more than double the percentage in Illinois as a whole.
- Food insecurity: In Austin, 39% of residents are food insecure, compared to Feeding America's projection that 11.8% of Cook County residents are food insecure.

Goals

The goals of the project are to:

- Improve clinical outcomes across a wide range of disease states
- Support patients across an integrated continuum of care
- Expand upon an already robust menu of services to address Social Determinants of Health
- Provide fitness, nutrition, lifestyle, and meal preparation education in a facility designed for these purposes
- Provide job opportunities to community residents

Key Program Components and Interventions

The Austin Collaborative's value proposition is this: onsite specialty care, supported by telehealth, expanded care coordination and case management services, expanded social determinants of health programs, the soon-to-be-constructed PCC Pavilion housing a lifestyle and fitness center on the PCC campus (described in more detail below) and a scheduling and transportation hub that coordinates appointments for specialty care and program supports and arranges free transportation to offsite locations (described in more detail below) will result in dramatically improved health outcomes and quality of life, serving as a primary catalyst for achieving health equity in a community that currently has some of the worst health outcomes in all of Chicago.

Specialty Care Physicians, Nurses, Medical Assistants, Care Coordinators and Other Staff

The primary cost of the program is the salaries of the Specialty Care Physicians, Nurses, Medical Assistants, Care Coordinators, Health Care Coach, Community Health Worker, X-ray/ultrasound Technician on the medical side of the operation as well as the Specialty Care Clinic Executive Director, Quality Manager, Accountant, Medical Records Data Entry Clerk and Receptionists on the administrative side. Up to nine Specialty Care Physicians will be hired in Year 1 and up to seven in Year 2. Supporting staff will be hired over Year 1. Working together in a medical home model that includes specialty care, social determinants of health supports and a Lifestyle and Fitness Center will provide continuity of care and supportive structure in a one-stop-shop that will help the Austin community to achieve health equity. The personnel cost over the five-year funding period of an eventual funding agreement, as proposed, is $8,400,000.

Onsite Specialty Care Clinic:

As part of the transformation of the PCC Austin campus, the first floor of the existing facility will be re-purposed for specialty care and diagnostics provided by the hospital partners – with the facility's current primary, mental and dental health services moving across the street to the new PCC Pavilion in Spring, 2023. In total, 9,000 square feet of space in the existing structure will be renovated and made available, via a negotiated sublease agreement, to the three hospitals to provide onsite specialty care and diagnostics services. The rollout of specific individual specialties is articulated in the Milestones section of this proposal.

The proposed budget carries allocations of $1 million to retrofit the first floor of the current PCC site as a specialty care clinic (construction costs are included in the $16 million construction budget of which $12 million will be obtained from other sources) and $1,177,150 for equipment. Construction costs will occur in Year 1. Equipment costs will occur over Years 1 and 2. The specialty care clinic is expected to be ready for occupancy by Year 2, Q2. Up to nine specialties will come online in Year 1 with up to an additional seven specialties in Year 2. All specialties will then remain in place throughout the five-year period of an eventual funding agreement. Until the specialty care clinic is ready for occupancy, specialty care

services will be provided in available spaces at PCC, via telehealth and potentially at the AMITA Health Saints Mary and Elizabeth Medical Center, The Loretto Hospital and West Suburban Medical Center, as needed.

The PCC Pavilion:

The expansion of PCC's Austin campus will serve as the catalyst for achieving and building out the Austin Collaborative's purpose and design. The 34,282- square foot- PCC Pavilion, soon to be built across the street from PCC's current site (PCC Austin Family Health Center) at 5425 W. Lake Street, will provide Austin and surrounding West Side communities with a Lifestyle Center for exercise and fitness education, nutrition assistance, enhanced care coordination and enhanced case management, including connecting individuals to supportive employment, affordable housing and other social determinants of health resources in the community. In combination with PCC's current array of primary, mental, dental and social determinant of health services and the specialty, inpatient and emergency care services provided by the three hospital partners, the PCC Pavilion will serve as the catalyst for creating and managing a state-of-the-art model of comprehensive, whole person care in a trusted medical home. The model is designed to be strategically complemented with hospital-specific resources provided by the three hospital partners that surround it.

To address the continuing threat of COVID-19 and prepare for subsequent outbreaks of highly contagious diseases, the PCC Pavilion will be constructed to earn certifications from the Green Buildings Initiative (GBI), a US-based organization that provides third-party credentialing and verification for several rating systems relating to the built environment, and the International WELL Building Institute, which certifies spaces that advance human health and well-being. One of the primary transmission routes for COVID-19 is through particles and droplets in the air. Constructing the PCC Pavilion to WELL Building standards will help prevent airborne infections like COVID-19 and other upper respiratory infections though advanced air filtering and ventilation systems.

The construction of the PCC Pavilion is not contingent upon HFS funding. PCC is committed to building the new health center and has already purchased the land, completed the architectural drawings and applied for a construction permit. Construction is anticipated to begin in the spring of 2022. However, partial HFS funding would be very useful as it would allow PCC to reallocate funds that would have been used for construction costs to increase direct health care services for PCC patients. Thus, HFS capital funding would substantially benefit underserved communities.

The proposed budget carries a $3 million capital allocation for construction of the new PCC Pavilion (which has a total budget of $15 million with the balance funded by other sources). The Pavilion is expected to be ready for occupancy in April 2023.

The Scheduling and Transportation Hub:

The Austin Collaborative's Scheduling and Transportation Hub (the "Hub") plays an especially important role in care coordination across all specialties and case management services for any and all identified social determinants of health needs.

As an example, a PCC primary care physician may refer a patient with hip pain to an orthopedist embedded at PCC, initiating a sequence of scheduling, transportation, care coordination and case management activities. If that patient ultimately requires hip replacement surgery followed by physical therapy and is also found to have needs related to social determinants of health, the Hub may initiate activities which may look like this:

- The Hub schedules an onsite appointment for the patient at PCC for the next available orthopedic rotation.
- Based on orthopedic physician's evaluation, the Hub schedules the patient for further diagnostic testing at PCC or one of the hospital partner sites, if necessary, providing the patient with transportation to and from the hospital through a ride share program and alerting the care coordination team.
- Based on accurate diagnosis from a board-certified orthopedist, the Hub schedules the patient for joint replacement surgery at one of the hospital partner sites, providing the patient with transportation to and from the hospital and alerting the care coordination team.
- Joint Camp is initiated with the patient to outline expectations, review patient's comorbidities and any additional issues. The physical therapist would also provide an onsite home evaluation to determine any challenges with the home environment for safe convalescence.
- Post-surgery, the Hub schedules the patient for a round of 12 physical therapy appointments providing the patient with transportation to and from the physical therapy site and alerting the care coordination team.
- If, in the course of treatment, the orthopedic physician recommends a fitness and nutrition/weight loss program designed to maintain strength and reduce stress on the artificial joint, the Hub alerts the case management team and schedules the patient for fitness and nutrition educational training at the PCC Pavilion.

Scheduling appointments, removing transportation barriers, educating patients and their families, and facilitating care coordination and case management provide patients with wraparound services that help them to stay compliant with treatment and lifestyle recommendations, improve health literacy over the long-term and achieve better outcomes from the surgery immediately and over the long-term.

The cost of the Scheduling and Transportation Hub includes $125,000 over five years for Kizen Health, a healthcare logistics and Non-Emergency Medical Transportation (NEMT) company and additional staffing for care coordinators that is part of the personnel budget. Kizen will be engaged at $5,000 in the first year and $30,000 per year afterward.

In addition to these key components, the Collaborative partners will expand upon current programs designed to help achieve health equity through a range of community and person-centered programs and activities such as:

- A Community Advisory Board that helps to define and develop a shared vision of community health and well-being including:
  - An ongoing focus on monitoring and achieving health equity goals
  - Listening and learning from the experience of community leaders, organizations, institutions, and residents
- Deploying a group of Community Outreach Workers to meet people in the community by enhancing and expanding outreach to:
  - Faith-based organizations
  - Community organizations
  - Schools
  - Libraries
- A safe, community-based Lifestyle Center where residents can benefit from:
  - Fitness activity and education

  - Healthy foods and nutrition education, including a demonstration kitchen

- Social Determinants of Health programs, including existing, expanded and newly developed programs including but not limited to:
  - Veggie Rx program
  - Access to PCC's Austin Farm and AMITA Health's West Town Health Market for fresh produce along with educational and culturally sensitive nutritional cooking opportunities
  - Employment opportunities for community residents – both within and outside the Austin Collaborative itself
  - Legal support services related to safe and affordable housing

The following attachment includes four documents that provide additional information and visual depictions of the Collaborative's vision for achieving health equity in Austin:

- Healthcare Transformation Overview
- PCC Pavilion renditions
- A Driver Diagram detailing the primary and secondary drivers contributing to achieving project aims
- A West Side Health Resources Map

[Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Project Description Attachments

3. Governance Structure

Structure and Processes

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

The Austin Collaborative, as proposed, will be an affiliation of physicians within the three hospitals to provide specialty care services at the PCC Community Wellness Center site in Austin to meet the needs of the Austin community. Care coordination and communication through a scheduling and transportation hub is a critical component to ensure a seamless experience in the patient care continuum. The initiative will be governed by a binding Master Affiliation Agreement created and executed by each of the three hospitals/health systems and PCC Community Wellness Center.

Policies will be formulated and priorities set by the Governing Body (see attached graphic depicting relationships among the Collaborative partners and the Collaborative's relationship to the Community Advisory Board).

In this hub-and-spokes project, the four collaborative entities agreed to weight voting rights as follows:

- PCC Community Wellness Center 40%
- AMITA Health Saints Mary and Elizabeth Medical Center 20%
- West Suburban Medical Center 20%
- The Loretto Hospital 20%

In addition, specific language will be incorporated into the Master Affiliation Agreement for supermajority circumstances.

While the four collaborative entities will share oversight responsibilities, each entity will provide particular health care services, social determinants supports and administrative supports – proposed as described in the accompanying budget and subject to revision in an eventual funding agreement. All matters of individual responsibilities, staffing and resource commitments, in-kind support and financial management will be detailed in conjunction with the HFS funding agreement process. All four entities have policies in place regarding human resource issues and unshakable commitments to non-discrimination, diversity, training, ethics and other issues of human resource management and faimess. Each of the four entities supports prioritizing the hiring of community residents and community residents of color in building out the Collaborative's activities.

Disclosure of AMITA Health dissolution. Currently, AMITA Saints Mary and Elizabeth Medical Center is part of AMITA Health, a joint operating company between AdventHealth and Ascension formed in 2015. On October 21, 2021, the leaders of AdventHealth and Ascension announced that it is in the best interest of both organizations to unwind the AMITA Health partnership. Each health system will move forward separately to more nimbly meet the changing needs and expectations of consumers in this rapidly evolving healthcare environment. This separation is expected to be completed by March 31, 2022. Following the transition, the Ascension hospitals and care sites (formerly part of Alexian Brothers Health System and Presence Health) will begin to be clinically and operationally integrated with Ascension. Keith Parrott, AMITA Health President and CEO, will continue to serve as the leader for the Ascension ministries in the Illinois market, including Saints Mary and Elizabeth Medical Center. Robert Dahl will continue to be the President and CEO of Saints Mary and Elizabeth Medical Center.

The attached graphic depicts the organizational relationships among Austin Collaborative partners and the Collaborative's relationship to the Austin community.

[1. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Austin Collaborative Partners_

Accountability

2. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally, and with extensive participation from each participating entity? What methods will be used to enforce policy and procedure adherence?

The governance model has been agreed to in principal along with associated voting rights. Initial thoughts center on the Steering Committee outlining policies and procedures. The executive director may monitor performance, compliance and outline any gaps or deviations and report those findings to the Steering Committee. The Steering Committee will be entrusted to enforce policy and procedure adherence and to ensure transparency in mitigating any deficiencies.

The Affiliation Master Agreement will outline the scope, responsibilities, and expectations of the parties in providing consistency, continuity, and coordination of care to patients. A physician lease agreement may be entered with each hospital entity and PCC that defines the service-related duties with each specialist to be supplied, such as time of day/day of week onsite or accessible via telemedicine, communication expectations, and continuity of care between hospitals and specialists.

To ensure, monitor and validate the effectiveness of the program model, a Steering Committee will be established to help with guiding principles for managing day-to-day activities as well as monitoring operational and clinical metrics. Each participating entity may appoint a member of the Steering Committee and each member will have an equal vote brought forth to the committee with simple majority voting model. A charter will be developed coupled with decisions rights to help guide the Steering Committee. The overarching responsibilities of the committee will likely include, but are not limited to, which entity will be earmarked as the convener, criteria for disbursement of funds and agreed upon metrics that the Austin Collaborative will abide by.

The Steering Committee will be utilizing metrics that are evidenced-based with clinical pathways shown to improve care within those specified specialties identified by the Community Advisory Board. The intended purpose of the Steering Committee is to be a dynamic and agile committee that evolves to continuously meet the needs of the community.

The Committee will review the financial performance of the project in comparison to initial budget projections and variances; determining the model of care, specialists and sub-specialists, continuity of care, ancillary staff and ancillary diagnostic tests to be provided to meet the needs of the community; assisting in setting policy for scheduling patients, medical records completion, billing, coding and other operational activities; providing guidance on resources to ensure the effectiveness and capacity of specialist providers; providing guidance on financial, operational and patient satisfaction goals; reviewing reports from Quality Oversight Committee to monitor, track and meet/exceed clinical performance targets.

By providing oversight of the expenses and revenues associated with this initiative as outlined in the proposed budget, the oversight committee will ensure that funds are used for program's intended purpose.

[2. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

New Legal Entity

3. Will a new umbrella legal entity be created as a result of your collaboration?

○ Yes
◉ No

[3A. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Payments and Administration of Funds

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

The Austin Collaborative does not plan to use a fiscal intermediary. This initiative, as outlined, will not require the creation of a new legal entity. The collaboration design is intended to streamline and reduce the startup costs, administrative burden and legal implications of establishing a new organization.

As the lead applicant, AMITA Health, unless otherwise stated in an eventual funding agreement, suggests that PCC provide the overall financial oversight to the Austin Collaboration project ensuring that all direct payments earmarked as transformation funds will be distributed to the collaborating entities and utilized in accordance with the goals and activities proposed and the eventual funding agreement.

PCC Financial Controls:

PCC Community Wellness Center, in conjunction with the Master Affiliates Agreement, will establish a pass-through funding arrangement with its partners. That Master Affiliates agreement will designate the funding agreements upon which the pass-through arrangements will be based.

PCC uses the ABILA, MIP fund accounting system. The system provides for the discreet accounting for general ledger reporting including all disbursements, revenues and balance sheet accounts. PCC uses the accrual accounting method as required by Generally Accepted Accounting Principles. This allows for the preparation of detail financial records for the reporting entity by cost center and then, comparison to budget by line-item revenue and expense. PCC is a 501 C 3 entity with grants management policies and services. PCC has an annual audit and Single audit conducted by Clifton, Larson and Allen, Public Accounting Firm. All journal entries, procurement requests, travel requests and accounting entries require the review and approval by the Director of Finance and Chief Financial Officer at PCC. The Finance Department uses the PCC Policy on Uniform Guidance for the required controls and accounting for HRSA awards. The Abila MIP general accounting system provides a "fund accounting" feature which Finance uses to track grant expenditures for its financial reporting.

PCC will adhere to internal controls applicable to all federal awards. These internal controls will provide the oversight for funding awards through the HealthCare Transformation process. This includes cash management, allowable costs and related cost principles, eligibility, matching, procurement, program income and sub recipient monitoring. PCC has in place required policies on suspension and debarment as required by our procurement policy.

The PCC Financial Team includes a Chief Financial Officer, Director of Accounting, Grant Fund Accountant for Awards and senior Accountant assigned to the Transformation Grant. When Awards are received, the Foundation Manager will work to prepare a Grant Budget and the Director of Accounting will assign a funder code to the Award. The Grant Fund Accountant and Senior Transformation accountant will meet periodically, at least monthly, to review all transactions coded to the award are appropriate. PCC prepares monthly financial statements and these reviews are performed in conjunction with the monthly close. All variances between actual and budget are reviewed with the Director of Finance and Chief financial Officer. Significant variances will be appropriately addressed dependent upon the nature of the variance.

[4. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

4. Racial Equity

High-Level Narrative

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

Most Austin residents are Black/African American (83% of over 97,000 people). Most have faced and continue to face racial discrimination, social determinants of health challenges and persistent healthcare disparities. For example:

- In 2019, the national poverty rate for Black/African Americans was 18.8% and 7.3% for Whites. In Austin, the poverty rate is 25% (American Community Survey 2015-2019), far higher than the national rates.

The social and economic disadvantages experienced by individuals living in the Austin community place them at a high risk for poor health outcomes and high rates of morbidity and mortality. For example:

- In Austin, the lung cancer diagnosis rate is 120 per 100,000 people (90 for Chicago); colorectal cancer diagnosis rate is 77 per 100,000 people (67 for Chicago); and stroke mortality rate is 63 per 100,000 people (51 for Chicago); These rates are higher than Chicago as a whole and various affluent community areas of Chicago.

- New York University researchers examining life expectancy data from the Centers for Disease Control found that Chicago had the largest neighborhood-to-neighborhood life expectancy gaps in the nation. In downtown Streeterville, for example, residents live to an average age of 90; in low-income west side neighborhoods, the average plummets to as low as 60.

The expansion of PCC's Austin campus will serve as the catalyst for working toward and achieving racial equity in healthcare in the Austin community. As highlighted below and more fully described in the Quality Metrics section of this proposal, a variety of clinical outcomes and health disparities data will be regularly collected, monitored and reviewed by the Collaborative's Governing Body and Steering Committee and presented to the Community Advisory Board for review and input.

[High Level Narrative - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Racial Equity Impact Assessment Questions

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

The Austin Collaborative comprises PCC Community Wellness Center (PCC), AMITA Health Saints Mary and Elizabeth Medical Center, West Suburban Medical Center and The Loretto Hospital. The focus of the Austin Collaborative is to expand access to quality primary, preventative, and specialty care in the Austin community (primarily zip code 60644, with the inclusion of 60639, 60651, and 60707) on Chicago's West Side. The Austin community is 83% African American, 12% Hispanic, 4% White and 1% Asian or other. The economic and social disadvantages experienced by Austin's African Americans and Hispanicsbplace them at high risk for poor health outcomes.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

The Austin Collaborative members have obtained the input and collaboration of key stakeholders, as is evidenced by numerous letters of support from elected officials and community stakeholders. The Collaborative's partnership organizations have held numerous meetings with elected officials to discuss the purpose and potential of the Collaborative's work. For each of the partnership organizations, these conversations build upon years of community-based work. For instance, AMITA Saints Mary and Elizabeth is a member of West Side United, a coalition of six west side hospitals, and Senator Durbin's HEAL initiative; PCC is part of MHN ACO, a network of 12 health care providers including eight Federally Qualified Health Centers; and The Loretto Hospital is part of the West Side Collaborative. Individually and collectively, the Collaborative's partnership organizations have engaged local community leaders and organizations, including pastors, anchor community organizations, social service agencies, and grassroots organizations to explore interests and perspectives; how healthcare providers can better serve individuals and specific population groups; and what mode/methods may be the most effective to engage, communicate and forge strong relationships with community residents. Ongoing communication with community leaders and organizations, elected officials and others will identify trends, perspectives, challenges, and opportunities that further enhance project planning, prioritization and implementation.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

African-Americans and Hispanics make up 95% of the Austin community. The entire community has faced years of healthcare services inequalities, lack of preventive care, lack of primary care physicians, and overall social and economic disparities. Of Chicago's 77 communities, Austin has some of the worst rates measuring health disparities, including very high mortality rates for heart disease, stroke, diabetes and cancer. For example, per the Chicago Health Atlas, Austin's cancer-related mortality rate of 115 per 100,000 residents between 2014 and 2018 is significantly higher than the 91.5 per 100,000 residents rate for all of Chicago.

Historically, Black/African American community members have faced ongoing discrimination that is a well-documented causal factor resulting in lower socioeconomic and health status. The 2015-2019 Chicago Health Atlas data demonstrates the degree of systemic issues facing Austin residents: for instance, 25% of Austin residents live in poverty, which is defined as persistently living below 100% of the Federal Poverty Level. This is much higher than the U.S. Census Bureau's national rates of 18.8% for Blacks, 15.7% for Hispanics, and 7.3% for Whites in 2019. These kinds of socioeconomic disparities lead to poorer status, more late-stage illness and mortality, a lowered quality of life and shorter life expectancy.

Offering integrated specialty care services in a community-based medical home model of care will be a significant step toward reducing the community's health disparities. Therefore, we expect this majority minority community of largely African Americans will benefit substantially from the programs and services implemented by the Austin Collaborative.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

For decades, the diminishing access to healthcare services has had an impact on the rise of healthcare inequalities. Additionally, Austin community members have lost jobs and economic opportunities as large employers have relocated out of the area. Disinvestment in the community and disproportionate crime and unemployment have resulted in economic stagnation and decline. The Austin Collaborative's proposal will address one of the root causes of racial inequity, the lack of healthcare access, by providing community-based access to specialty care integrated into a system of primary, mental health and dental care, supported by care coordination, case management and social determinants of health supports.

[4 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

The Austin Collaborative's proposal seeks to expand access to quality primary, preventative, and specialty health care in the Austin community on Chicago's West Side. This collaboration will create an ongoing partnership between PCC Community Wellness Center, a Federally Qualified Health Center, and three hospitals that will provide integrated specialty, inpatient, and emergency care: AMITA Health Saints Mary and Elizabeth Medical Center, West Suburban Medical Center and The Loretto Hospital.

The project aims to reduce disparities by removing barriers to care and proving equitable access to specialty care services. For example, barriers to care such as long waits for appointments, distance and transportation lead to a high no-show rate when PCC patients are referred for specialty care at offsite locations. By co-locating specialty care at PCC, along with its primary, mental health and dental care, in an integrated medical home model, and providing transportation to and from offsite locations when hospital-based is required, the Collaborative will reduce the barriers, decrease the no-show rate and improve health outcomes for Austin residents.

In addition, some health care providers limit the number of appointment slots for Medicaid patients (thus increasing wait times) or do not accept many or all Medicaid insurance plans or uninsured patients. The specialists provided by the hospital partners in the Austin Collaborative will be dedicated to community-based specialty care for all Austin residents through face-to-face and, when needed, telehealth visits, thereby removing barriers, increasing access and working toward racial equity. All partners will accept the same MCO insurance plans and self-pay in accordance with federal poverty guidelines.

The effect will be transformative. A healthier community will have more capacity for active, involved lives, including more job opportunities. When community residents are healthier, they are better able to maintain their jobs or obtain new positions, have fewer absences from work due to sickness, and are less distracted by no longer having to manage their own conditions or those of their loved ones. These incremental steps to increase healthcare access ultimately have the potential to reverse the impact of the divestment that exists, thereby uplifting the community.

[5 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

The Austin Collaborative does not anticipate any adverse impacts or unintended consequences resulting from the implementation of this project. If this proposal were to fail, there would be continued racial and economic disparities, continued under-utilization of available healthcare services, and high rates of admission for high-acuity conditions. Through the Collaborative, we will improve health, wellness and racial equity throughout Austin and the immediate vicinity. The largely African-American population in the area will benefit as a result.

[6 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

This project will maximize equitable opportunities and impacts for community members disproportionately affected by racial disparities. The purpose of this proposal is to integrate specialty care into primary, preventative, mental health and dental care in an integrated, community-based medical home model. The four members of the Collaborative will work together on an ongoing basis to address health care coordination and social determinants of health issues, and advocate for racial equity across the spectrum of related issues. As new issues are identified by our Community Advisory Board, other community stakeholders or through newly acquired data, additional measures may be added to enable the Collaborative to unwaveringly pursue the advancement of racial equity in healthcare and across other quality-of-life domains as well.

[7 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

The Austin Collaborative has been careful to request investment funds to create programs and services that will be sustainable after the initial deployment based upon additional funding in Medicaid MCO risk-based payments. The proposal will maximize the use of awarded funds to create the space needed to co-locate specialty care with primary, mental health and dental care.

A Governing Body with specific voting rights has been established. A Steering Committee reporting to the Governing Body has been established to manage the day-to-day operations of the Collaborative. A Community Advisory Board will be established to provide ongoing communication with key community stakeholders. Each of these entities is further described in the Governance section of this proposal.

Ongoing data collection is central to the purposes of the project especially as related to, but not limited to, clinical outcomes in selected specialty areas, engagement in addressing social determinants of health issues and indicators related to health disparities and the advancement of health equity. A Quality Dashboard will be created for each defined metric incorporated into the funding agreement. Data will be aggregated monthly and monitored quarterly. Public reporting and accountability will be maintained throughout the project.

[8 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

By increasing access to specialty services, the Austin community will experience improved health outcomes through the early detection of disease and chronic conditions. The Austin Collaborative will measure success by tracking racial and ethnic patient data alongside health outcomes data. Specific clinical metrics are detailed in the Quality Metrics section of this proposal and will be finalized, if the proposal is selected, in a subsequent funding agreement. All agreed-upon metrics will be monitored and tracked to evaluate the project's progress towards its goals. This data will be stratified by socio-economic status, race, and ethnicity using electronic health records systems.

[9 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

5. Community Input

Service Area of the Proposed Intervention

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

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

Select counties:
Cook

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

60104, 60153, 60160, 60302, 60304, 60402, 60612, 60623, 60624, 60634, 60639, 60641, 60644, 60647, 60651, 60707, 60804

Community Input

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

The Austin Collaborative aligns with INVEST South/West, Chicago Mayor Lori E. Lightfoot's community improvement initiative designed to marshal the resources of multiple City of Chicago departments, community organizations, and corporate and philanthropic partners to increase investment in Austin and nine other communities on Chicago's South and West Sides.

Through this initiative, the City of Chicago will align more than $750 million in public funding over three years, while seeking to maximize those public investments in order to attract significant additional private and philanthropic capital, respond to changing commercial trends, and enrich local culture. With a focus on 12 key commercial corridors in the 10 communities – the "front doors" to the neighborhoods – INVEST South/West collectively supports infrastructure development, improved programming for residents and businesses, and policies that impact each of the community areas surrounding these corridors to create lasting impact.

In alignment with Mayor Lightfoot's goal, this proposal is designed to enhance the design and infrastructure of community health in the Austin area by improving access to specialty care services.

The leaders of the partners in the Austin Collaborative are experienced health care providers who have been involved with many of the initiatives, coalitions, studies and projects that have helped to inform the HTC initiative. For instance:

- AMITA Saints Mary and Elizabeth is an anchor hospital in Senator Dick Durbin's HEAL Initiative and a founding member of West Side United - a coalition of hospitals and other community stakeholders whose mission is to improve neighborhood health by addressing inequality in healthcare, education, economic vitality and the physical environment using a cross-sector, place-based strategy. The hospital is also in the beginning stages of a new collaborative sponsored by Ann & Robert H. Lurie Children's Hospital of Chicago to help reduce infant and mother mortality on the West Side. The Lurie Collaborative expects to submit a proposal in the third round of HFS funding in the spring.
- PCC, in addition to being a member of West Side United, is a member of the All Hands Health Network, led by the Ann & Robert H. Lurie Hospital of Chicago, Austin Coming Together and Mayor Lightfoot's Racial Equity Rapid Response Team.
- The Loretto Hospital is part of the West Side Collaborative – which is addressing adult and child behavioral health on the West Side and fully aligned with and supportive of this proposal.
- West Suburban Medical Center is a member of the West Side Housing Authority, Oak Park Homeless Coalition and Housing Forward.

Additionally, PCC Community Wellness Center, the hub in our "hub-and-spokes" collaborative, has obtained community input through its tri-annual community needs assessment, which was completed in October 2021. The analysis reviewed demographic, socioeconomic and population health status data for PCC's service area. The assessment also included electronic surveys from patients and community residents, patient focus groups and subject matter expert interviews. Of the 539 total survey responses received, 79 responses came from 60644 (i.e., Austin). The other zip codes in the Austin Collaborative's service area were also reflected in the survey responses. Among other things, respondents expressed concern with access to specialty care. One such barrier is insurance: 11% (61) of respondents said they can't see specialists they want to see.

As a comprehensive research document, the tri-annual needs assessment provides the opportunity to reflect on the community's needs as well as those immediately presented by PCC's patients. Further analysis from the community needs assessment can be reviewed in the Health Equity and Outcomes section.

In addition, the Collaborative has assessed the input of historical data from local sources including but not limited to:

- HTC's Data and Community Needs Report
- The Chicago Health Atlas – produced by the Chicago Department of Public Health and the PHAME Center at University of Illinois Chicago
- The Chicago Department of Public Health's Healthy Chicago 2025
- West Side United
- The Austin Coming Together Quality-of-Life Plan – a 20-month-long process involving more than 500 community residents and community stakeholders including members of our Collaborative

Going forward, the Austin Collaborative will establish a Community Advisory Board to guide the Collaborative's policies and relationships with community residents and leaders, including key stakeholders from across Austin and surrounding communities.

The following attachment is a letter of support the Medical Home Network (MHN) MCO, a key participant in the West Side Collaborative addressing adult and child behavioral health.

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

Input from Elected Officials

1. Did your collaborative consult elected officials as you developed your proposal?
◉ Yes
○ No

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

Select legislators:
Aquino, O. - Ill. Senator - 2nd State Senate District, Davis, D. - U.S. Representative - 7th Congressional District, Ford, L. - Ill. Representative - 8th State Representative District, Lightford, K. - Ill. Senator - 4th State Senate District, Lilly, C. - Ill. Representative - 78th State Representative District

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

Daniel La Spata, Chicago 1st Ward Alderman

Brian Hopkins, Chicago 2nd Ward Alderman

Roberto Maldonado, Chicago 26th Ward Alderman

Emma Mitts, Chicago 37th Ward Alderman

Samir Mayekar, Deputy Mayor, Chicago

Maurice Cox, Commissioner, Department of Planning and Development, Chicago

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

6. Data Support

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

One single organization cannot adequately address health inequity in our patient communities. Thus, the organizations in the Austin Collaborative will work together to enhance access to specialty care in underserved communities. As a central member of the Austin Collaborative, PCC Community Wellness Center's patients will serve as the base for this project. The Collaborative anticipates serving the patients (current and future) who attend PCC Austin Family Health Center located in the Austin community on Chicago's West Side. There is sufficient data taken from assessment of current PCC Austin patients to demonstrate the need for improvement in specialty care access in Austin and its surrounding areas. The data below reflect that the Austin community is experiencing severe poverty and health disparities that necessitate increased access to specialty care.

In the Austin community of over 97,000 people, about 83% of residents are Black/African American and 11% are Hispanic. Most continue to face racial discrimination, social determinants of health challenges, and persistent health disparities. In Austin, the poverty disparity is even more extreme. According to the CDPH Chicago Health Atlas (2015-2019), the poverty rate for Austin is 25%, much higher than the national rates of 18.8% for Blacks, 15.7% for Hispanics, and 7.3% for Whites in 2019. Moreover, the uninsured rate for Austin is 11.58%, compared to 9.65% for all of Chicago.

PCC's patient data for the PCC Austin Family Health Center indicates that 87% of patients are covered by Medicaid or Medicare while 4% are uninsured. Of these patients, 90% are Black/African American and 5% are Hispanic. Based on self-reported patient data for 11% of patients for this health center, about 93% of patients live at 200% or below the Federal Poverty Level (FPL).

The Austin community has been designated by the U.S. Department of Health Resources and Services Administration (HRSA) as a Medically Underserved Area. The social and economic disadvantages experienced by individuals living in this community place them at a high risk for poor health outcomes such as infectious diseases, diabetes, premature delivery, and low birth weight. The highest morbidity and mortality rates for heart disease, stroke, diabetes, and cancer are in high poverty, primarily Black/African American communities. For example, in the Austin community, the lung cancer diagnosis rate is 120 per 100,000 people (90 for Chicago); colorectal cancer diagnosis rate is 77 per 100,000 people (67 for Chicago); and stroke mortality rate is 63 per 100,000 people (51 for Chicago); These rates are higher than Chicago as a whole and various affluent community areas of Chicago.

The Austin community also experiences slightly higher rates of breast and cervical cancer. The invasive breast cancer diagnosis rate per 100,000 females is 206.5 for Austin and 198 for Chicago. The cervical cancer diagnosis rate per 100,000 females is 15.4 for Austin and 15 for Chicago. The rates are even higher in other community areas within the Austin Collaborative's service area. The breast cancer diagnosis rates for East and West Garfield Park are 257 and 301 respectively and the cervical cancer diagnosis rates are 24 and 22 respectively.

Furthermore, the University of Illinois at Chicago's transformation report indicates that West Chicago (which includes all of the zip codes in the Collaborative's service area) is severely impacted by social determinants of health that negatively affect health outcomes. This is reflected in the Social Vulnerability Index (SVI) data regarding race/ethnicity/language, socioeconomic status, household composition, and housing/transportation. West Chicago has an SVI of 83.5, significantly higher than West Cook (58) or South Cook (56.6). The Austin Collaborative will address SDOH through several programs and partnerships (see SDOH section).

Lastly, the UIC team gathered significant health status data that supports the Austin Collaborative's proposal to increase outpatient care. One of UIC's main conclusions is that their data indicates that "Medicaid enrollees have poor access to outpatient care and higher levels of prevention-sensitive hospitalizations in West Chicago as well as the other four study areas. Improving accessibility to quality outpatient care will be critical to decreasing hospital admissions" for conditions such as diabetes, heart disease, hypertensive diseases, chronic obstructive pulmonary disease (COPD), and asthma. About 30% of the residents in the Austin Collaborative's proposed service area are Medicaid enrollees (per HRSA's Uniform Data System).

All of the health indicators and social determinants of health data described above support the need for increased access to specialty care, in addition to ongoing primary care. Many health conditions cannot be fully addressed by primary care providers alone. Additionally, the Collaborative will be structured to ensure specialty care access for a low-income population, including recipients of Medicaid and the uninsured. While there is significant funding for primary care, there is a clear need for additional financial support for specialty care to improve health outcomes in these underserved areas.

Methodology of Collection

Data pertaining to the health and socioeconomic status of the Austin community and surrounding areas and PCC's patient population were collected and analyzed. Data was available for poverty status, insurance status, and health conditions within the Austin Collaborative's service area.

Information was obtained from various sources, including, but not limited to, the following:

- American Community Survey (ACS) – June 2021
- Chicago Department of Public Health's (CDPH) Chicago Health Atlas
- Transformation Data and Community Needs Report – West Side, February 2021
- UDS Mapper (data from Uniform Data System (UDS); collaboration of Health Resources and Services Administration (HRSA), John Snow, Inc. and the American Academy of Family Physicians)
- PCC Community Wellness Center's patient data
- PCC's Community Needs Assessment – October 2021

Some of the data was obtained from PCC's community needs assessment, completed in October 2021. As a Federally Qualified Health Center, PCC is required by the U.S. Department of Health and Human Services' Health Resources and Services Administration to complete this assessment every three years. The analysis reviewed demographic, socioeconomic, and population health status data for PCC's service area. Health status focus areas included the following categories: mortality, morbidity, birth outcomes, mental health, oral health, healthy behaviors, community safety, opioid epidemic, life expectancy, and health care and professional shortages.

This in-depth, mixed-method assessment also included qualitative data:

- **Electronic survey/questionnaire** distributed to patients and community members: Conducted from June through July 2021; Available in English and Spanish; 539 total survey responses were received, of which 478 (315 complete responses) were from service area residents.

- **Patient Focus Groups**: Two groups were conducted virtually in July and August 2021.

- **Subject Matter Expert Interviews**: Conducted in July 2021 with four leaders in the service area, representing a hospital (West Suburban Medical Center), a public health department (Chicago Department of Public Health), and two social service organizations (Family Focus and Northwest Side Housing Center).

2. Attach the results of the data analyses used to design the project and any other relevant documentation. (Note: if you wish to include multiple files, you must combine them into a single document.)

Data Analysis

7. Health Equity and Outcomes

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

Per the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA), over 79,000 low-income residents remain unserved by any community health center in the Austin Collaborative's proposed service area. The primary zip codes (60612, 60623, 60624, 60644, 60651, 60639, and 60707) in the proposed service area have been designated as Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) by HRSA. Unemployment, lack of affordable housing, food insecurity, and community violence are all barriers to residents' health and wellbeing. The communities in this service area are among the ones facing the greatest hardships and structural inequities in Chicago and the near west suburbs, leading to significant geographic and racial/ethnic disparities in life expectancy across the service area.

More than 89% of the primary service area population (60644, 60651, 60639, 60707, 60612, 60624, and 60623) identifies as non-white, which is substantially more than in Cook County as a whole, where less than 58% of the population identifies as a racial or ethnic minority, and in Illinois less than 39%. Forty-two percent of residents identify as Black/African American and 45% identify as Hispanic. Due to generations of structural racial and ethnic inequity, there is significantly more economic hardship within the service area among patients that identify as a racial or ethnic minority.

Poverty rates for the five target communities – Austin, East Garfield Park, Humboldt Park, North Lawndale, and West Garfield Park – are extreme, ranging from 25 to 44%, much higher than 18.4% for all of Chicago and 10.5% for the national average.

Additionally, access to safe, non-crowded, and affordable housing is an ongoing need to improve service area residents' health. A household is considered "housing cost burdened" if the household spends more than 30% of their gross income on rent and utilities. In Austin, approximately 62% of renter-occupied units are considered rent-burdened. This is similarly severe in West Garfield Park (63%), East Garfield Park (58%), and North Lawndale (59%). These rates are astonishingly high, nearly double the averages for Cook County (36%) and Illinois (30%).

As a result of these poor social determinants of health, the service area population experiences severe health disparities in numerous health indicators, such as diabetes, cardiovascular disease, cancer, prenatal and perinatal health, child health, and behavioral health. Service area residents have high rates of diabetes prevalence and mortality, cancer mortality, adult and childhood obesity, opioid-related overdose mortality, and COVID-19 cases, hospitalizations, and deaths. Pre- and perinatal indicators are especially poor, exceeding national and state averages on indicators including low birthweight births, % of births that are preterm, infant mortality, births to teenage mothers, and late entry into prenatal care.

Cardiovascular disease is prevalent and a leading cause of death and disability. Risk factors include high blood pressure, high cholesterol, being obese or overweight, cigarette smoking, poor nutrition, and lack of physical activity. Several communities in this service area also have substantially elevated stroke mortality rates, including Austin, West Garfield Park, and East Garfield Park (between 52 and 63 per 100,000 in 2013-2017). Thus, residents of these communities would benefit substantially from increased access to cardiology.

According to the Chicago Health Atlas, several predominately Black West Side communities in the service area also experience elevated rates of infant mortality, low birthweight births, or births to teenage mothers compared to other communities, and Illinois as a whole. These communities include Austin, West Garfield Park, and East Garfield Park. This extends to the access to care measure of late entry to prenatal care.

In the Austin community, prenatal and perinatal health indicators are considerably worse than in Illinois or the US as a whole. The Austin community (60644, 60651, 60639, and 60707) exceeds both the state and national averages for all tracked indicators, including low birthweight births, percent of births that are preterm, infant mortality, births to teenage mothers, and late entry into prenatal care. Between 2013 and 2017, 13.7% of all births were preterm, above the state (10.7%) and national (10.2%) averages. Similarly, for late entry to prenatal care, defined as no prenatal care during the first trimester, 26.6% of service area pregnant women did not access prenatal care during the first trimester, above the state (21.5%) or national (21.9%) averages. This area also fares poorly for rates of infant mortality, with 11.0 infant deaths per 1,000 births compared to just 6.55 and 5.67 in the state and nation. Therefore, there is a need for specific interventions to improve access to prenatal care and maternal-fetal medicine specialty care.

Furthermore, the service area needs increased access to specialty care, such as podiatry and orthopedics, to improve musculoskeletal health. Although PCC's Sports Medicine and Prenatal Wellness Clinic provides specialized non-surgical musculoskeletal services for patients from all PCC clinics, there is a need for further musculoskeletal services, including orthopedics, pain, physiatry, podiatry, ortho-spine and neurosurgery related to back pain. The patient population currently using PCC's musculoskeletal services are representative of the PCC patient population overall; the most common communities are Austin and Belmont-Cragin.

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Our patient communities are in great need of dermatology services. According to a 2012 report, melanoma and non-melanoma skin cancer outcomes are poorer for ethnic minorities, people of low socioeconomic status, less educated people, the elderly, and those who are uninsured. Skin cancer morbidity and mortality are disproportionally higher among Blacks, Hispanics, and people of low socioeconomic status. Similarly, Black and Asian children are more often seen for the diagnosis of atopic dermatitis than white children, suggesting increased prevalence or severity of this disorder among these racial minorities.

Given the current dermatology workforce shortage, the increased patient load may have an adverse effect on dermatologic care access. Additional concerns include the state of dermatologic training, insufficient research involving ethnic minorities, and a lack of investigations of dermatologic health disparities.

Gastroenterology is another specialty that is much needed in these communities. According to a 2020 study published by US News, colorectal cancer accounts for 8.2% of all new cancer cases and is the second leading cause of cancer death in the United States. Colon cancer disproportionately affects communities of color and economically marginalized populations. This study also revealed that Black, Hispanic, and low socioeconomic status patients were less likely to be screened, more likely to be admitted for an emergent procedure, and had an increased risk of mortality and shorter overall survival time compared with wealthier, white patients. This analysis, combined with an investigation of peer-reviewed literature and interviews with clinical experts, revealed the pivotal role that preventive care has in driving some of these disparities.

Not only do the health indicators illuminate the need for increased access to specialty care, the focus group participants and subject matter experts interviewed for PCC's 2021 Community Needs Assessment also expressed a desire for more specialty care.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

The Austin Collaborative is designed to bring specialty care services tied to identified community needs into the heart of the community where they are easily accessed at PCC Community Wellness Center, a trusted Federally Qualified Health Center with a long and distinguished track record of service to the community.

PCC plans to construct a new health center, PCC Primary Care Pavilion, a 34,282 square-foot facility that will be located across the street from its current health center at 5425 W. Lake Street in Chicago. Upon completion, the new site will offer primary, specialty and behavioral health care, in addition to a Lifestyle Center for exercise and fitness classes and enhanced care management and case management, including connecting individuals to supportive employment and affordable housing resources in the community.

The immediate, measurable impacts that follow from the activities of the Austin Collaborative are:

- Reduced wait times for specialty care appointments
- Reduced no show rates for specialists
- Reduction in mortality, (or morbidity, if measurable) from;
  - Heart disease
  - Diabetes
  - Colon/Prostate/Breast/Lung cancer
- Increased preventative screenings and education removing transportation as a barrier and community health workers to enable connections
- Increased use of alternative therapies and lifestyle improvements with the new PCC Pavilion
- Increased referrals for nutrition education and nutrition Rx
- Increased referrals for Social Determinants of Health
- Reduction in Emergency Room visits

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

By creating a hub-and-spokes collaborative designed with PCC as the hub and three West Side hospitals covering all patient age groups and categories of specialty care as the spokes, the proposed project will have immediate and substantial impact on the community. The Austin community and the surrounding areas face numerous health care challenges and social determinants of health barriers. Through this project, we expect to see a significant impact on health outcomes, social determinants of health conditions and, ultimately, health equity in the Austin community. All specialties provided to the Austin community will be defined and validated by the Community Advisory Board.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

8. Access to Care

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

According to a 2018 study from the School of Nursing and Health Studies at the University of Washington, FQHCs are the core providers safety net and primary care accessible to anyone who walks through their doors; however, access to specialty care is a significant challenge for these patients. Patients living in underserved areas have reduced access to specialists, despite the fact that these services are critical for continued and consistent recovery or health maintenance. Findings show that the majority of specialty care services are provided outside of FQHCs and access to those services in those locations is challenging for patients.

Barriers to specialty care include long waits for appointments, distance, transportation, and specialists not accepting all types of insurance or not accepting uninsured patients. Despite the geographic proximity of PCC sites to major public transportation routes, transportation barriers still exist in our service area, with access to and affordability of transportation being the primary barrier. According to PCC's 2021 Needs Assessment, 17% (52/315) of respondents, said that lack of transportation is one of the top three factors that keep people in the community from receiving necessary care. Furthermore, 8% of respondents (31/394) said that in the past year, they or a family member had been unable to get transportation when it was really needed.

Some subsets of our high-risk patient populations face additional barriers to accessing transportation, such as those with substance use disorders, those who are pregnant and postpartum, and those with disabilities. These patient populations face additional challenges both physical and financial to accessing public transit. Although there are services available to support these populations, such as Medicaid managed care organization transportation services and the Pace bus paratransit program for seniors and people living with disabilities, these can sometimes be unreliable or require substantial support from care managers to get scheduled.

In addition to these barriers in transportation, PCC's Care Coordination Department has seen an increase in reluctance to use public transportation due to COVID-19. Despite understanding the risks of delaying routine care, many patients across the organization have chosen to forgo outpatient services out of fear of exposure to the novel coronavirus. Within PCC's patient population, there is a high percentage of patients that do not show for their scheduled appointments, with a medical no-show rate of about 18%; no-shows to specialty appointments, with all the transportation and other barriers listed above, is almost certainly significantly higher.

Research also suggests that shortages in specialty care providers is correlated with insurance reimbursement and specific specialties. For example, a public or private insurer may have only one or two providers in a particular area of specialty care, especially in low-income areas, whereas other geographic areas may have several providers. Examples of specialty care services that are in high demand and take more time and effort to arrange include cardiology, orthopedics, neurology, gastroenterology, rheumatology, urology, gynecology, oncology, dermatology, ophthalmology, and chronic pain management.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

To increase access to specialty care providers and eliminate barriers related to transportation and distance, the Austin Collaborative will co-locate specialty services with primary care. Adequate space to house specialists is a critical component of co-location. By developing a new health center, the Collaborative will create the necessary space for specialty care. PCC will transfer its primary care and behavioral health practice from the PCC Austin Family Health Center to the PCC Primary Care Pavilion. The building where PCC Austin Family Health Center is located will house specialty services on the first floor and the dental suite on the second floor. By co-locating primary care, dental, behavioral health care, and specialty care, we will see an immediate reduction in these barriers, ultimately decreasing the no-show rate for specialty care. While the facility is being built, the Collaborative will house specialists at PCC-Austin's existing facility onsite and via telehealth or an alternative hospital site to be determined.

Additionally, many hospitals limit the number of appointment slots for Medicaid patients (thus increasing wait times) or do not accept many or all Medicaid insurance plans or uninsured patients. The specialists in the Austin Collaborative will be dedicated to the care of a low-income population; therefore, increasing patients' access to care by removing any insurance barriers.

The immediate, measurable impacts to address health disparities mentioned above include:

- Reduced wait times for specialty care appointments
- Reduced no show rates for specialists
- Reduction in mortality, (or morbidity, if measurable) from;
  - Heart disease
  - Diabetes
  - Colon/Prostate/Breast/Lung cancer
- Increased preventative screenings and education removing transportation as a barrier and community health workers to enable connections
- Increased use of alternative therapies and lifestyle improvements with the new PCC Pavilion
- Increased referrals for nutrition education and nutrition Rx
- Increased referrals for Social Determinants of Health
- Reduction in Emergency Room visits

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

Understanding the complexities of specialty-care coordination processes and access helps determine the need for comprehensive and uninterrupted access to quality health care for vulnerable populations. Guaranteed access to primary care at FQHCs has not translated into improved access to specialty care. Therefore, it is critical that effective policies be pursued to address the barriers and minimize interruptions in care, and to ensure continuity of care for all patients needing specialty care.

To reduce these barriers to specialty care, the Austin Collaborative's co-location will allow patients to have easy access to care in their own neighborhoods, right across the street from their primary care providers. The collaborative will track both access as well as health outcomes for each of these identified specialties to ensure that increased access to specialty care leads to improved health outcomes. Certain services will still need to be performed on the hospital campus (such as diagnostics and procedures/surgery) but having primary care providers working closely with specialists will help patients in building trusting relationships with their specialists in a coordinated manner, decreasing insurance and income barriers to our service area population's access to specialty care.

No one will be denied services regardless of their financial or insurance circumstances.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

9. Social Determinants of Health

Note on the significance of social determinants of health:

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

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

The Austin Collaborative will target several social determinants of health in our service area including transportation, housing, food insecurity, access to nutrition education, employment opportunities, intimate partner violence and child abuse.

According to the CDC, social determinants of health are the conditions in the places where people live, learn, work, play, and worship that affect a wide range of health risks and outcomes. Some social determinants of health have historically prevented low-income racial and ethnic minority groups from having fair opportunities for economic, physical, and emotional health.

The primary service area for the Austin Collaborative is the Austin community. At PCC Austin, 90% of patients are Black/African American and 5% are Hispanic. Based on self-reporting surveys, 93% of patients live below 200% of the Federal Poverty Level. Racial and ethnic minority groups face multiple barriers to accessing health care. Issues such as lack of insurance, transportation, childcare, or ability to take time off work can make it hard to get the care they need. Furthermore, these groups also face economic inequities such as housing stability, employment, and food security.

The Austin Collaborative has chosen to address the transportation, housing, food insecurity, access to nutrition education and employment opportunities. Each of these barriers is the result of long-standing issues of race- and ethnicity-based injustices that have deprived members of minority groups to pursue housing, education, employment on level playing field. Following from these challenges, communities like Austin have seen disinvestment in their communities in both the public and private sector arenas.

The Austin Collaborative has selected these particular barriers because they are foundational to health and wellness in a number of ways including the following:

- *Transportation:* Lack of transportation negatively impacts an individual's capacity to comply with scheduled screenings, routine care and specialty care.
- *Housing:* Housing instability disrupts continuity of care while the burden of excessive housing costs places undue stress of individuals and families affecting their ability to leave work for routine or specialty care.
- *Food insecurity and nutrition education:* A shortage of food in the household is unhealthy both physically and emotionally for obvious reasons. A lack of healthy food, nutrition education or food preparation skills specific to developing and maintaining healthy eating habits all increase the risk of metabolic and other diseases.
- *Employment:* Steady jobs with decent pay are the basis of each individual's or family's capacity to maintain the basic needs of their households, reduce stress and increase their sense of well-being – without adequate employment, health care needs, healthy eating and exercise may take a back seat to high-stress economic survival strategies and an ongoing series of debilitating crises rooted in economic instability.

PCC's robust Care Coordination Department helps increase patient engagement with attending office visits and completing screenings, vaccinations, and treatments. The Austin Collaborative will build upon that solid base, linking PCC patients and other Austin area community members to lifestyle education, activities and exercise, nutrition education and healthy food, stable housing, employment opportunities, and an expanded set of resources to address social determinants of health needs.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

The PCC Care Coordination Department will address barriers to care at every specialty care appointment and examine potential risk factors to help patients and their families overcome crisis and adversity. Staff will inform patients of available services and raise awareness of the importance of having a medical home where health care and social determinants of health issues can be addressed in a single location. Case management services will help patients to coordinate complex healthcare needs and support patients in accessing programs for employment/job training; emergency, short-term and permanent housing; access to pantries and food support programs; benefit enrollment (e.g. SNAP, WIC, disability), and other external resources. All assistance provided will be documented in PCC's electronic health records system. Staff will use NowPow's services and an internal resource guide to connect patients with social services and support.

Employment

In the area of employment, the Austin Collaborative will offer specialty care patients support services through an existing collaboration between PCC and Impact Behavioral Health Partners. Impact's employment program adheres to the research-based IPS model developed by Dartmouth's Psychiatric Research Center to support participants in finding the right

kind of employment—work that will be rewarding and satisfying. These supports are provided to participants in the program:

- Completion of a vocational assessment
- Constant communication and collaboration with PCC's Behavioral Health team
- Development of a resume
- Coaching on how to interview and how to follow up with an employer
- Connection to resources for clothing, transportation, and certification
- Networking with employers on their behalf
- Job maintenance support once they are employed

Through this intensive approach, PCC patients in Impact's program find meaningful employment that results in long-term success and income. Impact's program placement rate is typically between 60% and 70%, which far exceeds the national average of 42% for similar programs. Once employed, 80% of participants maintain their employment for at least 90 days. Stably employed, PCC patients earn a consistent income level; develop work skills and experience that will contribute to a fulfilling career; and begin to develop the financial resources to obtain stable housing and plan for their future. In addition to the constant collaboration between Impact and PCC staff to ensure a patient's success, Impact also provides access to consultation with a Housing Stability Specialist who can provide expertise and information to those seeking to improve their housing situation.

Housing

Through an existing partnership among PCC, The Loretto Hospital, and the Lawyer's Committee for Better Housing, the Austin Collaborative will offer specialty care patients access to legal services related to housing issues through the Medical-Legal Partnership (MLP) program. Five key housing-related legal needs affect health: shelter access, access to housing subsidies, sanitary housing conditions, foreclosure prevention, and utility access. Through this program, specialty care patients have access to legal representation to support areas of housing legal need that have a direct impact on individual health. PCC has made 311 referrals to the MLP since its inception in 2016. Of those, attorneys were able to provide assistance and close 126 cases.

In addition, PCC has a partnership and primary care site at The Boulevard, Chicago's only homeless respite shelter. PCC's onsite clinic coordinator at The Boulevard is also involved in the Chicago Homelessness and Health Response Group for Equity (CHHRGE), an advocacy organization for people experiencing homelessness.

Food Insecurity and Nutrition

Members of the Austin Collaborative currently offer the following food access and healthy eating programs:

- The PCC Austin Farm: a resource for healthy, affordable, organically-grown produce and urban farming activities
- The VeggieRx Program: a resource for fresh produce that helps patients to decrease diabetic A1C levels and increase patient perception of self-efficacy in the self-management of their diabetes
- Saints Mary and Elizabeth Medical Center's West Town Health Market provides fresh produce from the community to the community and accepts SNAP and government subsidized payments.

Once completed, the PCC Pavilion will offer educational opportunities in nutrition and healthy cooking, including a demonstration kitchen with classes teaching about healthy food preparation. The three hospitals may provide nutritionist support and ongoing cooking classes designed to be culturally sensitive to enhance adoption and compliance.

Transportation

As described in detail in the Project Description section of this proposal, the Scheduling and Transportation Hub is a vital part of the Collaborative's strategy for healthcare transformation. Through the Hub, the Collaborative will provide free transportation to and from medical visits for any specialty care patient who requests it.

Other SDOH Needs

Additional programs currently in place at PCC that will become available to specialty care patients that address social determinants of health include:

- The Lifestyle Center: housing an exercise room, outdoor track, yoga classes, and demonstration kitchen for healthy eating
- Behavioral Health Resources: tools to address depression, substance use, chronic stress, trauma, and other conditions that may stem from the effects of the social determinants of health, such as inadequate housing, unemployment, and food insecurity
- Psychosocial Evaluations: for adults with substance use disorders and same-day access to medication-assisted treatment (MAT) with Suboxone or Vivitrol administered by providers with Drug Addiction Treatment Act (DATA) Waivers
- Collaboration and connection with Saint Mary's and Elizabeth's inpatient behavioral health and substance abuse units and services

The Collaborative's impact on social determinants of health can be measured in a variety of ways including but not limited to:

- Percent of patients enrolled in social services for which they are eligible, including Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), or Women, Infants, and Children (WIC).
- Percent of patients who are uninsured or underinsured
- Rate of no-shows to healthcare appointments

- Impact Behavioral Health Partners: Number of referrals
- Medical-Legal Partnership: Number of referrals
- VeggieRx Program: Number of participants and average decrease in A1C levels
- West Town Health Market: Number of participants and families served as well as number of individuals that participated in nutrition and cooking classes and education
- Lifestyle Center: Number of unique participants annually
- PCC Austin Farm: Total sales and total pounds of produce per year

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

The Austin Collaborative envisions a future in which society has developed a Culture of Health that guides our path to achieving and maintaining the healthiest population possible. The activities mentioned above lead to the impact we intend to have by addressing the social determinants and health disparities in the Austin community. As a Federally Qualified Health Center, PCC already has a deep commitment to address community health through a social determinants lens. The Austin Collaborative further stresses the importance of having a medical home where health care and social determinants of health issues can be addressed in a single location.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

10. Care Integration and Coordination

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

This proposal will substantially improve the integration, efficiency, and coordination of care across primary care, behavioral health, and specialty care providers. By locating specialists (either physically or through telehealth) within the same campus as primary, dental, and behavioral health care providers, the Austin Collaborative will provide patients with immediate and easy access to the full spectrum of health care. Access barriers, such as transportation, communication and insurance coverage or network issues will be greatly reduced or eliminated. By providing primary care practitioners with real-time access to hospital-based specialists, integration and care coordination will improve significantly, across providers and levels of care (especially primary care and secondary care).

Currently, PCC's care coordinators strive to remove barriers to specialty care for patients. Care coordinators follow up with patients initially after a provider has referred a patient to a specialist. The care coordinator may further educate the patient on the need for specialty care. The care coordinator also addresses barriers with the patient, such as the need for childcare, navigating the hospital's system, and obtaining prior authorization from the insurance provider. The care coordinator strives to ensure that the patient attends the appointment and receives the results. Thus, care coordinators are central in increasing the patient's ability to navigate the healthcare system.

To improve care coordination, the Austin Collaborative will develop a scheduling and transportation hub designed to create an ease-of-use model to improve overall compliance and care coordination. Ongoing discussions on how best to integrate documentation through a common electronic health records (EHR) system and develop a real-time communication system that may include in-person provider visits, E-consults, and PerfectServe or like communication application (a communications platform built specifically for healthcare). The goal is to ensure that patients receive the proper care, at the appropriate time, at a single location with coordination of care and transition of care to the appropriate setting.

Both an integrated documentation/EHR system and PerfectServe will clearly facilitate communication, E-consults may reduce the need for certain specialty visits altogether. Currently, PCC uses E-consults with a limited patient population, mainly for patients of Stroger Hospital of Cook County. Through the E-consult, specialists can provide counsel that may eliminate the need for an in-person visit or that may assist the patient in preparing for the visit, such as requiring lab tests and imaging prior to the appointment. This enhanced communication will ensure that the specialist has as much critical information as possible prior to the scheduled appointment, which will not only improve immediate care but may even reduce the need for additional specialty visits.

To further enhance communication and efficiency, PCC plans to develop a transparent system to track specialty care referrals. PCC is implementing a data warehouse that will increase the capacity of the EHR to create useful reports.

To ensure ideal continuity of care, PCC's care coordinators would follow specialty referrals from initiation by a primary care provider through receipt of specialist's consultant report by the PCP. This process includes ensuring patients can schedule and attend the specialty appointment, and assisting in overcoming barriers encountered by patients; ensuring patients show up for the appointment; and ensuring the report is received by the PCP. Currently, PCC does not have enough care coordinators to provide this level of follow up on every referral. In a more integrated system of care, such as proposed, care coordinators will become more efficient, as they will not have to spend as much time following up on specialty care referrals. They will have better access to the electronic health records of the partner organizations and enhanced communication overall. With the implementation of this proposal, care coordinators will be able to focus on other tasks critical to enhancing patient care and working toward health equity.

Additionally, sometimes patients are prevented from seeing a certain specialist either due to lack of transportation or because the patient's insurance is not accepted. The Austin Collaborative will work to remove these barriers by ensuring that both primary care providers and specialists are accepting the same insurance plans and that transportation, if needed, is provided and easily coordinated. The Collaborative intends to utilize Kaizen as the transportation search engine to coordinate the right transportation that fits the needs of each patient. Funding for the transportation is designed to be provided by transformation dollars in years 1-3. Years 4 and beyond, the transportation service is intended to be supported by foundation and grant efforts of the Collaborative entities.

As such, this new care delivery medical home model, the "one-stop-shop," will significantly enhance care integration and coordination. As specialists become more embedded in care management structure, we expect that patients will experience improved health outcomes.

Care coordination, inclusive of the scheduling and transportation hub, is a critical component for successful transformation efforts. Metrics associated with care coordination may be measured in the following ways:

- Reduction in no-show rates for specialty care
- Shorter wait times for specialty care appointments
- Appropriate anti-platelet use
- Appropriate statin use
- A1C testing compliance
- Colorectal screening rates
- Mammography screening rates
- COPD screening and treatment rates

To enhance coordination between primary care and access to secondary care for children, PCC is partnering with Ann & Robert H. Lurie Children's Hospital of Chicago to participate in the All Hands Health Network (AHHN). This network is a collaboration of local pediatricians, specialists, behavioral health providers, social service and community organizations and institutions to address the medical and social needs of children and their families who live in Chicago's North Austin, Belmont-Cragin, and Hermosa and communities (zip codes 60639 and 60651). There are numerous partners, including the Chicago Department of Public Health, the Illinois Department of Healthcare and Family Services, and the Illinois Department of

Children and Family Services.

The network aims to provide better communication and coordination between various agencies and providers; focus on early identification of children's physical, behavioral and social needs; decrease the need for emergency care and hospitalization due to delayed care; eliminate duplication of services; and enhance the health and well-being of children and their families.

To connect families to services, AHHN will deploy a team of Community Health Workers. The helpline and website will feature linkages to community services, facilitate referrals to other providers, and allow rapid access to Lurie Children's specialists for real-time questions. A team of Provider Network Liaisons will train and support staff in using and accessing network services. Lurie Children's specialists will also provide education to providers to assist them in treating common pediatric conditions in the outpatient setting. Through this program, pediatric care will improve significantly across the network and access to a data system will help to monitor and benchmark the quality of care and outcomes using a balanced set of metrics.

The Austin Collaborative will work with AHHN, the West Side Collaborative, West Side United and others to identify opportunities to work collaboratively to improve health outcomes and achieve health equity across the West Side.

The following attachment depicts the patient pathway through primary care to specialty care and social determinants of health supports.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Patient Pathway

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

- ◉ Yes
- ○ No

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

Care Coordinators: Caseload 3100 individuals per Care Coordinator; cost per caseload $45,687 per Care Coordinator.

Community Health Workers: Caseload 3120 individuals per Communtiy Health Worker; cost per caseload $28,103 per Community Health Worker.

[2A - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

- ○ Yes
- ◉ No

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

- ◉ Yes
- ○ No

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

The Austin Collaborative will work closely with MCOs to:

- inform them of our project and goals
- establish a funding distribution pool
- jointly develop a risk management model
- implement and manage a risk management model

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

11. Minority Participation

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

List entities here:

PCC Community Wellness Center

The Loretto Hospital

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

In this hub-and-spokes project, PCC is the hub. The partner hospitals will bring specialty care physicians and other resources to the project as described but the project will exist on the PCC campus and most of the support staff will report to PCC management.

PCC and The Loretto Hospital have been integral to the development of the project and will remain so through its implementation and governance.

Both PCC and The Loretto Hospital are majority minority governed and The Loretto Hospital is also majority minority led.

The following attachment provides relevant demographics for each organization's board and Loretto's senior and patient-facing staff.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Board and Staff Demographics

12. Jobs

Existing Employees

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

Please see attached.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Existing Employees

New Employment Opportunities

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

18

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

The three hospital partners will embed specialists, either in-person or via telehealth, as needed, in up to 16 types of specialty care to meet the Austin community's healthcare needs.

In addition, the partner organizations in the Austin Collaborative will hire, train and manage 18 new employees in the following types of positions:

- Clinical Support Staff including Registered Nurses, Medical Assistants, Scribes and a Receptionist
- Diagnostic Staff including an X-ray/Ultrasound Technician
- Ancillary Support Staff including a Manager of Care Coordination, Care Coordinator, Health Care Coaches and Community Health Workers
- Administration
- Accounting

As the Collaborative expands specialty and sub-specialty services to the Austin community beyond the five-year funding timeframe, we expect to grow the workforce to meet the needs of a community that is currently vastly underserved.

PCC collaborates with various colleges and universities to serve as a preceptor site for medical assistants, registered nurses, behavioral health staff, and clerical staff. In the preceptor role, PCC has an ongoing pipeline for training and hiring qualified staff from the West Side. These colleges and universities include, but are not limited to, the following: Triton College, Lincoln College of Technology, Loyola University Chicago, Rush University Medical Center, and the University of Illinois at Chicago.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

PCC invests in ongoing training and development for its employees. To promote this philosophy, PCC is fully committed to diversity, equity and inclusion (DEI) training and has contracted with the Exeter Group, a minority- and women-owned company, to facilitate training. PCC provides its staff with opportunities for advancement and education. Key workforce development programs are described below:

· DEI Training: All employees will participate in DEI training. As part of this initiative, The Exeter Group assesses PCC staffing, trains new staff leaders and provides staff leaders an opportunity to train the organization in the development and implementation of DEI policies and practices. DEI training is being added to New Employee Orientation.

· Tuition Reimbursement: PCC will reimburse eligible employees 100% of the cost of tuition up to the maximum amount established in each annual budget. PCC is committed to providing financial assistance to employees pursuing healthcare-related higher education courses. Tuition reimbursement improves employee retention, increases employee engagement and prepares staff for career development.

· Career Ladders: PCC recognizes the need to create career opportunities for staff. Career ladders for Medical Assistants and Care Coordinators enhance PCC's recruitment and retention strategies and grow the competencies of its staff. Career ladders are comprised of time, grade and performance requirements. Once staff members have met all requirement, the applicable compensation adjustments are applied.

· The newly hired Diversity, Equity & Inclusion Manager will develop and implement the organization's diversity initiatives and strategy to attract, hire, and maintain a diverse and equitable workplace. The DEI Manager will review policies and organizational practices from a DEI lens and work with leadership to make the necessary changes. The DEI Manager will develop initiatives representative of the employee and community population which includes development of cultural calendar and creation of employee groups.

· PCC Community Wellness Center is committed to quality improvement and aims to create an infrastructure that produces reliable, high-quality and equitable care by increasing organizational capacity and capability in the Science of Improvement. Time, support, and ongoing learning opportunities are key drivers to build capability, while dosing of the Science of Improvement among the workforce is a fundamental driver to increasing capacity. Change ideas already implemented for "max dose" groups include the Institute for Healthcare Improvement (IHI) Open School program and the IHI Improvement Coach program.

[4 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

13. Quality Metrics

Alignment with HFS Quality Pillars

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

The Austin Collaborative aligns with the Equity Pillar and will report on all four of the quality metrics associated with this pillar:

- Breast cancer screenings
- Cervical cancer screenings
- Controlling high blood pressure
- Adult access to preventative/ambulatory health services

AMITA Saints Mary and Elizabeth Medical Center (SMEMC) and PCC Community Wellness Center are both lead agencies in the Illinois Breast and Cervical Program. AMITA SMEMC has also earned the Blue Distinction from Blue Cross Blue Shield for its L&D and specialty care nursery units as well as their breast care program and is a longtime recipient of Susan G. Komen grants. SMEMC provides 800-900 free breast cancer screenings and 300-400 free cervical cancer screenings annually. PCC provides more than 300 free breast cancer and 100 free cervical cancer screenings annually. The Loretto Hospital provides more than 300 breast cancer and 60 cervical cancer screening annually. West Suburban Medical Center provides more than 9,000 breast cancer screenings and more than 3000 cervical cancer screenings annually.

In addition to tracking breast and cervical cancer screenings, controlling high blood pressure rates and access to preventative/ambulatory services, the Austin Collaborative may track and report on such sample clinical metrics as are described in the following pages and incorporated into an eventual funding agreement.

A Quality Dashboard will be created for each defined metric that is incorporated into an eventual funding agreement. Data will be aggregated monthly and monitored quarterly. To ensure the capacity and effectiveness of the care integration and coordination model, the Austin Collaborative will create a Quality Oversight Committee consisting of:

- The Director of Quality (or equivalent) at each of the four hospital partners
- The Medical Director of Performance Improvement at PCC
- The Chief Performance Improvement Officer at PCC
- The PCC Clinical Care Coordinator for Specialty Care – a new position created for this project
- Two community members nominated and voted upon by members of the Austin Collaborative per the Master Agreement (see Governance section for further detail).

As a high-level view of the project's impact on overall health disparities, the following metrics will be tracked at each of the three hospitals and stratified by socio-economic status, race and ethnicity.

- Catheter-associated urinary tract infection rate
- Central line-associated bloodstream infection
- Elective total joint replacement complication rate
- Infant mortality
- Mortality – all cause
- Mortality – sepsis
- Perioperative DVT/PE rate
- Pressure ulcer rate
- Readmission rate

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

2A. Maternal and Child Health?

- ○ Yes
- ◉ No

[Maternal and Child Heath - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2B. Adult Behavioral Health?

- ○ Yes
- ◉ No

[Adult Behavioral Health - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2C. Child Behavioral Health?

- ○ Yes
- ◉ No

[Child Behavioral Health - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2D. Equity?

- ◉ Yes
- ○ No

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

Please see the attached Quality Strategy & Additional Metrics document outlining an array of improved clinical outcomes, process improvements and enhanced social determinants of health supportive services.

[Equity - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Quality Strategy and Additional Clinical Metrics

2E. Community-Based Services and Supports?

- ○ Yes
- ◉ No

[Community-Based Services and Supports - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

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

- ◉ Yes
- ○ No

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

Please see the attached Quality Strategy & Additional Metrics document outlining an array of improved clinical outcomes, process improvements and enhanced social determinants of health supportive services.

[3A - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Quality Strategy and Additional Clinical Metrics

14. Milestones

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

	Year 1											
Milestone/Activity	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Planning												
Community Outreach (Notification of Funding)	x	x										
Develop/review/execute Joint Operating Agreement	x	x	x									
Develop & review Master Lease Agreement		x	x									
Establish work groups/committees to confirm model of care and develop care coordination and centralized call center workflows		x	x									
Operationalize clinical, financial and social determinants of health indicators			x	x								
Notify Medicaid MCO's regarding funding goals/ Establish a funding pool distribution model			x	x	x	x						
Sustainability Planning				x	x	x	x	x	x	x	x	x
Establish an Equity and Diversity training program				x	x	x						
Perform IT Gap Analysis				x	x	x						
Identify Tier 1 and 2 specialty care services for partial/full implementation							x					
Specialty Care and diagnostics services space planning for the Austin Center (1st floor)						x	x	x	x	x	x	x
Staffing												
Hire an Administrator		x	x	x								
Administrator will interview/hire in collaboration with designated partners: accountant, ancillary support staff, diagnostic / clinical support staff				x	x							
Recruit staff based on partial/full implementation plan							x	x	x			
Conduct equity and diversity training for all staff involved in the collaborative					x	x						
Implementation												
Partial Implementation of Speialty Care Model							x	x	x	x	x	x
Care Coordination and call center implementation							x					
Identify baseline data and begin tracking indicators												
Execution of of IT gap analysis plan							x	x	x			
Opening of new PCC Pavilion (April 2023)										x		
Execute Master Lease Agreement										x		
Execute Sub-Leasing Lease Agreements										x		

	Year 2			
Milestone/Activity	Q1	Q2	Q3	Q4
Implementation				
Partial Implementation of specialty care	X			
Remodel/Build out first floor Specialty Clinic	X			
Full Implementation of Specialty Care Model		X	X	X
Expand/hire staff based on an increase in specialist care		X	X	X
Hire diagnostic staff	X	X		
Operations				
Governance meetings			X	X
Advisory Board review			X	X
Sustainability				
Working with MCO's to create a risk arrangement model	X	X	X	X

	Year 3			
Milestone/Activity	Q1	Q2	Q3	Q4
Operations				
Full Implementation of Specialty Care Model	X	X	X	X
Governance meetings	X	X	X	X
Community Advisory Board meetings	X	X	X	X
Sustainability				
Finalize risk arrangement model w MCOs	X			
Implement and manage risk arrangement model		X	X	X

	Year 4, 5			
Milestone/Activity	Q1	Q2	Q3	Q4
Operations				
Full Implementation of Specialty Care Model	X	X	X	X
Governance meetings	X	X	X	X
Community Advisory Board meetings	X	X	X	X
Sustainability				
Manage risk arrangement model	X	X	X	X

15. Budget

1. Annual Budgets across the Proposal

When completed, please upload your spreadsheet here.
Austin Collaborative HTC Budget 11-15-21

[Budget - Optional] Please upload here any additional documentation or narrative you would like to provide around your budget. Include any documentation regarding budget items in the Construction category (drawings and estimates, formal bids, etc.) (Note: if you wish to include multiple files, you must combine them into a single document.)

2. Number of Individuals Served

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

Year 1 Individuals Served
32222

Year 2 Individuals Served
33319

Year 3 Individuals Served
34417

Year 4 Individuals Served
35516

Year 5 Individuals Served
36614

Year 6 Individuals Served

3. Alternative Payment Methodologies

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

Throughout the entirety of the project, the Collaborative will communicate funding goals and outcomes to the MCOs. In addition, the Collaborative will seek to establish a funding pool distribution model with the MCOs. A variety of risk-based, shared savings options will be considered. Additional payment opportunities, as they may become available, will be pursued. Increased Illinois physician rates will be pursued. Ultimately, the Collaborative will serve to demonstrate that timely, coordinated specialty care will result in lower taxpayer costs and therefore is a prudent financial investment in the health of our patients and communities.

[Alternative Payment Methodologies - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

16. Sustainability

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

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

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

Provide your narrative here:

The Austin Collaborative will reduce reliance on Transformation funding over the funding period by demonstrating that our model reduces overall costs to taxpayers and, based on those results, will access additional resources to sustain the program over time.

In order to reach sustainability over five years, the following initiatives will be undertaken to sustain enhanced payment to specialty care providers and to maintain social determinants of health supports for our patients:

- The Collaborative will create managed care savings and improved clinical outcomes to lower the overall spend for care and support the hourly professional fee(s) for the specialists
- The Collaborative will engage in risk-based shared savings program and/or additional payment programs with MCOs to create revenues to support the program
- The Collaborative will leverage federal grant revenues available in the Medicaid program for uncompensated care
- The Collaborative anticipates increases in Illinois Medicaid physician rates – which routinely result in significant financial losses for providers treating Medicaid-insured patients.
- The four partner organizations in the Collaborative may contribute in-kind support for the program dependent upon ability to successfully negotiate with the Medicaid MCOs

One of the key assumptions is a significant amount of ongoing cost will be allocated to maintaining Professional Services/Physician Agreements with specialty physicians for providing care based upon a supplemental stipend to offset lower Medicaid reimbursement rates. These costs will be offset by the revenue-enhancing, shared risk and shared savings initiatives described above or that may emerge over the next several years.

Another key assumption is that health care providers, researchers, private payers and public payers all generally realize the importance of designing and implementing care models that address social determinants of health, care coordination and integration (including the inclusion of specialty care) and work to address the injustice of severe health disparities such as we have documented in and around the Austin community. HFS's Healthcare Transformation Collaboratives funding opportunity is itself an indication that the State of Illinois, its MCOs and health care providers recognize the importance and potential of these models. Developing the specific care models and reimbursement systems to support these generally agreed-upon goals is crucial and it is a primary reason the Austin Collaborative's partners have chosen to work together in support of a community that faces substantial and unacceptable health care disparities that result in shorter lifespans and lowered quality of life. While HTC funding provides an opportunity to innovate new and better models of care as described in this request, we expect to see additional opportunities over the next several years to reduce costs while improving and patient experience.

Additional key assumptions include:

- There are significant one-time expenses in this project that will provide long-term value but have no cost burden in latter stages of the project or sustainability in the post-funding period.

- All of the program components described in this proposal will work together creating a powerful virtuous cycle that reduces costs by improving health care outcomes and health equity. As patients experience more comprehensive, coordinated care, compliance gaps and no-show appointments will decrease; wellness, nutrition and fitness programs will be increasingly adopted; and the efficacy of the new program components described in this request will accelerate. As a result, the acuity of care will begin to lessen and overall health care costs will lessen as well.

- The care model will be phased in during the project's initial stages. While new initiatives take time for staff hiring and training (including new training for existing staff), the benefits will be seen in the program's latter stages of the project as health care outcomes improve and efficiencies in the program model evolve with experience.

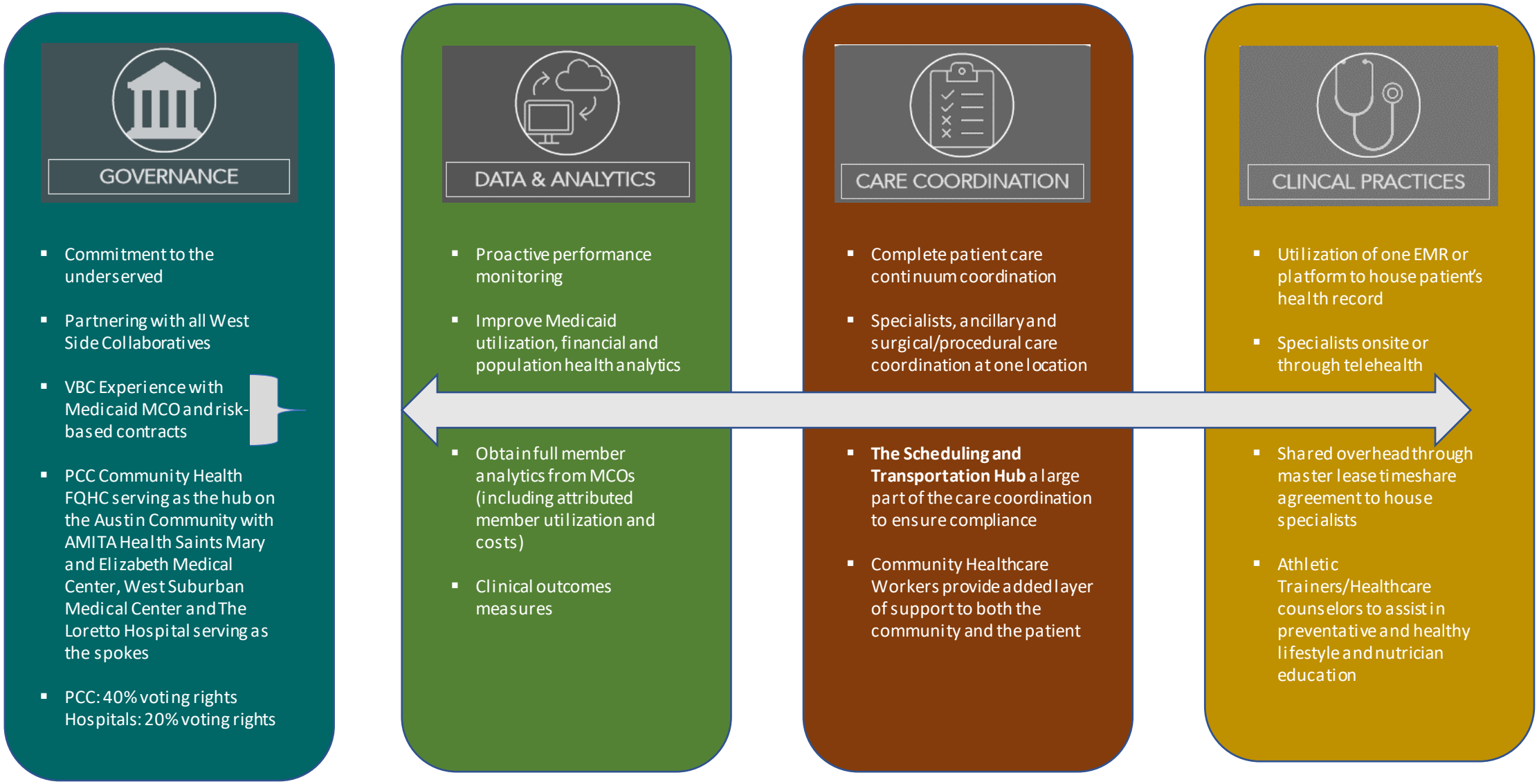
- As health equity improves in the Austin community, patients will experience better outcomes in other aspects of their lives – with less time focusing on illness, there will be more time to focus on employment and education and enjoying the benefits of living in a prosperous country. As other aspects of life are more stabilized and satisfying, overall health and well-being will increase, dependence on self-medication and acceptance of poor mental states will decrease, and that, too, results in a virtuous cycle where improvements in health care combined with social determinants of health supports enhance one another to accelerate the pace of achieving health equity.

In addition, the Collaborative will explore philanthropic support for our initiatives, including support for screenings for social determinants of health.

[Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

OVERVIEW

Healthcare Transformation Overview

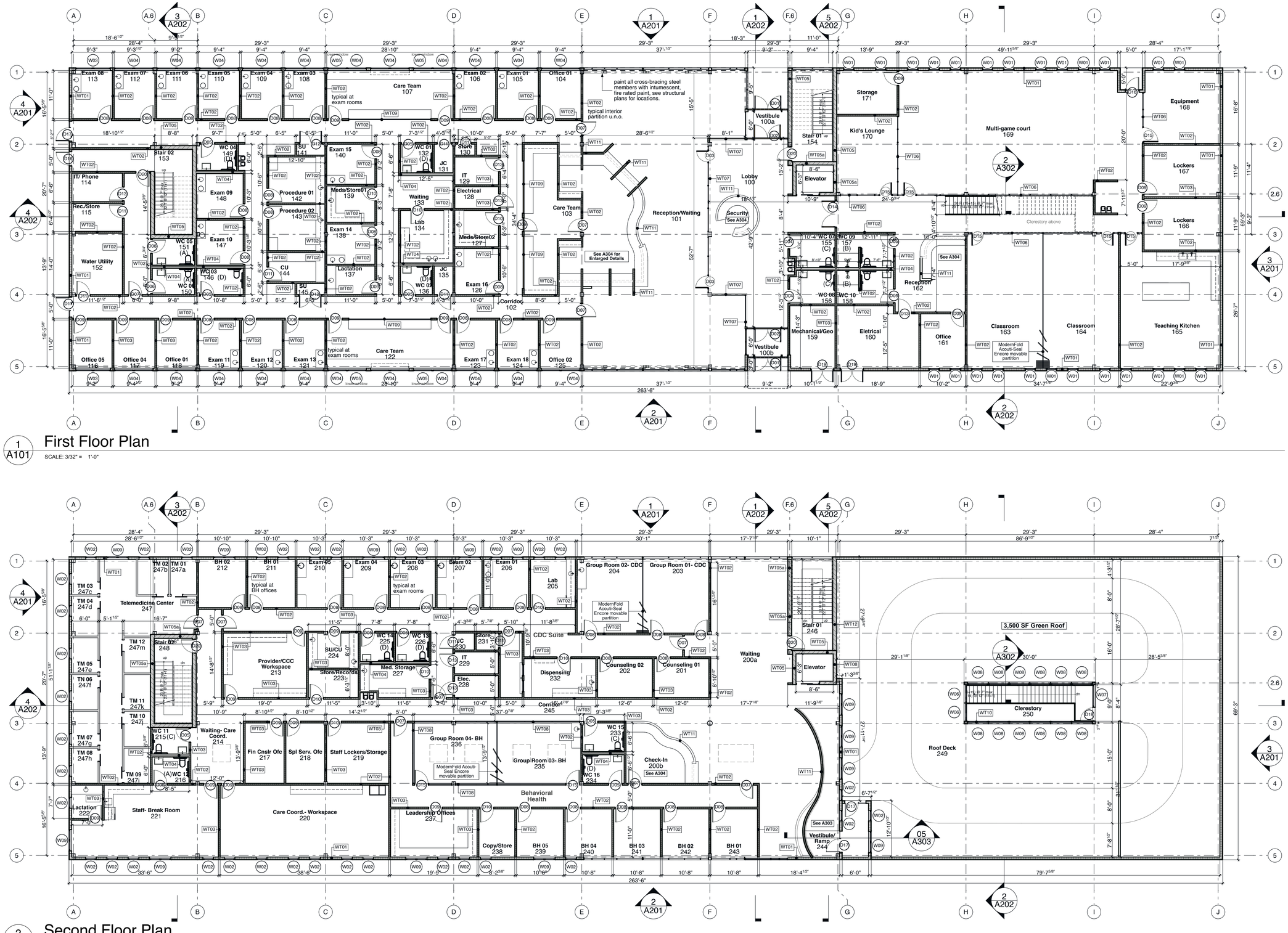


RENDERINGS
AND
FLOORPLANS


PCC
ONE WAY


PCC


PCC
Community Wellness Center



1 A101 First Floor Plan

SCALE: 3/32" = 1'-0"

2 A101 Second Floor Plan

SCALE: 3/32" = 1'-0"

MDT
manske • dieckmann • thompson
architecture • interiors
Registered Professional Design Firm # 184.000792

4629 N Broadway
Chicago, IL 60640

773.561.1987
www.mdtarch.com

Date	Issued For	RevID
09/24/21	Design Development	01
10/1/21	50% CD	02
10/22/21	For Bid/Permit	03

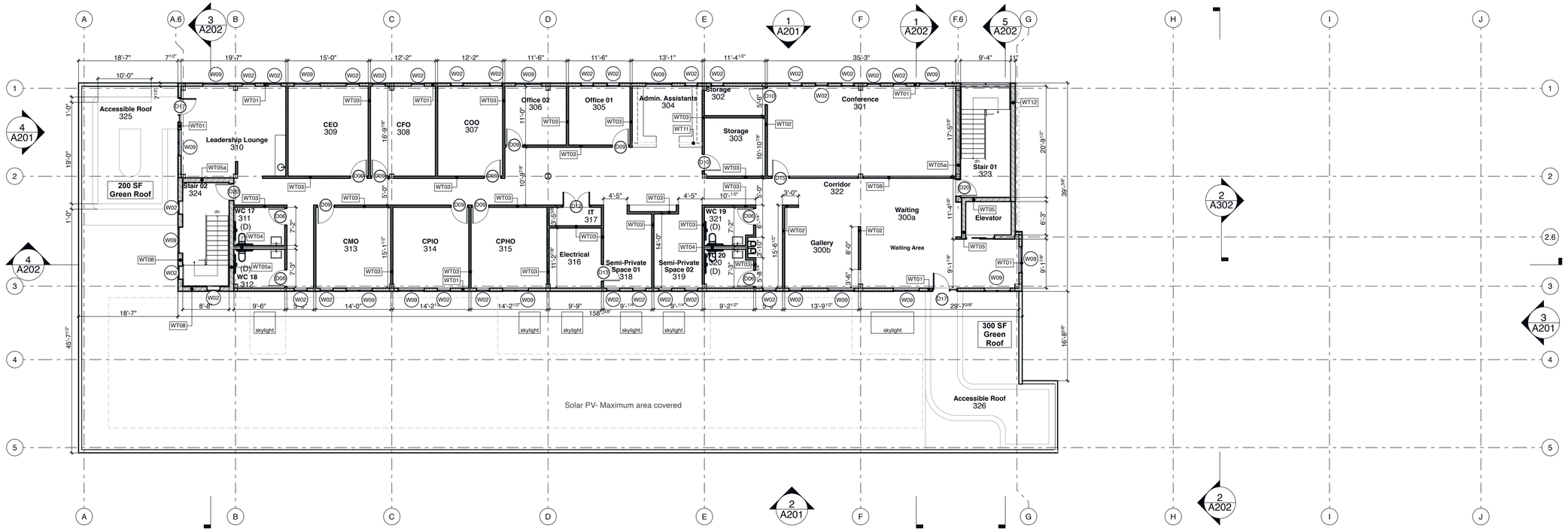
First and Second Floor Plans

PCC Pine Lake

5475 W Lake Street Chicago Illinois

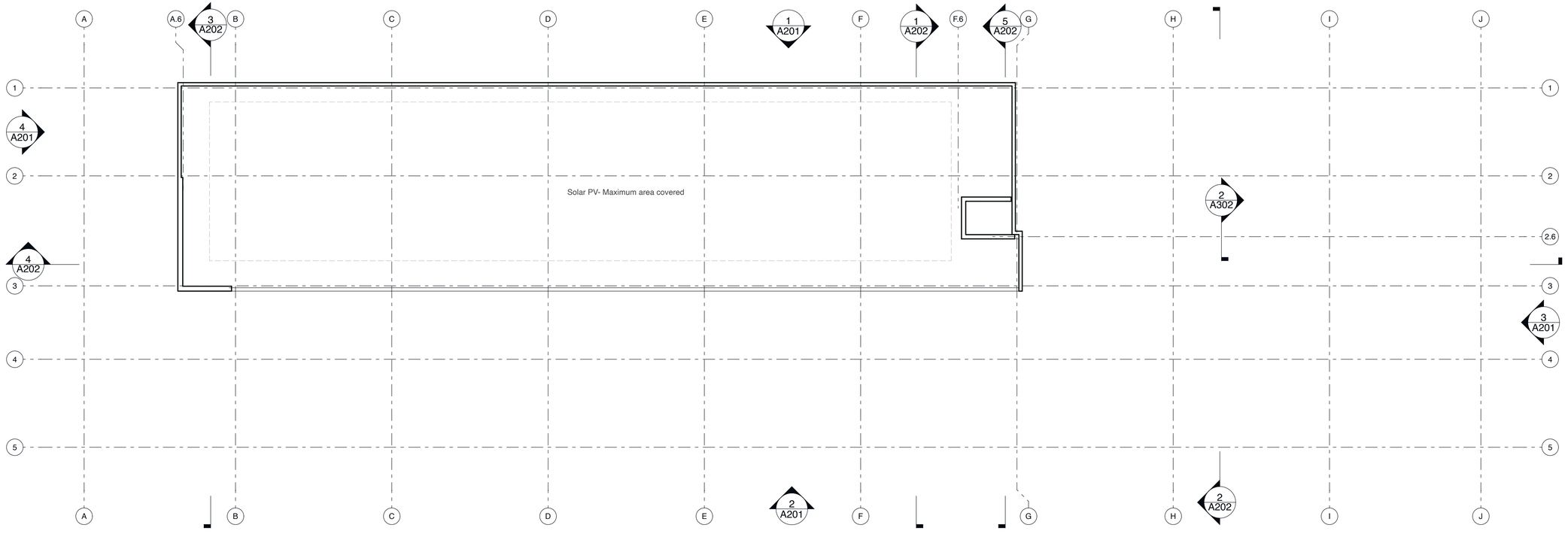
A101

Printed: 11/3/21



Third Floor Plan

SCALE: 3/32" = 1'-0"



Roof Plan

SCALE: 3/32" = 1'-0"

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architecture • interiors
Registered Professional Design Firm # 184.000792

4629 N Broadway
Chicago, IL 60640
773.561.1987
www.mdtarch.com

Date	Issued For	RevID
09/24/21	Design Development	01
10/1/21	50% CD	02
10/22/21	For Bid/Permit	03

Third Floor and Roof Plans

PCC Pine Lake

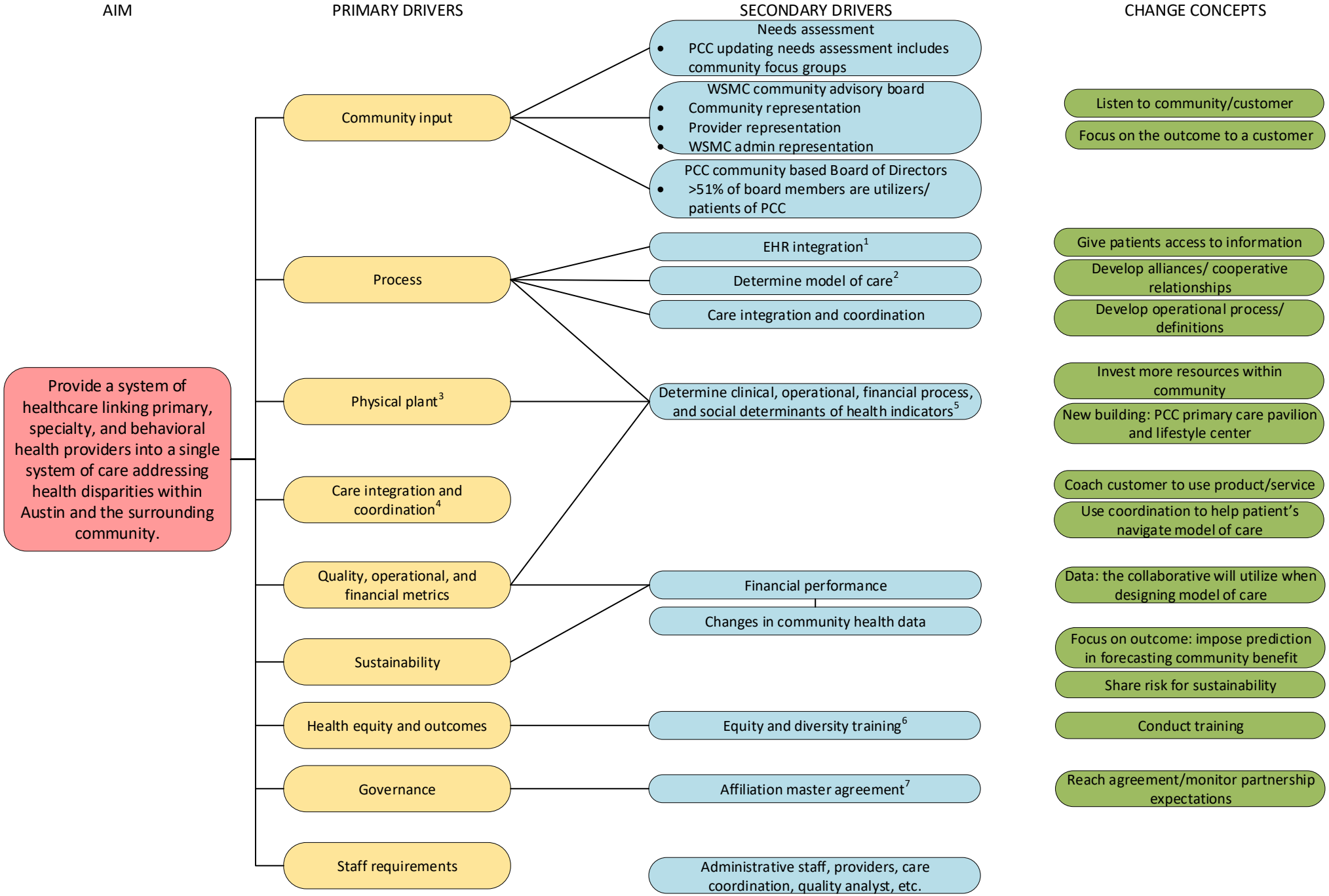
5475 W Lake Street Chicago
Illinois

A102

Printed: 11/3/21

DRIVER DIAGRAM

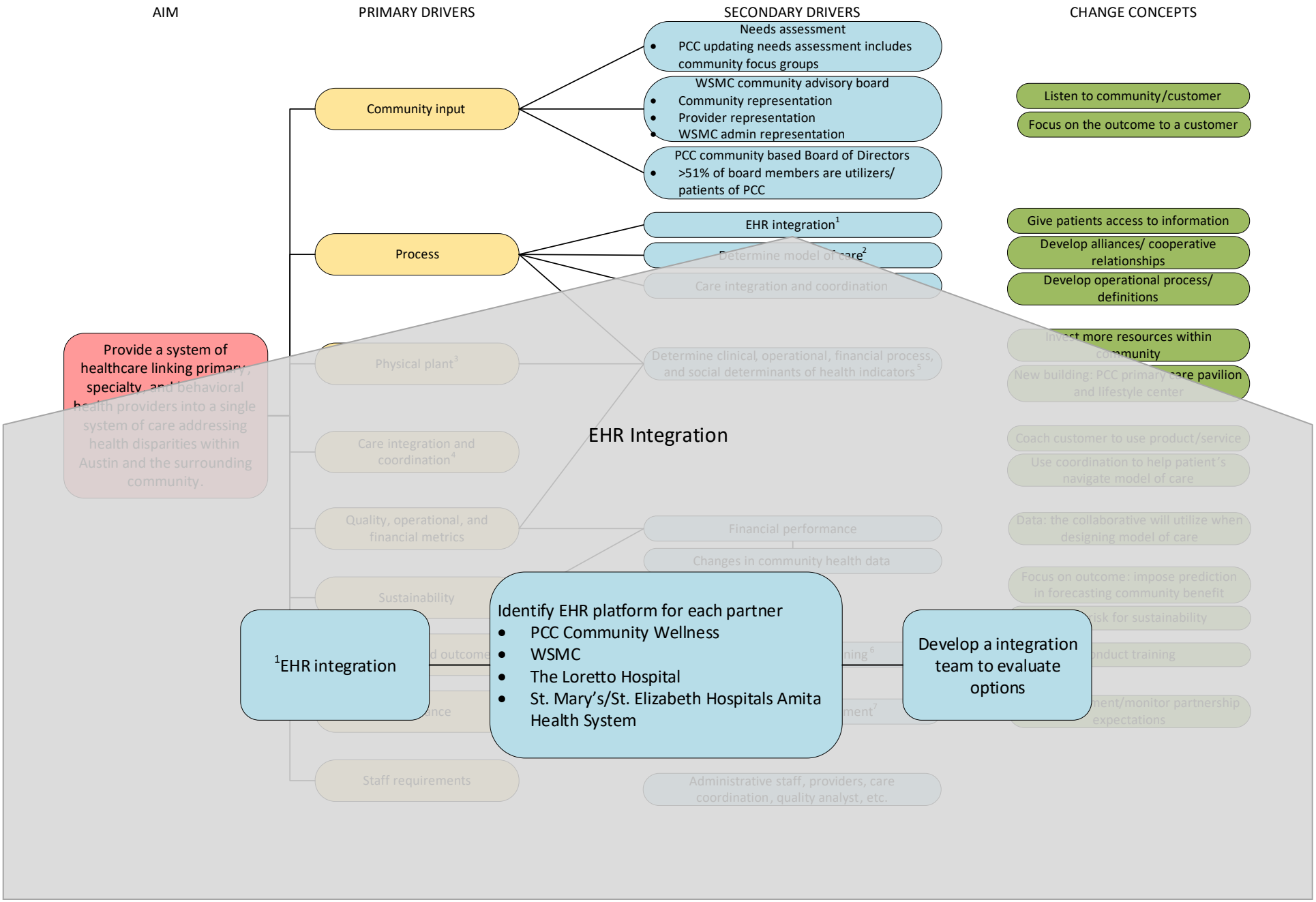
Problem: The lack of specialty care within vulnerable communities is a contributing factor to increased health disparities



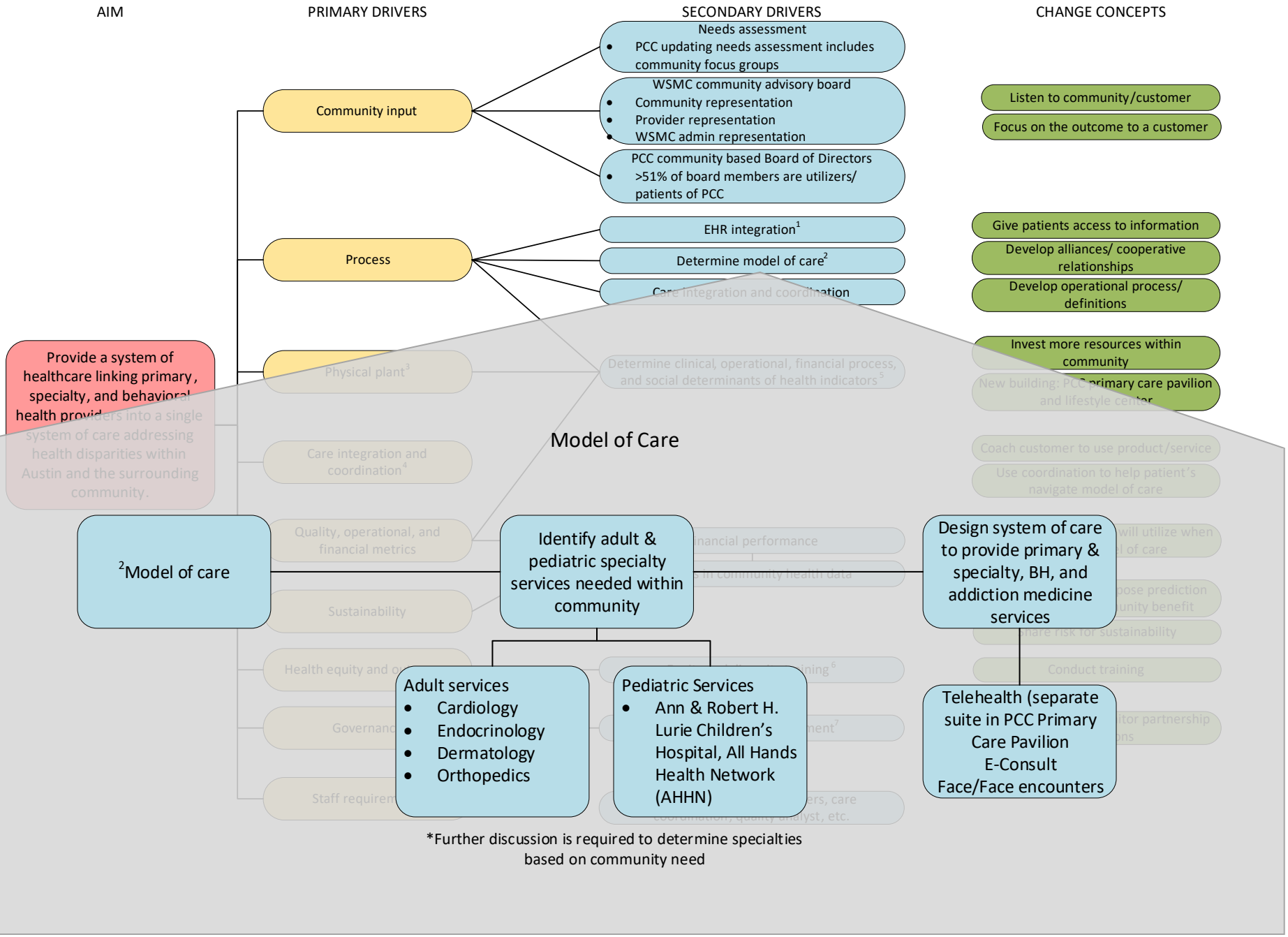
[1-7] Notation correlates with corresponding cascading driver diagram

A driver diagram is a visual display of a team's theory of what "drives," or contributes to, the achievement of a project aim. This clear picture of a team's shared view is a useful tool for communicating to a range of stakeholders where a team is testing and working. A driver diagram shows the relationship between the overall aim of the project, the primary drivers (sometimes called "key drivers") that contribute directly to achieving the aim, the secondary drivers that are components of the primary drivers, and specific change ideas to test for each secondary driver. (http://www.ihi.org/resources/Pages/Tools/Driver-Diagram.aspx)

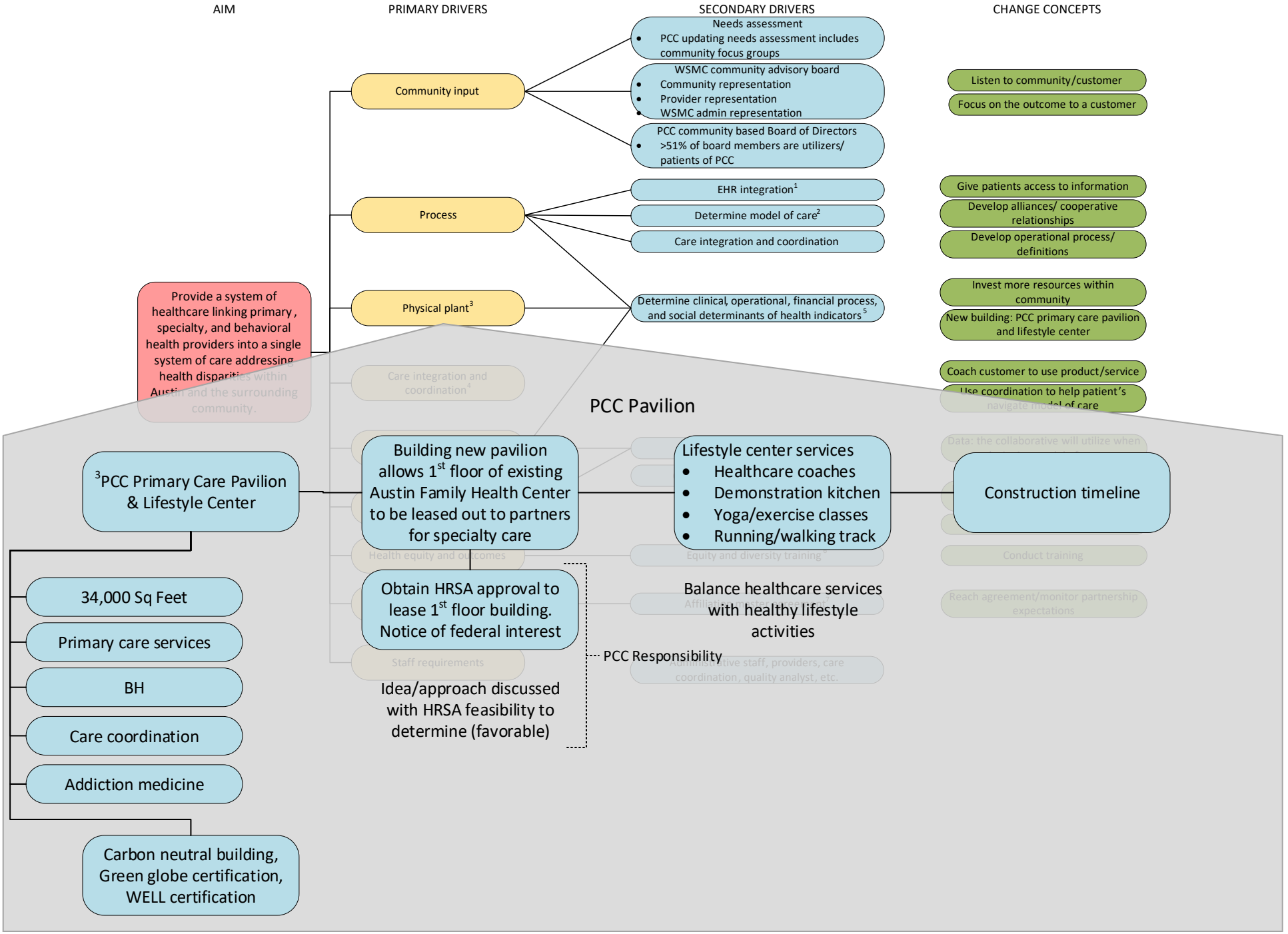
Problem: The lack of specialty care within vulnerable communities is a contributing factor to increased health disparities .



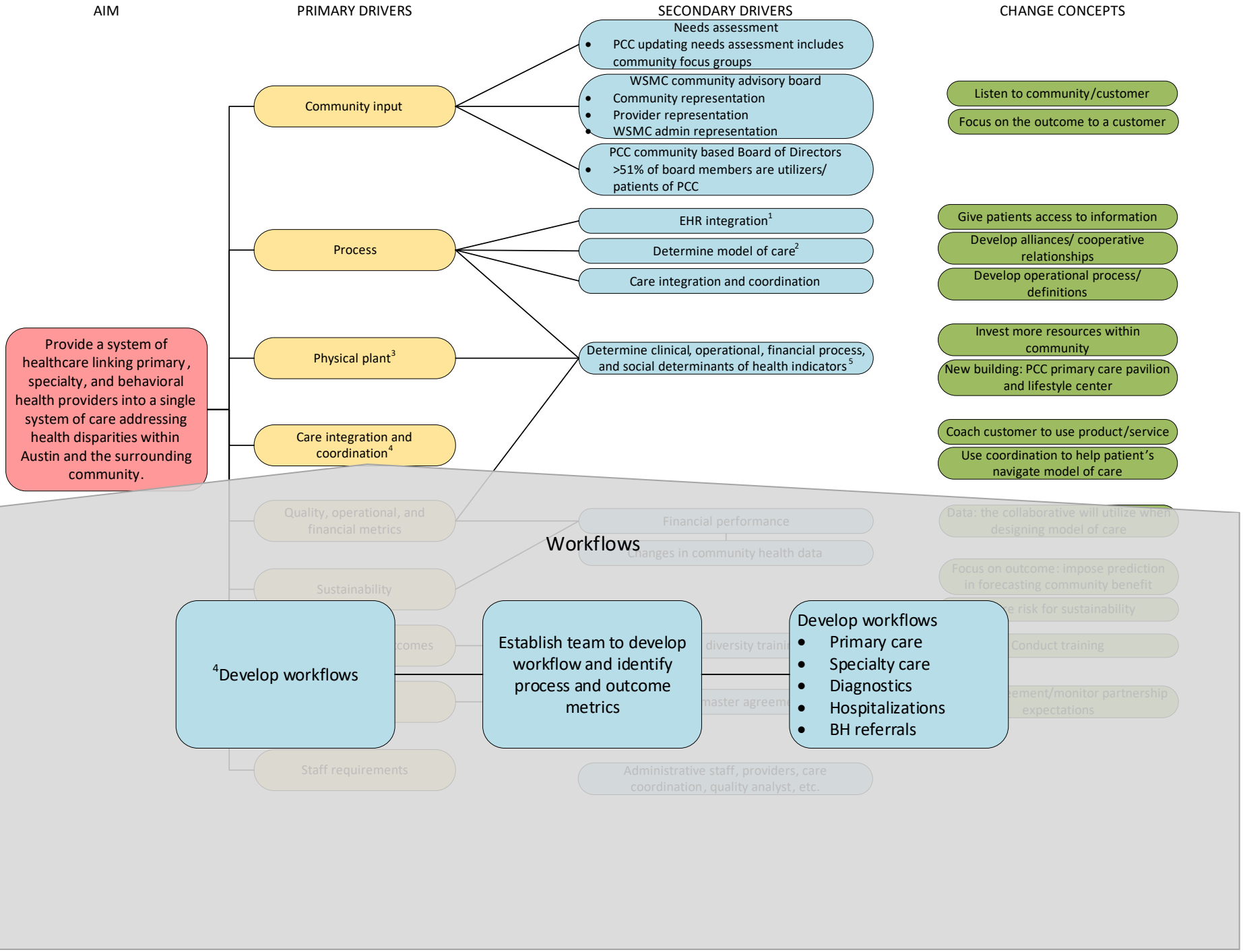
Problem: The lack of specialty care within vulnerable communities is a contributing factor to increased health disparities .



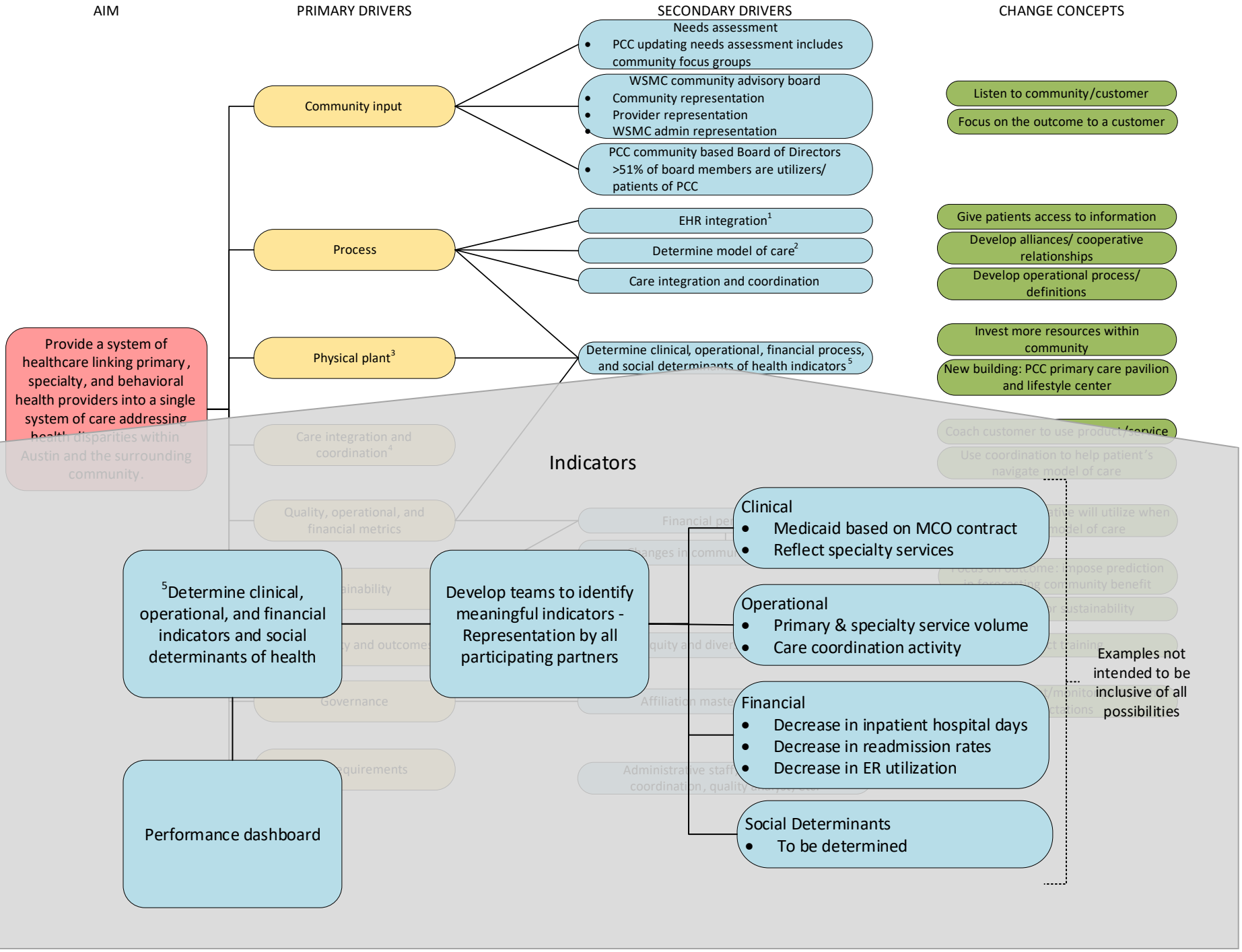
Problem: The lack of specialty care within vulnerable communities is a contributing factor to increased health disparities .



Problem: The lack of specialty care within vulnerable communities is a contributing factor to increased health disparities .



Problem: The lack of specialty care within vulnerable communities is a contributing factor to increased health disparities .



Equity and Diversity

Problem: The lack of specialty care within vulnerable communities is a contributing factor to increased health disparities .

[6]Equity and diversity training
- PCC contracted with Exeter group to complete training for Board of Directors, Senior Leadership, and all staff
- Recruiting for a Diversity Manager
- Employee Core Culture Committee

Implicit bias and racial disparities in healthcare

Minority contractor for PCC building

Complete HFS racial equity impact assessment guide

*Race conscious medicine

Race defined as a social and power construct

Effects of structural racism analyzed

Consequences of racism on health taught

Support provided to overcome structural barriers to health

Reduction in racial inequities

Race based medicine
vs.
Race conscious medicine

*The Lancet access provided by Kaiser Permanente. Published October 10, 2020.

Provide a system of healthcare linking primary, specialty, and behavioral health providers into a single system of care addressing health disparities within Austin and the surrounding community.

Process

Physical plant[3]

Care integration and coordination[4]

Quality, operational, and financial metrics

Sustainability

EHR integration[1]

Determine model of care[2]

Care integration and coordination

Determine clinical, social, and behavioral process, and determinants of health indicators[5]

Financial performance

Changes in community health data

Give patients access to information

Develop alliances/ cooperative relationships

Develop operational process/ definitions

Invest more resources within community

New building: PCC primary care pavilion and lifestyle center

Coach customer to use product/service

Use coordination to help patient's navigate model of care

Data: the collaborative will utilize when designing model of care

Share risk for sustainability

Conduct training

Reach agreement/monitor partnership expectations

Health equity and outcomes

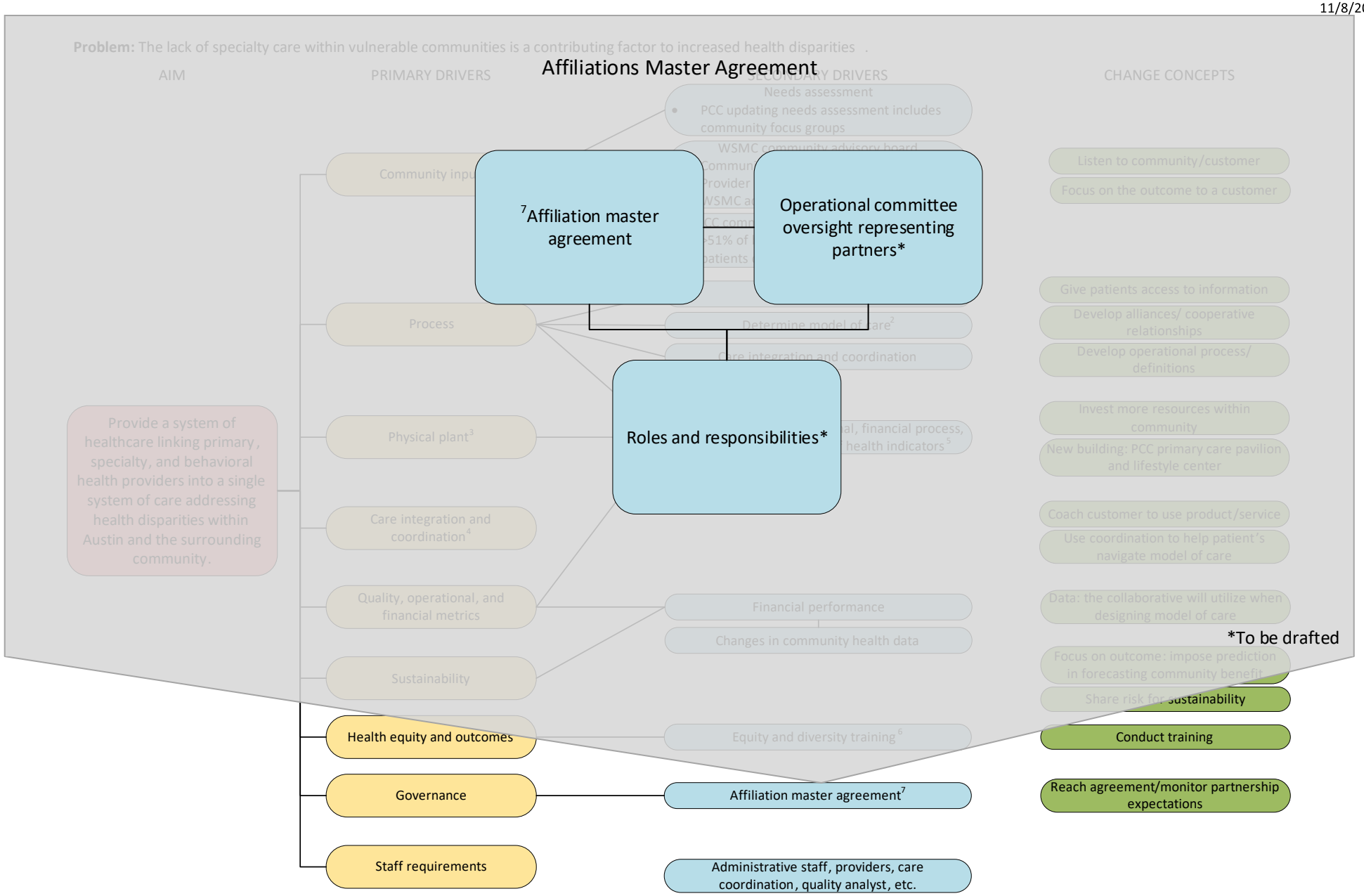
Equity and diversity training[6]

Governance

Affiliation master agreement[7]

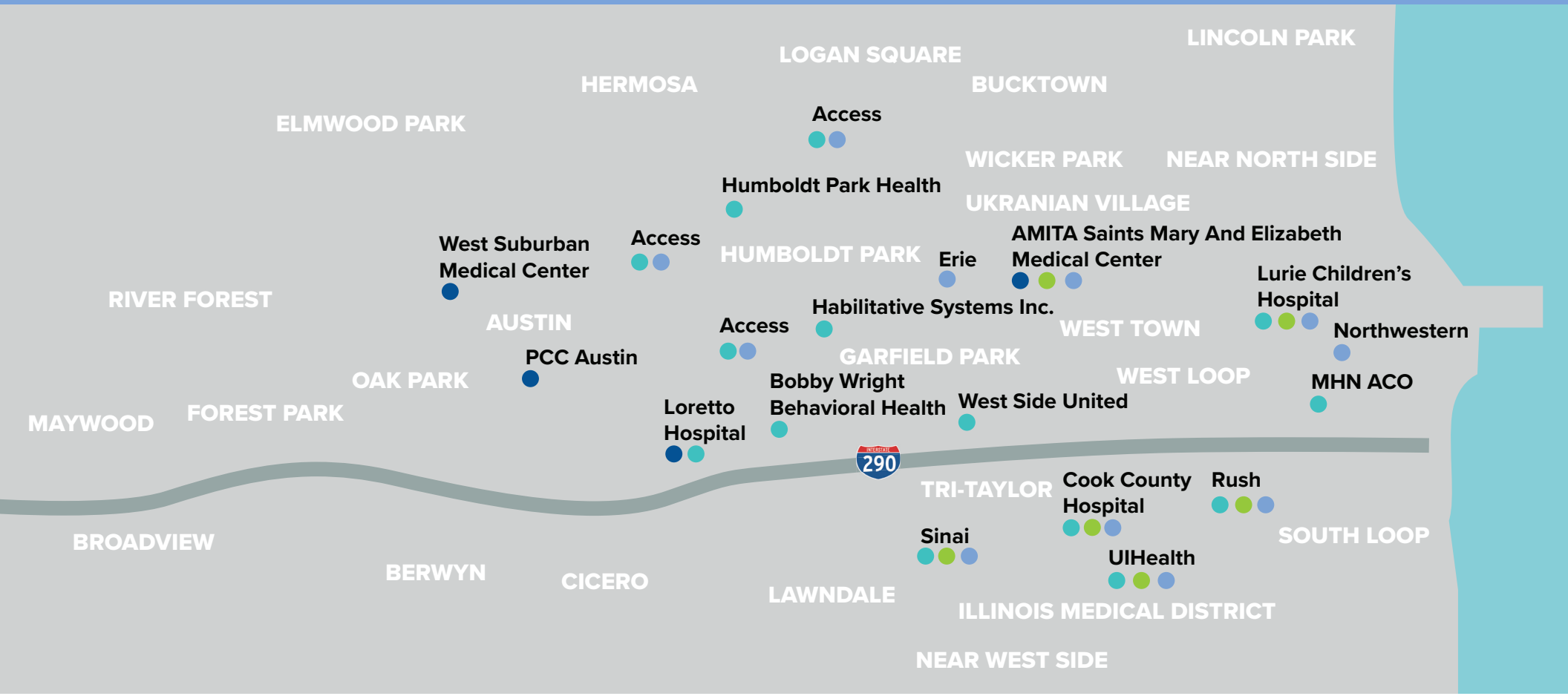
Staff requirements

Administrative staff, providers, care coordination, quality analyst, etc.


Problem: The lack of specialty care within vulnerable communities is a contributing factor to increased health disparities .
AIM
PRIMARY DRIVERS
SECONDARY DRIVERS
CHANGE CONCEPTS
Affiliations Master Agreement
Provide a system of healthcare linking primary, specialty, and behavioral health providers into a single system of care addressing health disparities within Austin and the surrounding community.
Community input
Process
Physical plant[3]
Care integration and coordination[4]
Quality, operational, and financial metrics
Sustainability
Health equity and outcomes
Governance
Staff requirements
Needs assessment
PCC updating needs assessment includes community focus groups
WSMC community advisory board
Determine model of care[2]
Care integration and coordination
health indicators[5]
Financial performance
Changes in community health data
Equity and diversity training[6]
Affiliation master agreement[7]
Administrative staff, providers, care coordination, quality analyst, etc.
[7]Affiliation master agreement
Operational committee oversight representing partners*
Roles and responsibilities*
Listen to community/customer
Focus on the outcome to a customer
Give patients access to information
Develop alliances/ cooperative relationships
Develop operational process/ definitions
Invest more resources within community
New building: PCC primary care pavilion and lifestyle center
Coach customer to use product/service
Use coordination to help patient's navigate model of care
Data: the collaborative will utilize when designing model of care
Focus on outcome: impose prediction in forecasting community benefit
Share risk for sustainability
Conduct training
Reach agreement/monitor partnership expectations
*To be drafted

MAP

West Side Healthcare Resources Map



The Austin Collaborative

Goals/Pillars:

Health Equity, Specialty Care, Medical Home encompassing primary, preventative, mental health, dental and specialty care

West Side Collaborative

Goals/Pillars:

Behavioral Health, Substance Abuse, Adverse Child Experience, Hypertension and Diabetes

West Side United

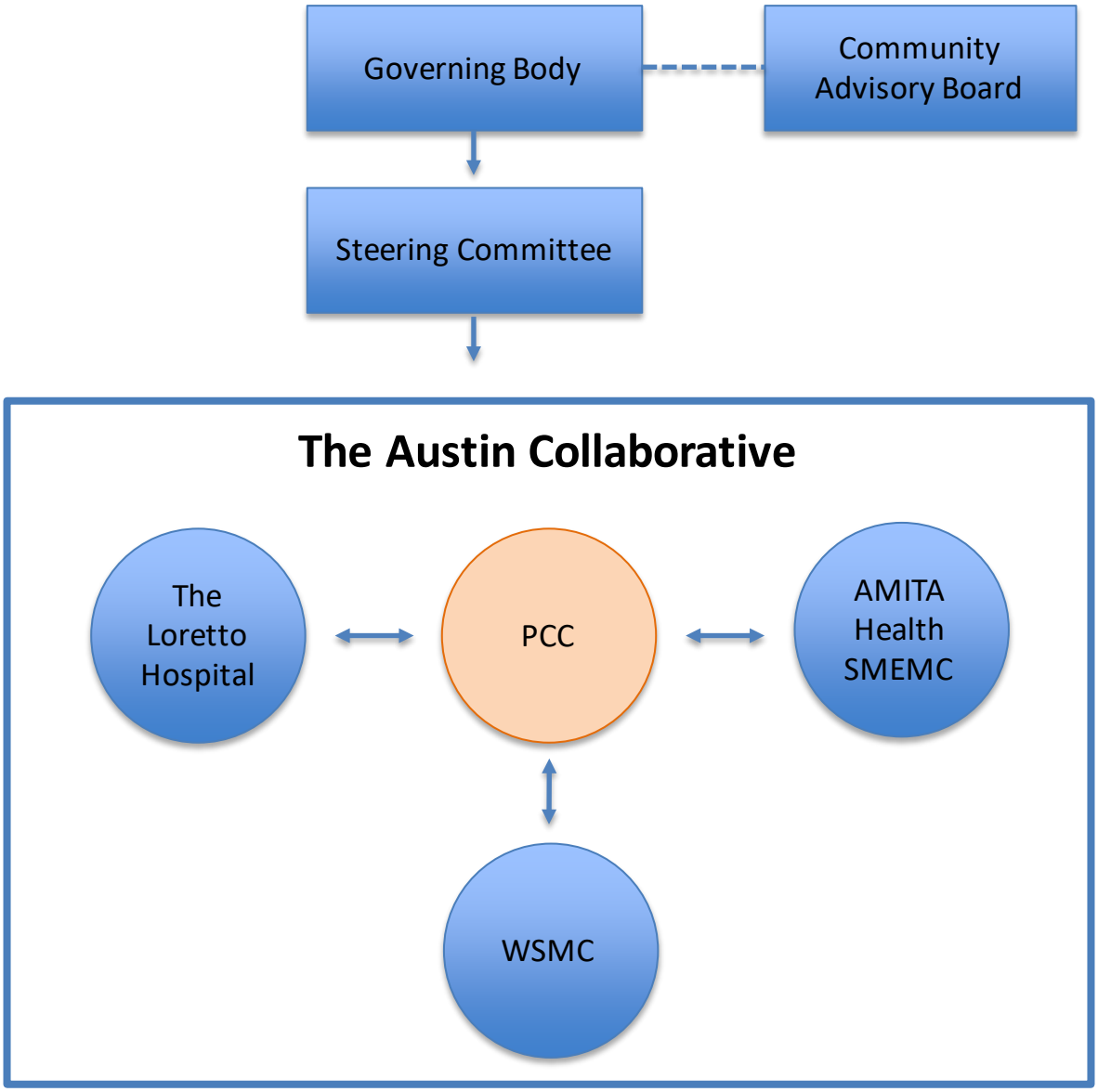
Goal:

To reduce life expectancy gap by 50% by 2030 between the West Side and The Loop

Lurie Children's Collaborative

Goal:

Improving outcomes for at-risk pregnant women and infants



Austin Collaborative	PCC Community Wellness Center	AMITA Health	The Loretto Hospital	West Suburban Medical Center
Scheduling and transportation hub Care Coordination EMR Connectivity Across Providers Governance SDOH	Primary Care Behavioral Health & Addiction Care Oral Health Preventive Care Urgent Care SDOH	Specialty and Subspecialty Care Emergency Care Behavioral Health & Addiction Care Behavioral Health IP & IOP Care General Surgery Hospitalization	Emergency Care Behavioral Health & Addiction Care Behavioral Health IP & IOP Care Hospitalization	Specialty and Subspecialty Care Emergency Care Hospitalization

MEDICAL HOME NETWORK

October 12, 2021

Robert M. Dahl MBA, FACHE
President and CEO
AMITA Health Saint Mary and Elizabeth Medical Center
2233 W Division
Chicago, IL 60622

Dear Bob,

I am pleased to provide this letter of support on behalf of Medical Home Network (MHN) for the PCC Community Wellness Center's application for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative grant funding opportunity.

MHN is a non-profit founded in 2009 by the Comer Family Foundation to improve the health of under-resourced communities in Chicago. Since that time, we have built partnerships in the community with hospitals, community health centers, behavioral health and social services to enable integrated systems of whole person care. We work closely with all of these organizations in various forums, and we are all deeply committed to improving the health of the communities we serve.

In 2014 we helped form the MHN ACO, which has 13 FQHCs (including PCC) and 3 health systems caring for 162,000 CountyCare members. We are enthusiastic about the PCC Austin Wellness Center, including bringing specialty care to the community on the West Side, and look forward to collaborating. Navigating the health care system can be challenging. I am encouraged by the prospect of comprehensive care delivered directly to West Side residents through a trusted healthcare partner, PCC Wellness.

The West Side communities in Chicago have historically been under resourced, leading to an increase in health disparities recently underscored by the COVID-19 pandemic. This innovative collaboration will bring specialty care services to Austin and surrounding neighborhoods, enabling a level of access to care that should be afforded to all. AMITA Health Saint Mary and Elizabeth Medical Center is a trusted high-quality medical center and health system within the community and I am excited to see that care extended to more West Side residents through this partnership.

We know the inequities that exist are not contained to the four walls of a hospital. This hub and spoke model reaches beyond the healthcare setting to address barriers such as transportation by creating a one-stop-shop medical home model with enhanced care coordination by the participating entities. Further, it aligns with AMITA's mission of treating the whole person.

2 Prudential Plaza
180 N. Stetson, Suite 600-1
Chicago, IL 60601
p312.274.0126
f 312.274.0555
mhnchicago.org

MEDICAL HOME NETWORK

The PCC Community Wellness Center application promises sorely needed investment and access to specialists across zip codes on the West Side of Chicago. I applaud AMITA Health

Saint Mary and Elizabeth Medical Center for their partnership and dedication to serving residents of the West Side and the City of Chicago. The PCC Community Wellness Center collaborative has my full support.

Please contact Angela Santiago from my office at asantiago@mhnchicago.org or (312) 967-1293 for additional information.

Sincerely,

Cheryl Lulias
President & CEO
MEDICAL HOME NETWORK
Phone: 312.967.1340
clulias@mhnchicago.org

MEDICAL HOME NETWORK

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mhnchicago.org

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Washington Office
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Washington, DC 20515
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Chicago Office
2813-15 West Fifth Avenue
Chicago, Illinois 60612
(p) 773-533-7520
(f) 844-274-0426

Congress of the United States
House of Representatives
Washington, D.C.

COMMITTEE ON
WAYS AND MEANS
subcommittees
Chairman, Worker and Family Support
Trade
COMMITTEE ON
OVERSIGHT AND REFORM
subcommittees
Civil Rights and Civil Liberties
Government Operations

August 19, 2021

Ms. Toni Bush
President and CEO
PCC Community Wellness Center
14 Lake Street
Oak Park, Illinois 60302

Dear Ms. Bush:

Please accept this communiqué as a letter in support of PCC's new expansion project and application for the Illinois Department of Healthcare and Family Services' Healthcare Transformation Collaboratives grant. The new health center, the PCC Primary Care Pavilion, will increase access to health care in the Austin community.

Many of the problems we face in underserved communities stem from social determinants of health. PCC's former CEO, Bob Urso, presented this project to me before he retired. I understand the goal of this project is to stimulate economic growth and development, improve the health of the community by addressing issues of chronic illnesses, and provide access to wellness programs in collaboration with other Austin community organizations. Offering programs such as a community garden/urban farm, a lifestyle center with exercise equipment and classes, and workforce development programming are valuable resources for West Side residents. In addition, the health care services proposed at the new campus, including primary health care, behavioral health, dental, and specialty services, are identified as high need in the community.

PCC has earned an outstanding record of accomplishment in the target communities. There remains a very significant unmet need for such programs. I trust the application will receive all due consideration.

Sincerely,

Danny K. Davis

Danny K. Davis
Member of Congress

DKD:ic

ROBERTO MALDONADO
ALDERMAN, 26TH WARD

2511 WEST DIVISION STREET
CHICAGO, ILLINOIS 60622
PHONE: 773-395-0143
EMAIL: ROBERTO.MALDONADO@CITYOFCHICAGO.ORG

CITY OF CHICAGO
CITY COUNCIL

COUNCIL CHAMBER
CITY HALL, ROOM 300
121 NORTH LASALLE STREET
CHICAGO, ILLINOIS 60602

COMMITTEE MEMBERSHIPS

AVIATION

COMMITTEES AND RULES

EDUCATION AND CHILD DEVELOPMENT

HOUSING AND REAL ESTATE

September 10, 2021

Bob Dahl
President and CEO
AMITA Health Saint Mary and Elizabeth Medical Center
2233 W Division
Chicago, IL 60622

Dear Mr. Dahl,

Please accept this letter of support for the PCC Wellness Center application for grant funding from the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative. This is a truly transformative proposal that will bring much needed specialty care services to the West Side of Chicago. AMITA Health Saint Mary and Elizabeth Medical Center, which serves the 26th Ward, is a trusted community partner, providing high quality healthcare to the surrounding community and I'm excited by the prospect of expanding their reach across the West Side.

This innovative proposal will help to transform not only the Austin neighborhood but also zip codes across the West Side where a lack of healthcare services, combined with social determinants such as transportation, has led to ongoing adverse health outcomes. The partnerships established through this proposal will bring quality specialty care to residents in need and foster a network that prioritizes the patient and encourages the continuum of care.

The PCC Community Wellness Center collaborative application has my support and I am grateful to AMITA Health Saint Mary and Elizabeth Medical Center for their partnership and dedication to serving residents of the 26th Ward and the West Side of Chicago.

Sincerely,

Roberto Maldonado
Alderman, 26th Ward

District Office
4053 W. Armitage Ave
Chicago, IL 60639
(773) 799-8219

Springfield Office
632 Capitol Building
Springfield, IL 62706
(217) 782-0150

Delia C. Ramirez
4th District State Representative

September 16, 2021

Bob Dahl
President and CEO
AMITA Health Saint Mary and Elizabeth Medical Center
2233 W Division
Chicago, IL 60622

Dear Mr. Dahl,

I am pleased to provide this letter of support for the PCC Wellness Center's Healthcare and Family Services Healthcare Transformation Collaborative grant application. This is an exciting partnership between typically competing institutions coming together to break down barriers to specialty care services in the Austin neighborhood and surrounding communities. By working with the community, this collaborative can address the specific health needs of area residents who have historically been underserved.

This hub and spoke model will bring the expertise and resources of AMITA Health St. Mary and Elizabeth Medical Center, as well as other partners, directly to West Side communities such as Austin, Humboldt Park and others where specialty care services has been out of reach for many of the most vulnerable residents. The proposal presents an exciting opportunity that will help to fill a gap in the healthcare system, allow for access and encouraging a continuum of care between trusted healthcare partners.

The PCC Community Wellness Center application delivers needed investment across zip codes on the West Side of Chicago. I applaud AMITA Health Saint Mary and Elizabeth Medical Center for their partnership and dedication to serving residents of the West Side and the City of Chicago. The PCC Community Wellness Center collaborative has my full support.

Sincerely,

Delia C. Ramirez
4th District State Representative

Illinois State Senator

Capitol Office:
627 State Capitol
Springfield, IL 62706
(217) 782-5652

District Office:
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Chicago, IL 60622
(773) 292-0202

Satellite Office:
4053 W. Armitage Ave.
Chicago, IL 60639
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Omar Aquino
Majority Caucus Whip
State Senator 2nd District

Committees:
Appropriations App - General Services (Sub-Chair)
Education
Energy and Public Utilities
Executive
Executive Appointment
Higher Education
Human Rights
Redistricting (Chairperson)

September 15, 2021

Bob Dahl
President and CEO
AMITA Health Saint Mary and Elizabeth Medical Center
2233 W Division
Chicago, IL 60622

Dear Mr. Dahl,

Please accept this letter of support on behalf the 2nd Illinois Senate district for the PCC Wellness Center's application for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative funding opportunity. In my role as Senator, but more importantly as a resident of the West Side of Chicago, I am excited about the opportunity presented by the PCC Wellness Center collaboration. AMITA Health Saints Mary and Elizabeth, which serves my district, is a staple in the community and their partnership in this collaborative brings with it a level of trust to residents in the surrounding neighborhoods.

Residents in West Side communities have historically experienced barriers to care that put individuals at a higher risk for chronic disease, such as hypertension and diabetes, and lead to increases in maternal and child morbidity and mortality. The lack of comprehensive care on the West Side has contributed to many years of disparate health outcomes. By establishing a collaborative with PCC Wellness Center, AMITA Health Saint Mary and Elizabeth will help to establish consistent access to comprehensive care where it has lacked.

I applaud AMITA Health Saint Mary and Elizabeth Medical Center for their partnership and dedication to serving residents of the West Side and the City of Chicago. The PCC Community Wellness Center collaborative has my full support.

Sincerely,

Senator Omar Aquino
Majority Caucus Whip
State Senator, 2nd District

Daniel La Spata

ALDERMAN, 1ST WARD
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CHICAGO, ILLINOIS 60647

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CITY OF CHICAGO
CITY COUNCIL

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CHICAGO, ILLINOIS 60602

Committees

Committees and Rules
Contract Oversight and Equity
Environment Protection and Energy
Housing and Real Estate
Pedestrian and Traffic Safety
Special Events, Cultural Affairs and Recreation

August 25, 2021

Bob Dahl
President and CEO
AMITA Health Saint Mary and Elizabeth Medical Center
2233 W Division
Chicago, IL 60622

Dear Mr. Dahl,

I am pleased to provide this letter of support on behalf of the 1st Ward for the PCC Community Wellness Center's application for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative grant funding opportunity. The West Side communities in Chicago have historically been under resourced, leading to deadly health disparities recently underscored by the COVID-19 pandemic. This innovative collaboration will bring specialty care services to Austin and surrounding neighborhoods, enabling a level of access to care that should be afforded to all. AMITA Health Saint Mary and Elizabeth Medical Center, which serves my Ward, is a trusted ally within the community and I am excited to see that care extended to more West Side residents through this partnership.

As you know, navigating the health care system can be challenging. I am encouraged by the prospect of comprehensive care delivered directly to West Side residents through a trusted healthcare partner, PCC Wellness. We know the inequities that exist are not contained to the four walls of a hospital. This hub and spoke model looks beyond the healthcare setting to address barriers such as transportation by creating a "one stop shop" and enhanced care coordination by the participating entities. Further, it aligns with AMITA's mission of treating the whole person.

The PCC Community Wellness Center application promises sorely needed investment across zip codes on the West Side of Chicago. I applaud AMITA Health Saint Mary and Elizabeth Medical Center for their partnership and dedication to serving residents of the West Side and the City of Chicago. The PCC Community Wellness Center collaborative has my full support.

Please contact Daniel Castañeda from my office at danielcastaneda@the1stward.com or (773) 904-8958 for additional information.

Sincerely,

Daniel F. La Spata

City of Chicago, 1st Ward Alderman

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COMMITTEES:

ASSIGNMENTS
CHAIRPERSON
EDUCATION
EXECUTIVE
HIGHER EDUCATION
LABOR

KIMBERLY A. LIGHTFORD
SENATE MAJORITY LEADER
STATE SENATOR ▪ 4TH DISTRICT

September 16, 2021

Ms. Toni Bush
President and CEO
PCC Community Wellness Center
14 Lake Street
Oak Park, IL 60302

Dear President Bush,

I am sending this letter to support Parent Child Center's new expansion project and application for the Illinois Department of Healthcare and Family Services' Healthcare Transformation Collaboratives grant. The new health center, the PCC Primary Care Pavilion, will increase access to health care in the Austin community. Offering programs such as a community garden/urban farm, a lifestyle center with exercise equipment and classes, and workforce development programming, this expansion provides an underserved community with much need resources.

This project would stimulate economic growth and development, improve the community's health by addressing issues of chronic illnesses, and provide access to wellness programs in collaboration with other Austin community organizations. In addition, the health care services proposed at the new campus, including primary health care, behavioral health, dental, and specialty services, have all been identified as essential services for the communities served by PCC. With the knowledge that quality health care is vital for everyone to live a healthful, prosperous life. PCC has my full support.

Sincerely,

Kimberly a. Lightford

Senator Kimberly A. Lightford
Senate Majority Leader
Illinois 4th Senate District

EMMA M. MITTS
ALDERMAN, 37TH WARD

4924 WEST CHICAGO AVENUE
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CITY OF CHICAGO
CITY COUNCIL

COUNCIL CHAMBER
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COMMITTEE MEMBERSHIPS
LICENSE & CONSUMER PROTECTION (CHAIRMAN)
AVIATION
BUDGET & GOVERNMENT OPERATIONS
COMMITTEES ON COMMITTEES AND RULES
ECONOMIC, CAPITAL AND TECHNOLOGY DEVELOPMENT
FINANCE
PUBLIC SAFETY
WORKFORCE DEVELOPMENT AND AUDIT

August 11, 2021

Ms. Toni Bush
President and CEO
PCC Community Wellness Center
14 Lake Street
Oak Park, IL 60302

Dear Ms. Bush,

Please accept this Letter of Support from the 37th Ward for PCC Community Wellness Center's application for Illinois Department of Healthcare and Family Services' Healthcare Transformation Collaboratives grant for its capital expansion project in the Austin community. As a new health center, the PCC Primary Care Pavilion is vital for the residents in the 37th Ward because it will help stimulate economic growth and development and improve our residents' health by addressing social determinants of health on the West Side of Chicago.

As you are aware, Austin is the second largest community area by population in the City of Chicago. As the Alderman representing the 37th Ward, I am responsible for ensuring residents in my Ward have access to all the necessary resources to experience a higher quality of life. This includes jobs, access to quality health care, including mental health care services, and a safe community. I am pleased to partner with PCC, Representative La Shawn K. Ford, and the Cook County Land Bank on this new project to expand access to quality health care, including specialty care, and ancillary services to the communities we serve. This project has the full support of the 37th Ward.

Sincerely,

Emma Mitts
Alderman, 37th Ward

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247-E STRATTON
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217.557.4502 FAX
Repford@lashawnford.com

La Shawn K. Ford
State Representative
8th District

August 17, 2021

Ms. Toni Bush
President and CEO
PCC Community Wellness Center
14 Lake Street
Oak Park, IL 60302

Dear Ms. Bush,

Please accept this Letter of Support of PCC Community Wellness Center's application for the Illinois Department of Healthcare and Family Services' Healthcare Transformation Collaboratives grant for its capital expansion project in the Austin community. As a new health center, the PCC Primary Care Pavilion is an important project for the communities served by PCC and for all residents on the Greater West Side of Chicago. A project of this magnitude will make quality health care services, including specialty care, accessible to all residents on the West Side. This new facility will also allow hospitals to collaborate by bringing their specialty care services under one roof, making the referral process easier for patients for continuity of care.

As a legislator, I have championed many bills fighting health disparities to improve the health and wellbeing of all Illinoisans. I have sponsored legislation holding hospitals accountable to provide patients safe and equitable mental health care, promoting farmer's markets in underserved communities and schools, and even urging the Illinois Department of Public Health to establish a comprehensive plan to slow the spread of HIV/AIDS in 2008. Now with COVID-19 in the forefront, I join the CDC's efforts to ensure Black and Brown residents are fully vaccinated and tested to slow the spread of this deadly virus. As a prostate cancer survivor, I also want to ensure that men in the Black community receive routine cancer screenings and quality continuity of care if they have cancer.

Quality health care is a priority and a right for everyone. I applaud PCC's efforts to ensure residents have a fighting chance to good health and happiness. For all the reasons stated above, I fully support PCC's pursuit of transformation funding to expand specialty care services on the West Side of Chicago.

Sincerely,

La Shawn K. Ford
State Representative--Eighth District

PCC COMMUNITY WELLNESS CENTER

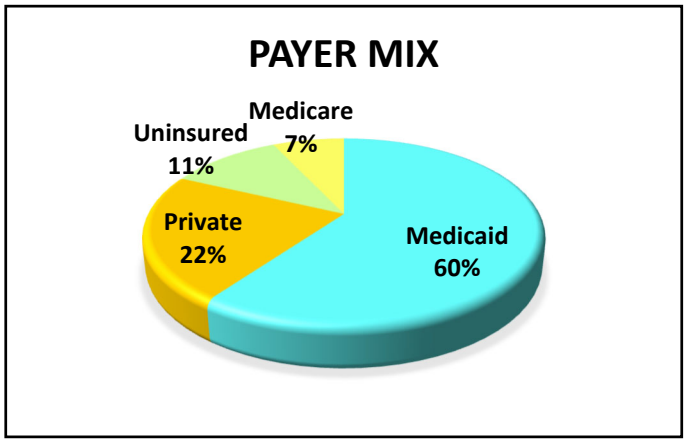
DEMOGRAPHICS AND CLINICAL DATA – CY 2020

Data Support Required Attachment: In designing the project, the Austin Collaborative utilized the following data – PCC specific demographics and clinical data – to identify the number and type of specialty services required. Specifically, the Collaborative looked at PCC's top medical and behavioral health diagnoses along with referral patterns. The result was the development of a two-tier specialty physician approach. The type and amount of specialty care is based on a formula of specialty care per 100 primary care encounters.

Total Number of PCC Patients Served in CY2020 **47,180**

Patient Age	Males	Females	Total
Under 2	1,471	1,517	2,988
2 - 9	3,118	3,062	6,180
10 - 19	3,211	4,113	7,324
20 - 29	1,900	5,892	7,792
30 - 39	1,947	5,431	7,378
40 - 49	2,030	3,947	5,977
50 - 59	2,020	2,924	4,944
60 - 69	1,379	1,883	3,262
70 and Older	453	882	1,335
TOTAL	**17,529**	**29,651**	**47,180**

Patients by Major Geographic Areas	
Austin	7,691
Belmont Cragin	6,770
Humboldt Park	4,704
Berwyn	1,980
Garfield Park	1,912
Cicero	1,564
Dunning	1,459
Maywood	1,439
Oak Park	1,426
Elmwood Park	1,330
Melrose Park	1,074
Portage Park	1,012



Medicaid Managed Care Covered Lives	
MHN	14,000
Aetna/Illinicare	6,700
BCBS Community	4,200
Meridian	5,600
Molina	2,600

Medicare Patients	3,100
West Suburban Health Providers Patients	1,500
Private Insurance Patients	4,118
Uninsured Patients	5,362

Payer mix is based on patients seen at PCC in CY 2020.

TOP FIVE DIAGNOSES

Diagnoses - Medical
Essential (primary) hypertension
Opioid dependence, uncomplicated
Type 2 diabetes mellitus without complications
Acute upper respiratory infection, unspecified
Unspecified asthma, uncomplicated

Problem List - Medical
Hypertensive disorder
Obesity
Hyperlipidemia
Asthma
Allergic rhinitis

Diagnoses - Behavioral Health
Major depressive disorder, single episode, unspecified
Generalized anxiety disorder
Bipolar disorder, unspecified
Post-traumatic stress disorder, unspecified
Adjustment disorder, unspecified

Problem List - Behavioral Health
Adjustment disorder
Generalized anxiety disorder
Major depressive disorder
Post-traumatic stress disorder
Attention deficit hyperactivity disorder

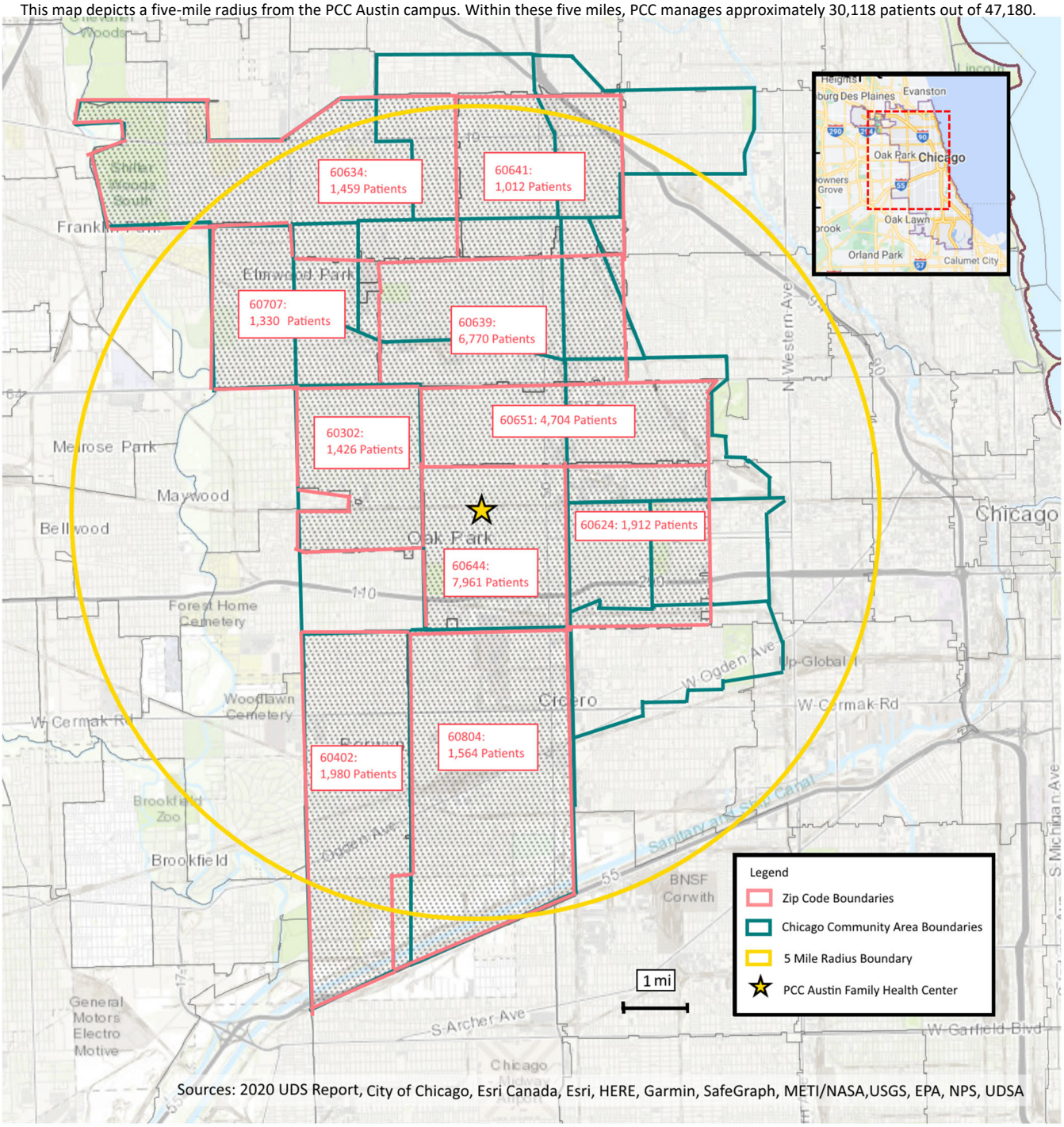
TOP FIVE REFERRALS - CONSULTS AND PROCEDURES

Referrals - Consults
Physical therapy
Ophthalmology
Podiatry
Gastroenterology
Dermatology

Referrals - Procedures
Colonoscopy
Lexiscan cardiolite stress test
Upper endoscopy
Nerve conduction study/EMG, upper extremity
Ultrasound guided core biopsy

PCC Patients by Major Demographic Areas

This map depicts a five-mile radius from the PCC Austin campus. Within these five miles, PCC manages approximately 30,118 patients out of 47,180.



Sources: 2020 UDS Report, City of Chicago, Esri Canada, Esri, HERE, Garmin, SafeGraph, METI/NASA,USGS, EPA, NPS, UDSA

Primary Care at PCC Austin based on expansion:

	Existing	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Primary Care Encounters	20,750	27,059	30,353	33,647	36,941	40,235	43,520
Unduplicated Patients	6,916	9,020	10,117	11,215	12,314	13,412	14,507

Five-mile radius with expansion:

	Existing	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Primary Care Encounters	85,535	91,510	94,626	97,744	100,865	103,984	107,094
Unduplicated Patients	30,118	32,222	33,319	34,417	35,516	36,614	37,709

Totals for PCC:

	Existing	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Primary Care Encounters	133,750	140,059	143,353	146,647	149,941	153,235	156,529
Unduplicated Patients	47,180	49,284	50,381	51,478	52,575	53,672	54,769

Behavioral Health at PCC:

	Existing	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Behavioral Health Encounters	21,750	23,131	23,856	24,606	25,356	26,106	26,856
Note: Patients are also included unduplicated PCC census above	5,150	5,481	5,653	5,831	6,009	6,186	6,364

Specialist Care Referrals per 100 Primary Care Physician Encounters

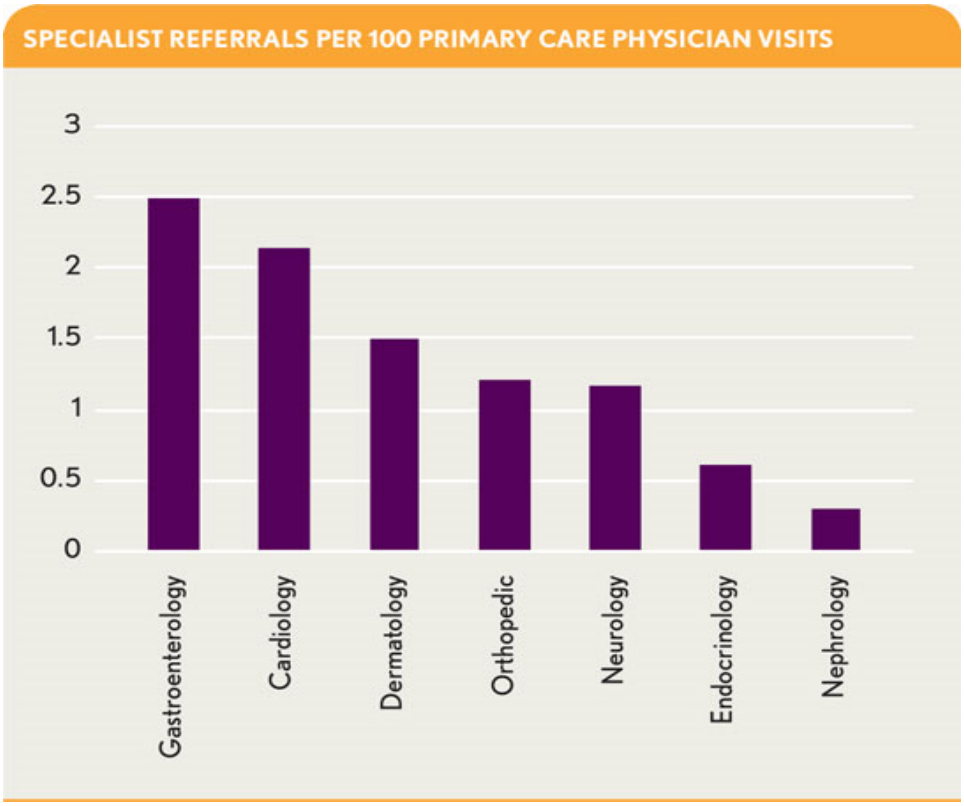
Population Health Management – July 1, 2018

Specialist Referrals per 100 Primary Care Visits	Gastroenterology	Cardiology	Dermatology	Orthopedic	Neurology	Endocrinology	Nephrology
	2.5	2.1	1.5	1.25	1.2	0.6	0.25

Total Specialist Referrals per 100 Primary Care Visits	9.4

	Existing	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Specialty Care Encounters - Austin	1,951	2,544	2,853	3,163	3,472	3,782	4,091
Specialty Care Encounters - 5-Mile Radius	8,040	8,602	8,894	9,188	9,481	9,774	10,067
Specialty Care Encounters - PCC	12,573	13,166	13,475	13,785	14,094	14,404	14,714

	Existing	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Primary Care Encounters	85,535	91,510	94,626	97,744	100,865	103,984	107,094
Unduplicated Patients	30,118	32,222	38,319	34,417	35,516	36,614	37,709



Austin Collaborative Data Support

UDS Mapper Data

This data was obtained from the Uniform Data System (UDS), which is a collaboration of Health Resources and Services Administration (HRSA), John Snow, Inc., and the American Academy of Family Physicians (https://udsmapper.org/).

Zip Code	Post Office Name	HCP: Health Center Count (Combined) 2019	HCP: Dominant Health Center 2019	HCP: Dominant Health Center Serving ZCTA (Share of Patients) 2019
60644	Chicago	18	PCC COMMUNITY WELLNESS CENTER	52%
60651	Chicago	19	PCC COMMUNITY WELLNESS CENTER	23%
60639	Chicago	19	PCC COMMUNITY WELLNESS CENTER	27%
60707	Elmwood Park	16	PCC COMMUNITY WELLNESS CENTER	31%
60612	Chicago	18	THE BOARD OF TRUSTEES OF THE UNIVERSITY OF IL	28%
60624	Chicago	18	LAWNDALE CHRISTIAN HEALTH CENTER	28%
60623	Chicago	20	LAWNDALE CHRISTIAN HEALTH CENTER	
Total:		108		

Key: HCP = Health Center Program; Pop = Population

Austin Collaborative Data Support

UDS Mapper Data

This data was obtained from the Uniform Data System (UDS), which is a collaboration of Health Resources and Services Administration (HRSA), John Snow, Inc., and the American Academy of Family Physicians (https://udsmapper.org/).

Zip Code	Pop: Total (#) 2015-2019	Pop: Low-Income (#) 2015-2019	HCP: Total Patients (#) 2020	HCP: Low-Income Not Served by Health Centers (#)	HCP: Penetration of Low-Income (%)	HCP: Penetration of Total Population (%)
60644	46,591	28,523	14,929	13,594	52%	32%
60651	63,492	32,346	20,464	11,882	63%	32%
60639	88,204	41,081	24,797	16,284	60%	28%
60707	43,093	11,475	4,426	7,049	39%	10%
60612	33,735	16,146	8,013	8,133	50%	24%
60624	34,892	23,077	13,952	9,125	60%	40%
60623	81,283	50,820	37,488	13,332	74%	46%
Total:	391,290	203,468	124,069	79,399	57%	30%

Key: HCP = Health Center Program; Pop = Population

Conclusion: Per UDS Mapper data from the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA), **79,399** low-income residents remain unserved by any community health center in the Austin Collaborative's proposed service area.

Austin Collaborative Data Support

Health Disparities Data

Source for all tables: Chicago Health Atlas

Community Area	Population 2015-2019	Uninsured Rate (% of residents) 2015-2019
Austin	93,941	11.58
Humboldt Park	55,049	16.18
North Lawndale	32,086	10.52
East Garfield Park	18,951	7.58
West Garfield Park	16,415	10.17
Chicago, IL	2,709,534	9.65

Community Area	Lung Cancer Diagnosis Rate 2014-2018	Colorectal Cancer Diagnosis Rate 2014-2018	Stroke Mortality Rate 2017
Austin	120.45	77.16	63.4
Humboldt Park	64.42	57.01	49.1
North Lawndale	118.32	104.68	54.5
East Garfield Park	156.47	92.17	55.7
West Garfield Park	175.54	79.72	52.2
Chicago, IL	89.5	66.60	51.7

Lung Cancer, Colorectal Cancer, and Stroke Mortality Rates are Per 100,000 Population

Community Area	Invasive Breast Cancer Diagnosis Rate, Females 2014-2018	Cervical Cancer Diagnosis Rate, Females 2014-2018	Cervical Cancer Mortality Rate 2018
Austin	206.50	15.42	1.0
Humboldt Park	165.02	23.23	2.6
North Lawndale	208.06	14.03	1.1
East Garfield Park	256.95	24.33	1.1
West Garfield Park	301.34	22.18	1.2
Chicago, IL	198.17	15.01	1.40

Rates are Per 100,000 Female Population

Austin Collaborative Data Support

Health Disparities Data

Community Area	Hypertension (count of adults) 2016-2018	Hypertension Rate (% of adults) 2016-2018
Austin	24,600	39.2
Humboldt Park	7,000	29.7
North Lawndale	8,500	23.2
East Garfield Park	2,800	25.6
West Garfield Park	4,900	34.5
Chicago, IL	698,000	33.1

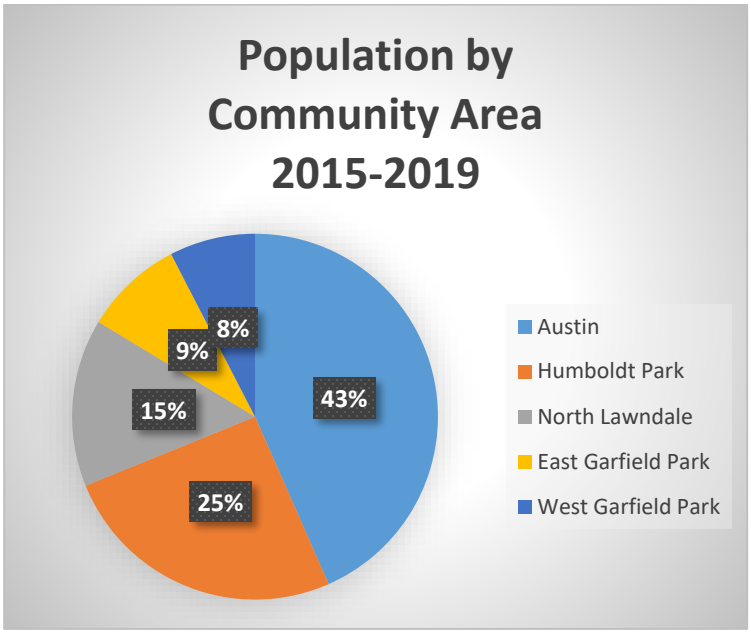
Community Area	Low Birthweight Rate (% of births) 2013-2017	Preterm Births Rate (% of births) 2013-2017
Austin	14.2	13.7
Humboldt Park	10.2	11.5
North Lawndale	14.5	14.1
East Garfield Park	15.3	15.3
West Garfield Park	16.2	14.8

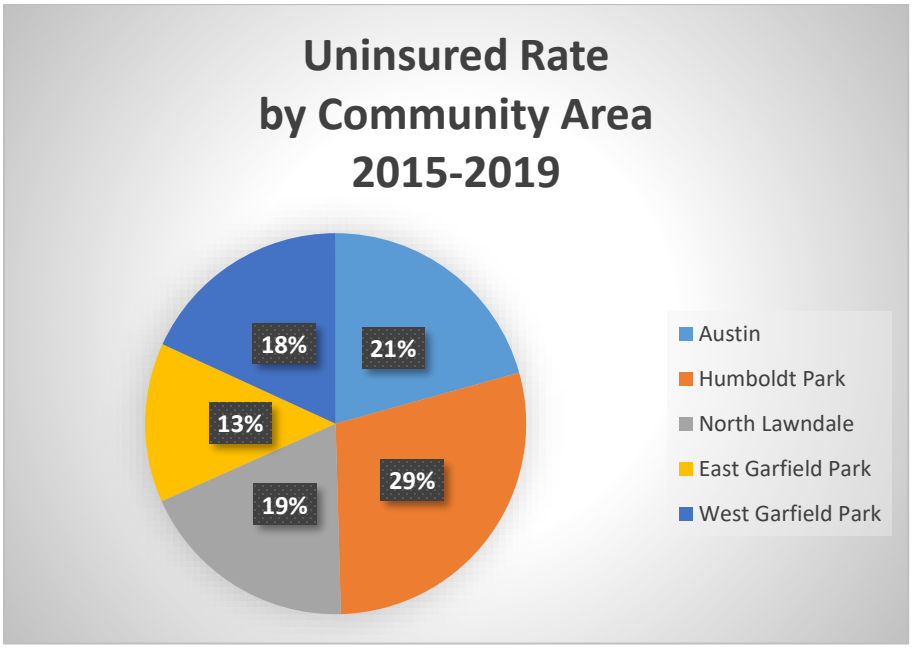
Community Area	Adult Asthma (count of adults) 2016-2018	Adult Asthma Rate (% of adults) 2016-2018	Adult Diabetes (count of adults) 2016-2018	Adult Diabetes Rate (% of adults) 2016-2018
Austin	8,800	12.6	8,800	12.4
Humboldt Park	6,900	17.1	5,200	12.8
North Lawndale	2,400	10.0	2,200	9.0
East Garfield Park	1,800	14.6	1,300	10.9
West Garfield Park	2,900	20.2	2,400	16.1

Austin Collaborative Data Support

Demographic and Health Status Data

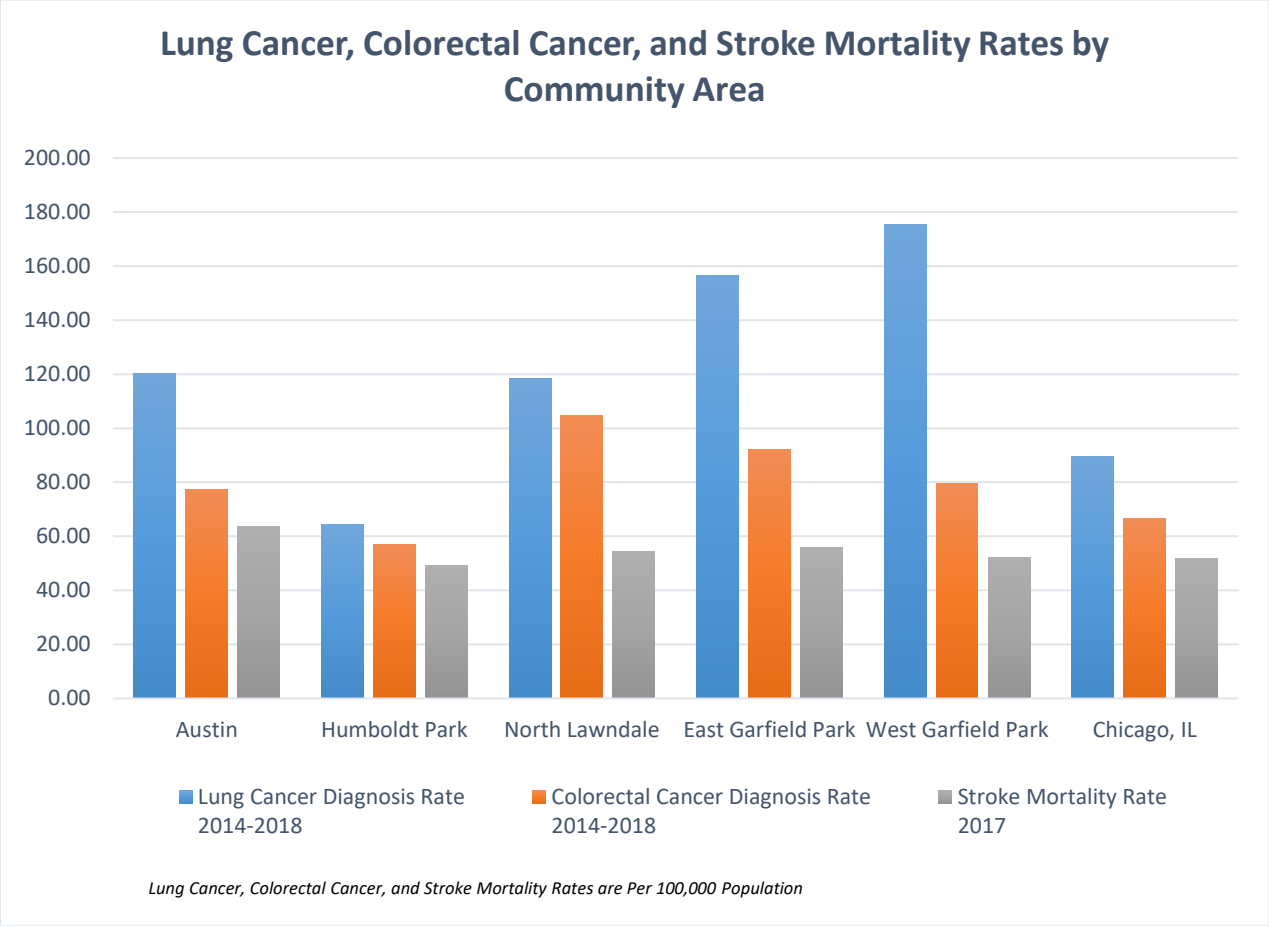
Proposed Service Area for Austin Collaborative:
Austin, Humboldt Park, North Lawndale, East Garfield Park, and West Garfield



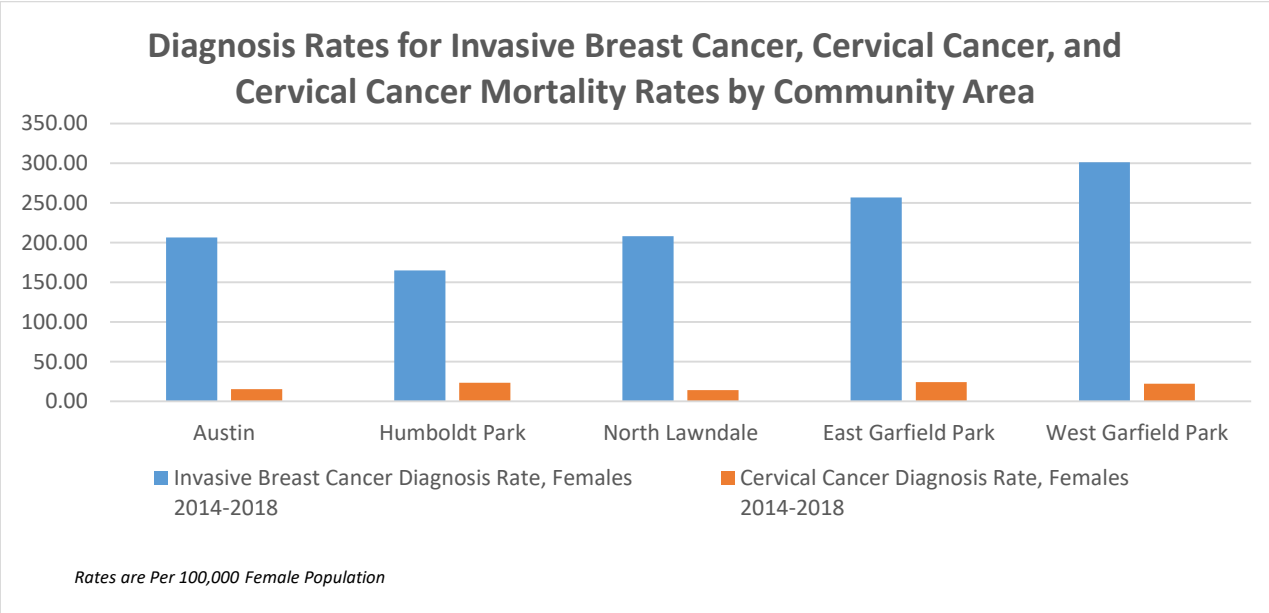


Austin Collaborative Data Support

Demographic and Health Status Data



Lung Cancer, Colorectal Cancer, and Stroke Mortality Rates are Per 100,000 Population



Rates are Per 100,000 Female Population

Austin Collaborative Data Support

Demographic Data – Proposed Service Area

Data Source: American Community Survey - June 2021

Total Non-White	Hispanic	Black
89%	45%	42%

Zip Code	Total Population: Race Data	# Black Non-Hispanic	% Black Non-Hispanic	# Black Hispanic	% Black Hispanic	# White Non-Hispanic	% White Non-Hispanic
60612	33,735	19,873	59%	249	1%	7,629	23%
60623	81,283	24,101	30%	657	1%	2,366	3%
60624	34,892	31,436	90%	205	1%	1,109	3%
60639	88,204	10,828	12%	1,113	1%	6,628	8%
60644	46,591	41,158	88%	225	0%	1,781	4%
60651	63,492	32,223	51%	575	1%	2,799	4%
60707	43,093	2,981	7%	61	0%	20,783	48%
TOTAL	391,290	162,600		3,085		43,095	

Zip Code	# White Hispanic	% White Hispanic	# Asian Non-Hispanic	% Asian Non-Hispanic	# Asian Hispanic	% Asian Hispanic	# Pacific Islander/ Native Hawaiian Non-Hispanic	% Pacific Islander/ Native Hawaiian Non-Hispanic
60612	2,273	0	1,449	4%	41	0%	2	0%
60623	28,529	0	80	0%	-	0%	-	0%
60624	453	0	53	0%	-	0%	28	0%
60639	34,484	0	1,124	1%	158	0%	11	0%
60644	1,104	0	103	0%	26	0%	24	0%
60651	10,092	0	295	0%	48	0%	-	0%
60707	10,374	0	1,533	4%	-	0%	-	0%
TOTAL	87,309		4,637		273		65	

Austin Collaborative Data Support

Demographic Data – Proposed Service Area

Data Source: American Community Survey - June 2021

Zip Code	# Pacific Islander/ Native Hawaiian Hispanic	% Pacific Islander/ Native Hawaiian Hispanic	# Amer. Indian/ Alaska Native Non-Hispanic	% Amer. Indian/ Alaska Native Non-Hispanic	# Amer. Indian/ Alaska Native Hispanic	% Amer. Indian/ Alaska Native Hispanic	# Multi-Racial Non-Hispanic	%Multi-Racial Non-Hispanic
60612	52	0%	9	0%	70	0%	695	2%
60623	16	0%	99	0%	262	0%	219	0%
60624	-	0%	13	0%	1	0%	411	1%
60639	15	0%	76	0%	343	0%	442	1%
60644	-	0%	7	0%	9	0%	297	1%
60651	-	0%	88	0%	167	0%	518	1%
60707	-	0%	109	0%	96	0%	658	2%
TOTAL	83		401		948		3,240	

Zip Code	# Multi-racial Hispanic	%Multi-racial Hispanic	# Other Non-Hispanic	% Other Non-Hispanic	# Other Hispanic	% Other Hispanic	# Total Hispanic	% Total Hispanic
60612	310	1%	22	0%	1,061	3%	4,056	12%
60623	638	1%	121	0%	24,195	30%	54,297	67%
60624	7	0%	69	0%	1,107	3%	1,773	5%
60639	1,822	2%	303	0%	30,857	35%	68,792	78%
60644	100	0%	27	0%	1,730	4%	3,194	7%
60651	919	1%	324	1%	15,444	24%	27,245	43%
60707	643	1%	167	0%	5,688	13%	16,862	39%
TOTAL	4,439		1,033		80,082		176,219	

Austin Collaborative Data Support

Demographic Data – Proposed Service Area

Data Source: Uniform Data System (UDS) Mapper

Zip Code	Total Population Insurance Status	Population Uninsured	Population Uninsured %	Pop: Medicaid/ Public Ins., est. (#) 2017	Pop: Medicaid/ Public Ins., est. (%) 2017	Pop: Medicare/ Private Ins., est. (#) 2017	Pop: Medicare/ Private Ins., est. (%) 2017
60612	33,735	3,324	10%	7,246	21%	19,983	59%
60623	81,283	12,483	15%	29,136	36%	30,115	37%
60624	34,892	5,131	15%	13,208	38%	12,758	37%
60639	88,204	10,192	12%	23,638	27%	52,456	59%
60644	46,591	5,396	12%	15,661	34%	25,233	54%
60651	63,492	8,818	14%	19,781	31%	30,743	48%
60707	43,093	4,208	10%	7,341	17%	32,719	76%
TOTAL	391,290	49,552		116,011		204,007	

Proposed Service Area - Medicaid Enrollees:	**30%**

UDS Mapper: The Uniform Data System Mapper is a collaboration of Health Resources and Services Administration (HRSA), John Snow, Inc., and the American Academy of Family Physicians.

https://udsmapper.org/

Austin Collaborative Data Support

Social Vulnerability Scores

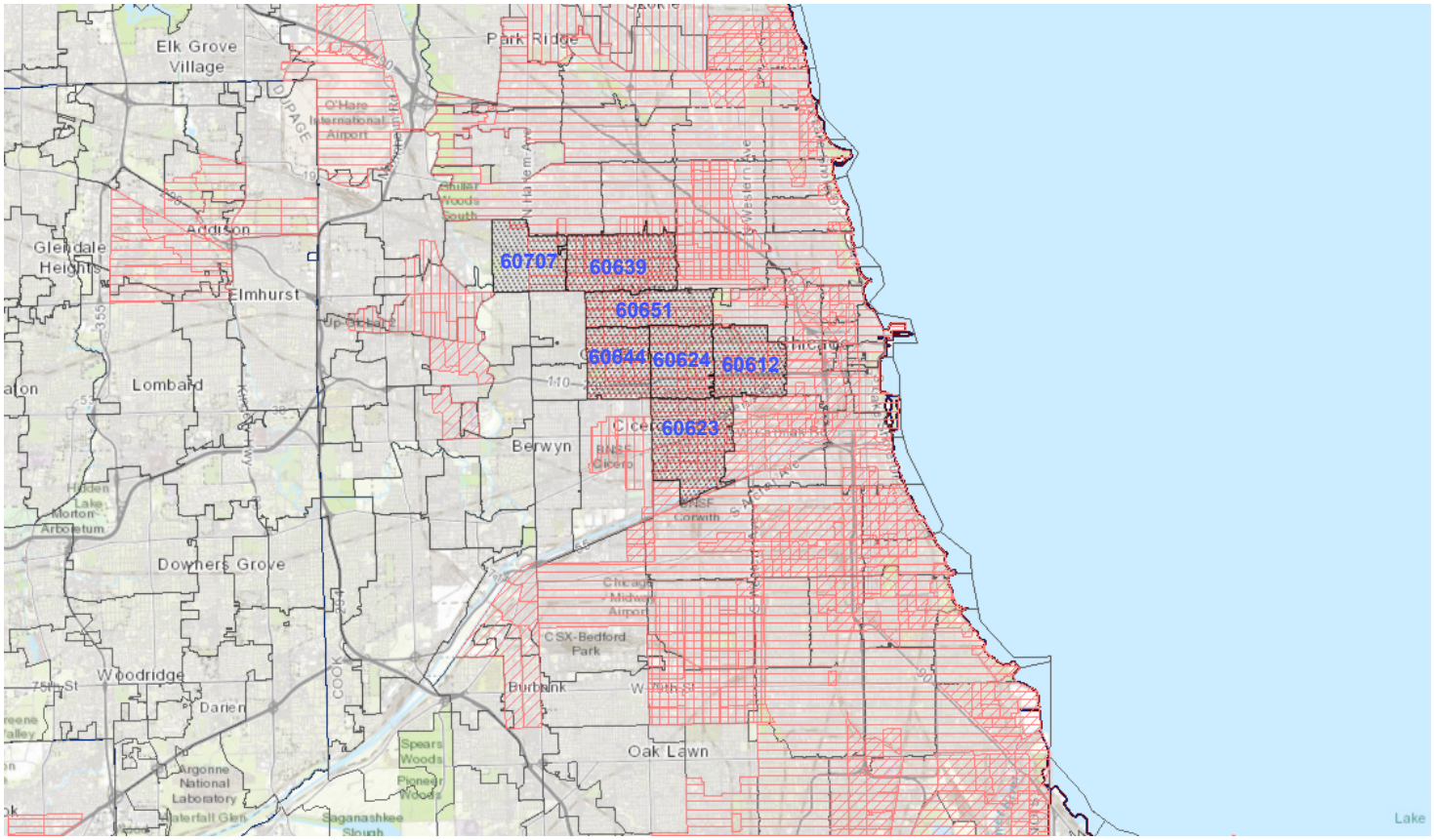
Statewide Scan of Areas in Illinois with Above Average SVI (>50 Percentile)

Areas from UIC Study

Areas with CDC Social Vulnerability Index Percentile Score >50	*Pop. Count*	*CDC SVI Percentile Score*	*Sample of Zip Codes w/SVI Score >754 ("most vulnerable")*
Chicago – South	1,026,829	87.6	60621, 60636, 60637
Chicago – West	590,175	83.5	60623,60624, 60644
East St. Louis Metro	522,652	58.8	62201, 62203, 62204
West Cook	529,407	58.0	60104, 60153, 60804
South Cook	895,830	56.6	60472, 60501, 60827

University of Illinois at Chicago School of Public Health and Institute for Healthcare Delivery Design. Transformation Data & Community Needs Report: West Side Report. February 2021: page 18.

UDS Mapper Printout

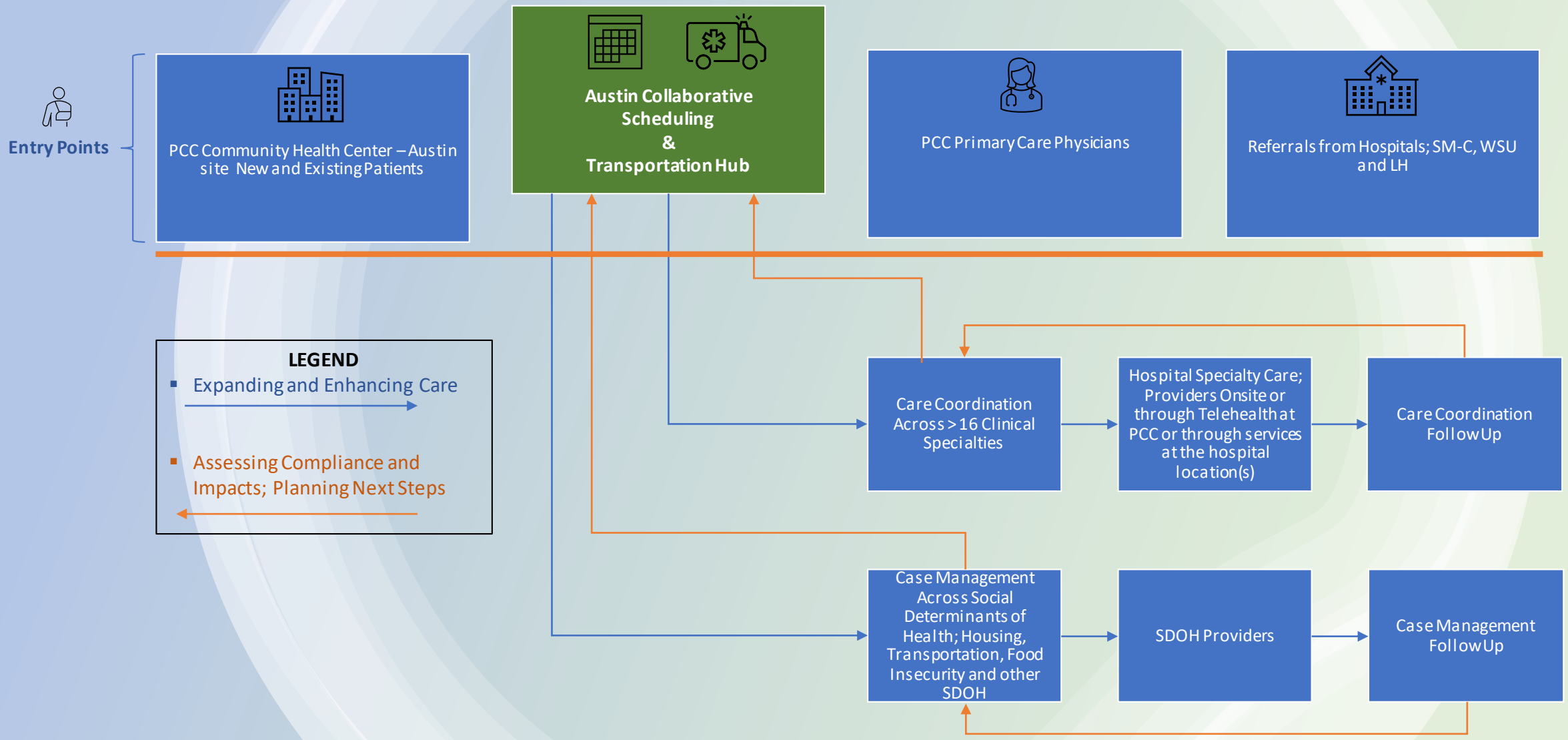


States	
Counties	
ZCTAs	
Medically Underserved Areas/Populations (MUA/P)	MUA MUP Governor Designated
Selected ZCTAs	

This map demonstrates that much of the Austin Collaborative's proposed primary service area (seven zip codes) includes Medically Underserved Areas and Medically Underserved Populations, as defined by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA).

The UDS Mapper (Uniform Data System) is a collaboration of HRSA, John Snow, Inc., and the American Academy of Family Physicians (https://udsmapper.org/).

The Austin Collaborative: Patient Pathway



The Loretto Hospital: Board of Directors and Senior Leadership Team Demographics

	Board of Directors	Senior Leadership Team	Patient Facing Staff
American Indian or Alaska Native	0%	0%	1-9%
Asian	0%	10-19%	10-19%
Black or African American	80-89%	40-49%	60-69%
Hispanic or Latino/a/Latinx	0%	0%	10-19%
Native Hawaiian or Other Pacific Islander	0%	0%	0%
Two or More Races	0%	0%	1-9%
White	10-19%	30-39%	10-19%

PCC Community Wellness Center: Board of Directors Demographics

Name	Race	Ethnicity	Sex	Minority	Health Center Patient
Mr. Ronald Austin, Jr.	African-American	Non-Hispanic or Latino	M	Yes	No
Dr. Kenneth Blair	Caucasian	Non-Hispanic or Latino	M	No	No
Ms. Velda Brunner	African-American	Non-Hispanic or Latino	F	Yes	Yes
Ms. Barbara Diggins	African-American	Non-Hispanic or Latino	F	Yes	Yes
Dr. Carolyn Fitzpatrick	African-American	Non-Hispanic or Latino	F	Yes	Yes
Ms. Patricia Ford	African-American	Non-Hispanic or Latino	F	Yes	No
Ms. Wrenetha A. Julion	African-American	Non-Hispanic or Latino	F	Yes	No
Mr. John McDonnell	Caucasian	Non-Hispanic or Latino	M	No	No
Ms. Marianna Osoria	More than one race	Hispanic or Latino	F	Yes	Yes
Ms. Juliette Stancil	African-American	Non-Hispanic or Latino	F	Yes	Yes
Ms. Teresa Reyes	More than one race	Hispanic or Latino	F	Yes	Yes

The Austin Collaborative – Sample Clinical Metrics – Year 1

	Nine specialty care areas including dermatology, orthopedics, maternal-fetal medicine, general surgery, GI, neurology, nephrology, endocrinology and podiatry
Growth in breast cancer screenings, cervical cancer screenings, controlling high blood pressure and adult access to preventative/ambulatory health services	10% improvement over baseline
Access: Specialist Wait time reduction	10% improvement over baseline
Care coordination: Specialist No show rate reduction	10% improvement over baseline
Growth in alternative therapies: PT/OT, acupuncture, exercise, cardiac rehab and healthy lifestyle	10% improvement over baseline
Growth in referrals for nutrition education, cooking demonstrations and Nutrition Rx including PCC Veggie Rx program and Saints Mary and Elizabeth Food Market	10% improvement over baseline
Growth in referrals to organizations for SDOH: e.g. Medical-Legal Partnership, Impact Behavioral Health Partners, and Lifestyle Center	10% improvement over baseline
Reduction in Emergency Room Visits	10% improvement over baseline

The Austin Collaborative – Sample Clinical Metrics – Years 2 – 5

	16 specialty care areas including dermatology, orthopedics, maternal-fetal medicine, general surgery, GI, neurology, nephrology, endocrinology, podiatry, ophthalmology, pulmonology, cardiology (non-interventional), ENT, rheumatology, urology and hematology/oncology
Growth in breast cancer screenings, cervical cancer screenings, controlling high blood pressure and adult access to preventative/ambulatory health services	Continuous year-over-year improvement from Year 1 baseline
Access: Wait time reduction	Continuous year-over-year improvement from Year 1 baseline
Care coordination: No show rate reduction	Continuous year-over-year improvement from Year 1 baseline
Growth in alternative therapies: PT/OT, acupuncture, exercise, cardiac rehab	Continuous year-over-year improvement from Year 1 baseline
Growth in referrals for nutrition education, cooking demonstrations and Nutrition Rx including PCC Veggie Rx program and Saints Mary and Elizabeth Food Market	Continuous year-over-year improvement from Year 1 baseline
Growth in referrals for SDOH	Continuous year-over-year improvement from Year 1 baseline
Reduction in Emergency Room Visits	Continuous year-over-year improvement from Year 1 baseline