

Healthcare Transformation Collaboratives Cover Sheet

1. Collaboration Name:

Jackson Park Collaborative: Behavioral Health Equity in Chicago's South Side

2. Name of Lead Entity:

Jackson Park Hospital Foundation

3. List All Collaboration Members:

Jackson Park Hospital Foundation
Coordinated Care Alliance
Family Guidance Centers, Inc.

4. Proposed Coverage Area:

South Side Chicago

5. Area of Focus:

In pursuit of transforming the delivery of healthcare, the Jackson Park Collaborative: Behavioral Health Equity in Chicago's South Side (Collaborative) is committed to increasing access to enhanced and culturally responsive integrated behavioral health (IBH) and developing an innovative care model that addresses the significant health disparities and inequities experienced by residents of South Side Chicago. In addition to improving the community's health, the Collaborative will decrease inappropriate utilization of inpatient BH and medical surgical beds by managing care in outpatient settings that include improving follow-up, addressing barriers to care through socio-economic supports provided by CHW's, and ensuring access to home medications.

6. Total Budget Requested:

\$4,231,734

HTC Application
Jackson Park Collaborative: Behavioral Health Equity in Chicago’s
South Side

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Application Forms - Project Description

0. Start Here - Eligibility Screen

Does your collaboration include multiple, external, entities?

Yes

No

Can any of the entities in your collaboration bill Medicaid?

Yes

No

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?

Jackson Park Hospital and Medical Center

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

Entity Name	Primary Contact	Position	Email	Office	Secondary Contact	Secondary Contact Position	Secondary Contact Email
Jackson Park Hospital Foundation	William Dorsey, MD	President & CEO	WilliamDorsey@jacksonpark.com	773-947-7920	Nelson Vasquez	CFO	NelsonVasquez@jacksonp
Coordinated Care Alliance	Bailey Huffman	Executive Director	bhuffman@coordinatedcarealliance.org	715-851-5098	Marsha Johnson (CCSI)	Dir. Of CCU Services	Marsha.Johnson@ccsiccu

Family Guidance Centers, Inc.	Ron Vlasaty	COO	rvlasaty@fgcinc.org	224-659-7030 Ext. 2227	Maria Bruni, PhD	Senior VP	mbruni@fgcinc.org

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.

Participating Entities

We believe that to truly transform health, patients' physical health, behavioral health and social needs must be addressed in a coordinated way within their community. Given this, we are looking for collaborations that represent a broad and meaningful spectrum of the healthcare, behavioral health and social determinants of health delivery system at the community-level.

Please answer the following questions regarding the various entities that would comprise your collaborative. If you are unfamiliar with any key terms on this form, consult the glossary linked below.

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.

Jackson Park Hospital and Medical Center

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.

Jackson Park Hospital and Medical Center

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

Yes

No

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

Jackson Park Hospital and 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

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.

Jackson Park Hospital and Medical Center
Family Guidance Centers, Inc.

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.

Family Guidance Centers, Inc.

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.

Coordinated Care Alliance

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.

Jackson Park Hospital and 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.

n/a

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

The two Medicaid-eligible billers for this Collaborative are:
Jackson Park Hospital and Medical Center
Family Guidance Centers, Inc.

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

Safety Net Hospital Partnerships to Address Health Disparities

Safety Net plus Larger Hospital Partnerships to Increase Specialty Care

Hospital plus Other Provider Partnerships in Distressed Areas to Address Health Disparities (led By Critical Area Hospitals, Safety Net Hospitals or other hospitals in distressed communities)

Critical Access Hospital Partnerships (anchored by Critical Area Hospitals, or with Critical Area Hospitals as significant partners)

Cross-Provider Care Partnerships Led By Minority Providers, Vendors, or Not-For-Profit Organizations

Workforce Development and Diversity Inclusion Collaborations

Other

2. Project Description

Brief Project Description

1. Provide an official name for your collaboration.

Jackson Park Collaborative: Behavioral Health Equity in Chicago's South Side

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

In pursuit of transforming the delivery of healthcare, the Jackson Park Collaborative: Behavioral Health Equity in Chicago's South Side (Collaborative) is committed to increasing access to enhanced and culturally responsive integrated behavioral health (IBH) and developing an innovative care model that addresses the significant health disparities and inequities experienced by residents of South Side Chicago. In addition to improving the community's health, the Collaborative will decrease inappropriate utilization of inpatient BH and medical

surgical beds by managing care in outpatient settings that include improving follow-up, addressing barriers to care through socio-economic supports provided by CHW's, and ensuring access to home medications.

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:

The Jackson Park Collaborative: Behavioral Health Equity in Chicago's South Side (Collaborative) is a partnership among Jackson Park Hospital and Medical Center (Jackson Park), the Collaborative Care Alliance (CCA), and Family Guidance Centers, Inc. (FGC), have come together to transform the delivery of healthcare by increasing access to enhanced and culturally responsive integrated behavioral health (IBH) services. This initiative includes the development of an innovative care model that addresses the significant health disparities and inequities experienced by residents of South Side Chicago, as well as decrease hospital readmissions and utilization among patients with behavioral health and chronic diseases.

South Side Chicago identified as one of five areas in Illinois with the greatest concentration of social vulnerability to health inequities and poor health outcomes by HFS. The safety-net hospital is licensed for 256 beds for medical, surgical and inpatient behavioral health services. Their recently completed Community Health Needs Assessment (March 2021) prioritized five significant community needs:

- Access to healthcare
- Chronic Disease Management and Prevention
- Housing and Homelessness
- Community Education – Maternal and Child Health including prenatal care
- Mental Health and Substance Use Disorders

Jackson Park seeks to enhance the health services in its primary service area by building upon the collaboration with the South Side Healthy Community Organization (HTC project funded in May 2021). Through the South Side Healthy Community Organization, Jackson Park patients will gain access to medical specialists that offer chronic disease management and prevention services without traveling to remote sites. These specialists will also enhance inpatient care and reduce the need to transfer patients to other facilities for specialty care.

In collaboration with their partners, Jackson Park will use a multi-pronged approach that centers health equity to address further needs identified in their community needs assessment including mental health, substance use disorders (SUD), and social needs. In response to a shortage of BH specialists in the South Side of Chicago, Jackson Park proposes to enhance outpatient psychiatric services by hiring a full-time board-certified psychiatrist specializing in adult outpatient behavioral health who will conduct clinic five days per week- in Jackson Park's medical office building and community-based locations to assure quality, accessible care for patients experiencing mental health (MH) and substance use disorders (SUD). These enhanced IBH services create access for patients who need ongoing outpatient behavioral health services to stabilize their condition,

decreasing hospital admissions. It also supports timely follow-up after an inpatient admission that assures patients remain stable, can access medication prescriptions and decrease readmission rates.

The recently implemented telehealth regulations during COVID gives Jackson Park the flexibility to also expand BH services through telemedicine. The services would include outpatient telehealth for ongoing monitoring of chronic behavioral health conditions, management of patients who present to the Jackson Park emergency department with behavioral health issues, and MAT (Medication Assisted Treatment) services for SUD.

Jackson Park will expand these services through a collaboration with Family Guidance Center (FGC) a local non-profit with more than 50 years of experience providing a variety of SUD services including hospital-based assessment and linkage services for patients with opioid use disorders (OUD) presenting in hospital emergency departments. The opioid crisis in Illinois has resulted in an increase in opioid-related emergency department and hospital visits across the state. FGC is already co-located in seven Illinois hospitals in high need areas and will add an eighth location through this Collaborative. FGC's facilitative role to triage persons with indicated OUD to local MAT providers includes working with the hospital's medical team to create a continuing care plan for individuals who present in the emergency department (ED) with heroin or illicit opioid use. Participating patients can expect to receive SUD education, a clinical assessment, a continuing care plan, and community referrals following discharge. FGC also provides E-COVID related services in which all hospital patients are screened (SBIRT) to increase engagement and access to SUD and recovery support services for persons with mental health and substance use disorders (not just opioid use disorders but also alcohol use disorders) who have been impacted by the COVID-19 pandemic crisis.

The program will be further augmented through the addition of physicians who currently have X-waivers to prescribe medication assisted therapy (MAT) for patients experiencing SUD will be co-located on Jackson Park's campus of a methadone treatment program managed by FGC, a highly respected local federally licensed SUD treatment provider.

Additionally, Jackson Park will partner with the Coordinated Care Alliance (CCA), a state-wide network of community-based organizations in Illinois that partner with payers, hospitals, skilled nursing facilities, accountable care organizations and physician groups to provide culturally responsive whole-person care. CCA offers a continuum of care services that integrate social and medical aspects of care to achieve the best outcomes at the lowest costs for healthcare entities. With experience serving diverse, at-risk populations with complex medical and social needs including older adults and individuals with disabilities- CCA would provide onsite, face to face care coordination for patients at discharge to provide holistic, person-centered care that addresses the social determinants of health (SDoH) by connecting them to local community resources. Patients would receive care coordination services that include outreach, health risk screening, annual care planning, monitoring, home safety check, skilled nursing facility diversion and evidence-based transitional care.

Patients would have access to embedded care management services in Jackson Park's inpatient and emergency department (ED) to support the unique needs of patients with multiple chronic conditions and decrease unnecessary admission and readmission, particularly for ambulatory sensitive conditions related to limited access to home medications, lack of appropriate follow-up or socio-economic challenges that impact their health such as housing, food-insecurity and nutrition, and transportation. Care management support is enhanced with the addition of Community Health Workers (CHW's) who will provide home care services and culturally responsive supports to patients in their natural settings.

As presented by HFS, this Collaborative combines the work of a safety-net hospital, community based-organization and substance use provider "work together to achieve better health outcomes and can become the basis for transformation that enables and sustains healthier lives." (Basu S. et al., 2021).

Reference

Basu, S., Flax-Hatch, J., Freeman, V.L., et al. (February 2021) Transformation Data and Community Needs Report:

Chicago-South Side. University of Illinois at Chicago School of Public Health and Institute for Healthcare Delivery Design for the Illinois Department of Healthcare and Family Services. Available at: <https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportSouthChicagoDigitalCMP.pdf>.

3. Governance Structure

The governance section should reflect serious thought regarding the execution, management, accountability, and interreliance of the participating members of your collaboration. It should be clear how the structure and governance will bind the various participating organizations into an interrelated enterprise to accomplish the scope of work and the promised outcomes of the proposal. A well-developed governance process is the engine that will drive the effective implementation of the project. Absent quality governance, great ideas and good intentions often fall short or fail altogether

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?

Governance and Authority

The Collaborative will establish and permanently appoint an Oversight Committee for the duration of the project. The Oversight Committee shall be comprised of each Partner's chief executive officer or executive director, who may appoint a proxy with decision-making authority, and one designated program director. At a minimum, there shall be six Oversight Committee bi-monthly meetings the first year, but additional Collaborative meetings can be called by a Partner's written request. The cadence for meetings in project years 2-5 will be determined after year 1 and with the approval of HFS. Partners will use Robert's Rules of Order's parliamentary procedure to conduct business efficiently and predictably through majority vote. A quorum of all Collaborative members in the Oversight Committee will have the authority and responsibility to:

- Develop, establish, amend, alter, or repeal the Charter
- Approve and enforce policies and procedures
- Authorize the voluntary dissolution of the Collaborative
- Adopt a plan for the distribution of the assets of the Collaborative
- Ensure the Department's reporting requirements are completed and submitted

The Oversight Committee shall oversee and drive the Collaborative's business, monitor the progress of stated objectives in the HTC application, ensure milestones and goals are being met. They shall also develop and adhere to policies and procedures, as well as manage budgets and resources.

Jackson Park will appoint a treasurer to review and provide guidance on the Collaborative's financial matters, assures internal controls, and financial analysis for the Collaborative as follows:

- Ensure internal fiscal integrity measures and safeguards are in place, including the monitoring of transformation funds, and for the creation of sustainability strategies
- Ensure the Department funds are being distributed to Partners in a timely manner and for the Collaborative's intended purpose
- Monthly review of revenue and expenditure, balance sheet, investments and other matters related to its continued solvency.
- Ensure that adequate policies and procedures are in place for optimal financial governance
- Ensure that an annual audit takes place if necessary or applicable. This may include the selection of an auditor and reviewing draft audit reports before they are signed off.

Sub-Committees

These are committees other than the standing committees and may be appointed from time to time by the Collaborative for the purpose of performing specific tasks outside the scope of the Oversight Committee, including appointed Ad Hoc committees to perform and complete reporting and other requirements from the Department. Each will consist of a minimum of one representative for each Partner. No such sub-committee shall have the authority of the Oversight Committee.

Virtual Meetings

Partners may participate in and act at any meeting via a conference video tool or other communications equipment by means of which all persons participating in the meeting can hear each other. Participation in such meeting shall constitute attendance and presence in person at the meeting of the person or persons so participating.

[1. Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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?

Accountability

The Collaborative will jointly agree to sign a binding agreement that includes accountability for an agreement to the duties, responsibilities, and outcomes listed below. Failure to comply by any member after implementing a remediation, will be reported within five (5) business days to HFS and could be grounds for removal from the Collaborative.

1. Responding and acting on the Department’s requests
2. Adhering to any Collaborative policies and procedures developed
3. Accountability to achieve the Collaborative’s said milestones and outcomes
4. Maintaining respectful and inclusive relationships among Partners
5. Acting ethically, prudently, legally and honestly in good faith regarding the Collaborative
6. Actively engaging and dedicating employees to represent and participate on behalf of each member of the Collaborative at each Oversight Committee (or otherwise) with decision-making authority

As part of the Oversight Committee’s responsibilities, the Collaborative’s policies and procedures will be developed and approved by the Oversight Committee. Failure to comply by any member of the Collaborative after implementing a remediation, will be reported within five (5) business days to HFS and could be grounds for removal from the Collaborative.

[2. Optional] Please upload any documentation or visuals you wish to submit in support of your response.

New Legal Entity

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

Yes

No

3A. Please give details on the new entity's Board of Directors, including its racial and ethnic make-up.

N/A

[3A. Optional] Please upload any documentation or visuals you wish to submit in support of your response.

Payments and Administration of Funds

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

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.

Upon notice of award, the Collaborative will ensure internal fiscal integrity measures and safeguards to ensure the Department's directed payments are distributed to each Participant and used for their intended purposes as stated in the application. As such, the Oversight Committee will develop fund distribution policies and corresponding procedures to be approved by all Parties.

Jackson Park will oversee the following aspects of the Department funds awarded:

- The receipt of HFS directed payments on behalf of the Collaborative upon approval from the Department
- Directed payments are received from the Department will be directed and distributed to members of the Collaborative according to the Plan's specifications and within a specified time frame agreed upon by the Collaborative
- Develop an ongoing monthly reporting methodology to ensure fiscal accountability

[4. Optional] Please upload any documentation or visuals you wish to submit in support of your response.

4. Race Equity

Background on HTC and racial equity:

This form contains a racial equity impact assessment, or REIA. An REIA is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision. REIAs are used to minimize unanticipated adverse consequences in a variety of contexts, including the analysis of proposed policies, institutional practices, programs, plans and budgetary decisions. The REIA can be a vital tool for preventing institutional racism and for identifying new options to remedy long-standing inequities. (Source: Race Forward - "Racial Equity Impact Assessment")

High-Level Narrative

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

This proposal directly addresses racial equity given that the population in the zip codes of focus are predominately Black and Hispanic, and the proposal seeks to directly address the following community needs identified by the March 2021, community health needs assessment: access to healthcare and access to mental health and substance use disorder treatment. The successful implementation of this proposal will directly reduce racial and health disparities that exist on the South Side of Chicago by increasing access to care and creating strong linkages to outpatient care and addressing social needs of patients.

Racial Equity Impact Assessment Questions

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

Jackson Park Hospital serves a predominantly Black and Hispanic population, who have historically suffered from persistent health inequities linked to racism. The marginalized communities served by Jackson Park Hospital have higher rates of heart disease mortalities, diabetes mortalities and hospitalizations than in Chicago overall. The communities in Jackson Park’s service area also experience the highest rates of mental health emergency department visits and Black people in Illinois are 5.5 more likely to visit the emergency department for an opioid crisis than white people in Illinois (Jackson Park Hospital Community Health Needs Assessment, 2021) Despite glaring health disparities in chronic disease and behavioral health, the predominantly Black and Hispanic communities in Jackson Park Hospital’s service area have limited access to primary care and behavioral health care. In fact, the Health Resources and Services Administration (HRSA) has designated the areas in which Jackson Park Hospital sits as health professional shortage areas. Moreover, Cook County health officials stress that there is a “skyrocketing” need for mental health services amidst a crisis in their county (Stroobandt., 2021).

The total population in these eight zip codes is estimated at 428,700; about 23% of the residents are under 18, while 15% are over the age of 65. Eighty-five percent of the population identifies as Black (84.6%), 9.7% Hispanic/Latinx, 4.0% White (non-Hispanic), and 0.7% Asian, with a small percentage identifying with other racial groups. (American Community Survey, US Census Bureau, 2014-2019 five-year estimates)

References

Jackson Park Hospital Community Health Needs Assessment (March 2021). Available at <https://www.jacksonparkhospital.org/assets/1/7/CHNA%20FINAL%202021.pdf>.

Stroobandt, I. (November 3, 2021) “Need for mental health services skyrocketing across Cook County Departments, health officials say.” The Daily Line. Available at: <https://www.thedailyline.com/mental-health-services-skyrocketing-cook-county>.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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 community health needs assessment for Jackson Park Hospital was conducted in March 2021. During this assessment, eight key informant interviews were conducted with community members and a thorough review of local resource lists and community plans were compiled. This assessment identified the following health needs and health inequities: Access to healthcare – inequities in service availability, access to primary and secondary care, and transportation; Care coordination and linkage to services; Chronic disease management and prevention – diabetes, hypertension, lung health; Food insecurity and food access; Housing and homelessness; Infectious disease, including COVID-19; Jobs and workforce development; Maternal and child health, including prenatal care; Mental Health; Substance Use Disorders; Trauma; Violence and community safety; Youth development and education.

Jackson Park Hospital Staff and Leadership Prioritized 5 of those needs: Access to Healthcare; Chronic Disease Management and Prevention; Housing and Homelessness; Community Education and Mental Health and

Substance Use Disorder. This proposal directly addresses two identified areas of need: Access to Healthcare and addressing Mental Health and Substance Use Disorder.

In addition, key leadership from The Collaborative reached out to key organizational and elected official stakeholders who are deeply rooted in the communities of focus to: 1) Share the proposal with the stakeholders to gain feedback and input; 2) To secure support for the proposal and commitment to receive updates regarding the proposal upon implementation.

Here are the leaders and organizations that were engaged and provided letters of support:

- Joyce M. Coffee, CEO/Executive Director - Family Rescue
- Gwen Fowler, Director of Shelter Programs – Margaret's Village
- Sheila Braxton, Executive CEO - A Little Bit of Heaven, Inc
- Deborah Parnell, Director of Clinical Strategies and Nursing Services- HRDI an affiliate of Friend Health
- Meisha D. Lyons, Associate VP - Catholic Charities of the Archdiocese of Chicago
- Frankye A. Payne, Executive Director - Southeast Chicago Chamber of Commerce
- Melinda Kelly, President - Chatham Business Association, Small Business Development, Inc.
- Jim Leo, CFO & Stanley C. Rakestraw, COO/VP - SCR Transportation
- Larry Huggins, President, Riteway-Huggins Construction, Inc.

Upon implementation of the proposal, the Collaborative will work to further engage community members and patients to gain input and aid in the successful implementation of this proposal. This will be done through direct surveys and community meetings.

In addition, those who provided letters of support for this proposal, as well as the community-wide, will be invited to bi-annual community updates where progress and input can be shared.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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?

In Jackson Park Hospital's service area, which consists of eight zip codes, 85% of the population are Black and 10% are Hispanic. These predominantly racial and ethnic minority communities are the most disadvantaged groups compared to the Chicago's population overall.

Almost all of Jackson Park's service areas have lower a life expectancy, and higher poverty rates, unemployment rates, heart disease mortality rates, diabetes mortality rates, diabetes hospitalizations than Chicago overall. All zip codes served by Jackson Park Hospital have higher rates of avoidable emergency department visits, ranging from 725 per 10,000 visits to 1088 per 10,000 visits, than the average 546 per 100,000 avoidable ED visits in Chicago overall. All but one community area in Jackson Park's service area has a higher rate of infant mortality than Chicago's rate overall of 7.1 per 1,000 live births, the highest being Avalon Park at 18.9 infant deaths per 1,000 live births.

Although health statistics broken down by zip code is a strong measure to assess racial and ethnic disparities, disaggregated data by race and ethnicity within each zip code will further illuminate disparities among Black and Hispanic individuals specifically within these communities.

Reference

Jackson Park Hospital Community Health Needs Assessment (March 2021). Available at <https://www.jacksonparkhospital.org/assets/1/7/CHNA%20FINAL%202021.pdf>.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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?

Health inequities result from unequal distribution of underlying social determinants of health including income, education, housing, nutrition, employment and access to care and transportation. Persistent structural racism, in which public policies, institutional practices and cultural representations reinforce and perpetuate white supremacy, is the root of this unequal distribution of resources and opportunities. The Jackson Park Collaborative proposal addresses the root cause by closing the gap in access to critically needed primary and behavioral health care in these communities, which in turn is a driver of racial health disparities.

References

The Aspen Institute. "Glossary for Understanding the Dismantling Structural Racism/Promoting Racial Equity Analysis." Available at: <https://www.aspeninstitute.org/wp-content/uploads/files/content/docs/rcc/RCC-Structural-Racism-Glossary.pdf>.

Lawrence, K & Keleher, T. Structural Racism. [Race and Public Policy Conference] Chronic Disparity: Strong and Pervasive Evidence of Racial Inequalities (2004). Available at: <https://www.intergroupresources.com/rc/Definitions%20of%20Racism.pdf>

[4 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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

The collaborative partners have come together to design an enhanced integrated behavioral health program that focuses on providing care in outpatient, community-based locations that assure quality, accessible care for patients experiencing mental health issues and substance use disorder.

This proposal will increase access to outpatient psychiatric care in the community and will provide much needed substance use disorder treatment. The connectivity of these services with Jackson Park Hospital will improve health outcomes and reduce costs. These efforts will reduce health disparities by increase access to care and provide additional support services to link people to healthcare but also, seek to identify and address social needs.

[5 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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?

There are no unforeseen consequences for this proposal. The Oversight Committee will monitor all programming to ensure disparate outcomes do not emerge and that equitable outcomes are maximized.

[6 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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?

In addition to implementing the proposal to advance racial equity, addressing policy and system change to improve overall community needs would enhance this effort. For example, advocating for affordable and safe housing and access to food would strengthen this proposal. Members of the Collaborative will work with other partners leading policy and system change such as the Illinois Public Health Institute, who also serve to create the Chicago-wide community health needs assessment that creates alignment of community health needs assessment to strengthen the impact of the work.

[7 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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 proposal has a budget that was developed collaboratively by all the Oversight partners and adequately funds what is proposed by the Collaborative. To ensure community and stakeholder engagement, the Collaborative will work to create bi-annual reports to share with the community and they will conduct community forums as needed to receive feedback.

[8 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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?

Indicators of success for this behavioral health focused collaborative will include demonstrating improvement in key areas that impact the lives of patients who are experiencing behavioral health or substance use disorders. Through outpatient and community interventions, the Collaborative will show a decrease in readmissions within 30 days of hospitalization for behavioral health issues. They will also demonstrate an increase in adherence with SUD treatment including MAT. The collaborative will track these benchmarks and others for the patients they serve. Data collected will also include racial and ethnic demographics that demonstrate equity in providing services to the community.

Patient Advisory Council

The Collaborative will form a Patient Advisory Council comprised of community stakeholders representing Chicago's South Side residents. Community stakeholders should reflect the diverse interests, concerns, organizations, issues, and populations of Chicago's South Side. The Council would support community awareness about the Collaborative's services and ensure the project's programming reflects and meets the needs of the community.

[9 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

5. Community Input

Service Area of the Proposed Intervention

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

South Side 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.)

Cook County

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

60617, 60619, 60620, 60621, 60628, 60636, 60637, 60649

Community Input

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

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

The community health needs assessment for Jackson Park Hospital was conducted in March 2021, during this assessment, eight key informant interviews were conducted with community members and a thorough review of local resource lists and community plans were compiled. This assessment identified the following health needs and health inequities: Access to healthcare – inequities in service availability, access to primary and secondary care, and transportation; Care coordination and linkage to services; Chronic disease management and prevention – diabetes, hypertension, lung health; Food insecurity and food access; Housing and homelessness; Infectious disease, including COVID-19; Jobs and workforce development; Maternal and child health, including prenatal care; Mental Health; Substance Use Disorders; Trauma; Violence and community safety; Youth development and education.

Jackson Park Hospital Staff and Leadership Prioritized 5 of those needs: Access to Healthcare; Chronic Disease Management and Prevention; Housing and Homelessness; Community Education and Mental Health and Substance Use Disorder. This proposal directly addresses two identified areas of need: Access to Healthcare and addressing Mental Health and Substance Use Disorder.

In addition, key leadership from The Collaborative reached out to key organizational and elected official stakeholders who are deeply rooted in the communities of focus to: 1) Share the proposal with the stakeholders to gain feedback and input; 2) To secure support for the proposal and commitment to receive updates regarding the proposal upon implementation.

Here are the leaders and organizations that were engaged and provided letters of support:

- Joyce M. Coffee, CEO/Executive Director - Family Rescue
- Gwen Fowler, Director of Shelter Programs – Margaret's Village
- Sheila Braxton, Executive CEO - A Little Bit of Heaven, Inc
- Deborah Parnell, Director of Clinical Strategies and Nursing Services- HRDI an affiliate of Friend Health
- Meisha D. Lyons, Associate VP, Catholic Charities of the Archdiocese of Chicago
- Frankye A. Payne, Executive Director, Southeast Chicago Chamber of Commerce
- Melinda Kelly, President, Chatham Business Association, Small Business Development, Inc.
- Jim Leo, CFO & Stanley C. Rakestraw, COO/VP - SCR Transportation
- Larry Huggins, President - Riteway-Huggins Construction, Inc.

Upon, implementation of the proposal, the Collaborative will work to further engage community members and patients to gain input and aid in the successful implementation of this proposal. This will be done through direct surveys and community meetings. In addition, those who provided letters of support for this proposal, as well as the community-wide, will be invited to bi-annual community updates where progress and input can be shared.

Finally, the Collaborative will document and respond to all feedback and questions submitted to HFS during the public comment period regarding the Collaborative's application. All comments will be considered, either individually or collectively, to:

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

2. Please upload any documentation of your community input process or findings here.

See [Attachment 1](#)

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:

Elgie R. Sims Jr. – State Senator
Lamont J. Robinson – State Representative
Kam Buckner – State Representative
Mattie Hunter – State Senator
Marcus Evans – State Representative

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

Michelle Harris – Alderman

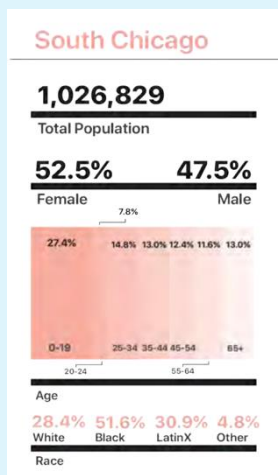
[Input from Elected Officials - Optional] Please upload any documentation of support from or consultation with elected officials.

See [Attachment 2](#)

6. Data Support

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

The Transformation Data and Community Needs Report indicates that nearly all of South Chicago is designated as a mental health (and primary care) professional shortage area by the Health Resource and Administration. It is also a food desert (as defined by the USDA) compounded by sociocultural barriers that also exacerbate chronic conditions.



More than half of Chicago's South Side residents (52%) are Black. Black communities experience lower access to IBH treatment than the general population. According to the SAMHSA, approximately 66% of Latino and 67% of Black Americans did not receive treatment for mental health conditions in 2019, compared to 55% of the general population. Also, in 2019, nearly 90 percent of people with a substance use disorder did not receive treatment.

The two disease groups comprising the greatest percentage of readmissions and resource intensive hospitalizations were mental illnesses and SUD, followed by ambulatory care sensitive conditions for Medicaid residents in Chicago's South Side. According to CMS, more than half of the Medicaid enrollees in the top five percent of expenditures with asthma or diabetes also had a behavioral health condition.

Individuals with a severe mental illness die 10 to 20 years earlier than the general population, mostly from preventable physical diseases.

The study also concluded that few patients who were admitted to the hospital for these reasons also received outpatient care before or after their visit to the ED. Among the barrier residence identified, was long wait times for appointments, "transactional care," facilities in poor conditions, and care that doesn't fit the cultural context of the residents.

Collectively, the Collaborative assembled, collected, and analyzed the following quantitative and qualitative data for the development and design of the project as outlined below.

Jackson Park

Basu, S., Flax-Hatch, J., Freeman, V.L., et al. (February 2021) Transformation Data and Community Needs Report: Chicago-South Side. University of Illinois at Chicago School of Public Health and Institute for Healthcare Delivery Design for the Illinois Department of Healthcare and Family Services. Available at: <https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportSouthChicagoDigitalCMP.pdf>.

Jackson Park Hospital Community Health Needs Assessment (March 2021). Available at <https://www.jacksonparkhospital.org/assets/1/7/CHNA%20FINAL%202021.pdf>.

The Aspen Institute. "Glossary for Understanding the Dismantling Structural Racism/Promoting Racial Equity Analysis." Available at: <https://www.aspeninstitute.org/wp-content/uploads/files/content/docs/rcc/RCC-Structural-Racism-Glossary.pdf>.

Lawrence, K & Keleher, T. Structural Racism. [Race and Public Policy Conference] Chronic Disparity: Strong and Pervasive Evidence of Racial Inequalities (2004). Available at: <https://www.intergroupresources.com/rc/Definitions%20of%20Racism.pdf>.

Ralls, M. "Behavioral Health Integration Across All Levels of the System" (November 11, 2021) Center for Healthcare Strategies [Blog Post]. Available at: https://www.chcs.org/behavioral-health-integration-across-all-levels-of-the-system/?utm_source=CHCS+Email+Updates&utm_campaign=e423595dad-PCI+Behavioral+Health+Blog+Post+-+11%2F11%2F21&utm_medium=email&utm_term=0_bbc451bf-e423595dad-157234266.

The American Community Survey of the United States Census Bureau, 2018 Edition (ACS).

Uniform Data System Mapper (UDS), 2018.

The Health Professional Shortage Area/Medically Underserved Area Data Bases of the Federal Department of Health and Human Services/Health Resources and Services Administration/Bureau of Primary Health Care (DHHS/HRSA/BPHC).

The Vital Statistics/Records Unit of the Illinois Department of Public Health (IDPH).

The Chicago Community Area Health Care Atlas of the Chicago Department of Public Health (CDPH).

American Hospital Association (2014, February). Integrating behavioral health across the continuum of care. Chicago, IL: Health Research & Educational Trust. Available at: <http://www.hpoe.org/Reports-HPOE/Behavioral%20health%20FINAL.pdf>.

Powers, B.W. et al. (February 2020) Impact of Complex Care Management on Spending and Utilization for High-Need, High-Cost Medicaid Patients. The American Journal of Managed Care, 26(2). Available at <https://www.ajmc.com/view/impact-of-complex-care-management-on-spending-and-utilization-for-highneed-highcost-medicaid-patients>.

CCA

AIMS Intervention to Improved Mental Health

- "The findings reveal that social workers spend significantly more time with patients than UC providers addressing patients' nonmedical needs ($p < .0001$). At 6 months postintervention, reduced levels of depression were observed for AIMS patients when compared with uncompensated care patients ($p = .026$)."

Source: Rowe JM, Rizzo VM, Kang SY, Kukowski R, Ewald B, Newman M, Golden R. Time Contribution of Social Workers in Care Management: Value for Older Adults. Prof Case Manag. 2019 Nov/Dec;24(6):306-316. doi: 10.1097/NCM.0000000000000305. PMID: 31580298.

Bridge and AIMS Reduce Hospital Readmission Rates and ED Utilization; Improve Post-hospitalization Patient Engagement

- "An assessment comparing patient utilization 6 months before and 6 months after the intervention ($n = 456$) found a 61.1% 30-day readmission reduction, 50.3% admission reduction, 36.4% ED utilization reduction, and 19.8% outpatient no-show reduction."

Source: Renae Alvarez, Jacob Ginsburg, Jessica Grabowski, Sharon Post & Walter Rosenberg (2016) The Social Work Role in Reducing 30-Day Readmissions: The Effectiveness of the Bridge Model of Transitional Care, Journal of Gerontological Social Work, 59:3, 222-227, DOI: 10.1080/01634372.2016.1195781

Covid-19 and Cross-sector Care Management

Source: Dana Franceschini, Jessica Grabowski, Ester Sefilyan, Teresa T. Moro & Bonnie Ewald (2021): Covid-19: A critical time for cross-sector social work care management, Social Work in Health Care, DOI: 10.1080/00981389.2021.1904319

2. Attach the results of the data analyses used to design the project and any other relevant documentation.

See [Attachment 3](#)

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.

In Jackson Park Hospital's Community Health Needs Assessment completed in March 2021, health inequities are defined as differences in the incidence, prevalence, mortality, burden of disease, or the distribution of health determinants between different populations. Health inequities can exist across many dimensions such as race, ethnicity, gender, sexual orientation, age, disability status, socioeconomic status, geographic location, and military status.

This proposal seeks to address the lack of access to behavioral health services for Black and Hispanic residents in the South Side of Chicago, as well as provide stronger linkages to outpatient care through care coordination post release from the inpatient setting. The Collaborative has chosen to address these disparities within the community because there is a strong need to improve health outcomes for those discharging out of the inpatient setting into the community.

Reference

Jackson Park Hospital Community Health Needs Assessment (March 2021). Available at <https://www.jacksonparkhospital.org/assets/1/7/CHNA%20FINAL%202021.pdf>.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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 Collaborative is committed to increasing access to enhanced and culturally responsive integrated behavioral health (IBH) and developing an innovative care model that addresses the significant health disparities and inequities experienced by residents of South Side Chicago. In addition to improving the health of this community, the Collaborative will decrease inappropriate utilization of inpatient BH and medical surgical beds by managing care in outpatient settings that include improving follow-up, addressing barriers to care through socio-economic supports provided by CHW's, and ensuring access to home medications.

The immediate and measurable impacts of these activities that will show progress soon after implementation because patients who are being discharged from the inpatient setting will have stronger linkages to community outpatient care and services. This linkage to care will reduce the number of people returning to the inpatient setting due to lack of engagement in the community outpatient setting. In addition, there will be expanded behavioral health care services in the community, including substance use disorder treatment. Access to these services in the community setting will reduce the need for inpatient hospitalization and improve health outcomes broadly.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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

The activities the Collaborative proposed will lead to the impact that is intended because all the partners are committed to ensuring that both the community and patient needs are met. The expansion of behavioral health services is greatly needed on the South Side of Chicago and will be utilized as soon as the services are available. This proposal directly addresses the needs of the community, and the Collaborative will stay in contact with the community and community stakeholders to ensure successful implementation.

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.

As discussed in Jackson Park's 2021 community health needs assessment there are multiple factors that contribute to barriers to care such as proximity, affordability, and reliability.

Jackson Park Hospital sits amidst several health professional shortage areas for primary care, mental health, and dental providers. The Health Resources and Services Administration designates Health Professional Shortage Areas for primary care, dental health, and mental health. Shortage areas are either due to geography (shortage of providers for the entire population within a defined geographic area) or are population specific for low-income residents in an area. Primary Care Health Professional Shortage Areas, HRSA, 2020 Mental Health Professional Shortage Areas, HRSA, 2020 Jackson Park Hospital CHNA, March 2021.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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 Collaborative proposal creates additional access to outpatient behavioral health services, substance use disorder treatment and linkage to resources to address social needs.

The immediate, measurable impacts to follow from these activities will be availability of these services in the community that have not been available previously at this location. The increased accessibility of these services will lead to a reduction of emergency room usage and a decreased use of inpatient psychiatric beds for those who can be treated within the community.

Additionally, the Collaborative will contract with BEP vendor SCR Medical Transportation, Inc. one of the largest passenger transportation companies (including wheelchair-accessible transportation within the special needs community) in the Midwest – transporting over 1.5 million passengers per year with a workforce of 1,000 dedicated employees and 500 vehicles. SCR also operates one of the largest paratransit call centers in the United States, handling nearly 10,000 calls per day to facilitate trips amongst two dozen transportation providers throughout Chicago and the surrounding suburbs. During the COVID-19 pandemic, SCR made valiant efforts to provide personal protective equipment and undertook rigorous steps to ensure the safety of its passengers and employees. SCR also assisted the City of Chicago by delivering meals to families in need and transported individuals without homes to shelters for COVID-19 testing.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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

These activities will provide the intended impact because the Collaborative working together will ensure that the new service accessibility will be communicated to the community to ensure utilization. Given that there is a such a high need for outpatient behavioral health services that it is expected that the services will be engaged quickly, which will lead to the decrease of unnecessary inpatient hospitalization.

9. Social Determinants of Health

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

According to a recent community needs assessment completed by HFS, the average life expectancy in South Chicago is only 72 years (Basu et al., 2021). In neighboring communities, the life expectancy increases by five years or more. The disparity is stark, and through this Collaborative, CCA is uniquely poised to address behavioral health disparities in this community. CCA's Care Coordinators implement the evidence-based Bridge Model and assess the following domains that include the social determinants of health (SDoH):

- Access to primary care provider and/or other health care provider
- Access to health coverage
- Medication history
- Health literacy
- Level of patient activation/activation
- Connection to public benefits such as SNAP, energy assistance, etc.
- Concerns for abuse or neglect in the home
- Safe home environment
- Access to transportation
- Access to affordable and safe housing
- Caregiver stress
- Access to adequate nutrition

The Care Coordinators use motivational interviewing and patient activation strategies to learn what is important to the patient. The collaborative development of a care plan with attainable goals is key to ensuring the plan is person-centered, culturally responsive, and strengths based. For example, if a patient's priority is to have the energy for quality time with their grandchildren, the Care Coordinator will help the patient identify the barriers to this goal and how they can work collaboratively to achieve it. Care Coordinators work with other health factors that include individual and lifestyle factors, family dynamics, neighborhood conditions, and barriers within macro-level systems.

Reference

Basu, S., Flax-Hatch, J., Freeman, V.L., et al. (February 2021) Transformation Data and Community Needs Report: Chicago-South Side. University of Illinois at Chicago School of Public Health and Institute for Healthcare Delivery Design for the Illinois Department of Healthcare and Family Services. Available at: <https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportSouthChicagoDigitalCMP.pdf>.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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?

Community-based Care Management begins well before a patient is discharged home. Care Coordinators meet with patients at hospital bedside to establish rapport and begin building trust. There, the Care Coordinator begins the biopsychosocial assessment, engagement continues after discharge telephonically and through a home visit. Ensuring the discharge plan is understood by the patient and their families is crucial to their following through with post-discharge care. It is equally important to ensure home health or telehealth appointments are not only scheduled, but that both provider and patient follow-through. Home visits provide insight into aspects of home and community that contribute to poor physical or behavioral health challenges.

Immediate, measurable impacts are:

- Patients follow up with their providers within seven days of discharge
- Patients are linked with community-based services, including supportive services through Medicaid waiver programs, behavioral health, and SDOH providers
- Reduction in hospital ED utilization and readmissions
- Increased engagement with healthcare and behavioral health providers

The Collaborative will also measure patient impact of housing, transportation, food insecurity, and successful linkage to community-based services such as homemaker services.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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

Care Coordinators are trained in clinical techniques such as: therapeutic alliance building, person centeredness and empowerment, cognitive restructuring, motivational interviewing, cultural competency, and person-in-environment perspective when engaging with patients. The development of a care plan with attainable goals is a key factor in ensuring the plan is person-centered and strengths based. It is critical for patients to be actively involved in the development of their care plan and that it prioritizes what is important to them to ensure follow through and attainment of goals. Care coordinators utilizing this intervention build a true partnership with patients. In addition, and equally important, CHW's will be integrated into the interdisciplinary team to ensure successful, ongoing connection to critical services.

The Bridge Social Worker (Care Coordinator) are focused on clinical objectives such as: successful discharge, connection with home health, engagement with providers, and utilization of behavioral health services. Care Coordinators utilizing Bridge or AIMS must terminate patients to ensure their case loads are manageable; typically, this happens 30 days post-discharge. They remain the patient's point of contact and work to ensure any care plan items identified are able to be met and then provide a warm handoff to a CHW who will track their social needs. The CHW will collaborate with existing resources available to the patient, such as their MCO Care Coordinator, for long-term support.

For example, a Medicaid redetermination application may be needed for ongoing medical coverage; a Bridge Care Coordinator may not have the capacity to assist, so the CHW could be deployed to ensure this emergent need is met and coverage is maintained. If a complex clinical need is identified (ex: abuse/neglect, hospital admission or ED visit, other critical incident) during the CHW's engagement with the patient, the Bridge Social Worker and CHW will work together to identify best next steps, including re-engagement with the Bridge/AIMS Care Coordinator.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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.

The Coordinated Care Alliance (CCA) is an innovative network of community-based service providers who serve thousands of people across the state in their homes and communities daily with state, federal, and privately funded social service programs. Because each provider agency is located in the communities they serve, they have the knowledge and expertise of services and resources available – making them the best agencies to serve even the most high-risk adults. CCA's delivery network member in Chicago, CCSI-Case Management, currently provides case management for home and community-based elderly waiver services to 1,776 older adults in 60649 zip code. This organization is in tuned with the needs of this community and understand the complex medical and social needs of individuals and families they serve.

Using the Bridge/AIMS Social Work Care Model training, CCA's care coordinators and community health workers (CHW's) hired for this program will be equipped with expertise in local resources and have the clinical skills needed to integrate the social and medical needs of the individuals being served. Care Coordinators will be embedded in Jackson Park Hospital, so they are truly part of the interdisciplinary care team. This model of care is highly effective at reducing discharge-related errors and ensuring a safe transition home. Jackson Park Hospital will work with CC to ensure care coordinators understand the inner workings of hospital care planning and discharge as well as the resources and programs available in the community so that meaningful linkages can be made.

Bridge and MCO Care Coordinators

The Bridge Care Coordinator can utilize resources to make daily contact with a participant for up to 30 days (or more if necessary) post hospital discharge to ensure there is no hospital readmission. Bridge Care Coordinators can also quickly and efficiently implement services during the high-risk period post-discharge including, but not limited to:

- in-home services throughout the area
- medical appointment scheduling
- ensuring transportation to appointments
- assisting with medication management,
- connecting them with an accessible pharmacy,
- mitigating insurance issues
- providing home delivered meals or meet other nutritional needs, and
- make sure participant's home is safe and meets all needs

Anyone with Medicaid Managed Care also has access to a managed care organization (MCO) Care Coordinator that focuses on coordination of medical and covered benefits and conducts an annual health risk assessment to develop a patient care plan. MCO Care Coordinators assess clients for in-home services and in addition to helping them manage medical needs through nurse case managers within their MCO. They must refer to community agencies for anything beyond in home services, Emergency Home Response System, and medical assistance. Additionally, MCO Care Coordinators conduct Health Risk Assessments once a year, as mandated by their contractual obligations. The Bridge Care Coordinators are complimentary to MCO Care Coordination as they are focused on a successful hospital-to-home transition and embedded in the hospital as an interdisciplinary team member. Bridge Care Coordinators also assess emergent needs in the home following discharge. They will share the patient's care plan with the MCO Care Coordinator and communicate any goals or needs that remain.

In addition, CCA will utilize Hucu.ai, a HIPAA compliant, patient-centered messaging network with powerful reporting. Hucu.ai was designed to improve the efficiency, accuracy, and security of care coordination communication. Hucu.ai replaces old methods like phone, fax, and text and brings care collaborators into patient-centered channels. It is being used by more than a thousand users in home health, hospice, area agency on aging, physician, and senior living organizations. People access Hucu.ai via Mobile apps (iOS, Android) and also via a Web browser.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

See [Attachment 4](#)

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).

The following are care coordination caseload numbers and cost per caseload:

Care coordinator caseload: 30 patients per month per FTE (at full ramp up)

Based on the care coordinator's salary and a patient caseload of 30 patients per month, the cost per caseload is per case per month.

[2A - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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

Yes

No

3A. Please list the names of the managed care organizations in your collaborative.

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 Collaborative is interested in engaging the Illinois Medicaid MCOs to discuss opportunities to enter into value-based payment arrangements that consider total cost of care for individuals. The anticipated savings from intensive care management for patients who present to the emergency department or require an inpatient behavioral health admission that leads to lower utilization of high-cost services could offset the funds needed to support the care-management services being offered by this collaborative.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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.

Note on BEP partners/vendors:

If one of the members of your collaboration already contracts with a BEP-certified firm or a not-for-profit entity that is majorly controlled and managed by minorities, only include the services of the firm that will be used on this project.

To be included, these services must increase the entity's volume of work above the level of services already provided to the collaborating member.

List entities here:

At this time, Jackson Park Hospital maintains business relationships with the following BEP-certified firms below:

- Abbey's Sealcoating and Paving
- L.B. Hall
- MJC Demolition

- MORFIN Construction
- Powers and Sons
- SCR Medical Transportation, Inc
- 2032 Decorating

These BEP's corporations are significant regarding the renovation/modernization/re-equipping of space within the professional office building on the hospital campus which will be designed to house FGC's staff and program. The anticipated office space is approximately square feet with an office for physicians, administrative staff, a waiting area, and other appropriate spaces.

There may be further opportunities for the Collaborative to engage a BEP for the recruitment of physicians and race equity training for program employees.

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.

Name	Area of Enterprise	Role
Abbey's Sealcoating and Paving	Paving/Sealcoating/Asphalt	Ongoing operations
L.B. Hall	Fireproofing and Insulation	Ongoing operations
MJC Demolition	Demolition Contractor	Ongoing operations
MORFIN Construction	General Carpentry Contractor	Proposal implementation
Powers and Sons	General Contractor	Proposal implementation
SCR Medical Transportation, Inc	Patient transportation (medical and non-medical)	Proposal implementation
2032 Decorating	Interior Decorating/Painting	Proposal implementation

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.

Data for existing employees delineated by job category (Clinical and Non-clinical) for each collaborating organization is provided in the attached PDF labeled "Attachment 5."

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

See [Attachment 5](#)

New Employment Opportunities

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

9

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

The Collaborative believes that building robust and inclusive local hiring practices is a long-term investment in a workforce that is productive and invested, as well as a community that is healthier and more economically secure.

As evidenced by the data provided for the Collaborative's employee place of residence, the Collaborative is committed to hiring a diverse workforce that contributes to improved organizational and community outcomes that are critical to this project such as addressing issues of health equity and identified community health needs, increasing community impact by targeting underserved neighborhoods, leveraging public resources by linking existing workforce development dollars to employer demand, and improve employee morale through internal investment and strong community ties. Should the Collaborative's yield improved health and wellbeing of patients of Jackson Park, this model would be replicated broadly with other safety net hospitals in Chicago and parts of the state where there is similar need. This would create opportunities for Care Coordinators, CHW's, and additional administrative staff.

Job Descriptions for the following positions are provided in the attached PDF labeled "Attachment 6":

- Bridge/AIMS Care Coordinator (CCA)
- Community Health Worker (CCA)
- Staff Nurse (FGC)
- Recovery Support Specialist (FGC)
- Hospital-Based Counselor (FGC)
- Project Director position (FGC)

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

See [Attachment 6](#)

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

Funding has been allotted for the Collaborative members to ensure the implementation of best practices and the effective, culturally responsive provision of services. The following are planned workforce development activities for each employee of the Collaborative as part of the project.

Race Equity Training

Implicit bias among healthcare providers contributes to health disparities through patient-physician interactions in communities of color who experience lower quality of care and poorer communication when compared to their white counterparts. Employees hired for this project can benefit from increased knowledge about the interplay between structural racism, behavioral health institutional racism, implicit bias, and behavioral health disparities

CCA

CCA's growth is dependent on strengthening the network of aging services providers. Securing diverse revenue streams on behalf of its delivery network will give CCA the ability to hire program specialists and support staff. CCA provides flexible, remote, work-from-home opportunities and is committed to equitable hiring practices.

FGC

The Illinois Department of Human Services, Division of Substance Use Prevention and Recovery (DHS-SUPR) recently announced they will release approximately \$27.2 million in funds to currently contracted SUD providers, including FGC, to provide retention payments to SUD treatment program staff. FGC is currently

working with DHS-SUPR to finalize the total amount of workforce retention grant dollars expected and we expect to begin retention disbursements to begin in January 2022.

Jackson Park

By expanding behavioral health services to include a full-time outpatient psychiatric practice, the collaborative will create additional jobs for support staff and care managers. Patients seen in the practice will receive support services by peer support specialists and community health workers. These will initially be employed by other members of the collaborative, but as the volume increases, additional CHWs may be added to provide support to other underserved populations, creating employment opportunities within the neighborhoods served through this project.

[4 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

13. Quality Metrics

Alignment with HFS Quality Pillars

In order to complete this section, you will need to reference the HFS Quality Strategy document linked below.

HFS Quality Strategy:

<https://www.illinois.gov/hfs/SiteCollectionDocuments/IL20212024ComprehensiveMedicalProgramsQualityStrategyD1.pdf>

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

The Collaborative strongly supports HFS’s Quality Strategy and applauds its commitment to improving lives by addressing SDoH and empowering patients to maximize health and well-being. Like HFS, the Collaborative desires to make racial and health equity the foundation of improving quality in the care provided.

The programs being implemented by the Collaborative align with the following pillars of the HFS quality framework: adult behavioral health, equity and community-based services and supports.

By broadening outpatient behavioral health services, the community will gain equitable access to care in appropriate ambulatory settings for both mental health and SUD treatment. Underserved populations, particularly those requiring care for IBH are often left with the emergency department as their sole primary care and crisis access point. Additional ambulatory access points will provide more opportunities for lower cost, more appropriate care.

This project proposes to strengthen the care management program at Jackson Park that enable patients to locate and obtain needed services, better navigate the health care system, and improve IBH care and care for patients with chronic disease. Patients will have an assigned care manager to assist with navigation of all aspects of health. By adopting a CHW model that allows patients with both BH and chronic medical conditions to receive support in their homes, the Collaborative can support healthier living by addressing SDoH that drive poor health outcomes for vulnerable populations. CCA’s care management model employs the evidence based, person-centered models- Bridge and AIMS. Both programs have demonstrated improved health outcomes and lower costs of care by decreasing utilization of more expensive services and managing patients in the ambulatory or community setting.

HFS has outlined three overarching goals: Better Care, Healthy People/Health Communities and Affordable Care. Each of these goals are shared by the Collaborative, which seeks to provide better care by improving

access to adult behavioral health and achieving improved quality metrics. With a broader continuum of care for IBH and by employing an enhanced care management program, patients will experience better health and lead to overall improvement of health for the community. Finally, treating patients in outpatient, lower cost settings will allow the state to spend fewer dollars on sick care and make the Medicaid program more affordable overall.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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

2A. Maternal and Child Health?

Yes

No

2B. Adult Behavioral Health?

Yes

No

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

1. Improved percentage of patients receiving appropriate follow-up within seven days of discharge from an inpatient behavioral health stay.
2. Improve transitions of care from inpatient to community-based services
3. Improve care coordination and access to care for individuals with alcohol and/or substance use disorders

[Adult Behavioral Health - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

2C. Child Behavioral Health?

Yes

No

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.

Adults' Access to Preventive/Ambulatory Health Services (AAP) – Through CM can track improvement in BH patients receiving preventive services.

[Equity - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

2E. Community-Based Services and Supports?

Yes

No

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

1. During the first year of funding, providers participating in the JPC will adopt a validated SDOH screening tool for all of their patients receiving inpatient and outpatient BH services.
2. Over the 5 years of funding, the collaborative will show an increase in services provided to patients for housing, transportation and food insecurity.

[Community-Based Services and Supports - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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.

n/a

[3A - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

Note: Once metrics are agreed upon in the negotiated funding agreement, HFS will proceed to establish a baseline for the service community, a tracking process, and negotiated improvement targets.

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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.

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

	Year 1
--	--------

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Planning												
Execute Binding Agreement	x											
Establish HFS Meetings	x											
Notify Stakeholders	x	x	x									
Establish Oversight Committee and Subcommittees	x	x										
Develop Policies/ Procedures	x	x	x	x	x	x	x	x	x	x	x	x
Engage MCO's	x	x	x	x	x	x	x	x	x	x	x	x
Sustainability Planning		x	x	x								
Develop BEP RFP												
Execute Contracts: Renovation and Hucu.ai	x											
Hire BEP Employee Recruiter	X	X										
Staffing and Infrastructure												
Facility construction	x	x	x									
Purchase office equipment		x	x									
Hire Staff		x	X	x								
Onboarding/ training		X	X	X								
Implementation												
Hucu.ai test /go live		x	x									
Begin Monthly Collection of Baseline Quality and SDoH Data			x	x	x	x	x	x	x	x	x	x
Develop and Submit HFS Six Mo. Report					x	x						
Develop and Submit HFS Yearly Report											x	x

Implementation	Years 2 and 3			
	Q1	Q2	Q3	Q4
Monthly Collection of Quality Metrics and SDoH Information	x	x	x	X
Explore MCO Planning Partnership for Value-Based Payment Strategies	x	X	x	x
Ongoing Yearly HFS Reporting				x

15. Budget

1. Annual Budgets across the Proposal

[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.)

2. Number of Individuals Served

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

Year 1 Individuals Served

Year 2 Individuals Served

Year 3 Individuals Served

Year 4 Individuals Served

Year 5 Individuals Served

3. Alternative Payment Methodologies

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

The Collaborative is interested in engaging the Illinois Medicaid MCOs to discuss opportunities to enter into value-based payment arrangements that consider total cost of care for individuals. The anticipated savings from intensive care management for patients who present to the emergency department or require an inpatient behavioral health admission that leads to lower utilization of high-cost services could offset the funds needed to support the care-management services being offered by this collaborative.

[Alternative Payment Methodologies - Optional] Please upload any documentation or visuals you wish to submit in support of your response.

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:

AHA report showed benefit of integration of BH and Primary care leading to decreased cost of ED visits, inpatient BH stays that will lead to sustainability (AHA, 2014).

According to the American Journal of Care Management, in 2020, the estimate the average savings for high cost, high need patients to be over per year through intensive care management (Powers et al., 2020). The collaborative anticipates managing approximately 60 patients per month once fully implemented. Estimating that at least 50% of these patients could be unduplicated, patients per year would be part of the program. The total savings to the healthcare system would be over million dollars annually. This would more than offset the increased cost of care managers embedded in the hospital to manage these patients.

Other savings not as easily quantified include the decrease in crime that improves the quality of life in local communities by managing behavioral health issues.

The members of the Collaborative are interested in engaging with the Medicaid Managed Care Organizations with whom they contract to consider alternative payment models that consider the total cost of care for patients with behavioral health issues who are high need and complex. A payment model that allows shared savings for decreasing the total cost of care is the primary method for achieving a sustainable project that continues to provide critical services in an equitable manner to the underserved populations in the South Side of Chicago.

Reference

American Hospital Association (2014, February). Integrating behavioral health across the continuum of care. Chicago, IL: Health Research & Educational Trust. Available at:

<http://www.hpoe.org/Reports-HPOE/Behavioral%20health%20FINAL.pdf>.

Powers, B.W. et al. (February 2020) Impact of Complex Care Management on Spending and Utilization for High-Need, High-Cost Medicaid Patients. The American Journal of Managed Care, 26(2). Available at

<https://www.ajmc.com/view/impact-of-complex-care-management-on-spending-and-utilization-for-highneed-highcost-medicaid-patients>.

[Optional] Please upload any documentation or visuals you wish to submit in support of your response.

Attachment 1

Section 5. Community Input

Community Input

Question 2

Letters of Support from the Community



A Little Bit of Heaven, Inc.

Providing Heavenly Shelter for the Homeless

Nov 08, 2021

Founder

Ms. Lardell Braxton

Officers of the Board

Leanne Faine

Chairman of the Board

Delisa Ibrahim

Treasurer

Margret Vaughn

Secretary

Sheila Braxton

Executive CEO

Members of the Board

Linda Allen

Board Member

Lamar Smith

Board Member

Cornell Smith

Board Member

Deacon Ricky Harvest

Board Member

Michelle Ratliff

Board Member

Karla Richardson

Board Member

Margaret Vaughn

Board Member

Kevin Braxton

Board Member

Advisory Board Members

Valerie Batteast

Sis. Ellen Clare Measner

Theresa Eagleson, MSN, Director
Illinois Department of Healthcare and Human Services
201 South Grand Avenue E
Springfield, IL. 62704

Dear Director, Eagleson

I would like to express my wholehearted support for the Illinois Healthcare Transformation Collaborative (HTC) collaborative application for the Jackson Park Collaborative (The Collaborative), led by Jackson Park Hospital in partnership with the Coordinated Care Alliance (CCA) and Family Guidance Center (FGC).

The Jackson Park Collaborative seeks to improve access to outpatient behavioral health care and enhance the care model with wrap-around care management that will also address social needs. In addition, the collaborative will decrease inappropriate utilization of inpatient psychiatric and medical surgical beds by managing care in the outpatient setting and improving follow-up and access to home medications and linkage to services that address social needs that improve the health of the population.

Jackson Park Hospital & Medical Center in a 256-bed acute, short-term comprehensive care facility serving the southside of Chicago. The hospital offers a wide range of inpatient and outpatient diagnostic, therapeutic and ancillary services with a commitment to medical education at all levels. The hospital offers full medical cardiology, pulmonary, gastrointestinal disease, renal, orthopedics, ENT, ophthalmology, infectious disease, HIV, hematology/oncology, and geriatrics. Ambulatory care is provided through the family medical center and senior health center. Approximately 80 percent of the hospital's patients are covered by Medicare and Medicaid.

Jackson Park Hospital's mission is to provide compassionate and high-quality healthcare service to meet the needs of the patients and communities we serve. They believe that all human beings possess intrinsic value. And they strive to ensure operations will be patient-centered; all patients will be treated with dignity and respect; patient's rights will be 20 community areas in the City of Chicago.

As you review the Jackson Park Collaborative application; you will find that it directly aligns with the goals identified to achieve healthcare transformation serving the South Side of Chicago and I strongly urge you to approve funding for this proposal to improve the healthcare outcomes for those living on the South Side of Chicago.

Ms. Sheila Braxton
Executive CEO
A Little Bit of Heaven Homeless Shelter



Theresa Eagleson, MSN
Director
Illinois Department of Healthcare and Human Services
201 South Grand Avenue E
Springfield, IL 62704

November 10, 2021

Dear Director Eagleson,

Catholic Charities of the Archdiocese of Chicago would like to express our wholehearted support for the Illinois Healthcare Transformation Collaborative (HTC) collaborative application for The Jackson Park Collaborative (The Collaborative), led by Jackson Park Hospital in partnership with the Coordinated Care Alliance (CCA) and Family Guidance Center (FGC).

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Catholic Charities of the Archdiocese of Chicago provides a multitude of services to communities neighboring Jackson Park Hospital. We see firsthand the health-related social challenges faced by residents on the South Side including housing instability and quality, food insecurity, utility needs and transportation.

As you review The Jackson Park Collaborative application, you will find that it directly aligns with the goals identified to achieve healthcare transformation serving the South Side of Chicago and we strongly urge you to approve funding for this proposal to improve the healthcare outcomes for those living on the South Side of Chicago.

Thank you,


Meisha D. Lyons

Associate Vice President

Catholic Charities of the Archdiocese of Chicago
721 N. LaSalle Street
Chicago, Illinois 60654

Theresa Eagleson, MSN
Director
Illinois Department of Healthcare and Human Services
201 South Grand Avenue E
Springfield, IL 62704

November 5, 2021

Dear Director Eagleson,

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Thank you,



Deborah Parnell RN MS CADC
Director Clinical Strategies and Nursing Services
HRDI a subsidiary of Friend Health
dparnell@hrdi.org
Fax: 773-660-4650
Cell: 773-757-3672

November 8, 2021

administration@familyrescueinc.org
www.familyrescueinc.org

Theresa Eagleson, MSN, Director
Illinois Department of Healthcare and Human Services
201 South Grand Avenue E
Springfield, IL 62704

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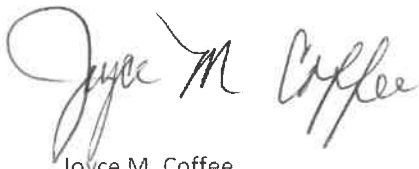
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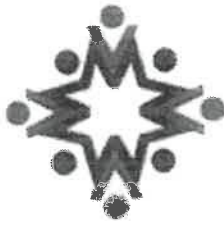
Thank you,



Joyce M. Coffee

CEO/Executive Director

Family Rescue



Margaret's Village

Strengthening Families. Building Communities. Opening Doors.

November 8, 2021

Theresa Eagleson, MSN, Director
Illinois Department of Healthcare and Human Services
201 South Grand Avenue E
Springfield, IL 62704

Dear Director, Eagleson,

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Thank you,


773-994-5350

8334 S. Stony Island Ave.
773.734.0626
773.734.0649
southeastchgochamber.org



November 11, 2021

Ms. Theresa Eagleson, MSN, Director
Illinois Department of Healthcare and Human Services
201 South Grand Avenue E
Springfield, IL. 62704

Dear Director Eagleson:

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Sincerely,
Frankye A. Payne
Executive Director

Executive Board

Chairman (Emeritus)
William Garth
CEO & Publisher
Citizen Group

President
Melinda Kelly
CEO
Melkel Group, LLC

Vice Chair
Ashante Boone
Vice President
PNC Bank

Secretary
Gwen Shaw
Financial Representative
Country Financial Insurance

Assistant Secretary
Dr. Felicia Blasingame
BLBR Holdings LLC
Productions

Treasurer
Monica Linares
Bank Manager
Fifth Third

Interim Executive Director
Jennipher Atkins

Asst. Executive Director
Karletta Kelly

Board Members

Cory Foster
External Affairs Manager
Com-Ed

Elayne Granger
Director External Affairs
AT&T

John Griffin
President, CEO & Owner
AGB Investigative Services

Karl Riley
Vice President
Fifth Third Bank

Ananias Granger Jr
President/CEO
A&D Property Service, Inc,



CHATHAM BUSINESS ASSOCIATION, SMALL BUSINESS DEVELOPMENT, INC.

800 E. 78th St, Chicago, Illinois 60619
773-994-5006 (Office) 773-855-8905 (Fax)
“Sustaining Communities by Building One Business at a Time”

November 9, 2021

Ms. Theresa Eagleson, MSN, Director
Illinois Department of Healthcare and Human Services
201 South Grand Avenue E
Springfield, IL. 62704

Dear Director, Eagleson:

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Thank you,

Melinda Kelly

Melinda Kelly
President

cc: Jennipher Adkins



The Vision to Move Forward

November 9, 2021

Ms. Theresa Eagleson, MSN, Director
Illinois Department of Healthcare and Human Services
201 South Grand Avenue E
Springfield, IL. 62704

Dear Director Eagleson:

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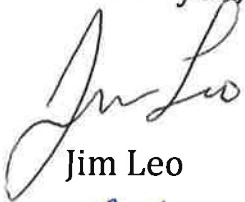
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Thank you,

A handwritten signature in blue ink that reads "Jim Leo".

Jim Leo

A handwritten signature in blue ink that reads "Stanley C. Rakestraw".

Stanley C. Rakestraw



1030 E 87th Street
Chicago, IL 60619

Phone: 773-734-1600
Fax: 773-374-8166
www.riteway-huggins.com

November 9, 2021

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Illinois Department of Healthcare and Human Services
201 South Grand Avenue E
Springfield, IL. 62704

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As you review, The Jackson Park Collaborative application, you will find it directly aligns with the goals identified to achieve healthcare transformation serving the South Side of Chicago. I strongly urge you to approve funding for this proposal to improve the healthcare outcomes for those residents living on the South Side of Chicago

Thank you,

A handwritten signature in blue ink, appearing to read 'Larry Huggins', is written over the typed name.

Larry Huggins

Jonathan Lavin
9052 Laramie Ave.
Skokie, Illinois 60077
708-309-1361 cell

Theresa Eagleson, MSN
Director
Illinois Department of Healthcare and Family Services
201 Grand Avenue E
Springfield, IL 62704

Dear Ms Eagleson,

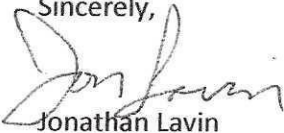
I am writing this letter to offer support for the Jackson Park Hospital proposal to the Illinois Department of Healthcare and Family Services (HCFS) - Healthcare Transformation Collaborative Program. I understand that HCFS is funding various demonstrations to increase coordination and effective mental health services to multi-generations of those in need of behavioral support. The Jackson Park proposal offers strong community-based interventions and service in the Hospitals catchment area. I am very pleased with the full involvement of the Care Coordination Unit - Family Guidance Center (FGC) - and the use of Illinois Care Coordination Units represented by the Coordinated Care Alliance (CCA).

One of the highlights of my professional career was the creation of the Illinois Care Coordination Unit system for case management services, assessment, program access, assignment of services and follow-up for homebound older persons throughout the state. Added to those responsibilities was the creation of Illinois Adult Protective Services working with many of the CCUs that are anchored in the community with jointly funded programs from Illinois Area Agencies on Aging, the Illinois Department on Aging and local communities. The strength of local not for profits and/or local government units brings assistance and advocacy services close to the service population. It empowers community organizations to fully support their neighbors and all those in their service regions.

Although retired, I seek to continue to promote the aging network and, with this initiative, the mental health network to work together and build from their distinctive strengths and services that promote the dignity of every community member in need. Furthermore, the innovation being marshalled with Hucu.ai care coordination and related outcomes analytics will further the community's interest.

Please do not hesitate to contact me if you have questions on this letter.

Sincerely,



Jonathan Lavin

jonthanlavin@rcn.com

Attachment 2

Section 5. Community Input
Input from Elected Officials

Question 1

Letters of Support from Elected Officials

MICHELLE A. HARRIS
ALDERMAN, 8TH WARD
8539 SOUTH COTTAGE AVENUE
SUITE A
CHICAGO, ILLINOIS 60619
PHONE: 773-874-3300
FAX: 773-224-2425
E-MAIL: WARD8@CITYOFCHICAGO.ORG



CITY OF CHICAGO
CITY COUNCIL

CITY HALL ROOM 200
121 NORTH LASALLE STREET
CHICAGO, ILLINOIS 60602
PHONE: 312-744-3075

COMMITTEE MEMBERSHIPS

COMMITTEES AND RULES
(CHAIRMAN)
BUDGET AND GOVERNMENT OPERATIONS
ECONOMIC, CAPITAL AND
TECHNOLOGY DEVELOPMENT
EDUCATION AND CHILD DEVELOPMENT
FINANCE
HOUSING AND REAL ESTATE
HUMAN RELATIONS AND HEALTH
IMMIGRANT AND REFUGEE RIGHTS
TRANSPORTATION AND PUBLIC WAY

November 9, 2021

Ms. Theresa Eagleson, MSN, Director
Illinois Department of Healthcare and Human Services
01 South Grand Avenue E
Springfield, IL. 62704

Dear Director Eagleson:

I would like to express my wholehearted support for the Illinois Healthcare Transformation Collaborative (HTC) application for The Jackson Park Collaborative (The Collaborative), led by Jackson Park Hospital and Medical Center in partnership with the Coordinated Care Alliance (CCA) and Family guidance Center (FGC).

The Jackson Park Collaborative seeks to improve access to outpatient behavioral health care and enhance the care model with wrap-around care management that will also address social needs. In addition, the collaborative will decrease inappropriate utilization of inpatient psychiatric and medical surgical beds by managing care in the outpatient setting and improving follow-up and access to home medications and linkage to services that address social needs that improve the health of the population.

Jackson Park Hospital and Medical Center is a 256-bed acute, short term comprehensive care facility serving the south side of Chicago. The hospital offers a wide range of inpatient and outpatient diagnostic, therapeutic and ancillary services with a commitment to medical education at all levels. The hospital has full medical, surgical, psychiatric and medical stabilization services as well as medical subspecialties including: cardiology, pulmonary, gastrointestinal disease, renal, orthopedics, ENT, ophthalmology, urology, infectious disease, HIV, hematology/oncology and geriatrics. Ambulatory care is provided through the family medicine and senior health centers. Approximately, 80 percent of the hospital's patients are covered by Medicare and Medicaid.

As you review, The Jackson Park Collaborative application, you will find it directly aligns with the goals identified to achieve healthcare transformation serving the South Side of Chicago. I strongly urge you to approve funding for this proposal to improve the healthcare outcomes for those residents living on the South Side of Chicago.

Thank you,

Michelle A. Harris
Alderman, 8th Ward

ILLINOIS HOUSE OF REPRESENTATIVES

District Office
449 East 35th Street
Chicago, IL 60616
773-924-1755



Capitol Office
4252 W. Stratton Building
Springfield, IL 62706
(217) 782-2023

KAM BUCKNER
STATE REPRESENTATIVE
26TH HOUSE DISTRICT

November 10, 2021

Theresa Eagleson, MSN Director
Illinois Department of Healthcare and Human Services
201 South Grand Avenue E
Springfield, IL 62704

Dear Director Eagleson,

I would like to express my wholehearted support for the Illinois Healthcare Transformation Collaborative (HTC) collaborative application for The Jackson Park Collaborative (The Collaborative), led by Jackson Park Hospital in partnership with the Coordinated Care Alliance (CCA) and Family Guidance Center (FGC).

The Jackson Park Collaborative seeks to improve access to outpatient behavioral health care and enhance the care model with wrap-around care management that will also address social needs. In addition, the collaborative will decrease inappropriate utilization of inpatient psychiatric and medical surgical beds by managing care in the outpatient setting and improving follow-up and access to home medications and linkage to services that address social needs that improve the health of the population.

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Jackson Park Hospital's mission is to provide compassionate and high-quality healthcare service to meet the needs of the patients and communities we serve. They believe that all human beings possess intrinsic value. And they strive to ensure operations will be patient-centered; all patients will be treated with dignity and respect; patients' rights will be honored. Jackson Park Hospital's primary service area includes eight zip codes corresponding to 20 community areas in the City of Chicago.

As you review The Jackson Park Collaborative application, you will find that it directly aligns with the goals identified to achieve healthcare transformation serving the South Side of Chicago and I strongly urge you to approve funding for this proposal to improve the healthcare outcomes for those living on the South Side of Chicago.

Best regards,

A handwritten signature in black ink that reads "Kam Buckner". The signature is written in a cursive, flowing style.

Rep. Kam Buckner
Illinois House of Representatives
26th Legislative District

ILLINOIS HOUSE OF REPRESENTATIVES

DISTRICT OFFICE:
8500 S. STONY ISLAND AVE.
CHICAGO ILLINOIS 60617
TEL: 773-783-8492

SPRINGFIELD OFFICE:
268-S STRATTON OFFICE BUILDING
SPRINGFIELD, ILLINOIS 62706
TEL: 217-782-8272



MARCUS C. EVANS, JR.
ASSISTANT MAJORITY LEADER
STATE REPRESENTATIVE 33rd DISTRICT

CHAIR PERSON:
• Labor & Commerce

SUB- CHAIRPERSON:
• Business & Innovation Subcommittee
• Income Tax Subcommittee
• Minority Impact Analysis Subcommittee
• Wage Policy & Study Subcommittee

COMMITTEES
• Appropriations-Human Services
• Ethics & Elections
• Executive
• Healthcare Availability & Access
• Medicaid Managed Care Subcommittee
• Revenue & Finance
• Workforce Development Subcommittee

Theresa Eagleson
Director, Illinois Department of Healthcare and Family Services
Prescott Bloom Building
201 South Grand Avenue, East
Springfield, IL 62763

November 9, 2021

Dear Director Eagleson:

I would like to express my enthusiastic support for the Illinois Healthcare Transformation Collaborative (HTC) application for The Jackson Park Collaborative, led by Jackson Park Hospital in partnership with the Coordinated Care Alliance and Family Guidance Center.

The Jackson Park Collaborative seeks to improve access to outpatient behavioral healthcare and enhance the care model with wrap-around care management that will also address social needs. The collaborative will decrease inappropriate utilization of inpatient psychiatric and medical surgical beds by managing care in the outpatient setting. In addition to improving follow-up, access to home medications, and linkage to services that address social needs that improve the health of the population.

Jackson Park Hospital & Medical Center is a short-term comprehensive care facility serving 20 communities on the south side of Chicago. The hospital offers a wide range of inpatient and outpatient diagnostic, therapeutic, and ancillary services with a commitment to medical education at all levels. Jackson Park Hospital's mission is to provide compassionate and high-quality healthcare service to meet the needs of the patients and communities we serve. I strongly urge you to approve funding for this proposal to improve the healthcare outcomes for those living on the South Side of Chicago.

Please feel free to contact me if you have any questions regarding my support.

Sincerely,

A handwritten signature in black ink, appearing to read "M.C. Evans, Jr." with a stylized flourish at the end.

Marcus C. Evans, Jr.
Assistant Majority Leader
State Representative, 33rd District

ILLINOIS HOUSE OF REPRESENTATIVES

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

DISTRICT OFFICE:
5048 S. Indiana Ave
Chicago, Illinois 60615
(773) 924-4614 (Office)
(773) 924-4652 (Fax)



Lamont J. Robinson, Jr.
STATE REPRESENTATIVE
5th DISTRICT

COMMITTEES:

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

Theresa Eagleson, MSN
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue E
Springfield, IL 62704

November 10, 2021

Dear Director Eagleson,

I would like to express my wholehearted support for the Illinois Healthcare Transformation Collaborative (HTC) application for The Jackson Park Collaborative (The Collaborative), led by Jackson Park Hospital in partnership with the Coordinated Care Alliance (CCA) and Family Guidance Center (FGC).

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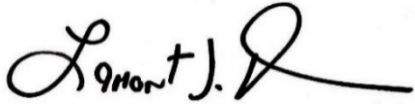
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As you review The Jackson Park Collaborative application, you will find that it directly aligns with the goals identified to achieve healthcare transformation on the South Side of Chicago. I strongly urge you to approve funding for this proposal to improve the healthcare outcomes for the residents of Chicago's South Side.

ILLINOIS HOUSE OF REPRESENTATIVES

Thank you for your consideration of this application.,

Sincerely,

A handwritten signature in black ink, appearing to read "Lamont J. Robinson". The signature is written in a cursive style with a large initial "L" and a long horizontal stroke at the end.

Lamont J. Robinson

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

STATE OF ILLINOIS



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

DISTRICT OFFICE:
2929 S. WABASH AVENUE, SUITE 102
CHICAGO, ILLINOIS 60616
312-949-1908
FAX: 312-949-1958
senator03district@gmail.com

WEBSITE
SENATORHUNTER.COM

MATTIE HUNTER
MAJORITY CAUCUS CHAIR
STATE SENATOR- 3RD DISTRICT

November 9, 2021

Theresa Eagleson, MSN, Director
Illinois Department of Healthcare and Human Services
201 South Grand Avenue E
Springfield, Illinois 62704

Dear Director Eagleson:

This letter is written in support of the Illinois Healthcare Transformation Collaborative (HTC) application for the Jackson Park Collaborative (The Collaborative), led by Jackson Park Hospital in partnership with the Coordinated Care Alliance (CCA) and Family Guidance Center (FGC).

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I believe the Jackson Park Collaborative application directly aligns with the goals identified to achieve healthcare transformation serving the South Side of Chicago. I look forward to your approval of funding for this proposal.

Sincerely,

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

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

CHICAGO OFFICE
8233 S. PRINCETON
CHICAGO, IL 60620
(773) 933-7715



SPRINGFIELD OFFICE
307 CAPITOL BUILDING
SPRINGFIELD, IL 62706
(217) 782-3201

THE OFFICE OF
ELGIE R. SIMS, JR.
STATE SENATOR • 17th DISTRICT
Esims@SenatorElgieSims.com
www.SenatorElgieSims.com

COMMITTEE MEMBERSHIPS

Chairman, Appropriations
Vice Chairman, Criminal Law
Judiciary
Ethics
Public Safety
Revenue

November 9, 2021

Ms. Theresa Eagleson, MSN, Director
Illinois Department of Healthcare and Human Services
201 South Grand Avenue E
Springfield, IL. 62704

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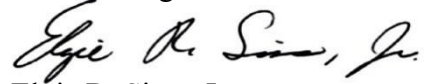
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Warmest regards,

A handwritten signature in black ink that reads "Elgie R. Sims, Jr." in a cursive style.

Elgie R. Sims, Jr.

State Senator, 17th District

Attachment 3

Section 6. Data Support Question 2

JPH Community Health Needs Assessment March 2021



Jackson Park Hospital
caring for you

Community Health Needs Assessment



March 2021

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Introduction

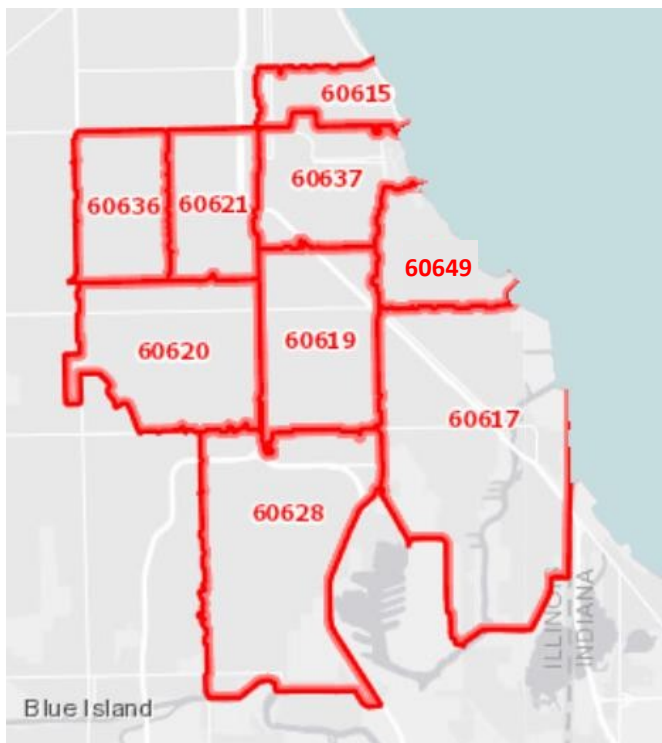
Description of Jackson Park Hospital and the communities we serve

Jackson Park Hospital & Medical Center is a 256-bed acute, short-term comprehensive care facility serving the south side of Chicago. The hospital offers a wide range of inpatient and outpatient diagnostic, therapeutic and ancillary services with a commitment to medical education at all levels. The hospital offers full medical, surgical, psychiatric, and medical stabilization services as well as medical sub-specialties including cardiology, pulmonary, gastrointestinal disease, renal, orthopedics, ENT, ophthalmology, infectious disease, HIV, hematology/oncology and geriatrics. Ambulatory care is provided through the family medicine center and senior health center. Approximately 80 percent of the hospital's patients are covered by Medicare and Medicaid.

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Jackson Park Hospital's primary service area includes eight zip codes corresponding to 20 community areas in the City of Chicago.

Jackson Park Hospital's Primary Service Area

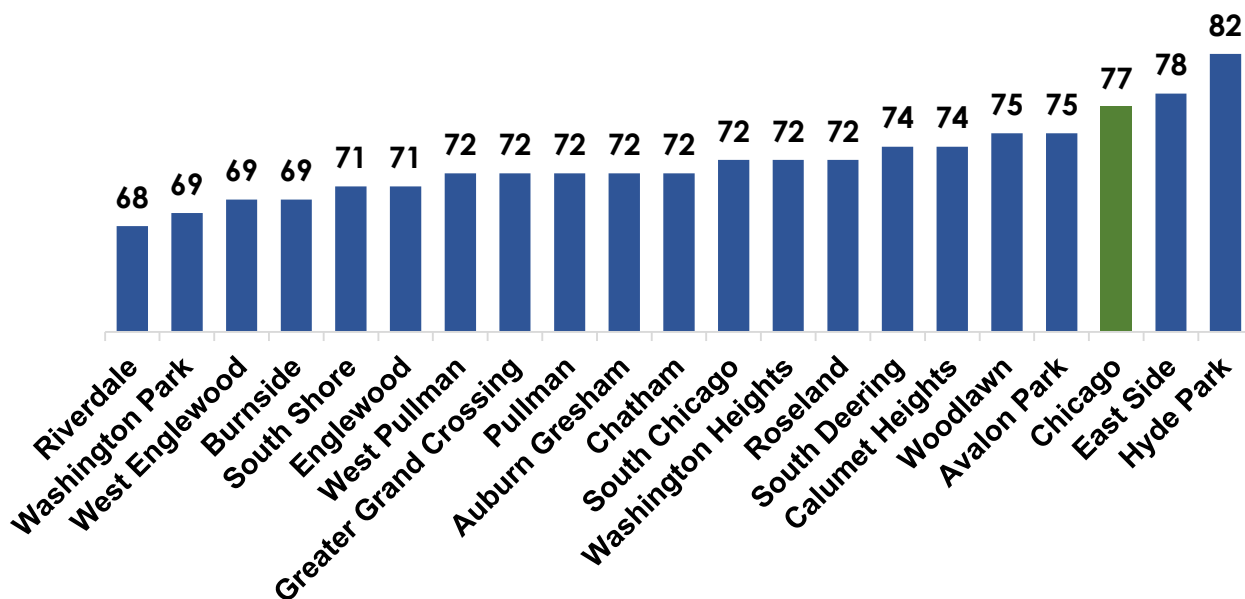


Zip Code	Community Areas
60649	South Shore
60619	Greater Grand Crossing, Chatham, Burnside, Avalon Park
60637	Washington Park, Hyde Park, Woodlawn
60617	Calumet Heights, South Chicago, South Deering, East Side
60620	Washington Heights, Auburn Gresham
60628	Roseland, West Pullman, Pullman, Riverdale
60621	Englewood
60636	West Englewood

The total population in these eight zip codes is estimated at 428,700; about 23% of the residents are under 18, while 15% are over the age of 65. Eighty-five percent of the population identifies as Black (84.6%), 9.7% Hispanic/Latinx, 4.0% White (non-Hispanic), and 0.7% Asian, with a small percentage identifying with other racial groups. (American Community Survey, US Census Bureau, 2014-2019 five-year estimates)

In the communities that make up Jackson Park Hospital’s service area, life expectancy ranges from 68 to 82 years of age, with almost all of the community areas having a life expectancy lower than the Chicago average of 77 years of age. (Chicago Department of Public Health, Chicago Health Atlas)

Life Expectancy, 2017



Overview of the Alliance for Health Equity

The Alliance for Health Equity is a collaborative of 36 hospitals working with health departments and regional and community-based organizations to improve health equity, wellness, and quality of life across Chicago and Suburban Cook County. The purpose of the Alliance for Health Equity is to improve population and community health by:

- promoting health equity;
- supporting capacity building, shared learning, and connecting local initiatives;
- addressing social and structural determinants of health;
- developing broad city and county wide initiatives and creating systems;
- engaging community partners and working collaboratively with community leaders;
- developing data systems for population health to support shared impact measurement and community assessment; and
- collaborating on population health policy and advocacy.

The Alliance for Health Equity was developed so that participating organizations can collaboratively assess community health needs, collectively develop shared implementation plans to address

community health needs, more efficiently share resources, and have a greater impact on the large population residing in Cook County. Currently, 36 hospitals, 6 local health departments including Chicago Department of Public Health and Cook County Department of Public Health, and nearly 100 community-based organizations are participating in the Alliance for Health Equity. The Illinois Public Health Institute (IPHI) serves as a backbone organization that helps to facilitate the assessment and implementation processes, convenes partners across sectors, and provides technical support. The Alliance for Health Equity is comprised of a steering committee and workgroups and committees collaborating on implementation strategies for several community health priorities. Jackson Park Hospital sits on the steering committee for the Alliance for Health Equity.

Community Engagement

In keeping with our purpose, vision, and values, the Alliance for Health Equity prioritizes engagement of community members and community-based organizations as a critical component of assessing and addressing community health needs. The Alliance for Health Equity's methods of community engagement for the CHNA and implementation strategies include:

- Gathering input from community residents who are underrepresented in traditional assessment and implementation planning processes;
- Partnering with community-based organizations for collection of community input through surveys and focus groups;
- Engaging community-based organizations and community residents as members of implementation committees and workgroups;
- Utilizing the expertise of the members of implementation committees and workgroups in assessment design, data interpretation, and identification of effective implementation strategies and evaluation metrics;
- Working with hospital and health department community advisory groups to gather input into the CHNA and implementation strategies; and
- Partnering with local coalitions to support and align with existing community-driven efforts.

The community-based organizations engaged in the Alliance for Health Equity represent a broad range of sectors such as workforce development, housing services, food security, community safety, planning, community development, immigrant rights, primary and secondary education, faith communities, behavioral health services, advocacy, policy, transportation, older adult services, health care services, higher education, and many more. All community partners work with or represent communities that are disproportionately affected by health inequities such as communities of color, immigrants, youth, older adults and caregivers, LGBTQ+, individuals experiencing homelessness or housing instability, individuals living with mental illness or substance use disorders, individuals with disabilities, veterans, and unemployed youth and adults.

Jackson Park Hospital's CHNA process

Jackson Park Hospital worked with the Alliance for Health Equity and the Illinois Public Health Institute (IPHI) to conduct this Community Health Needs Assessment (CHNA), using community health status data from approximately 20 publicly available sources that are accessible through the Chicago Health Atlas and SparkMap websites. IPHI reviewed local resource lists and community plans to compile community assets. IPHI also conducted eight key informant interviews with community members who have been active partners to Jackson Park Hospital. Jackson Park Hospital wrote up a summary of implementation activities completed since the 2018 CHNA.

This CHNA was conducted to meet federal requirements and guidelines, including:

- clearly defining a community served by the hospital, and ensuring that defined community does not exclude low-income or vulnerable communities in proximity to the hospital;
- a clear description of the CHNA process and methods; community health needs; collaboration, including with public health experts; and a description of existing facilities and resources in the community;
- input from persons representing the broad needs of the community;
- opportunity for community comment on the CHNA and health needs in the community;
- posting the CHNA and making it available to the public;

And, Jackson Park Hospital will adopt and submit an implementation strategy to the IRS following the posting of this CHNA.

This Community Health Needs Assessment (CHNA) identifies many health needs and health inequities affecting the communities served by Jackson Park Hospital: (in alphabetical order)

- Access to healthcare – inequities in service availability, access to primary and secondary care, and transportation
- Care coordination and linkage to services
- Chronic disease management and prevention – diabetes, hypertension, lung health
- Food insecurity and food access
- Housing and homelessness
- Infectious disease, including COVID-19
- Jobs and workforce development
- Maternal and child health, including prenatal care
- Mental Health
- Substance Use Disorders
- Trauma
- Violence and community safety
- Youth development and education

Priority Community Health Issues

Jackson Park Hospital staff and leadership prioritized five significant community health needs¹

Access to Healthcare

Chronic Disease Management and Prevention

Housing and Homelessness

Community Education - Maternal and Child Health, including prenatal care

Mental Health and Substance Use Disorders

The Community Health Needs Assessment (CHNA) was adopted by the hospital board on March 19, 2021.

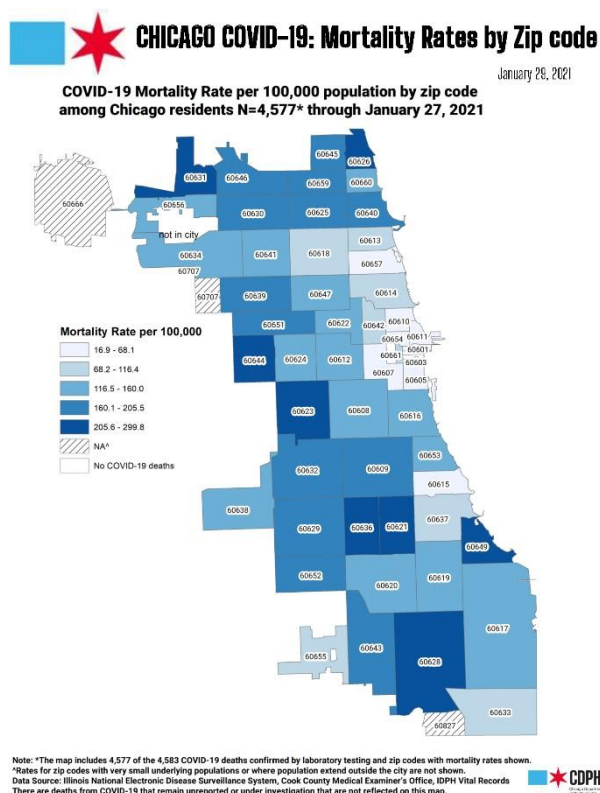
COVID-19 Impacts

The COVID-19 pandemic has had profound effects on health and well-being within the communities served by Jackson Park Hospital. Mortality rates in four of the zip codes served by Jackson Park Hospital are among the highest in the City (60649, 60621, 60628, 60636).

COVID-19 has also had substantial impacts on other health issues such as: mental health, trauma, unemployment, food security and nutrition, and housing instability.

COVID-19 has amplified longstanding racial inequities in access to healthcare, quality of care, poverty and economic opportunity, housing and homelessness, food security, and prevalence of chronic illness. Black and Latinx communities in Chicago (including the communities in Jackson Park Hospital's service area) have experienced disproportionate severe cases and death from COVID-19 as well as a disproportionate economic burden.

Throughout 2020, Jackson Park Hospital focused a substantial amount of time and energy on COVID-19, as described in more detail in Appendix 3.



¹ Priority community health issues were selected based on size and seriousness of the issue, value to the community, addressing disparities, opportunity to make an impact, and feasibility.

Key Findings

Health Inequities

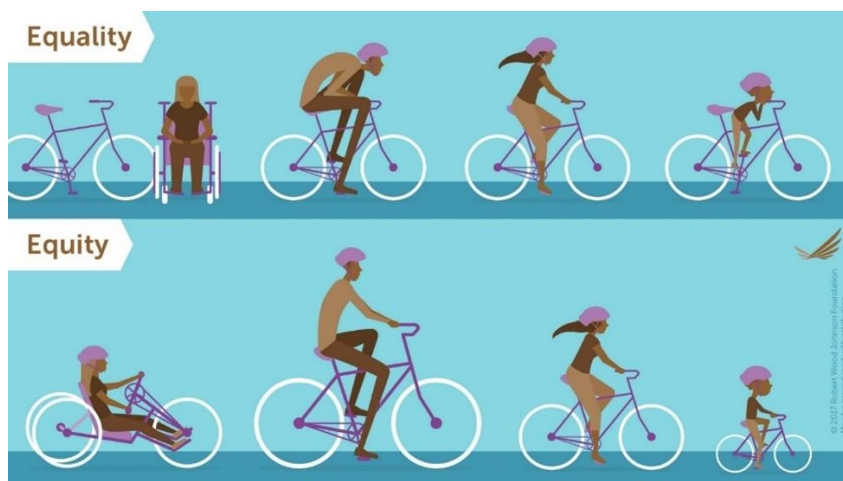
Overview of Health Inequities

Health inequities can be defined as differences in the incidence, prevalence, mortality, burden of disease, or the distribution of health determinants between different population groups (National Institutes of Health, 2017; World Health Organization, n.d.-b). Health inequities can exist across many dimensions such as race, ethnicity, gender, sexual orientation, age, disability status, socioeconomic status, geographic location, and military status (National Academies of Sciences, Baciú, Negussie, Geller, & Weinstein, 2017). There are four overarching concepts that demonstrate the necessity of addressing health inequities:

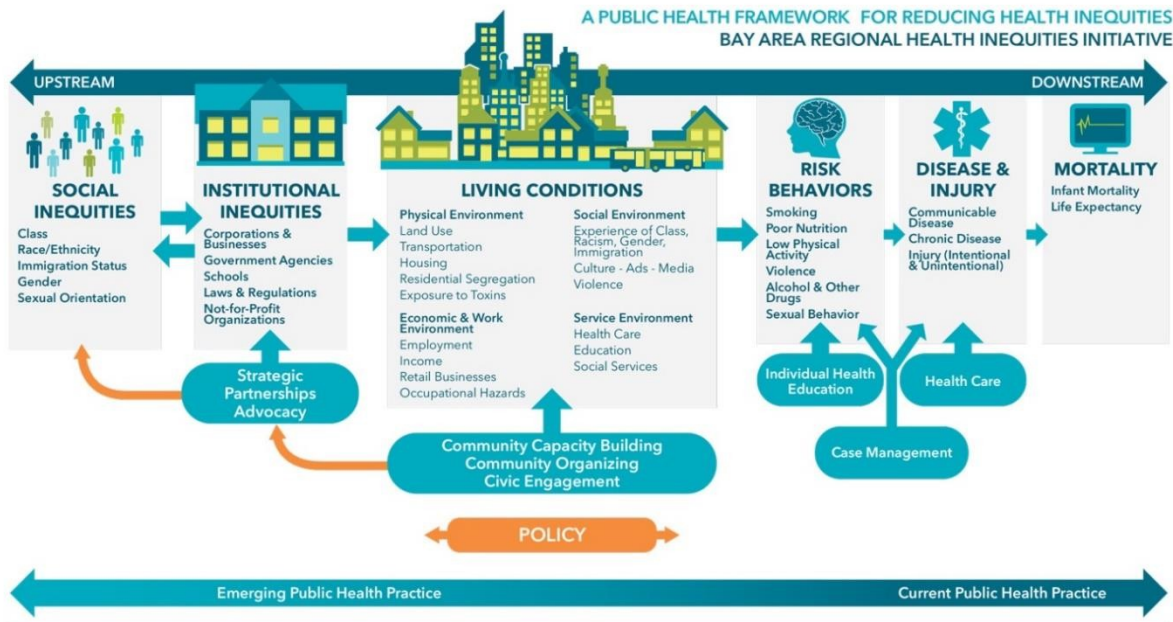
1. Inequities are unjust – Health inequities result from the unjust distribution of the underlying determinants of health such as education, safe housing, access to health care, and employment;
2. Inequities affect everyone – Conditions that lead to health disparities are detrimental to all members of society and lead to loss of income, lives, and potential;
3. Inequities are avoidable – Many health inequities stem directly from government policies such as tax policy, business regulation, public benefits, and health care funding and can, therefore, be addressed through policy interventions; and
4. Interventions to reduce health inequities are cost-effective – Evidence-based public health programs to reduce or prevent health inequities can be extremely cost effective particularly when compared to the financial burden of persistent disparities (Metropolitan Planning Council, 2017; National Academies of Sciences et al., 2017).

It is important to note that equality and equity are different. Health inequities involve more than unequal access to the resources needed to maintain or improve health (World Health Organization).

The difference between equality and equity



(TEQuity and Robert Wood Johnson Foundation, 2018)



BARHII Bay Area Regional Health Inequities Initiative, (2015)

Racial Inequities, and the role of racism

Race and ethnicity are socially constructed categories that have profound effects on the lives of individuals and communities as a whole. Racial and ethnic disparities are arguably the most persistent inequities in health over time in the United States (National Academies of Sciences et al., 2017). Racial and ethnic inequities in health are directly linked to racism.

“Racism is the system of structuring opportunity and assigning value based on the social interpretation of how one looks. which is what we call “race”, that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.” American Public Health Association (APHA) Past President Camara Jones, MD, PhD, MPH

Racism structures opportunity and assigns value based on how a person looks resulting in conditions that unfairly advantage some and unfairly disadvantage others (American Public Health Association, 2019). Racism diminishes the overall health of our nation by preventing some people the opportunity to attain their highest level of health and is a driving force of the social determinants of health (American Public Health Association, 2019). In addition, racism can be traumatic to the individuals and communities that are routinely exposed to it thus causing and exacerbating health inequities. Racism can be unintentional or intentional and operates at individual, interpersonal, institutional, and structural levels.

Racial equity is reached when race and ethnicity no longer determine an individual or community's socioeconomic and health outcomes. Racial equity is achieved when those most impacted by structural and institutional inequity are meaningfully involved in the creation and implementation of institutional policies and practices that impact their lives (Center for Social Inclusion).

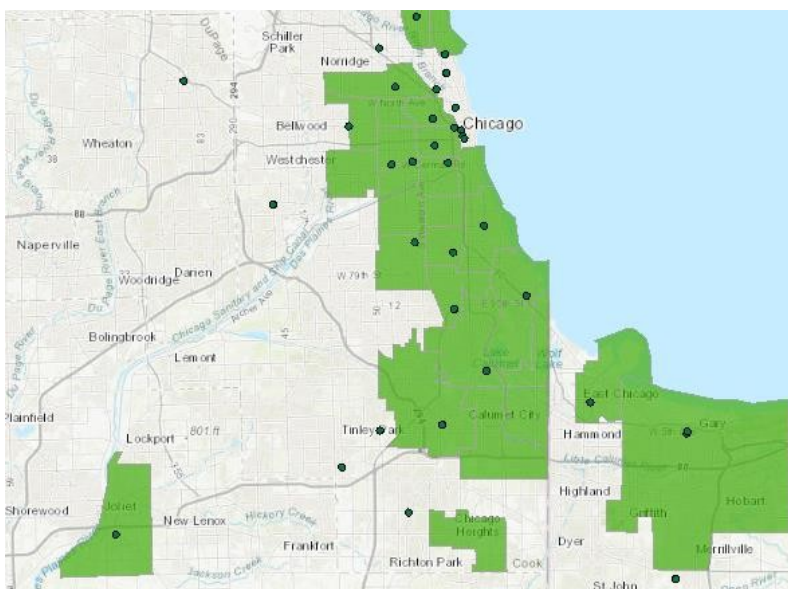
Inequities in Access to Health Care

Access to health care is a complex and multifaceted concept that includes dimensions of proximity; affordability; availability, convenience, accommodation, and reliability; quality and acceptability; openness, cultural responsiveness, appropriateness and approachability.

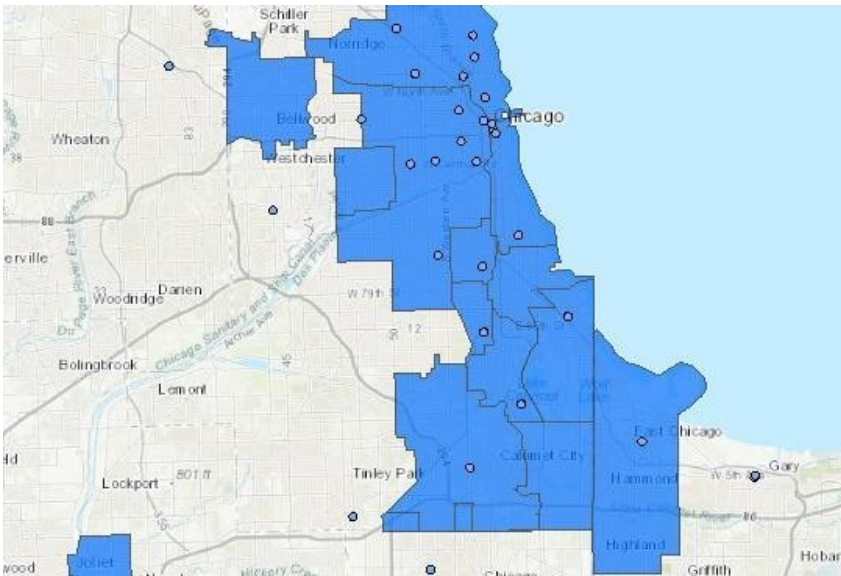
One of the strongest and most researched causes of inequities in health care and health outcomes is income inequality. Around the world, wealthy individuals have better health than low-income individuals. However, the United States has one of the world's largest health gaps between its wealthiest and poorest citizens (Hero, Zaslavsky, & Blendon, 2017). In a study of 32 middle- and high-income nations, the United States ranked 30th in health outcome disparities between the richest and poorest with only Chile and Portugal fairing worse (Hero et al., 2017). Low-income communities historically have less physical access to hospitals, clinics, doctor offices, skilled professionals, medical technology, essential medicine, and proper procedures to deal with illness and disease (A. Powell, 2016). Additionally, quality of health care services can vary greatly between communities. Inequalities in health insurance are another factor leading to significantly worse health outcomes in low-income communities (A. Powell, 2016). Health insurance is the primary way in which individuals access the U.S. health care system, with 53% of Illinois residents receiving coverage through employer sponsored plans. However, one in five low-income Americans still go without care because of cost compared to 1 in 25 high-income Americans (Amadeo, 2019).

Jackson Park Hospital sits amidst several health professional shortage areas for primary care, mental health, and dental providers. The Health Resources and Services Administration designates Health Professional Shortage Areas for primary care, dental health, and mental health. Shortage areas are either due to geography (shortage of providers for the entire population within a defined geographic area) or are population specific for low-income residents in an area.

Primary Care Health Professional Shortage Areas, HRSA, 2020



Mental Health Professional Shortage Areas, HRSA, 2020



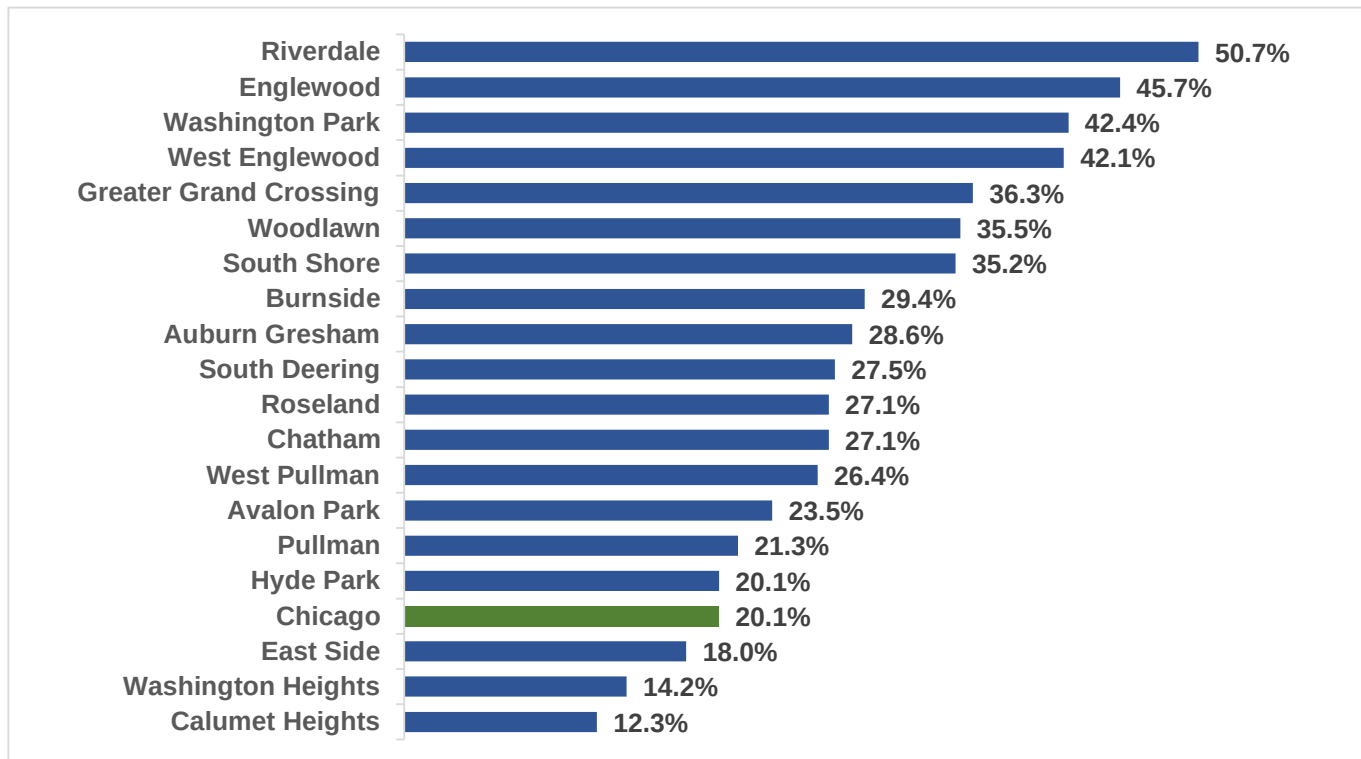
Inequities in Community Safety and Trauma

Although violence occurs in all communities, it is concentrated in low-income communities of color. The root causes of community violence are multifaceted but include issues such as the concentration of poverty, education inequities, poor access to health services, mass incarceration, differential policing strategies, and generational trauma. Research has established that exposure to violence has significant impacts on physical and mental well-being. In addition, exposure to violence in childhood has been linked to trauma, toxic stress, and an increased risk of poor health outcomes across the lifespan.

Inequities are particularly detrimental not only because they limit access to services and other resources, but also because the experiences of marginalization and discrimination are traumatic. Research has established that traumatic experiences can cause stress that is toxic to the body and can result in dysregulation, inflammation, and disease. The effects of trauma and toxic stress are detrimental throughout the lifespan but can be particularly deleterious when exposure begins in childhood. As a result, exposure to trauma and the resulting toxic stress contribute to widening health disparities. Supporting and partnering with communities that have experienced trauma to build resiliency is an important step in reducing health inequities, however, it is critical to address the underlying root causes of traumatizing inequities with a focus on future prevention.

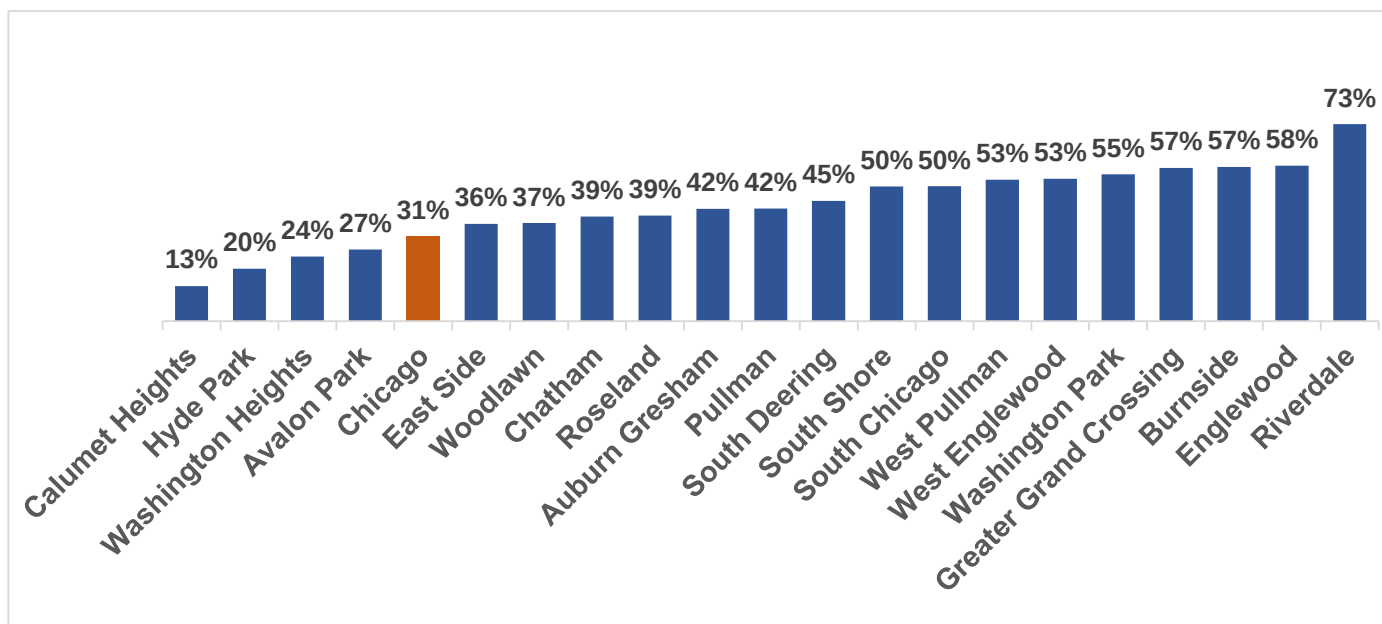
Social, Economic, and Structural Determinants of Health

Poverty: Percentage of households living below the poverty threshold, 2015-2019



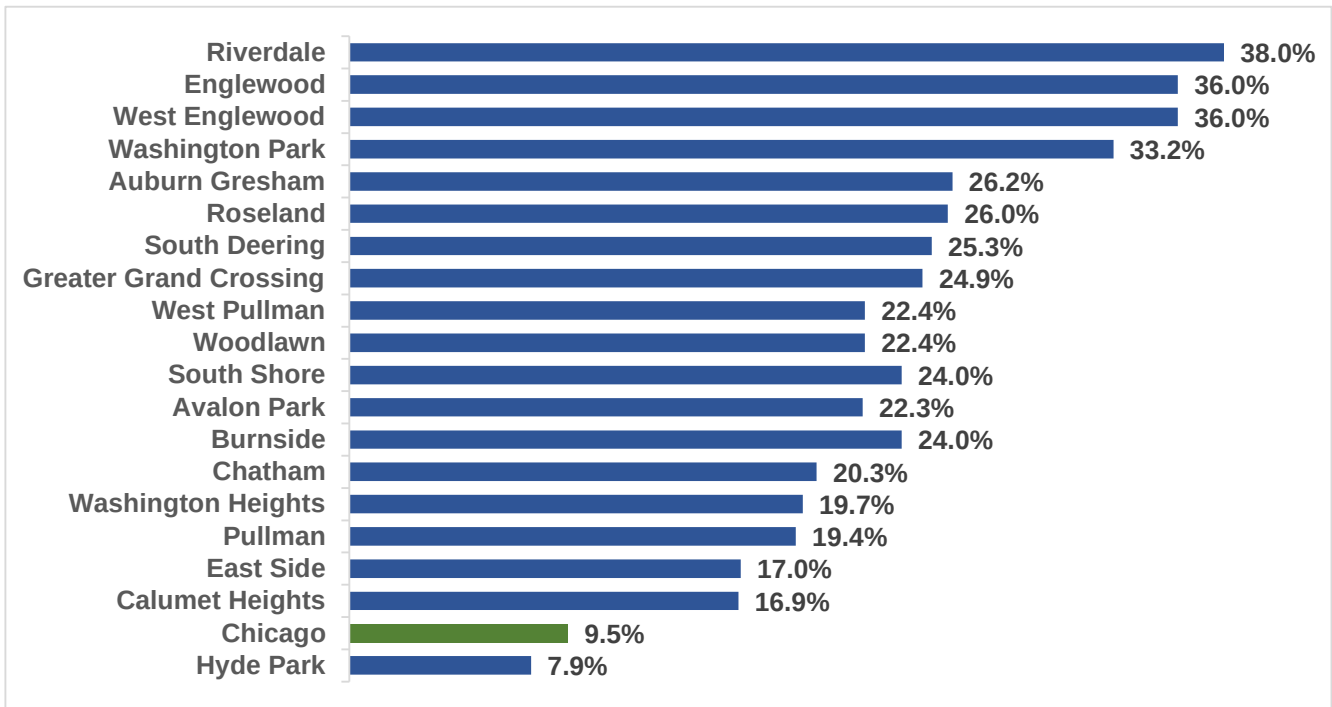
Data Source: US Census Bureau: American Community Survey. Five-year estimates.

Childhood Poverty: Percentage of children (under 18 years old) living below the poverty threshold, 2015-2019



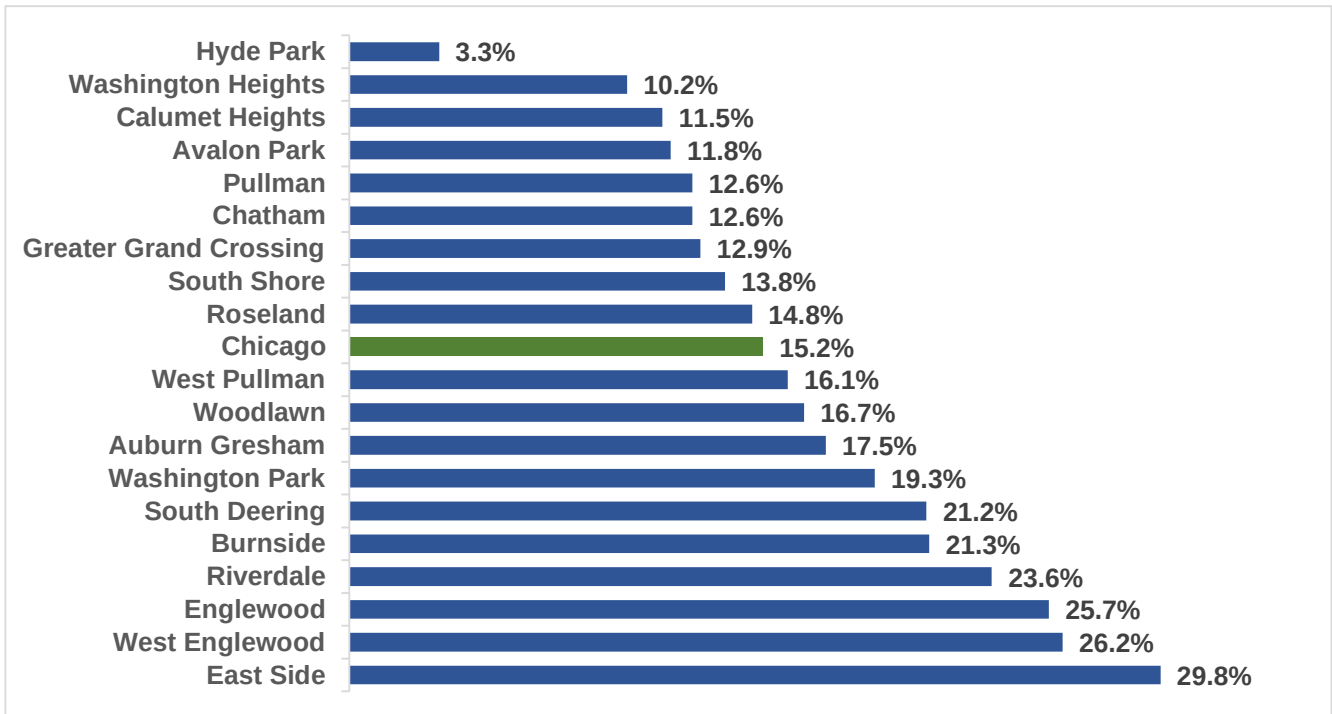
Data Source: U.S. Census Bureau: American Community Survey. Five-year estimates for community areas, one-year estimate for Chicago.

Unemployment: Percentage of adults aged 16 years and over in the civilian labor force who were unemployed, 2015-2019



Data Source: *Illinois Department of Public Health, Vital Statistics; US Census Bureau.* Five-year estimates for community areas, one-year estimate for Chicago.

Educational Attainment: Percentage of adults aged 25 years and older without a high school diploma or equivalency, 2015-2019



Data Source: U.S. Census Bureau: American Community Survey. Five-year estimates for community areas, one-year estimate for Chicago.

Mental Health and Substance Use Disorders

Quality: An overarching need for Behavioral Health Care

NAMI Chicago's "Roadmap to Wellness: Reframing the Mental Health Conversation for Chicago" explicitly makes the case for an understanding of mental health that is inclusive of all people and is "seen as primary health care" (NAMI Chicago, 2019). Mental health is separated from general health providers and state agencies, and in our everyday language, "mental health" is detached from a general concept of wellness in a way that "cardiac health," for example, is not. As a result, mental health services are provided in a distinct, stigmatized silo that is not subject to the same demand for quality as most other health care sectors. Validated symptom rating scales for monitoring outcomes of mental health interventions, for example, are rarely used, and incentives for implementing such measurement-based care practices are missing (The Kennedy Forum, 2015).

Fragmentation of services, integration of care, and reimbursement

- A common theme in mental health assessments is fragmentation—gaps, bottlenecks, and silos within and between types of providers and health plans and between various state agencies responsible for health and human services.
- The physical, operational, and financial separation of mental health from general health care creates barriers to timely access to necessary services for individuals and families and interferes with population health approaches that depend on seamless connections between various services.
- Efforts toward integrating primary and mental health care are underway, from county-wide care coordination strategies to neighborhood partnerships. At the state-level, Illinois' Behavioral Health Transformation Plan presents opportunities to strengthen and replicate these local projects.
- A workforce that is linguistically competent and culturally humble is a necessary condition to overcoming the burden of stigma and structural racism. In particular, access to providers of evidence-based practices, such as Assertive Community Treatment, Medication for Opioid Use Disorders, and peer support, is crucial for people with serious mental illness and opioid use disorders.
- State programs to increase the number of certified prescribers and expand reimbursement for telehealth and telepsychiatry, and local initiatives create opportunities to extend the existing workforce to reach more people in need. There is need to advocate for higher state reimbursement rates to address the workforce crisis (Illinois Department of Human Services, 2018; Illinois General Assembly, 2019).

Trauma and childhood adversity

- Experiences of trauma and adversity in childhood, including abuse and household instability, extreme discrimination and poverty, or the loss of a parent, is widespread, affecting more than half of all adults in Illinois.
- Research is revealing how exposure to trauma and adversity puts individuals at greater risk for mental illness, substance use disorder, and chronic illness across the lifespan. Trauma and adversity disproportionately affect communities of color and sexual and gender minorities, and are particularly prevalent among justice-involved populations, making addressing trauma a priority for achieving health equity (SAMHSA, 2014).

- Trauma-informed practice protocols are available for health care, schools, law enforcement and corrections, and child welfare systems to mitigate past experiences of stigma and trauma and to prevent further harm.

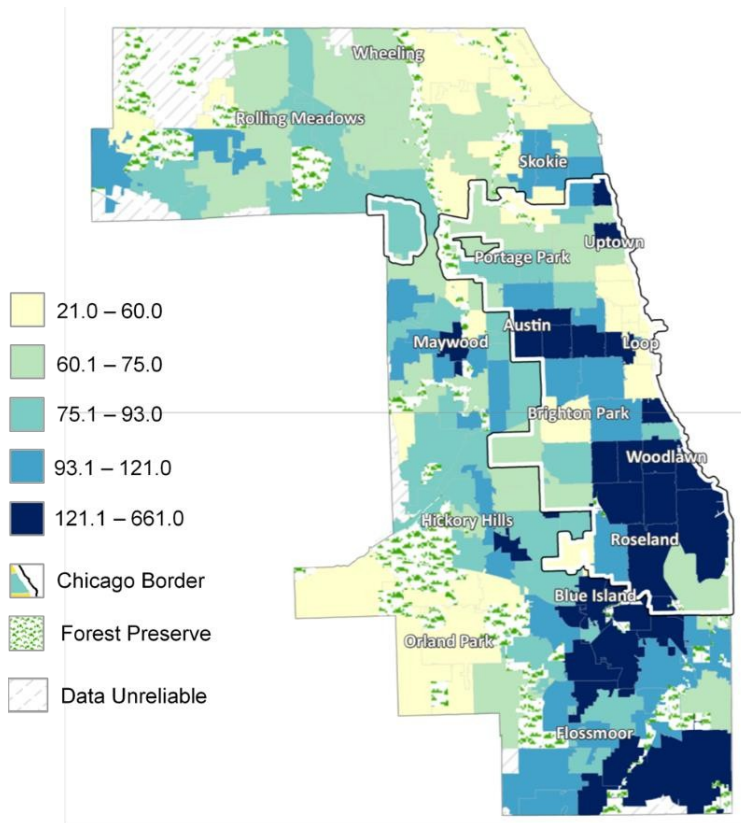
Stigma and discrimination

- Assessments of mental health needs across Chicago indicate that stigma and discrimination against people with mental illness and substance use disorder persists in communities, schools, workplaces, and even in health care settings. For older adults, ageism combines with stigma to overshadow mental illness when symptoms are dismissed as part of a normal aging process.
- Stigma deters people from seeking treatment before a crisis, and the experience of discrimination discourages ongoing engagement with treatment.
- Insurance parity laws and mental health awareness training resources create opportunities to reduce stigma and fight discrimination, while the national response to the opioid crisis has increased mainstream attention to individual lived experiences of both substance use and harm reduction.
- Any progress in reducing stigma and discrimination is likely to increase demand for services. Yet community residents and referring medical providers already report barriers to access due to mental health professional shortages. Low reimbursement rates stifle the potential for workforce growth.

Behavioral Health - Utilization of emergency care

Mental health-related ED visit rates for adults in Cook County communities range from 21 per 10,000 to 661 per 10,000 illustrating that the need for quality community-based and preventative behavioral health treatment is staggeringly high in some communities. As shown in the map below, people living in the communities in Jackson Park Hospital's service area on the south side of Chicago experience the highest rates of emergency department visits for mental health.

Age-adjusted mental health emergency department visit rates per 10,000 (adults)



Illinois COMPdata, 2015-2017, Analysis conducted by Conduent Healthy Communities Institute

Suicide and intentional injury

Suicide among Black Chicagoans increased significantly between 2019 and 2020.

Deaths due to suicide by race/ethnicity

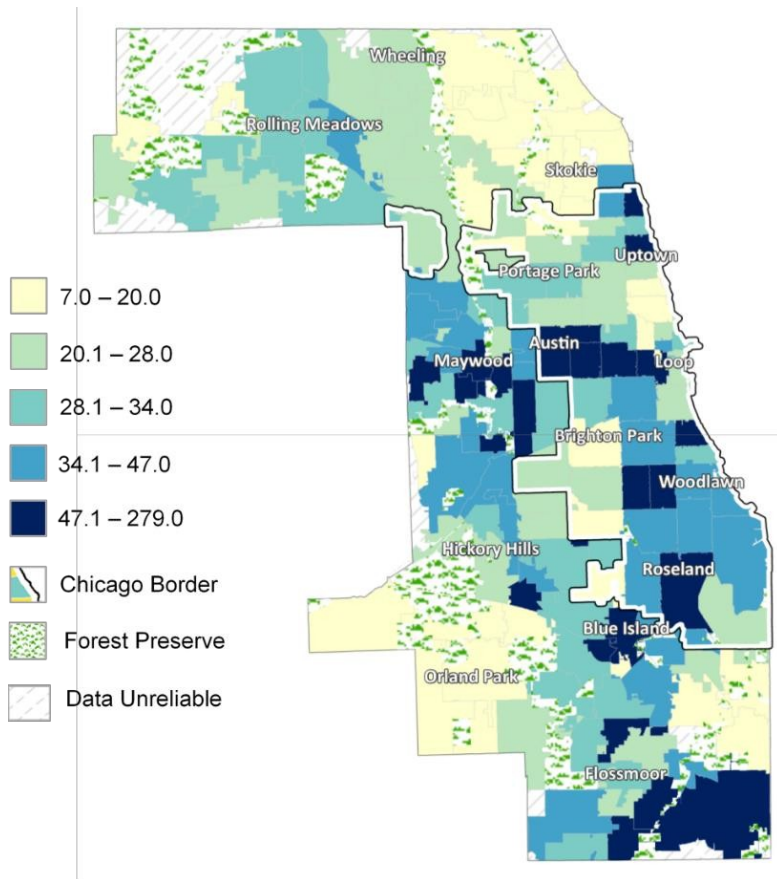
From January through June for each year

2020 suicide deaths 2019 suicide deaths Percentage change 2019-2020

Chicago

	2020 suicide deaths	2019 suicide deaths	Percentage change 2019-2020
White, non-Hispanic	36	71	-49%
Black, non-Hispanic	35	17	106%
Hispanic	18	25	-28%
Other, non-Hispanic	6	5	20%

Suicide/self-inflicted injury emergency department visit rates per 10,000, 2017 (Adults, age-adjusted rates)



Illinois COMPdata, 2015-2017, Analysis conducted by Conduent Healthy Communities Institute

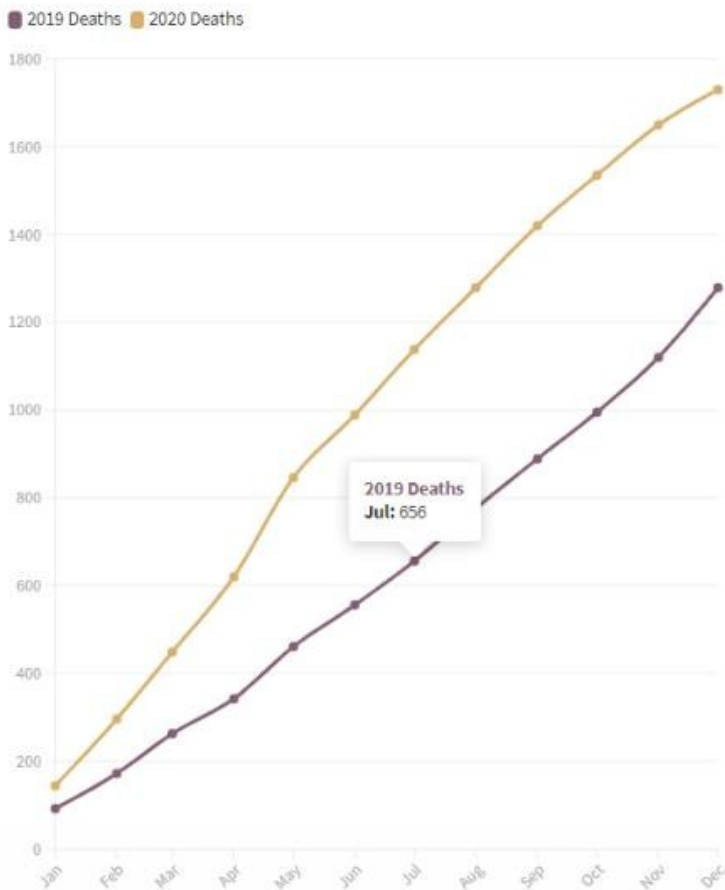
Substance use disorders

Opioid overdose deaths are increasing across Cook County and particularly on the south and west sides of Chicago. Chicago communities saw a dramatic uptick in 2020 amidst the COVID-19 pandemic. In Chicago, opioid-related overdose deaths increased by over 50% between 2019 and 2020. There are striking racial inequities in opioid overdoses statewide; Black Illinoisans are 5.5 times more likely to visit the emergency department for opioid overdose than White Non-Hispanic Illinoisans

Between January and June of 2020, there were 573 opioid-related deaths. While overdoses are experienced citywide, Chicago’s West and South Sides have an extremely disproportionate burden of overdose fatalities.

Cook County Opioid Deaths: 2019/2020 Comparison

Each line below shows cumulative Cook County opioid deaths for their year.



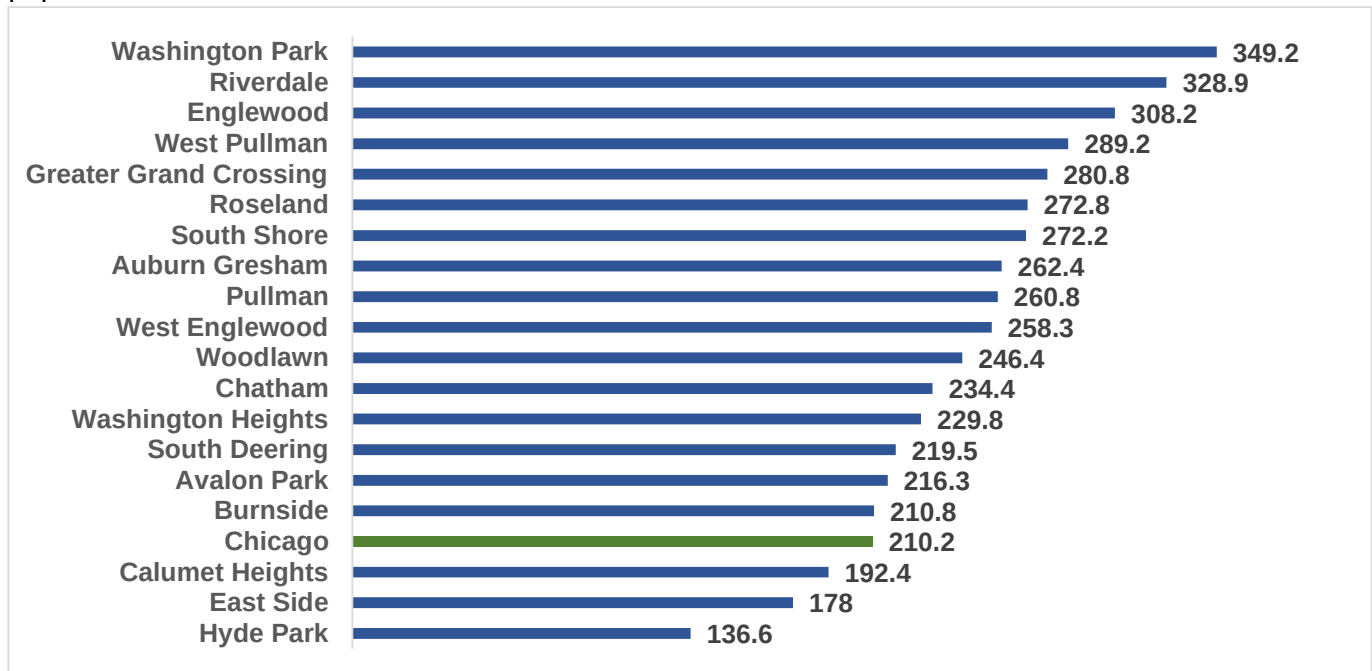
Source: [Cook County Medical Examiner Case Archive](#)

Community input, public health data, and assessment findings show that communities on the south side of Chicago (and across the City) need a mental health system that aligns programs, public agencies, and funding to provide accessible, affordable, culturally competent, and trauma-informed prevention and early treatment services as well as crisis intervention through partnerships that include schools and the justice system. Building and maintaining that system will require investments in housing, workforce development, data-sharing infrastructure, payment reform, and eliminating stigma.

Chronic Disease

Heart Disease

Heart Disease Mortality: Age-adjusted rate of people who died due to heart disease per 100,000 population, 2017

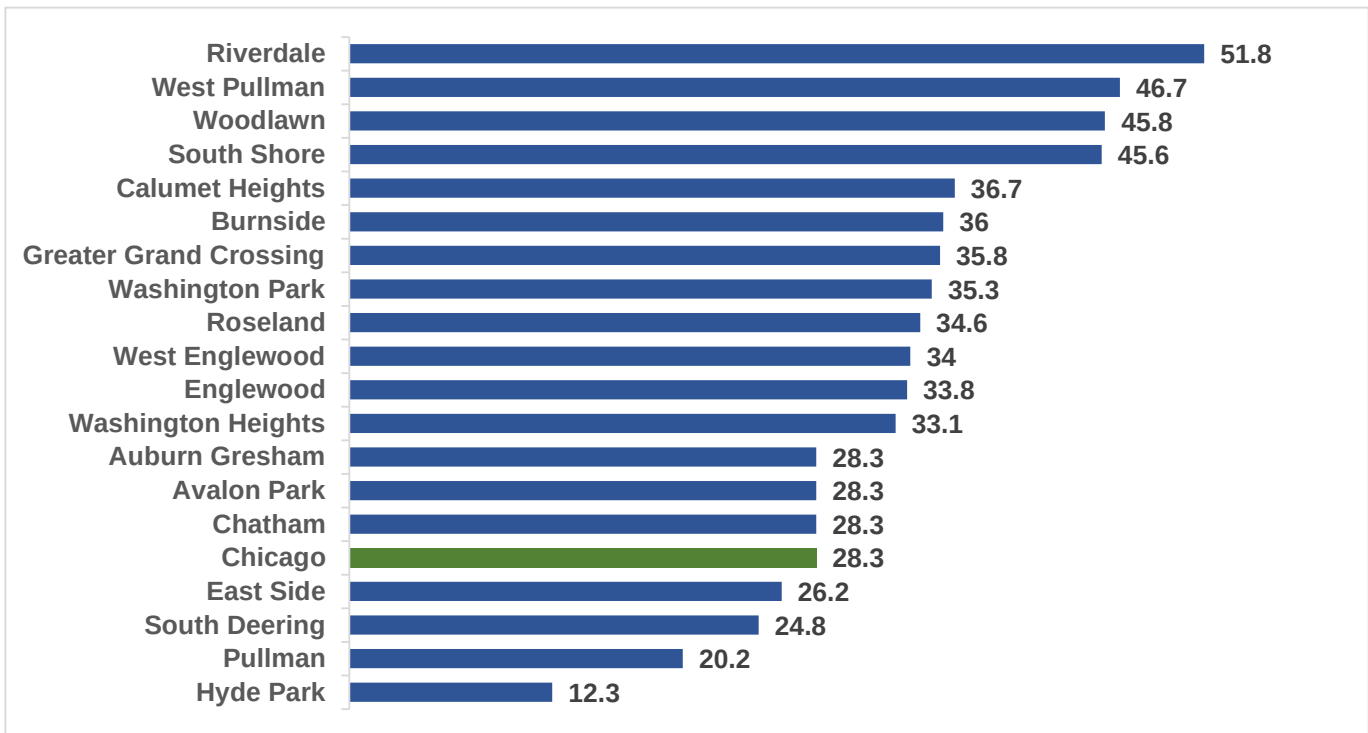


Data Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files; US Census Bureau. Five-year estimates for community areas, one-year estimate for Chicago.

The communities served by Jackson Park Hospital have rates of heart disease deaths ranging from 143.6 per 100,000 population (Hyde Park) and 361 per 100,000 population (Washington Park), with most of the communities having a higher rate than the Chicago average of 207.4 per 100,000 population.

Diabetes

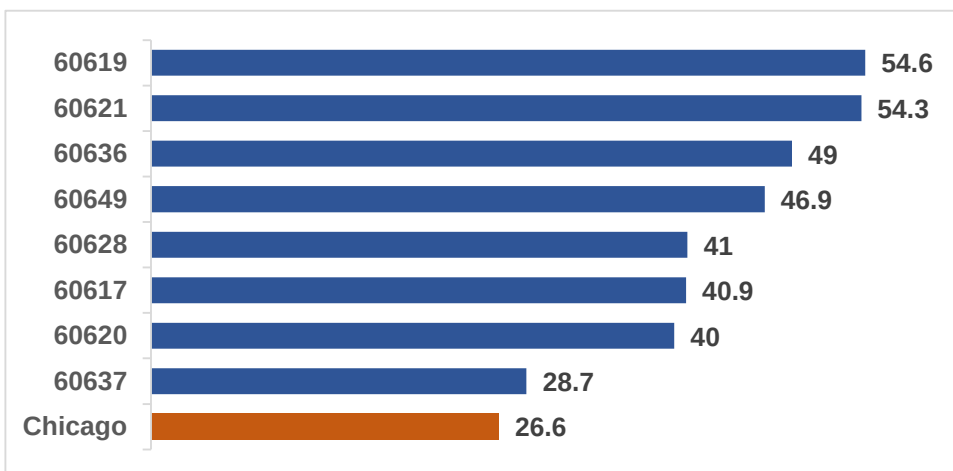
Diabetes Mortality: Age-adjusted rate of people whose deaths were diabetes-related, per 100,000 population, 2017



Data Source. Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files; US Census Bureau. Five-year estimates for community areas, one-year estimate for Chicago.

Diabetes mortality rates in Jackson Park Hospital's service area ranges from 12.3 per 100,000 population (Hyde Park) to 51.8 per 100,000 population (Riverdale). Most of these community areas have diabetes mortality rates higher than Chicago overall.

Diabetes Hospitalization: Age-adjusted rate of diabetes-related hospitalization discharges, per 10,000 population, 2017

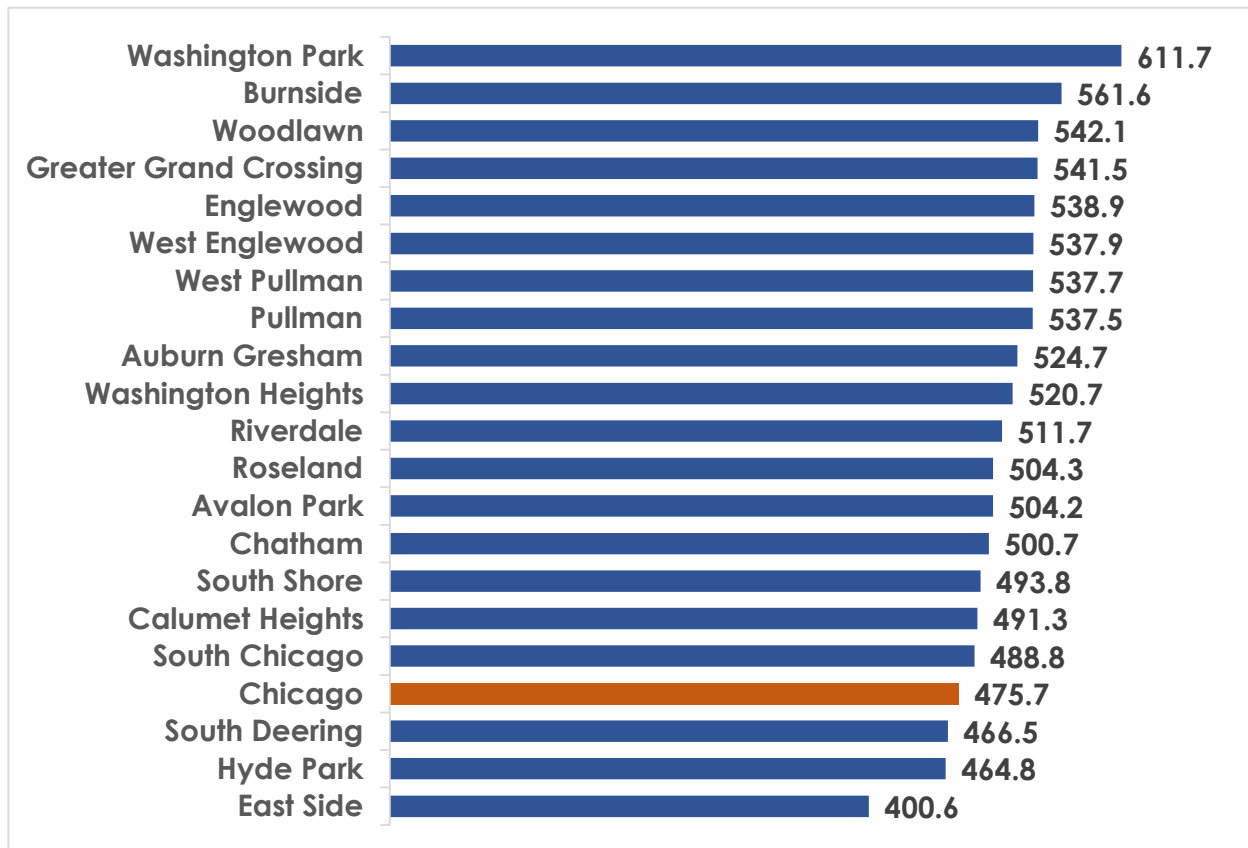


Data Source: Data, Division of Patient Safety and Quality, Illinois Department of Public Health; US Census Bureau.

The zip codes served by Jackson Park Hospital all have higher rates of diabetes-related hospitalizations than Chicago, with 60619 having the highest rate of diabetes-related hospitalizations at 54.6 per 10,000 population.

Cancer

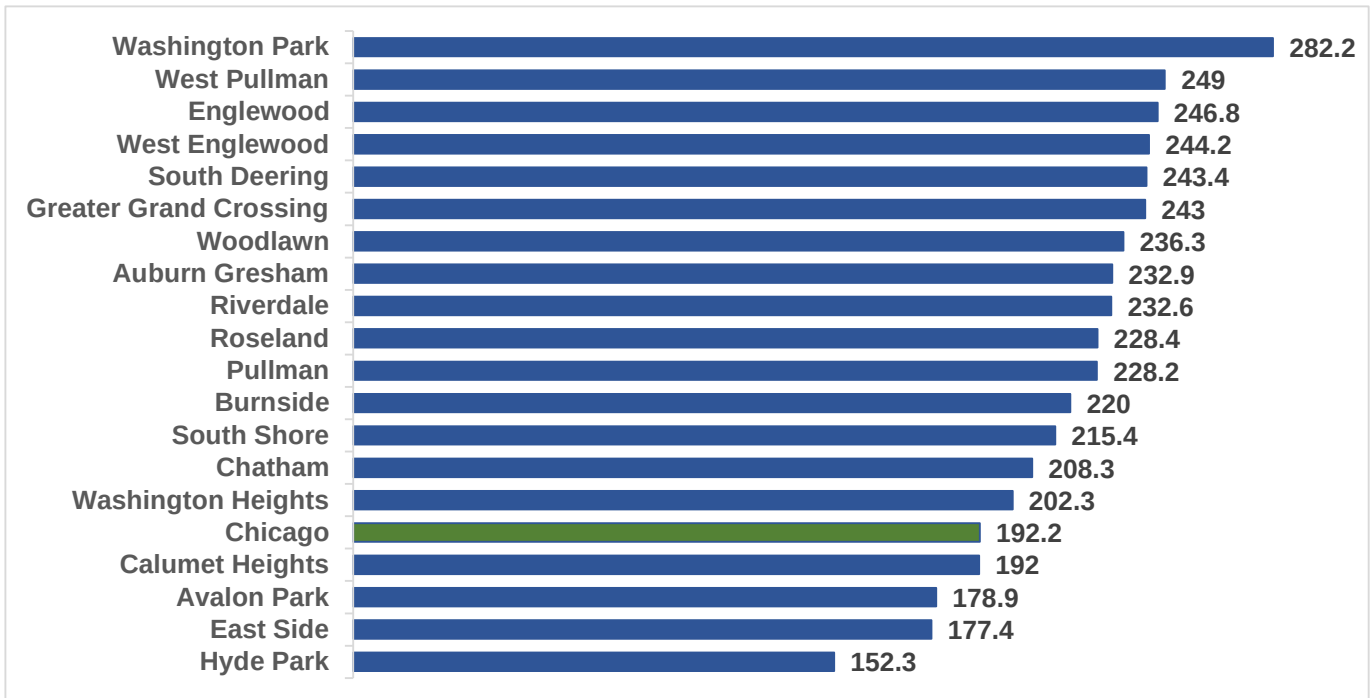
Cancer incidence: Age-adjusted rate of diagnosed incident cases of all cancer types per 100,000 population, 2015



Data Source: Illinois Department of Public Health, Illinois Cancer Registry.

Cancer incidence in these community areas ranges from 400.6 per 100,000 population (East Side) to 611.7 per 100,000 population (Washington Park). Most of the community areas have a higher incidence of cancer than Chicago overall.

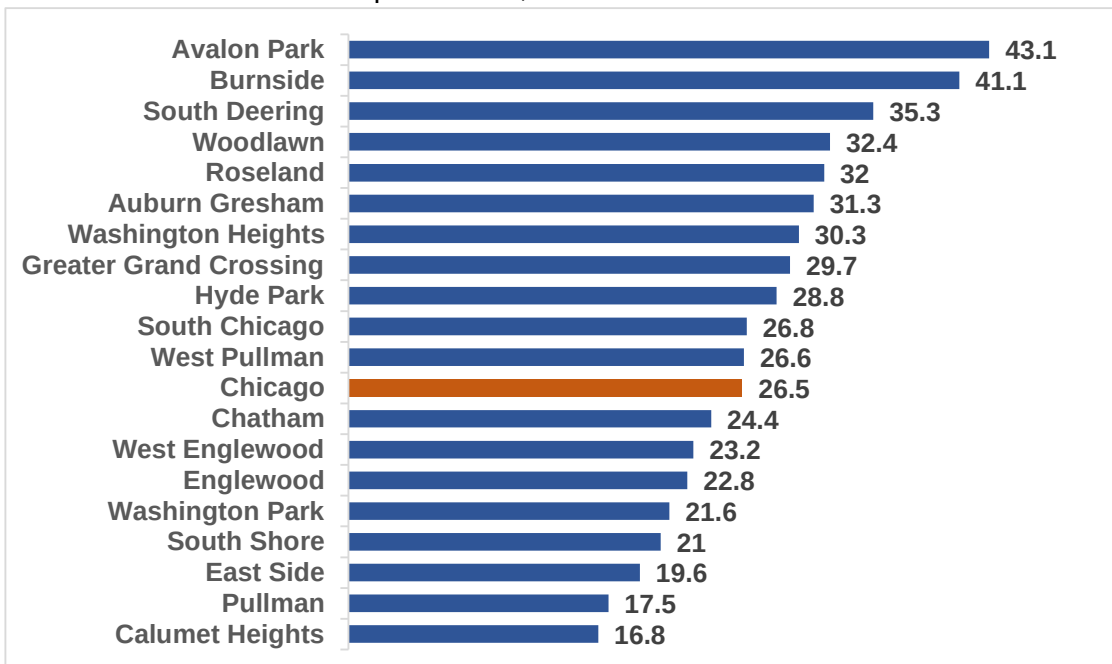
Cancer Mortality: Age-adjusted rate of people who died due to cancer per 100,000 population, 2017



Data Source: Illinois Department of Public Health, Division of Vital Records, Death Certificate Data Files.

Cancer mortality rates in the Jackson Park Hospital’s service area range from 152.3 per 100,000 population (Hyde Park) to 282.2 per 100,000 population (Washington Park). Most of these community areas have cancer mortality rates higher than Chicago overall.

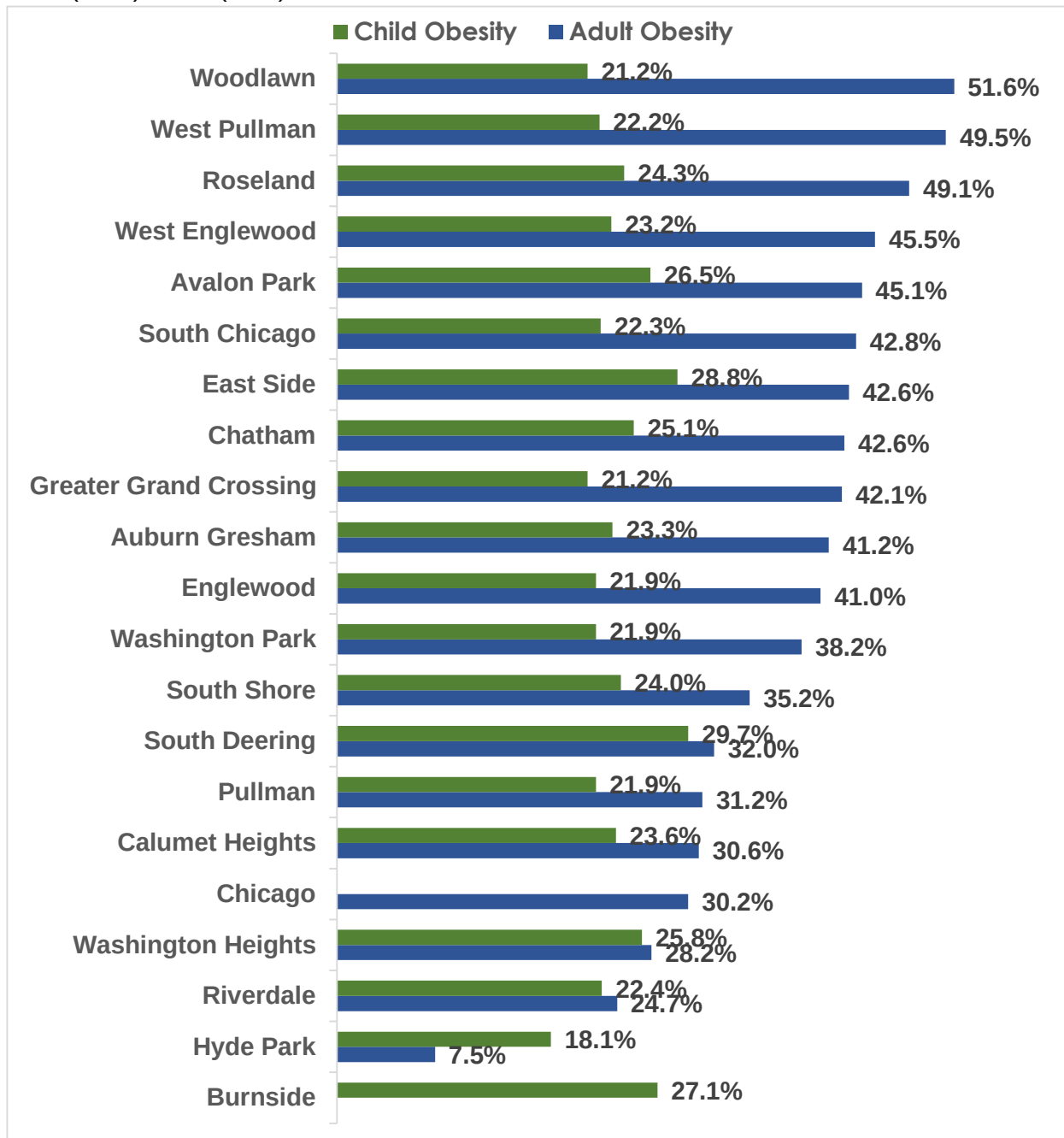
Physical Inactivity: Percentage of adults who reported that they did not participate in any physical activities or exercises in the past month, 2016-2018



Data Source: Chicago Department of Public Health, Healthy Chicago Survey (2016-2018). Three-year estimates for community areas, one-year estimate for Chicago.

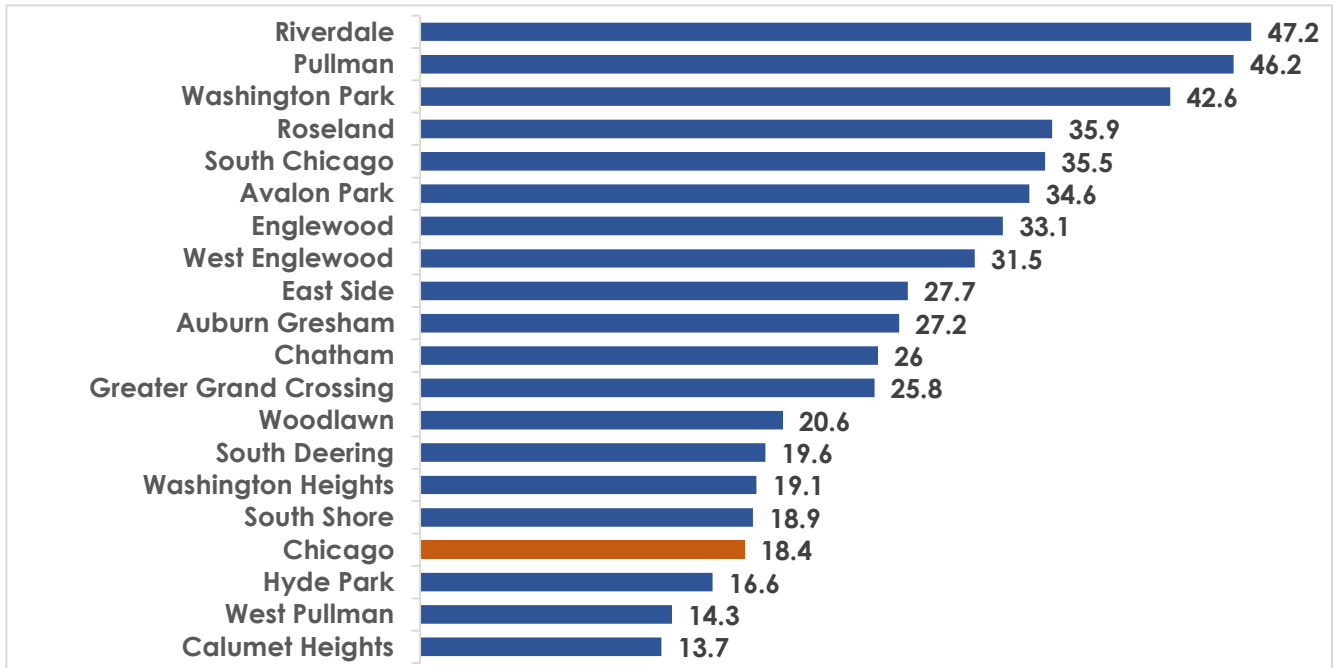
Between 16% and 43% of adults in Jackson Park Hospital's service area reported that they had not participated in any physical activities in the past month. Survey data may be less reliable in community areas with smaller populations (Burnside, Pullman, Washington Park, Avalon Park, and Riverdale).

Obesity in Adults and Children: Percentage of adults and children with a BMI that qualifies as obese, 2018 (adult), 2013 (child)



Adult data: CDPH Healthy Chicago Survey (2016-2018). Three-year estimates for community areas, one-year estimate for Chicago; Adult obesity defined as percentage of adults (18 years and older) who reported a height and weight that yield a body mass index of 30 or greater; adult obesity data unavailable for Burnside because of the small number of residents. Survey data may be less reliable in community areas with smaller populations (Pullman, Washington Park, Avalon Park, and Riverdale).

Current Smokers: Estimated percentage of adults who report that they've smoked at least 100 cigarettes in their life and that they currently smoke, 2016-2018



Access to Care and Maternal and Child Health

Access to health care is broadly defined as the “the timely use of personal health services to achieve the best health outcomes” (Institute of Medicine, 1993). Healthy People 2020 describes the three steps required for an individual to access health care services:

- gaining entry into the health care system;
- accessing a location where needed health care services are provided; and
- finding a health care provider whom the patient trusts and can communicate with (U.S. Department of Health and Human Services, 2019b).

There are several complex factors that further influence access to health care including proximity; affordability; availability, convenience, accommodation, and reliability; quality and acceptability; openness, cultural responsiveness, appropriateness and approachability.

Uninsured: Percentage of people with no health insurance coverage among the total civilian non-institutionalized population, 2017

Year 2017	Number	Rate
▼ Race-Ethnicity		
Chicago	263,376	9.8
Hispanic or Latino	136,933	17.5
Asian	14,177	7.8
African American or Black	58,862	7.4
Non-Hispanic White	50,072	5.6
▼ Age		
0-18	17,515	2.9
19-64	239,919	13.6
65+	5,942	1.8
▼ Gender		
Male	148,053	11.4
Female	115,323	8.3

Data Source: US Census Bureau: American Community Survey 2017.

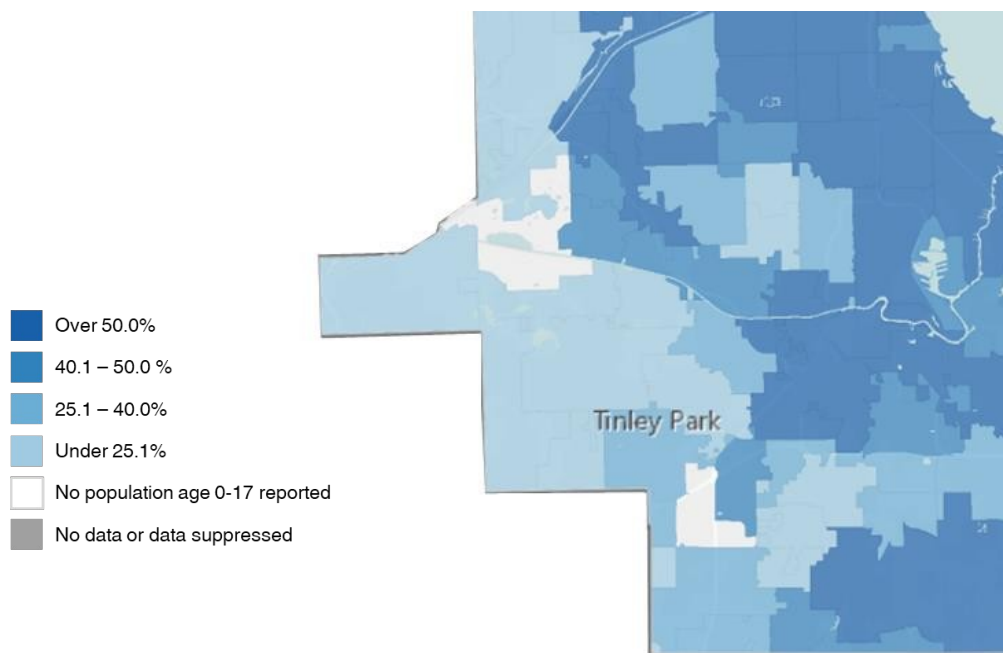
Pre-COVID in Chicago, 9.8% of the population reported being uninsured, including 17.5% of Latinx Chicagoans and 7.4% of Black Chicagoans. Several national studies in 2020 have estimated that the rates of uninsured have increased substantially over the past year with individuals and families losing coverage as they are laid off from work.

Also, as shown in the map below, most of the communities in Jackson Park Hospital's service area have a high proportion (over 40% pre-COVID) of children that receive coverage through Medicaid. Therefore,

availability of providers that accept Medicaid is very important in the communities served by Jackson Park Hospital.

Children receiving Medicaid coverage

U.S. Census Bureau, American Community Survey, 2012-2016



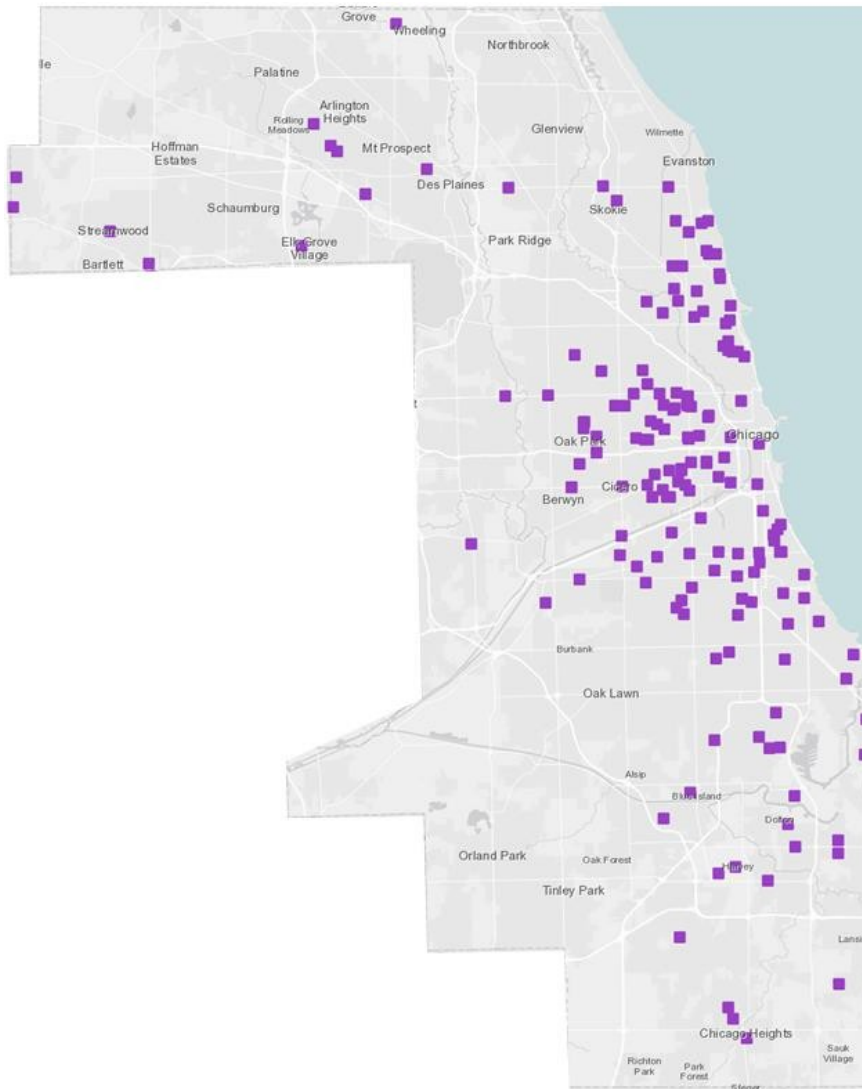
Map source: CARES Engagement Network

Federally Qualified Health Centers (FQHCs) have an important role in eliminating disparities in access to health care. For example, nationwide, most FQHC patients have low-incomes with 93% falling below the 200% Federal Poverty Level (FPL) and 72% below the 100% FPL (National Association of Community Health Centers, 2015). Besides primary and preventative care, most FQHCs provide behavioral, oral, vision, and pharmacy services (National Association of Community Health Centers, 2015). By law FQHCs must:

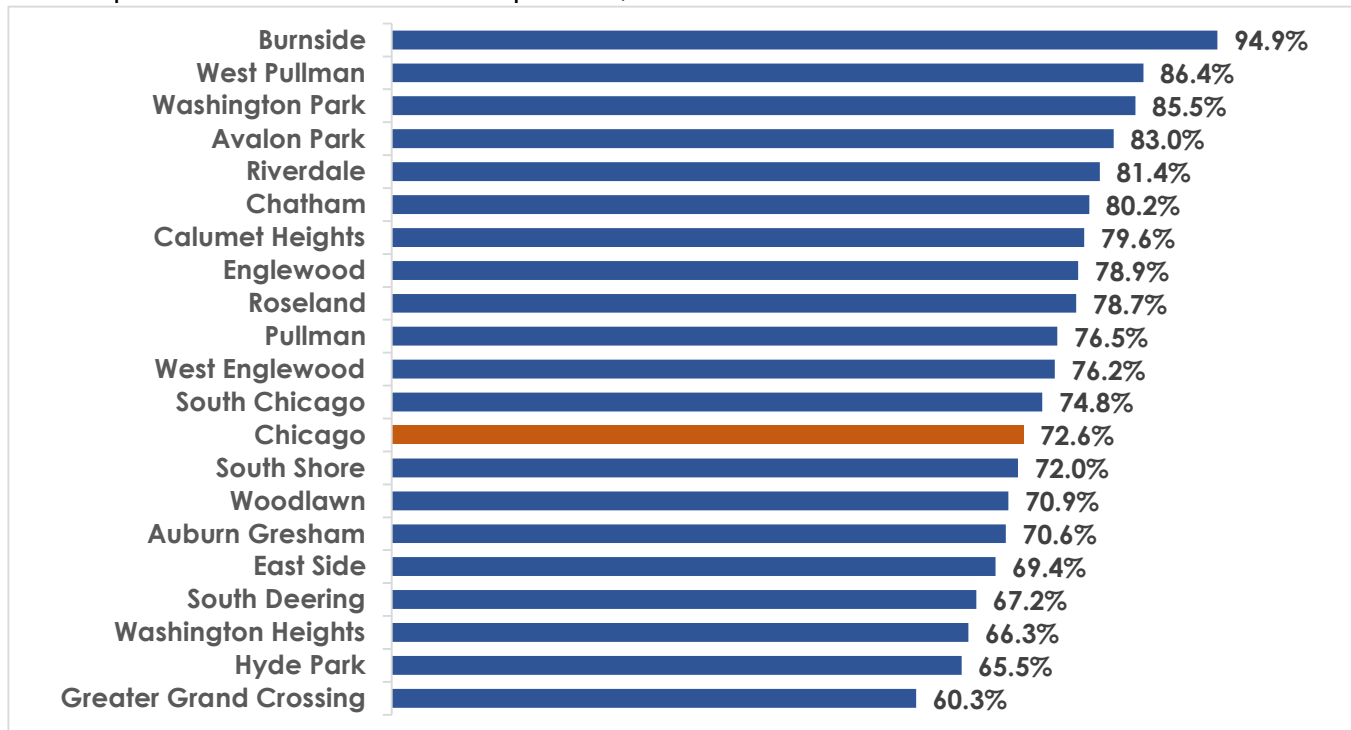
- serve a federally-designated medically underserved area or a medically underserved population;
- serve all individuals regardless of ability to pay;
- charge no more than a “nominal fee” to uninsured and underinsured individuals with incomes below 100% FPL, and charge uninsured and underinsured individuals between 101% - 200% FPL based on a sliding fee scale; and
- provide non-clinical enabling services to increase access to care, such as transportation, translation, and case management (National Association of Community Health Centers, 2015).

The map below shows the distribution of FQHCs across Cook County, including the south side of Chicago.

Federally Qualified Health Centers (FQHCs). CMS Providers of Service (POS) database, 2018



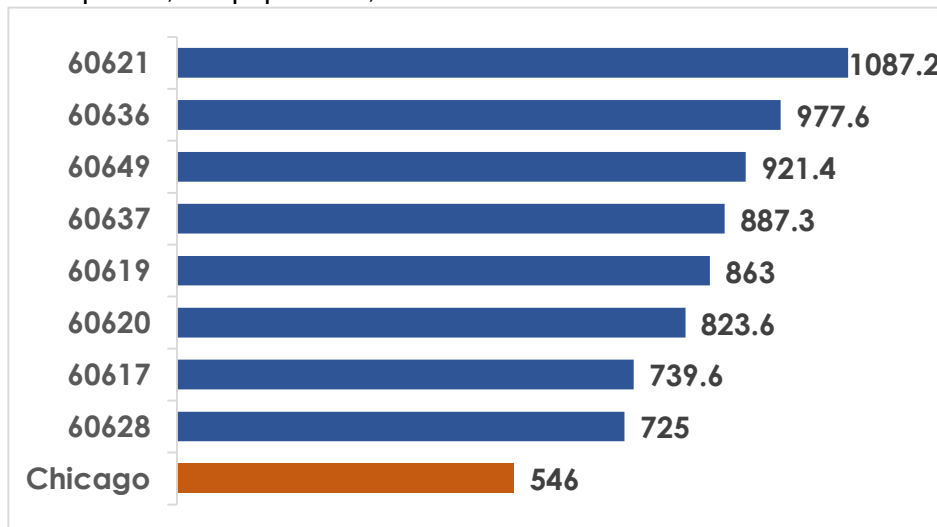
Primary Care Provider: Percentage of adults who report that they have at least one person they think of as their personal doctor or health care provider, 2018



Data Source: Chicago Department of Public Health, Healthy Chicago Survey. Three-year estimates for community areas, one-year estimate for Chicago.

In the communities served by Jackson Park Hospital, between 60.3% and 94.9% of adults report having a primary care provider. Survey data may be less reliable in community areas with smaller populations (Burnside, Pullman, Washington Park, Avalon Park, and Riverdale).

Avoidable emergency department (ED) visits, that are non-urgent or primary care treatable, age-adjusted rates per 10,000 population, 2017



Data Source: Discharge Data, Division of Patient Safety and Quality, Illinois Department of Public Health; US Census Bureau.

The zip codes served by Jackson Park Hospital all have higher rates of avoidable ED visits than Chicago overall, with 60621 having the highest rate of avoidable ED visits.

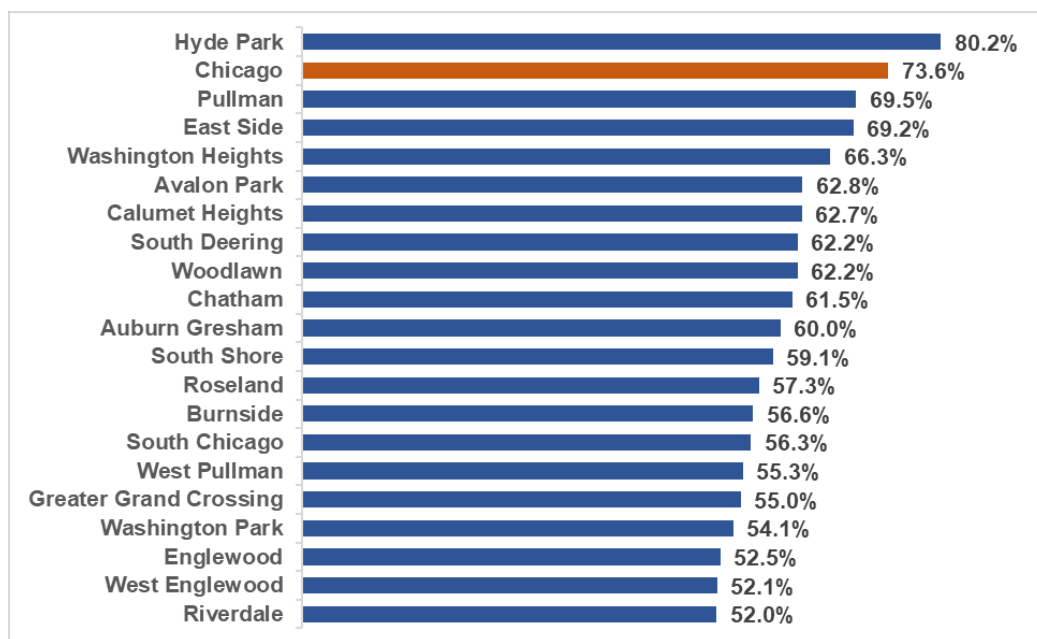
Health care quality can vary greatly between communities due to several factors including the geographic proximity of a spectrum of emergency or urgent care services, percentage of the population receiving public benefits, funding for community-based services, education and training levels of health care staff, and localized provider shortages. Race and ethnicity also play a critical role in the quality of health care that patients receive.

Previous studies have established that racial and ethnic disparities in health care are in part a result of differential access to care and differing socioeconomic conditions. However, previous research has also established that when these differences are accounted for, race and ethnicity remain significant predictors of the quality of health care received (IOM, 2015). For example,

- A study of patient weight, race, and provider communication quality found that overweight/obese African American patients and healthy weight Hispanic patients experienced disparities in provider communication quality (Wong, Gudzone, & Bleich, 2015).
- In a study of providers, physicians were more likely to rate their African American patients as less educated, less intelligent, more likely to abuse drugs and alcohol, and less likely to adhere to treatment regimens (van Ryn & Burke, 2000). The differences in perceptions persisted even after controlling for confounding variables (van Ryn & Burke, 2000).

Perceptions of discrimination in health care have been associated with several outcomes among patients of color including decreased use of preventative health care, delayed use of prescription medication and medical tests, and worse chronic disease management and outcomes (Hausmann et al., 2008; Trivedi & Ayanian, 2006; Van Houtven et al., 2005). In addition, research has shown that persistent exposure to racism is traumatic for individuals and that trauma is an underlying root cause of many negative health outcomes.

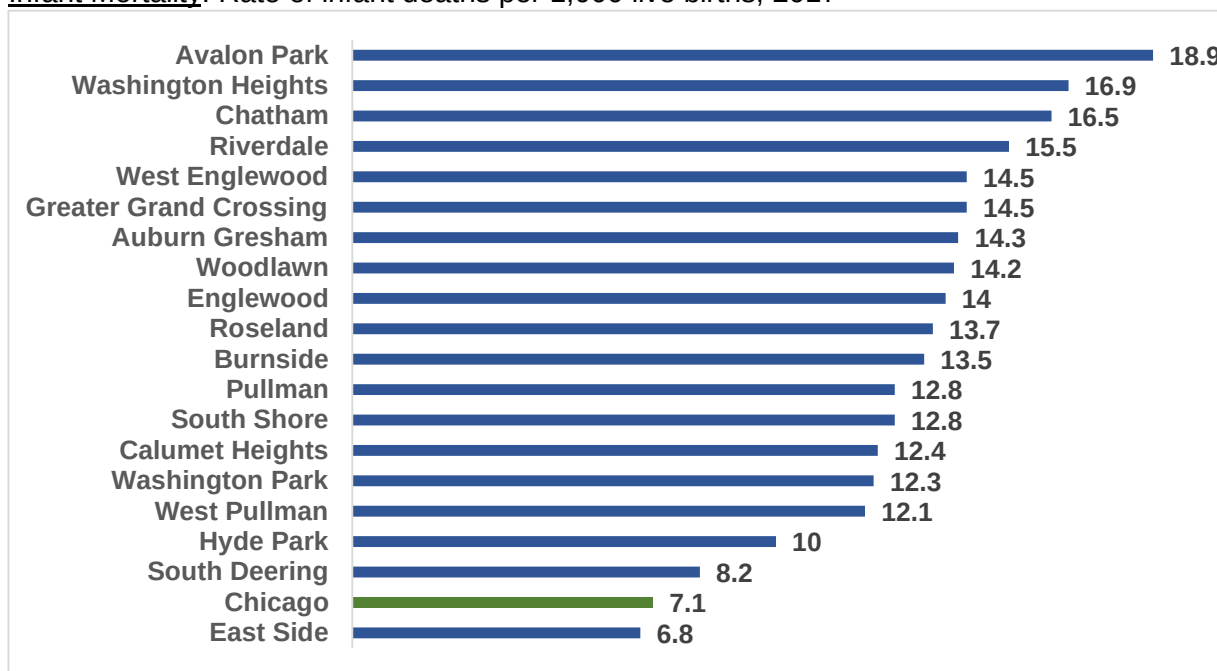
Prenatal Care: Percentage of births where the mother received adequate prenatal care by the Adequacy of Prenatal Care Utilization Index (APNCU), 2015



Data Source: Illinois Department of Public Health, Vital Statistics. Three-year estimates for community areas, one-year estimate for Chicago.

In the community areas served by Jackson Park Hospital, between 52% (Riverdale) and 80.2% (Hyde Park) of mothers receive early and adequate prenatal care, with all but one community area having a lower rate of early and adequate prenatal care than the Chicago average of 73.6%.

Infant Mortality: Rate of infant deaths per 1,000 live births, 2017

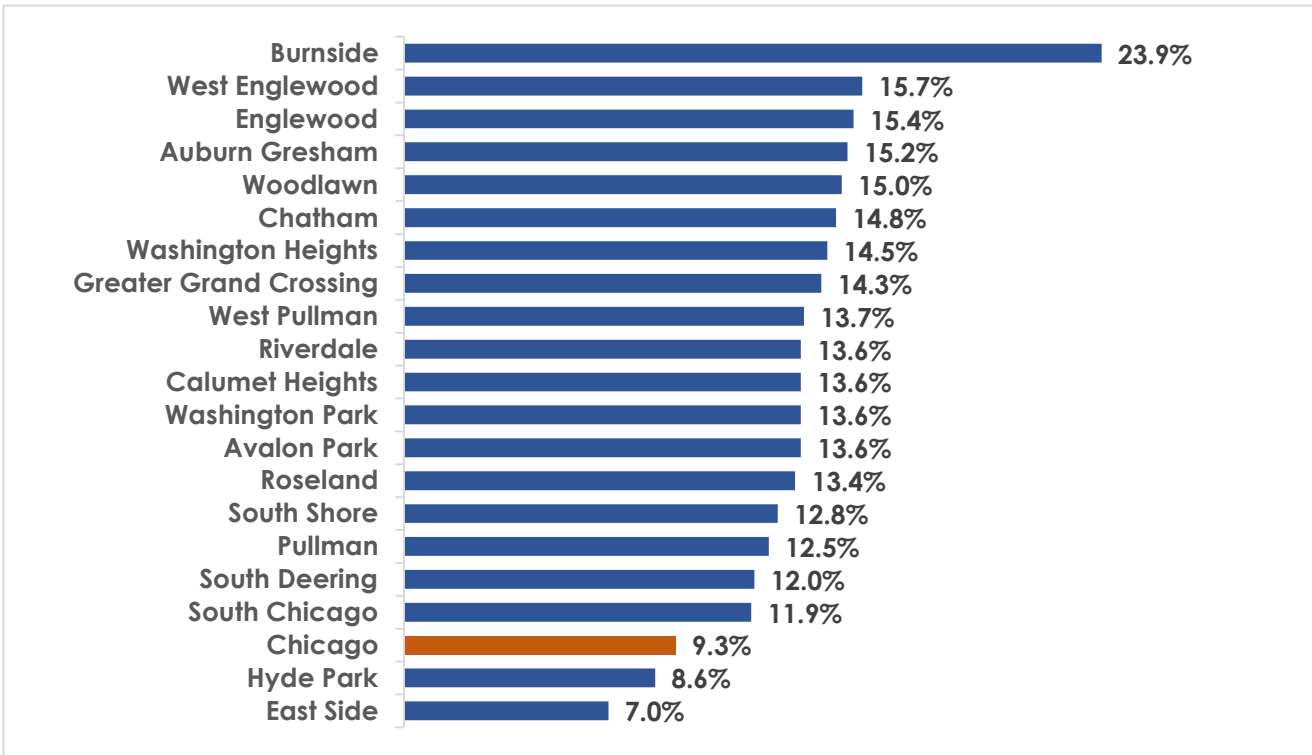


Data Source: Illinois Department of Public Health, Vital Statistics. Five-year estimates for community areas, one-year estimate for Chicago.

There are high rates of infant mortality in the Jackson Park Hospital service area. All but one community area has a higher rate of infant mortality than Chicago overall.

A recent Illinois Department of Public Health (IDPH) report also pointed to disparities in maternal mortality as a major public health issue that disproportionately impacts Black communities in Chicago and across the state.

Low Birthweight: Percentage of births with a birthweight less than 2500 grams, 2013-2017



Data Source: Illinois Department of Public Health, Vital Statistics. Five-year estimates for community areas, one-year estimate for Chicago.

Almost all of the community areas served by Jackson Park Hospital have a higher percentage of babies born with a low birthweight than the Chicago average.

Appendices

Appendix 1. List of community-based organizations and assets

Federally Qualified Health Centers (FQHCs) on the South Side of Chicago

- Access Community Health Network
- Beloved
- Chicago Family Health Center
- Christian Community Health Center
- Cook County Health, Ambulatory Care Centers
- Friend Health
- Heartland Alliance Health
- Howard Brown Healthcare
- IMAN
- TCA Health

Community Mental Health Centers on the South Side of Chicago:

- City of Chicago Mental Health Clinics
- Gateway
- Healthcare Alternative Systems (HAS)
- HRDI
- Roseland Community Triage Center
- Thresholds

United Way Neighborhood Networks on the South Side of Chicago

- Auburn Gresham / Greater Auburn Gresham Development Corporation
- Bronzeville
- South Chicago / Claretian Associates

LISC Community Development Quality of Life Plans on the South Side of Chicago

- Auburn Gresham
- Englewood
- Back of the Yards
- Bronzeville
- Quad Communities

Homeless Service Organizations on the South Side of Chicago

- Margaret's Village
- Featherfist
- Zacchaeus House
- Family Rescue
- Ignite (formerly Teen Living)

Appendix 2. Summary of community input from key informant interviews

Summary of community input from key informant interviews

The Illinois Public Health Institute (IPHI) conducted eight (8) key informant interviews with community members that live in Jackson Park Hospital's service area during January-February 2021. Because of COVID-19 precautions, all interviews were conducted by phone. The majority of the community members we spoke with were older adults along with about three younger people. Two of the people we interviewed also identified themselves as faith leaders.

Key Community Issues, as identified by key informants

- COVID-19
- Access to Healthcare and Wellness Education
- Mental Health
- Substance Use Disorders
- Economic Opportunity and Jobs
- Community Safety Issues
- Education and Youth Development
- More funding to local community organizations and services

COVID-19 and Access to Care

- Given the timing of these interviews (Jan/Feb 2021), there was a lot of discussion and questions about vaccine access.
- COVID-19 has caused a lot of ongoing health problems and trauma in the community, particularly in African American communities in Chicago.
- COVID has shown disparities in access to care, especially on the South Side of Chicago.
- People with chronic conditions like heart disease, high blood pressure, lung disease, obesity, and diabetes were most impacted by bad outcomes in COVID. Shows the need to continue to address these chronic conditions in our community.
- Many people, across all generations, are dealing with isolation and mental health issues during COVID. This particularly affects seniors and young people in our community.

Access to Healthcare and Wellness Education

- Overall medical services for prevention, education, and early detection.
- Need for mental health services and also treatment options for opioids and substance use disorders.
- Need for dental and eye care.
- COVID has shown the need for services directly in the community and mobile options and home care.
- Continued need for senior wellness checks.
- Need for connection between healthcare and social services like food access, homeless services, employment help, services for families and children, services for older adults, etc.
- Continued need for women's health services on the south side of Chicago and also for prenatal care.

- There is a need for classes for parents and families to support them in raising mentally and physically strong children.

Mental Health and Substance Use Disorders

- COVID and the events of 2020 show this is a major need – both mental health and also treatment for substance use disorders including alcohol and opioids.
- More locations for people to receive services, both for mental health and for substance abuse. Several people mentioned having family members or neighbors who are not able to access the services they need.
- One person we talked to works in the mental health field and agrees there are not enough services available especially for people with Medicaid or uninsured/underinsured.
- Better linkages and connections between mental health services and other healthcare.
- Faith communities are also providing important mental health and spiritual care for community members.
- People of all ages need to learn how to handle depression and also be resilient to trauma.
- The people we interviewed identified that some people in their communities don't feel comfortable seeking care for mental health, that there is still stigma about mental health in the community.
- A few people we interviewed also identified that homelessness related to mental health conditions was a concern in the community, and that homeless are some of the most vulnerable in the communities on the southside.

Economic Opportunity and Jobs

- COVID has caused a lot of layoffs, less hours for some, and difficulties for local businesses.
- We all need to come together to support local business opportunities and jobs in the community for youth and for families in our south side communities.
- Pipelines for healthcare careers from the local community that start in the schools and continue through college. And, pathways to advance in health careers as well.
- For youth and for people who are laid off, there is a need for more free training program and especially training and job opportunities in high-demand careers.
- Needs for youth also tie into education.

Community Safety

- Children, youth, and their families need safe places to play.
- Seniors in the community sometimes don't feel safe going outside and can be isolated. (both because of community safety and violence concerns and because of COVID concerns)
- There are a number of organizations that sponsor community events and those organizations need our support and funding and resources to continue their work. There is a need to have more opportunities for neighbors to know each other.
- Faith communities are important partners in addressing safety, trauma, and positive opportunities for youth.
- There should be partnerships between community organizations, healthcare, mental health, and police and the City to support community safety.

Education and Youth Development

- Many children and families have struggled during the COVID-19 pandemic, and there is a need to focus on education in the coming years as we come out of the pandemic.
- Teachers need extra support in classrooms to support students and the issues they are dealing with, especially now with COVID.
- Extracurricular youth development programs are needed in greater numbers, and community members need to know about the ones that do exist.
- Intergenerational activities to ensure everyone feels included in the community. Affordable places for families to enjoy healthy activities together.

Key Community Strengths

- Local School Councils, faith-based organizations, block clubs, community development organizations, and other community groups
- In some communities in the Jackson Park service area, there is a strong sense of community and ties to a vibrant history but it seems to vary across communities and some don't have as much of connection and sense of community. Those communities need support.
- In many areas across the Jackson Park service area, there is a strong sense of spirituality and faith-based leadership on community issues.
- Community-based safety net providers like Jackson Park Hospital are needed in the community and appreciate the community-based services.

Appendix 3. Summary of Jackson Park Hospital's work on 2019 implementation strategies

Jackson Park Hospital Foundation
 CHNA Implementation Strategy, Fiscal Years 2019-2021
 Update as of March 5, 2021

Goal 1.A. Provide comprehensive medical and social services to older adults (55+) to maintain and improve independent living, with a particular focus on residents of senior buildings.

- Free transportation to all clinic appointments
- Multidisciplinary team dedicated to the senior's care
- Dedicated specialty unit for all seniors who require admission to the hospital
- Discounts on prescriptions, and free delivery of prescriptions

Plan for Measuring and Tracking Impact:

1.A. Jackson Park Hospital will track number of seniors served through the Golden L.I.G.H.T. program, use of different services and benefits by Golden L.I.G.H.T. participants, and satisfaction with the program.

Update:

Due to the COVID 19 pandemic, all marketing and education services under the Golden L.I.G.H.T. umbrella have been suspended indefinitely. The staff has been re-deployed in assisting discharged patients follow up with their primary care physicians by making appointments with the physician and transportation.

1.B. Jackson Park Hospital will keep a log of the transportation trips provided and types of services used by patients served through transportation. This log will track transportation provided for the Golden L.I.G.H.T.

program as well as expanded transportation services. Since this is a new program and service, there is not a baseline available as of May 2018. We will establish a baseline by September 2018 as well as targets for increased service. We will also look into opportunities to track patient and provider satisfaction with transportation services.

Update:

Since we began free transportation to all clinic appointments we have recorded 6,062 trips. In addition to clinic appointments, we will transport patients for our specialist, physical therapy, surgery, oncology and ancillary testing.

1.C. Jackson Park Hospital and First Source keep records of individuals enrolled in insurance coverage and patients' use of charity assistance.

Update:

For the twelve ending December 31, 2020, First Source has assisted 554 individuals enroll into a health insurance plan to cover their inpatient stay. They also assisted 1,763 individuals obtain health insurance to cover their outpatient expenses. They have also assisted 1,238 individuals obtain charity assistance from the hospital which amounted to \$9,996,292 in charity care in 2019 and \$7,085,908 in 2020. Through January 31, 2021 (nine months), the hospital has provided \$5,366,798 in charity care.

Behavioral Health (Mental Health and Substance Use)

Goal 2.A. Increase access to Suboxone treatment in the community.

Strategy: Implement a program to provide Suboxone treatment in both inpatient and outpatient settings.

Update:

In April 2020, the hospital began to provide Suboxone treatment on an inpatient basis. Outpatient Suboxone treatment has been limited again because of the effects COVID 19 has had on the City of Chicago.

Goal 2.B. Explore development of telehealth services for outpatient mental health.

Strategy: Explore development of telehealth services for outpatient mental health.

Update:

The hospital and one of its leading Psychiatrists researched the cost of developing telehealth services at the hospital. It was determined that the cost of implementing this new program along with the startup cost could not be supported alone. This item may qualify as a transformation program request with the State of Illinois once the transformation program is approved by the legislators.

Goal 2.C. Explore partnerships for promoting mental health wellness in the community.

Strategy: Work with the Alliance for Health Equity and community-based partners to understand opportunities for partnerships related to models for serving people with behavioral health needs in the community such as drop-in center/welcoming center/living room, addressing barriers to medication access, and community trainings such as mental health first aid.

Strategy: Identify ways to leverage existing outreach staff and events to share information and health education on behavioral health. Develop new relationships with community-based partners as part of the 1115 waiver program that is in various stages of implementation by the State of Illinois.

Update:

The 1115 waiver program has been delayed by the State of Illinois. Until this program has been started by the State, the hospital does not want to start any new programs that may interfere with the 1115 waiver program. The hospital is recruiting a Board Certified Psychiatrist to provide outpatient behavioral medicine services to the community as part of our Family Practice residency program.

Chronic Disease Prevention

Goal 3.A. Increase community access to wellness resources, knowledge of chronic disease risk factors, and chronic disease prevention through health education and prevention services in the community.

Strategy: Provide access to chronic disease prevention and management services through three clinics: smoking cessation clinic, weight management clinic, and diabetes clinic.

Strategy: Provide chronic disease services and education/outreach to older adults through the Golden L.I.G.H.T. program.

Strategy: Partner with community organizations, agencies, and businesses to provide prevention and wellness services within the community including health screenings, health education, training and/or seminars. This includes:

- Hospital outreach staff visit surrounding neighborhoods, participating in events and health fairs, providing information and services not only to people who are sick but also to teach community residents how to stay healthy.
- Free blood pressure/hypertension screenings, and diabetes risk assessments
- Information on health and nutrition, breast self-exams and mammography, P.S.A. lab testing, and pulmonary function testing at outreach events
- Clinical experts from the hospital providing health education and answering community questions via community seminars and radio talk shows
- The hospital sponsors a Family Practice Residency program that has 18 medical Residents. These residents see patients at local supportive living facilities as well as skilled nursing homes in addition to the patients they serve at the hospital.

Update:

Because of the pandemic, the hospital has postponed all of its outside community activities until the governor and mayor have lifted all travel restrictions in the City and State,

Goal 3.B. Explore partnerships for community-based chronic disease prevention related to nutrition and diet, diabetes, obesity, cancer, and lung health.

Strategy: Work with the Alliance for Health Equity and community-based partners to understand opportunities for partnerships for community-based chronic disease prevention related to nutrition and diet, diabetes, obesity, cancer, and lung health.

Update:

After the governor and mayor have lifted all travel restrictions in the City and State, the hospital will work with the Alliance for Health Equity and community-based partners to understand opportunities for partnerships for community-based chronic disease prevention related to nutrition and diet, diabetes,

obesity, cancer, and lung health. The hospital is also ready to partner with the appropriate community organization to apply for transformation funds through the State of Illinois.

Maternal and Child Health, including Prenatal

Goal 4.A. Expand the hospital's role to partner with social agencies and community based providers and OB physicians to provide education in the community about prenatal care and increase the proportion of women who are accessing prenatal care. Strategy: Identify partners in the community to work together on prenatal care.

Goal 4.B. Increase community knowledge and resources on topics related to maternal and child health. Strategy: Expand outreach and education in the community on topics related to maternal and child health including: immunization, child nutrition, prenatal care, and mental health and substance use.

Plan for Measuring and Tracking Impact:

4.A. and 4.B. The strategies under goals 4.A. and 4.B. are new and in an exploratory phase. As any new programs or initiatives are developed and implemented, we will develop plans for measuring and tracking impact. Jackson Park Hospital anticipates providing education and resources on topics related to maternal and child health at 12 events in 2018.

Update:

After the governor and mayor have lifted all travel restrictions in the City and State, the hospital will work with the Alliance for Health Equity and community-based partners to understand opportunities for partnerships for community-based maternal and child health including: immunization, child nutrition, prenatal care, and mental health and substance use. The hospital is also ready to partner with the appropriate community organization to apply for transformation funds through the State of Illinois to address these needs.

Workforce Development

Goal 5.A. Explore partnerships for increasing community-based workforce development and retention in entry-level positions such as medical assistant (MA), constant observers, and others.

Strategy: Work with 8th Ward Alderman Michelle Harris, community partners, job training sites, and regional workforce collaborative to design a pilot project for workforce development.

Plan for Measuring and Tracking Impact:

5.A. The strategy under goal 5.A. is new and in an exploratory phase. As any new programs or initiatives are developed and implemented, we will develop plans for measuring and tracking impact.

Partners to Engage:

Hospital resource development leadership and staff, Alderman Michelle Harris, community partners, job training sites, and regional workforce collaborative.

Update:

After the governor and mayor have lifted all travel restrictions in the City and State, the hospital will work with the Alliance for Health Equity and community-based partners to understand opportunities for partnerships for community-based workforce development programs. The hospital is also ready to partner with the appropriate community organization to apply for transformation funds through the State of Illinois to address these needs.

Attachment 4

Section 10. Care Integration and Coordination

Question 1

Hucu.ai Sample Data Collection

Analysis of Patients Who Have Assessments

Breakdown of Acuity Scores

	100-76	75-51	50-26	25-0	Total Patients
Score:	100-76	75-51	50-26	25-0	
Number:	2	41	108	188	339
Percentage:	1%	12%	32%	55%	100%
Change:	0%	-1%	2%	-1%	30

Breakdown of Assessments

	# Patients	% of Patients	Change
Total Patients:	339	100%	
Given LACE Assessment:	110	32%	5%
Given Fall Risk Assessment:	223	66%	3%
Given Loneliness Assessment:	90	27%	8%
Given PHQ Assessment:	297	88%	1%
Given HS Assessment:	314	93%	0%

Took all 5 assessments	70	21%	5%
4 assessments	28	8%	1%
3 Assessments	110	32%	-3%
2 Assessments	111	33%	-3%
1 Assessment	1	0%	-7%

Case Manager	# Assessments Completed	Last Week	Change
Team Member A	171	132	39
Team Member B	124	104	20
Team Member C	121	128	-7
Team Member D	103	91	12
Team Member E	93	83	10
Team Member F	88	83	5
Team Member G	83	79	4
Team Member H	79	58	21
Team Member I	63	46	17
Team Member J	60	44	16
Team Member K	31	27	4
Team Member L	5	5	0
Team Member M	5	5	0
Team Member N	4	4	0
Team Member O	3	3	0
Team Member P	2	2	0

Attachment 5

Section 12. Jobs Existing Employees

Question 1

JPH Collaborative – Number of Existing Employees for
each Partner by Job Category and Zip Code

Jackson Park Hospital Employee Counts by Zip Code			
Zip Code	Clinical	Non-Clinical	Grand Total
46307	0	1	1
46311	1	0	1
46312	0	3	3
46321	1	4	5
46323	1	1	2
46324	1	0	1
46342	1	0	1
46394	0	1	1
46403	1	0	1
46404	0	1	1
46405	1	0	1
46406	0	1	1
46407	1	1	2
46410	4	3	7
60016	1	0	1
60020	1	0	1
60053	3	0	3
60056	2	0	2
60060	1	0	1
60068	1	0	1
60076	2	0	2
60077	1	0	1
60101	2	0	2
60106	1	0	1
60148	2	1	3
60181	1	0	1
60302	1	0	1
60402	1	1	2
60404	1	0	1
60406	0	1	1
60409	12	9	21
60411	3	0	3
60415	1	0	1
60419	10	5	15
60422	2	1	3
60423	2	1	3
60425	1	0	1
60426	6	2	8
60428	1	4	5
60429	0	2	2
60430	5	0	5

60435	1	0	1
60438	4	2	6
60439	1	0	1
60443	4	5	9
60445	0	1	1
60446	2	0	2
60449	0	1	1
60452	1	0	1
60453	2	1	3
60457	1	1	2
60459	1	0	1
60461	1	0	1
60462	2	0	2
60463	1	0	1
60466	3	2	5
60471	1	3	4
60472	2	0	2
60473	5	1	6
60477	2	1	3
60478	1	1	2
60482	1	0	1
60484	0	1	1
60487	2	0	2
60503	1	0	1
60517	3	1	4
60521	1	0	1
60523	4	0	4
60527	3	0	3
60532	1	0	1
60540	1	0	1
60544	1	0	1
60561	0	1	1
60564	3	0	3
60565	1	0	1
60586	1	0	1
60601	1	1	2
60605	4	0	4
60606	1	0	1
60607	1	0	1
60608	1	0	1
60609	3	1	4
60610	0	3	3
60611	1	0	1

60612	1	0	1
60613	2	0	2
60615	13	0	13
60616	14	2	16
60617	30	31	61
60618	1	1	2
60619	30	26	56
60620	19	12	31
60621	9	3	12
60623	2	2	4
60624	1	1	2
60625	1	0	1
60626	0	1	1
60627	0	1	1
60628	18	5	23
60629	7	3	10
60634	2	1	3
60636	6	5	11
60637	11	6	17
60638	1	0	1
60639	0	1	1
60640	1	0	1
60641	2	0	2
60643	8	13	21
60644	3	2	5
60645	2	2	4
60646	1	0	1
60649	42	22	64
60651	1	1	2
60652	10	5	15
60653	5	2	7
60655	0	1	1
60657	1	0	1
60659	2	0	2
60660	2	0	2
60712	2	0	2
60714	1	0	1
60804	0	1	1
60805	1	1	2
60827	9	5	14
60914	0	1	1
Grand Total	407	227	634

FGC Employee Counts by Zip Code			
Zip Code	Clinical	Non-Clinical	Grand Total
45249	0	1	1
46323	0	1	1
46409	0	1	1
60004	0	1	1
60007	0	2	2
60015	0	2	2
60016	1	1	2
60026	0	1	1
60035	0	1	1
60077	0	1	1
60103	0	1	1
60112	0	1	1
60119	0	1	1
60130	0	1	1
60133	0	1	1
60174	0	1	1
60175	0	1	1
60193	0	1	1
60202	0	1	1
60302	1	1	2
60303	0	1	1
60402	0	1	1
60403	0	1	1
60409	1	3	4
60410	0	1	1
60411	1	1	2
60419	0	2	2
60423	0	1	1
60424	0	1	1
60426	0	2	2
60429	0	1	1
60433	0	1	1
60434	0	1	1
60435	2	1	3
60436	0	2	2
60441	0	1	1
60443	0	2	2
60446	0	2	2
60447	0	1	1
60449	0	1	1
60450	0	1	1

60451	0	1	1
60456	1	1	2
60466	1	3	4
60471	2	1	3
60477	1	2	3
60484	1	1	2
60487	0	1	1
60501	0	1	1
60504	0	2	2
60527	0	1	1
60544	0	1	1
60546	0	1	1
60548	0	1	1
60558	0	1	1
60559	0	1	1
60586	0	1	1
60601	0	1	1
60605	0	1	1
60608	0	1	1
60609	1	4	5
60610	3	1	4
60611	0	1	1
60612	2	2	4
60613	0	1	1
60614	0	2	2
60615	0	2	2
60616	0	1	1
60617	3	2	5
60619	5	3	8
60620	0	2	2
60621	3	1	4
60622	0	1	1
60623	0	1	1
60624	0	1	1
60625	0	1	1
60626	1	3	4
60628	2	3	5
60629	0	3	3
60631	0	1	1
60632	3	1	4
60634	0	2	2
60636	0	1	1
60637	1	2	3

60640	0	1	1
60641	0	1	1
60642	0	1	1
60643	0	3	3
60645	0	1	1
60649	2	2	4
60651	0	2	2
60653	0	1	1
60655	0	3	3
60657	1	1	2
60660	0	1	1
60706	0	2	2
60707	0	1	1
60804	0	1	1
60827	1	1	2
60901	2	1	3
60914	8	3	11
60915	0	5	5
60950	0	2	2
60964	0	2	2
61341	0	2	2
61554	0	1	1
62301	1	1	2
62347	0	1	1
62521	0	1	1
62540	0	1	1
62561	0	1	1
62568	0	1	1
62626	0	1	1
62629	0	2	2
62638	0	1	1
62650	0	4	4
62675	0	1	1
62684	1	1	2
62690	0	1	1
62702	0	11	11
62703	8	4	12
62704	0	8	8
62711	0	3	3
62712	0	1	1
63401	0	1	1
77002	0	1	1
Grand Total	60	199	259

CCA Employee Counts by Zip Code			
Zip Code	Clinical	Non-clinical	Total
60181	0	1	1
Grand Total	0	1	1

Attachment 6

Section 12. Jobs New Employment Opportunities Question 3 Job Descriptions

Bridge/AIMS Care Coordinator Job Description

Duties and Responsibilities

- Provide Bridge/AIMS Model transitional care services to clients and their caregivers; follow the evidence-based protocols, assessments and timeframes accordingly; connect individuals to state, federal and community-based resources as appropriate; complete Illinois Department on Aging Comprehensive Assessment as needed; understand diagnosis specific protocols
- Conduct Bridge/AIMS comprehensive social work assessments before and after client discharge from the partner hospital; the pre-discharge assessment is completed at hospital or skilled nursing facility bedside; the post discharge social work assessment is completed in the patients' home within 24-48 hours of discharge
- Work directly with clients and caregivers to address unmet needs by connecting necessary care providers to each other or to the client/caregiver, exchanging health information in a timely manner, and setting up necessary community services before and after discharge; work with the client and family member for 90 days post discharge; connect the client/family member to long term services and supports if additional supports are needed following the 30-day intervention
- Develop and maintain partnerships with nonprofit and for-profit organizations involved in client care. Examples of organizations include, but are not limited to hospitals, home health agencies, home care agencies, community physicians and clinics, volunteer organizations, religious organizations, and local businesses involved in care provision
- Document transitions in accordance with local guidelines in the appropriate database and electronic medical record (as applicable)
- Be familiar with various Medicare and Medicaid regulations, the Affordable Care Act and The Readmissions Reduction Program and Bundled Payments for Care Improvement (BPCI)
- Be comfortable with data collection and analysis; work with appropriate staff in developing program reports and present to healthcare partners which includes outcome data (readmissions) and process metrics
- Attend various meetings with hospital personnel and present as appropriate i.e. readmission review, programmatic meetings etc.

Knowledge, Skills and Abilities

- Interpersonal communication and rapport development skills with older adults, family members and interdisciplinary teams
- Cultural competency of the community served; bilingual/bicultural as appropriate to the community
- Must be comfortable working in a variety of settings, with people's different living situations, and across all levels of socio-economic status.
- Experience in diverse community settings preferred – in particular, in Chicago's South Side
- Familiarity with state, federal and local community resources
- Client-centered, motivational, and empathic interviewing skills
- Comprehensive social work assessment skills
- Computer literacy (Microsoft Office suites)

Requirements

- Master's degree in social work
- 2-5 years of experience in healthcare, social services or a related field; healthcare experience strongly preferred
- Clinical experience with older adults and caregivers
- Driver's license and dependable mode of transportation

CHW Job Description

Duties and Responsibilities

- Provide health education and information to assist clients in achieving health goals by discussing behavioral risk factors, recommended lifestyle changes, and ways to reduce barriers to treatment adherence.
- Act as a member of the interdisciplinary team alongside patient, Bridge Care Coordinator, hospital staff including discharge planners, navigators, nurses social workers, and other providers
- Create tailored strategies for addressing community health concerns by assisting clients to overcome obstacles to care.
- Triage and address emerging Social Determinants of Health needs
- Build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, counseling, social support and advocacy.
- Address barriers that inhibit clients' access to health care and information.
- Conduct screenings, navigation services, one-on-one visits, groups sessions and phone calls within various community settings if needed
- Public Benefits enrollment assistance
- Provide social support to clients as needed
- Motivate and praise clients for even small accomplishments and assist them to develop strategies to overcome barriers in order to achieve their behavior change goals
- Mediate between participants and healthcare and social service systems or community resources (e.g. management of healthcare utilization) to improve the quality and cultural competency of service delivery.
- Advocate for individuals and communities to ensure clients receive the care they need in localized accessible settings
- Refer clients to community resources and follow up using various platforms (e.g. NowPow)
- Performs other duties as assigned.

Knowledge, Skills and Abilities

- A high school graduate or GED is required.
- 1-2 years of experience of working in community settings as a community health worker or navigator is desirable.
- The ability to work independently and solve problems along with strong multi-tasking, organization, communication
- Working knowledge of health information systems and Microsoft Office Suite are required.
- Ability to work comfortably and independently with technological platforms such as Excel, Epic, and Salesforce upon receiving training
- Experience in community service through volunteering, internships, committee service, community networks, etc. preferred.
- Experience working in and/or with communities of color
- Demonstrated knowledge and/or experience with care management-related service functions such as: patient interviews, discharge planning/social service basic assessment and referral processes, community resources.

- Must be comfortable working in a variety of settings, with people's different living situations, and across all levels of socio-economic status.
- Experience in diverse community settings preferred – in particular, in Chicago's South Side
- Excellent written and verbal communication and interviewing skills.
- Commitment to teamwork, collaborative approach and customer service focus preferred.
- Applicant must live in the Chicagoland area, have their own transportation with proof of current auto insurance, be able to navigate the Chicagoland area

FGC-Jackson Park Hospital - STAFF NURSE

Education and/or Experience:

Two years post degree experience in hospital or agency setting. Individual must possess good communication skills. General basic nursing and medical knowledge. Must have knowledge of substance abuse pathology. Must have knowledge of all state and federal rules and regulations.

Certificates, Licenses, Registrations: R.N. or L.P.N. registered in the State of Illinois and certified in CPR.

Reports to: Nurse Manager.

Essential Duties and Responsibilities:

Dispenses all medication uses at Family Guidance Centers under procedures set by DASA, DEA, and FDA. Monitors appropriateness of methadone and other medication dosages. Monitors physical well-being of clients and makes notes of specific findings. Confers with medical doctors on specific medical findings. Confers with counselors on cases as needed. Completes initial medical assessment results. Follows up on TB tests and reactive results. Follow up on recommendations and referrals made in medical visits. Update client records of prescriptions. Breathalyzing of clients as needed. Completes OASA reports of dispensing, methadone counts, and medical visits as needed. Complete nursing notes, doctors' orders. Ensures safekeeping of methadone and other prescription medications. Participates In utilization review and quality assurance. Performs other nursing duties and attends daily rounds as assigned.

Other Duties: as assigned.

Physical Demands: While performing the duties of this job, you will be regularly required to talk or hear. This is largely a sedentary role; however, some filing is required. You would be required the ability to lift files, open filing cabinets, and sit or stand as necessary. You would also be required to view a computer screen for long periods of time. Ability to communicate in English via phone, in writing, and verbally in conversation with different levels of staff patient families, and any outside patients.

1. The physical demands described are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.
2. While performing the duties of this job, the employee is frequently required to stand and walk, often up and down stairs. The employee is frequently required to sit; use hands or fingers, handle, or feel; reach

with hands and arms, and talk or hear. Specific vision abilities required by this job include close vision and ability to adjust focus. Employee must be able to utilize a computer, phone, etc. for extended period of time and write or type notes for at least two (2) to four (4) hours per day.

3. While performing the duties of this job, the employee may be occasionally exposed to blood or other body fluids. The noise level in the work environment is usually moderate

Schedule: Monday thru Friday: 6:15 am – 2:45 pm. Rotating Saturdays. Flexibility is Required.

Job Description Review: I understand the job description, its requirements, and that I am expected to complete all duties as assigned. I understand that job duties may be altered from these duties. I will support the Mission, Values, and Vision of Family Guidance Centers and the facility.

FGC-Jackson Park Hospital RECOVERY SUPPORT SPECIALIST

Education and Experience: An Associate's Degree required. A Bachelor's degree in Psychology, Social Work, or Counseling is preferred. Understanding of substance use disorders, mental disorders, and importance of well-coordinated care required. Knowledge of the local care service delivery system and skills in motivating patient behavior. A minimum of two years of experience working in the field of substance use and/or mental health is preferred.

Certificates, Licenses and Registrations: Certified Recovery Support Services (CRSS) is preferred.

Reports to: Program Manager

Essential Duties and Responsibilities:

Engages patients in treatment through motivational interviewing and motivational enhancement techniques.

Develops individualized Recovery Plans with patients that emphasize relapse prevention strategies and use of natural supports in patient's community.

Assists with monitoring patient engagement and communicate with the treatment team regarding patient attendance, participation and any barriers or needs to support treatment involvement.

Conducts recovery coaching groups providing recovery and relapse prevention education and support.

Conducts individual recovery support sessions to assist patients in following and strengthening ongoing relapse prevention plans.

Provides education both in group and individual settings on the appropriate use of medication assisted treatment (e.g.: Methadone, Suboxone, Vivitol).

Provides employment coaching in individual and group settings to assist patients in; identifying employment experiences and skills, identifying appropriate potential places of employment or

appropriate job training services, developing patient employment resumes, completing employment applications, preparing for job interviews, and strategies for successful adjustment to new employment.

Provides spiritual support groups that assist patients in identifying meaning in recovery and reasons for hope, strengthening a spiritual component to the recovery process that aligns with the patient's values and beliefs and that incorporates individual spirituality as well as spiritual support within the patient's community.

Conducts intake assessments and document in the electronic record.

Collaborates with patients to engage family members or other significant support people in the recovery process including probation officers, DCFS workers, 12 step sponsors, other healthcare providers etc. as appropriate.

Documents services provided in the individual patient record in a timely fashion and in accordance with IL.SUPR, SAMHSA, and FGC standards.

Maintains confidentiality of patient information in accordance with HIPAA and 42 CFR.

Demonstrates professionalism in working with patients, staff and other outside professionals or collateral contacts.

Assists in coordinating transitions for aftercare and discharge planning and conduct alumni/aftercare group session for patients who have completed treatment to assist in ongoing maintenance of sobriety.

Consults with FGC staff and the Mile Square team regarding patient needs for support related to housing, medical, dental, transportation, childcare, mental health or other needs.

Administers toxicology tests with patients and enter accurate toxicology information into database.

Ensures that all completed state and private drops are being logged into SAMMS.

Stores all toxicology tests, including urine specimens properly.

Packages and mails out all toxicology tests, including urine specimens, as scheduled.

Observes all toxicology tests, including urine drops appropriately and carefully.

Participates in supervision with assigned supervisor as well as appropriate continuing education activities related to care management and maintenance of relevant certification or licensure.

Dedicates a minimum of 50% of worktime to provision of billable services, with timely documentation, according to FGC and applicable state and federal guidelines.

Other Duties: Perform tasks which are supportive in nature to the essential functions of the job, recognizing that they be altered or redesigned depending upon individual circumstances.

Standard Requirements:

- Possess a working knowledge of FGC applicable Standard Operating Procedures (SOP).

- Knowledgeable of patient rights and ensures an atmosphere which allows for the privacy, dignity, and the well-being of all patients in a safe, secure environment.
- Attend in-service and other training events to continue education and expand knowledge to improve the quality of patient services.
- Demonstrate the ability to follow written and oral instructions and procedures.

Skills:

- Active reflective listening, ability to engage and motivate, de-escalation.
- Strong verbal and written communication skills.
- Ability to use analytical software.
- Ability to use calendar and scheduling software.
- Experience using desktop computers, copier, and fax machine.
- Experience using electronic mail software.
- Must have strong collaboration skills and the ability to work and travel to multiple sites in the course of each week if required. Leadership skills are necessary to ensure program development.

Physical Demands:

- The physical demands described are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.
- Ability to communicate in English via phone, in writing, and verbally in conversation with different levels of staff patient families, and any outside patients.
- While performing the duties of this job, the employee is frequently required to stand and walk, often up and down stairs. The employee is frequently required to sit; use hands or fingers, handle, or feel; reach with hands and arms, and talk or hear. Specific vision abilities required by this job include close vision and ability to adjust focus. Employee must be able to utilize a computer, phone, etc. for extended period of time and write or type notes for at least two (2) to four (4) hours per day.
- While performing the duties of this job, the employee may be occasionally exposed to blood or other body fluids. The noise level in the work environment is usually moderate.
- Ability to travel to multiple program sites; is flexible with time and travel; and has a current Illinois Driver's License and automobile insurance coverage. If required, must provide copies of driver's license and proof of insurance to Human Resources.

Schedule: 6:00 am – 2:30 pm, M-F and rotating Saturdays

Hospital-Based Counselor Job Description

Education and/or Experience: Bachelor's degree (or higher) and prior substance abuse treatment experience preferred. Will consider relevant internship experience in lieu of paid employment.

Certification, Licensure, Registrations: Licensure (LPC, LCPC, LSW, LCSW) or CADC certification preferred, and required within two years of starting work as a counselor. Clearances from CFS 689 Child Abuse and Neglect Tracking System, and CFS 708-C Background Check for Non-Licensed Contract Staff.

Reports to: AVP of Joliet Site

Essential Duties and Responsibilities:

- Assists in performing comprehensive psychosocial assessments with patients in order to determine appropriate level of care and discharge planning needs.
- Conducts informational/educational sessions providing appropriate materials to educate patients on addiction recovery and aftercare options.
- Complete opening and closing data collection tools (GPRAs), consents, locator forms, and other paperwork for STR program patients, and send to the designated contact person.
- Acts as coordinator for discharge needs of assigned patients. Maintains current knowledge of resources available within the community, maintains supply of resource materials to be distributed to patients when needed. Is able to network to obtain other resources for patients as needed.
- Works collaboratively in formulating an appropriate and realistic discharge care plan, communicating with the patient. Completes appropriate forms, and contracts all appropriate individuals to facilitate the transfer/linkage of patients to other community based agencies and services. Ensures all referrals are linked through follow-up.
- Documents all relevant clinical information pertaining to patients based on assessment, education, and discharge planning activity.
- Prioritizes and organizes work according to the acuteness of the situations presented.
- Treats patients with respect and dignity and maintains and respects the confidentiality of all patients in accordance with 42 CFR and HIPAA regulations. Maintains a professional demeanor at all times.
- Maintains good working relationships with hospital staff.
- Attends in-house and off-site trainings for continuing education, in order to expand knowledge, improve the quality of patient services, and to maintain licensure and/or certification at all times.
- Ability to use calendar and scheduling software, email, and agency's clinical software program. Experience using desktop computers, copier, and fax machine.
- Other duties as assigned, including but not limited to performing tasks which are supportive in nature to the essential functions of the job, but may be altered or redesigned depending upon individual or programmatic circumstances.

Physical Demands: Ability to communicate in English via phone, in writing, and verbally in conversation with different levels of staff patient families, and any outside patients.

1. The physical demands described are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform essential functions.
2. Ability to communicate in English via telephone, in writing, and verbally in conversation with different levels of staff, patients, and their families, as well as external clients.
3. The employee is frequently required to stand and walk. The employee is occasionally required to sit; use hands and fingers, handle, or feel; reach with hands and arms, and talk and hear. Must be able to lift a minimum of 25 pounds.
4. Specific vision abilities required by this job include close vision, distance vision, peripheral vision, depth perception, and ability to adjust focus. Employee must be able to utilize a computer, telephone, etc., for an extended period of time, and write or type notes for at least two to three hours per day.

Schedule: Sunday through Thursday 12:00pm – 8:30pm, with some flexibility required to meet patient, agency, and hospital needs.

Job Description Review: I understand the job description, its requirements, and that I am expected to complete all duties as assigned. I understand that job duties may be altered from these duties. I have noted below any accommodations that are required to enable me to perform these duties. I have also noted below any job duties that I am unable to perform, with or without accommodations. I will support the Mission, Values, and Vision of Family Guidance Centers and the facility.

Project Director

Education and/or Experience: Master's degree in Psychology, Social Work or Counseling, with 3-5 years of supervisory/management/program development in behavioral healthcare environment is required. Excellent working knowledge of program development concepts, ASAM clinical guidelines, DHS/OASA contractual language and deliverable expectations, JCAHO/CARF guidelines, and CSAT rules, regulations and guidelines. Knowledgeable in standard office equipment and software. Strong verbal and written communication skills.

Certificates, Licenses and Registrations: State of Illinois Licensed Professional Counselor or Licensed Social Worker required. IAODAPCA Certified Alcohol and Other Drugs Counselor (CADC) preferred. State of Illinois Licensed Clinical Professional Counselor or Licensed Social Worker or Licensed Clinical Social Worker preferred.

Reports To: Vice President - Hospital Based Programs

Essential Duties and Responsibilities:

Ensures that prompt and adequate service, from intake assessment through discharge, is provided according to contract guidelines and census parameters for all programs on site. This includes priority admission for special populations.

Ensures that substance abuse treatment is provided according to best practices and in accordance with ASAM criteria, CSAT guidelines, JCAHO requirements, and IL.DHS.SUPR licensure requirements.

Ensures that individual counseling, group counseling and case management services are provided (in type and frequency) to meet individual patient needs in accordance with treatment plans and program design.

Ensures that toxicology services are properly administered, consistently provided, sent for processing in a timely manner, and that the results are entered into SAMMS and incorporated into treatment interventions.

Reviews and approves clinical documentation overseeing both timeliness and quality of records.

Reviews and responds promptly to monthly internal performance improvement chart audits.

Coordinates services with counseling staff and medical team, assisting with recommendations for medication take home code changes, continued stay, and discharge decisions.

Makes recommendations for staff hires and discharges.

Trains new support staff and new clinical employees and interns.

Provides prompt performance evaluations, clinical competency reviews and help staff define learning and training needs as well as the development of future goals.

Ensures that both routine and emergency building/facility issues are promptly communicated with FGC or STBH Facilities Management, as applicable, and that action has been taken to resolve the issue.

Ensures FGC Team participation in all fire and safety hospital-wide codes/drills.

Ensures clear concise written reporting of any incidents and forward to FGC Risk Management Officer.

Knows and disseminates FGC policies and procedures, periodically reviewing key SOP areas with staff.

Actively contributes to a culture of high level communication by clearly modeling active communication to staff and soliciting information and feedback from staff and sharing with the management team.

Supervises dedicated Security Officers by scheduling, monitoring performance, providing performance counseling, documenting and conducting probationary/annual performance reviews.

Provides community relations interacting as appropriate with other providers and community members (eg. DCFS, local Police Dept., local businesses, treatment facilities, health and mental health service providers, etc.) and maintains active linkage agreements.

Serves as an effective role model for written and verbal communication.

Performs tasks which are supportive in nature to the essential functions of the job, but may be altered or redesigned, depending upon individual circumstances.

Attends in-service and other training events to continue education and expand knowledge to improve the quality of patient services.

Other Duties: Performs tasks which are supportive in nature to the essential functions of the job