

Healthcare Transformation Collaboratives Cover Sheet



1. Collaboration Name:

MyCorCare Hub™: South Cook Regional Community Health Home Collaborative

2. Name of Lead Entity:

The Link & Option Center, Inc.

3. List All Collaboration Members:

The Link & Option Center, Inc.
Aunt Martha's Health & Wellness
Hartgrove Behavioral Health System
Garfield Park Behavioral Hospital
Elite Houses of Sober Living
Victory Pharmacy

South Suburban Pharmacy
Together We Cope
So-Well Dental Associates
Franciscan Health Olympia Fields Hospital
TDG & Associates, Inc.

4. Proposed Coverage Area:

South Suburban Cook County Region

5. Area of Focus:

The mission of the MyCorCare Hub™ is to build clinic-community linkages for our target area's most vulnerable Medicaid enrolled children and adults facing health inequities and experiencing barriers to care. Our network will promote rapid access to mental health and substance use and opioid disorder treatment, primary and specialty care, dental care, and services to address social needs such as housing, food, and transportation.

6. Total Budget Requested:

\$21,608,500.60

Application Information

Application Name: MyCorCare Hub™: South Cook Regional Community Health Home Collaborative

Award Request: \$21,608,500.60

Primary Contact Information

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Phone Number: 708-331-8111

Project Description

Does your collaboration include multiple, external entities?

Yes

Can any of the entities in your collaboration bill Medicaid?

Yes

Participating Entities

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

The Link & Option Center, Inc.

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

The Link & Option Center									
Aunt Martha's Health & Wellness									
Hartgrove Behavioral Health System									
Garfield Park Behavioral Hospital									
Elite Houses of Sober Living									
Victory Pharmacy									
South Suburban Pharmacy									
Together We Cope									

So-Well Dental Associates									
TDG & Associates									
Franciscan Health Olympia Fields Hospital									

Are there primary or preventive care providers in the collaborative?

Yes

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

- Aunt Martha's Health & Wellness
- Victory Pharmacy
- South Suburban Pharmacy

Are there any specialty care providers in your collaborative?

Yes

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

- So-Well Dental Associates

Are there any hospital service providers in your collaborative?

Yes

Name of the first entity that provides hospital services.

- Franciscan Health Olympia Fields Hospital

Which MCOs does this hospital participate in?

1. CountyCare Health Plan (Cook County only)
2. IlliniCare Health

Name of the second entity that provides hospital services.

- Hartgrove Behavioral Health System

Which MCOs 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

Name of the second entity that provides hospital services.

- Garfield Park Behavioral Hospital

Which MCOs 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

Are there any mental health providers in your collaborative?

Yes

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

- The Link & Option Center, Inc.

Are there any substance use disorder services providers in your collaborative?

Yes

Please enter the names of entities that provide substance use disorder services in your collaborative.

- Elite Treatment Center

Are there any social determinants of health services providers in your collaborative?

Yes

Please enter the names of entities that provide social determinant of health services in your collaborative.

- Together We Cope

Are there any safety net or critical access hospitals in your collaborative?

No

Are there any entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that are majorly controlled and managed by minorities?

Yes

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

- The Link & Option Center, Inc – Majorly Controlled and Managed by Minorities
- Aunt Martha's – Majorly Controlled and Managed by Minorities

- So-Well Dental Associates – Majorly Controlled and Managed by Minorities
- Elite Houses of Sober Living – Majorly Controlled and Managed by Minorities
- TDG & Associates, Inc - BEP
- Victory Pharmacy - BEP

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

Name	Medicaid ID
The Link & Option Center, Inc.	
Hartgrove Behavioral Health System	
Aunt Martha's	
Franciscan Health Olympia Fields	
Victory Pharmacy	
South Suburban Pharmacy	

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).

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

Project Description

Official Collaborative Name:

MyCorCare Hub™: South Cook Regional Community Health Home Collaborative

Collaboration Goals (one to two sentences):

The mission of the MyCorCare Hub™ is to build clinic-community linkages for our target area's most vulnerable Medicaid enrolled children and adults facing health inequities and experiencing barriers to care. Our network will promote rapid access to mental health and substance use and opioid disorder treatment, primary and specialty care, dental care, and services to address social needs such as housing, food, and transportation.

Detailed Project Description:

The Link & Option Center, Inc. (TLOC) and its multidisciplinary collaborative partners seek to implement a Health Home Network called the MyCorCare Hub™ (Hub). The mission of the Hub is to build clinic-community linkages for the most vulnerable Medicaid-enrolled children and adult residents facing health inequities resulting from barriers faced accessing quality care. Our collaborative intends to target the local population of 137,146 youth and adult Medicaid enrollees residing in the 38 communities within the South Suburban Cook County region, providing CHW support in year one to 15,405 individuals

each year and thereafter for a total of 30,435 Medicaid recipients over five years, with a 50% ramp up the first year.

The Hub will employ multidisciplinary teams to guide the healthcare transformation and support integrating care and evidence-based practices to build a Health Home and improve access to care in the 38 communities of the South Suburban South Cook region.

Our planned approach includes universal screening, comprehensive risk assessment, development of a single care plan, and support to facilitate access to quality care across our network of culturally aligned organizations. Consistent with the Quadruple Aim, we will staff a team able to enhance patient experience, improve population health, reduce costs, and improve the work life of our providers. Our Hub will provide connections to care via targeted outreach from locally recruited and racially representative CHWs supported by a multidisciplinary medical team. In this way, our collaborative will identify and engage those at highest risk due to unmet needs for appropriate linkages to existing community resources and for targeted advocacy to address gaps in the system of care. Data will be systematically gathered to track which needs can be met through local resources and for which needs resources do not exist, require enhancement, or could be expanded. This project's collaborative will be organized to engage stakeholders to collectively advocate with local service providers and with governmental and private funders to address local gaps in the 38 communities of the South Cook region.

The Hub will leverage evidence-based practice from three models: The Pathways Community Hub (Pathways), Community-Centered Health Home (CCHH) and IMPACT (Improving Mood – Promoting Access to Collaborative Treatment). The Hub will establish a community health workforce consistent with the Pathways Community HUB model and collaborative care coordination consistent with the Health Home model of care. The Hub will use features of the IMPaCT model to guide how we integrate our CHWs within clinical care, refine caseloads, and conduct documentation and reporting for operational success.

The Hub will be guided by these evidence-based models to provide person-centered, institutional, and community-centered practices to advance population health, increase access to care, improve quality, decrease health inequities, and improve environmental conditions for our population.

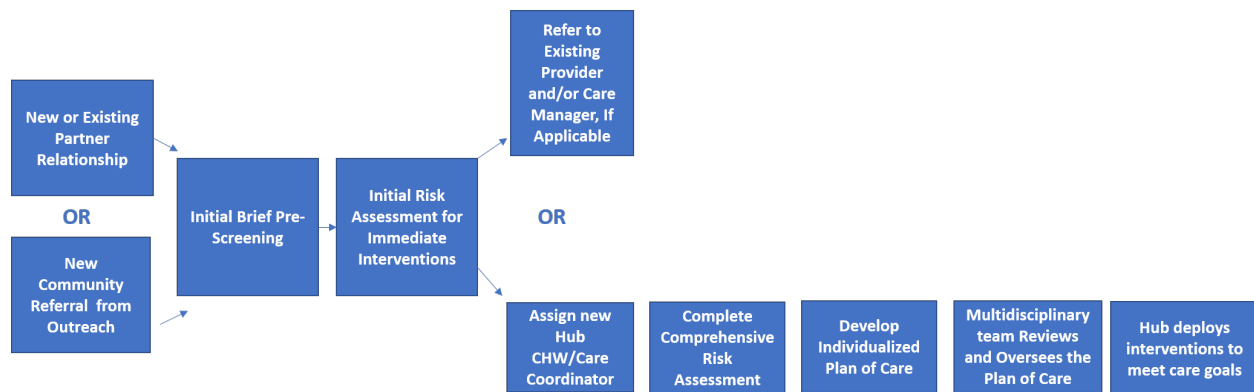
The Hub will be located in TLOC's dedicated office space in South Holland and will be staffed to provide a full range of support services to our community through dedicated Community Health Workers (CHWs) who will serve as Care Coordinators. In addition to CHWs the Hub will also have Mental Health Therapists, Substance Abuse Therapists, Licensed Practical Nurses (LPNs), Registered Nurses (RNs), Licensed Clinical Social Workers (LCSWs), Licensed Social Workers, Licensed Clinical Professionals (LPC), and Recovery Support Specialists.

The Hub will provide the following services to our target community:

Outreach and Engagement – We will contract with local leaders who represent the population we serve to conduct outreach and perform engagement activities at the organizational and community level. Our practitioners will perform these outreach and engagement activities once they receive training as community health workers (CHWs). We will recruit and hire, as necessary to ensure that our CHW teams are responsive to the race/ethnicity, language, cultures, values, attitudes, and beliefs of our South Suburban target population. Across our network of partners, staff will be trained to integrate an initial

brief screening to identify the highest risk individuals and families for referral to the Hub. Each identified or referred person will be assigned to the CHW best able to meet their needs in terms of race/ethnicity, culture, language, expertise, and geography. CHWs will also conduct targeted outreach into the community to find those at greatest risk.

The outcomes-based Pathways Community HUB model, on which our Hub is based, is designed to incentivize and motivate CHWs to find and build relationships with the highest need individuals and families in our region. Our Leadership Council, the governance body for our collaborative and its finance committee will develop a methodology that incentivizes risk mitigation. The Hub will provide what has been termed “care traffic control” within the system of care, by working to identify those who already have an assigned care manager, from a local organization or managed care organization, in order to coordinate and ensure that efforts are not duplicated. In these cases, a CHW may still be assigned to support timely access to care, facilitate care conferences among providers for those whose coordination needs are complex and for those whom treatment planning demands targeted support, or perform other functions unique to the individuals care plan and wellness goals, as described below. Each individual and family member onboarded will receive the standardized and comprehensive assessment of modifiable risk factors to inform whole-person, holistic care planning. The risk assessment process comprehensively identifies interrelated risk factors associated with medical, behavioral, dental, and social indicators of health:



Care Coordination – CHWs will empower participants to prioritize their needs in an individualized care plan, in which each risk factor is assigned a specific “Pathway” that identifies risk reduction interventions necessary to address the needs and mitigate the related risks. Our network of partners will operate as a Health Home for those served. Interventions will include services to address identified needs, such as provision of health education modules and support to access local food pantries, housing programs, job placement support, primary care, mental health care, services to address substance use, etc. Our progress addressing each person’s array of “Pathways” will be tracked in our population health platform, HealthEC, which will integrate ADT feeds. Two of our collaborating entities already use HEC, in combination with NowPow, a referral platform for local resources, which will make it more adaptive for our partners and streamline implementation. We will track our progress addressing each individual’s identified needs, or “Pathways”, and this data will also highlight which people and families present the greatest combined risks, as well as where, in the community, concentrated risks or delays/barriers in accessing care or services requires attention due to geographic, subpopulation, or systems issues. This population data, in combination with curated publicly available data from Metopio, will inform our

collaborative efforts with our partners and at the community level to address local barriers to care and health disparities. The Hub will establish care coordination consistent with the Health Home model of care and use features of the IMPaCT model to guide how we integrate our CHWs within clinical care, refine caseloads, and conduct documentation and reporting for operational success.

Maternal and Postpartum Access – The Hub will also provide a Doula-led Prenatal Care Coordination program for our pregnant and postpartum patients, to improve maternal outcomes and support high-risk pregnant women, including women in toxic Domestic Violence relationships in our community. These services will be coordinated and provided through TDG & Associates, a Business Enterprise Program (BEP) Vendor. TDG will receive referrals from family court, townships, local women, family shelters, DV advocates, and parenting programs. The Hub will recruit CHWs to be trained as Doulas and TDG will coordinate the Prenatal Care Coordination program, which will include outreach, assessment, care plan development, ongoing care coordination, childbirth companion, home visiting, monitoring, and health education and nutrition counseling. Key indicators for this pathway will include assessment of perinatal and postpartum depression, and attendance at sessions, including family planning, parenting, and mediation for involved fathers.

Dental Support – The Hub’s CHWs will educate patients on good oral health and provide referrals to our dental provider partner for adults and children to receive their annual screenings and routine dental care. In addition, the Hub will have a designated space to provide dental services on-site. In future years of the initiative, the Hub will explore the addition of a mobile dental van based on community need.

SDOH Services– The Hub will serve as a community referral partner with Social Determinant of Health Providers (SDOHs), including but not limited to food pantries, housing providers, and job placement and training programs. The Collaborative will leverage NowPow to facilitate referrals to the appropriate SDOH intervention to provide needed supports. Direct SDOH supports provided by the Hub will include recovery housing, transportation, food assistance and technology support to access telehealth.

Mobile Crisis Response Triage –TLOC’s state certified Mobile Crisis Response and Stabilization services will operate the Hub’s 24/7 triage crisis stabilization and provide mobile crisis response services to adults and children in all counties and areas of our region. Crisis Response Triage is a 24/7 behavioral health intervention enhancing the ability of people in crisis to stabilize by making crisis and emotional support services available in the community in which they reside, in real time, while diverting the burden of emergency room overcrowding, overutilization, higher cost hospital emergency departments, inpatient facilities and the Cook County jail. Hartgrove Hospital will be a part of the Response team when inpatient stay is warranted for further stabilization.

ER Transition of Care - For patients who present to the ER for all cause ED visits, our CHW-Navigators will coordinate patients’ ER access to the appropriate care they need and reduce high utilization rates for medical and behavioral health (mental health, alcohol, substance use and opioid use disorder), hospitalization, and Emergency Department visits through our partner hospital Franciscan Health Olympia Fields.

Pharmacy Medication Management and Adherence—Our Hub will prioritize resources to specifically target needed improvements to the workflows necessary among our network partners to support medication management (e.g., during hospital admissions and in the Emergency Department, during doctor visits or at the time of hospital discharge) and drive more effective and coordinated prescribing.

Our CHWs will facilitate access to and coordination of social determinants of health services to improve patients' medication adherence (economic instability, housing insecurity, lack of transportation, job insecurity, and literacy skills). As well, we will bring our partnering pharmacists from the Victory and South Suburban Pharmacies into the treatment team, when needed, to educate patients about why and how to take medicine. Our partners at Victory and South Suburban Pharmacy will provide the following Collaborative Partner Services:

- Medication Therapy Management: Review of the pertinent patient history, medication profile (prescription and non-prescription), and recommendations for improving health outcomes and treatment compliance.
- Tobacco Cessation using the Ask–Advise–Assess–Assist–Arrange (5 A’s), which include: Ask about tobacco use. Advise the patient to quit. Assess readiness to quit. Assist the patient with quitting, if ready. Arrange for follow-up. Pharmacists will provide all 5 A’s, plus the medication expertise as required to assist patients who are ready to quit. The 5 A’s model empowers the pharmacist to be involved in creating the quit plan with the patient, assisting in selecting appropriate pharmacologic therapies, providing counseling on the selected tobacco cessation therapy, and setting the schedule for routine monitoring and coaching of the patient toward goals. Key factors that improve quit rates within pharmacy-based programs deploying the 5 A’s model include the number of follow-ups, average duration of follow-ups, and format of counseling sessions.
- Diabetes Self-Management Education/Training (DSME/T): Pharmacists will provide instruction in self-monitoring of blood glucose, education about diet and exercise, support to develop an insulin treatment plan for those who are insulin dependent, motivation and skill building support for self-management, plus guidance when necessary related to furnishing and fitting therapeutic shoes.
- High Blood Pressure Management: Pharmacists will provide patients with educational materials to help them understand their condition and its implications; offer tools to support their medical visit agenda and goal setting; measure, document, and repeat BP correctly as indicated; flag abnormal readings; reconcile medications patient is actually taking with the EHR medication list; optimize the Patient–Pharmacist Encounter (e.g., documentation, orders, education/engagement); use documentation templates to help capture key data such as patient treatment goals and barriers to adherence; assess individual risk and counsel using motivational interviewing techniques; agree on a shared action plan and use “teach back” to confirm patient understanding.
- Provide patient supports for Self-Management:
 - medication adherence
 - Self-Measured Blood Pressure (SMBP) monitoring
 - increasing physical activity
 - dietary changes
 - managing Chronic Kidney Disease (CKD)

For reconciliation accuracy, our Pharmacies use an automated solutions platform to bring real-time data on medications prescribed and filled to the care team, filling common gaps in information and addressing inaccuracies that result from patient’s lack of understanding their medication regimen.

Physician Referral Network – Our team will identify individuals who do not have a relationship with their empaneled primary care provider/pediatrician and either support that linkage or, if necessary, help identify and choose a provider based on their preference. In the event there is an urgent medical need and access to the PCP is limited, our Hub nurses will expediate referrals to necessary physician services from our medical collaborative partners, including The Link & Option Center, Aunt Martha’s FQHC, Hartgrove Behavioral Health System, Garfield Park Hospital, and Franciscan Health Olympia Fields. Appointment scheduling will be rapidly facilitated via reserved appointments with network primary care providers (PCP), our onsite Primary Care Provider, via specialty care, and behavioral health providers. Expedited access will include in-person and telehealth connections to support initial psychiatric evaluation, medical management, and outpatient treatment intake.

Reserved Appointment – In partnership with managed care organizations and in coordination with our hospital and specialty network partners, our Hub will accept referrals and provide care coordination to expediate linkages to mental health appointments within 7 and 30 Days of inpatient mental health hospitalization or follow-up care after an Emergency Department admission for mental health and medical causes. Once referred, and as needed based on preference, individuals will be connected to reserved appointments with a Psychiatrist or Primary Care Provider in our network. Coordination of referrals to Specialty Care Providers will also be provided to expedite access to needed services.

Remote Patient Monitoring. The Hub will coordinate care for its enrolled patients. During regular case conferences/rounds under the leadership of our Medical Director Dr. Syed Khadri, the care team will identify patients who require in-home monitoring to manage their care. The Hub will deploy either the assigned CHW or one of the team’s nurses, based on the individual level of need, to assess weight, take vital signs, and facilitate instant connectivity to telehealth care for those whose risks and needs require home monitoring. The Link & Option Center will expand its current remote patient monitoring program, initiated for Blue Cross members, which provides needed medical equipment for vital signs, tablets enabled for home-based telehealth access and documentation straight to the EHR, and a modular unit used by the provider at the clinic which allows them to conduct the visit and directly access the Electronic Health Record. A second Patient Assessment Portal used for doctor’s telemedicine visits, and Portable Teleclinics for traveling nurses, and second Vivify Health solution, will be added within our network to support telehealth access to a primary care provider and remote monitoring.

Community access and planning The HUB will provide an access point for referrals, coordination, and community-led planning to reduce barriers to health and behavioral health care for this local population. We will convene a Monthly CHW Meeting with our team to coordinate service planning, expediate access to needed care, and resolve any barriers or issues that might jeopardize a person’s outcomes within our network of partners. Findings from this meeting will inform our messaging, education, outreach, and service delivery approach and be reported to our quarterly Community Advisory Council, which will address broader systemic needs and issues related to needed service improvements.

Key Collaboration Partners:

Key Partner Name	Type
The Link & Option Center, Inc. (Lead)	Community Mental Health Center
Aunt Martha’s	Federally Qualified Health Center
Franciscan Health Olympia Fields	Hospital—full-service community healthcare

Hartgrove Behavioral Health System	Hospital – Adult Behavioral Health
Garfield Park Hospital	Hospital – Children’s’ Behavioral Health
Elite Houses of Sober Living and Treatment Center	Recovery Housing & Addiction Treatment Center
Victory Pharmacy	Pharmacy
South Suburban Pharmacy	Pharmacy
Together We Cope	Food Pantry
So-Well Dental Associates	Dental Provider
TDG & Associates, Inc	BEP Vendor

Providing an integrated experience of care for our adult, child, and adolescent Medicaid beneficiaries requires a single platform population health management and care coordination solution that simplifies workflow for care coordinators, engages healthcare clients, and optimizes quality and performance for providers. Therefore, our collaborative will work with several technology vendors.

HealthEC	KLAS-recognized population health tool that provides a single-platform solution that aggregates clinical, claims, and quality data and provides the actionable insights that can improve health care outcomes across multiple dimensions.
NowPow	Provider referral and tracking system for population health and engagement and quickly make linkages to address SDOH needs.
State Fed Admission, Discharge, and Transfer (ADT) Data	The State will provide Admission, Discharge, and Transfer (ADT) data for the attributed population which will be ingested and leveraged through our population health initiative.
Metopio	Provides data curation, analytic support, and data visualization to create insights into patient care. Facilitated the ability to develop a custom region for targeting the collaborative’s interventions and assessing community need. Going forward it will supplement state data and our Hub’s data to inform evolving need and new partnership opportunities.
Partner Electronic Health and Electronic Medical Records	Partner Electronic Health Records (EHRs) will be integrated into a shared population health solution, HealthEC, and provide access to SDOH data via NowPow and State Fed ADT Data. The Link & Option Center’s EHR is Dr. Cloud.
Vivify Health	Vivify pulls patient data through mobile digital devices or at-home remote monitoring kits. This provides actionable insights to clinical staff for timely care interventions. Vivify addresses the health needs of healthy, rising-risk, and high-risk patients, driving stronger adherence rates that

	improve population health and lower costs per capita. Trinity Health used it to reduce re-admissions from 16% to 6% with a population of 44,000 Patients. UPMC reported a 74% reduction in Readmissions (within 90 days of discharge), and the Ontario Telemedicine Network (one of the largest telemedicine networks in the world) reported a 60% reduction in ED visits.
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Additional Partnerships:

In this capacity, the Collaborative will also work with additional supportive partners, including Franciscan Health Urgent Care Clinic, local dialysis centers, Dr. Marty Hall pain management clinic, and Specialty Physicians of Illinois. We also recognize how vital it is to partner with SDOH providers to facilitate access to housing, food and other supports and we are therefore partnering with three townships Bremen, Thornton, and Rich Township and their food pantries, churches, municipalities, and local hotels. We will also partner with the Illinois Department of Children and Family Services. DCFS will use the Hub in instances where they have youth that are in need of psychiatric services and/or when youth are sent to Hartgrove for crisis intervention services. The Illinois Department of Corrections (IDOC) Transitional Housing Providers are also partners providing access to clients who are returning citizens in need of immediate community integration services. The Hub will help individuals transition back to the South Suburban community.

Connection to the Budget:

The MyCorCare Collaboration proposes a team that will include new hires in our community and use of existing staff and resources to deploy them to our targeted interventions. Our hiring approach will look to preserve and build jobs in our community and provide opportunity for advancement. We will recruit directly from the community to ensure the racial and ethnic composition of our workforce mirrors the population we are serving and the values and goals of our respective organizations.

The Hub will hire 142 new full-time staff across various roles. To ensure appropriate administrative supervision, data collection, and quality oversight, the Hub will hire an overarching project director, a program evaluator/researcher, data analyst supervisor, data collection/integrity specialist, data analyst, quality assurance director, Hub referral specialist, an executive assistant, 2 medical billing specialist, and 2 reconciliation specialists. Each of these individuals will be a 1.0 FTE. For adequate clinical supervision the Hub will hire a project manager for intensive SUD, a project manager for intensive behavioral health, a social work manager, a nutritionist, wellness program coordinator, and project care coordinator. We will also hire several direct care workers including 48 Community Health Workers (CHWs) to serve as Case Managers, 12 CHWs to serve as Recovery Support Specialists, 24 CHWs to serve as Doulas, 4 Substance Abuse Counselors (CADC), 8 Mental Health Clinicians, 2 Licensed Clinical Social Workers, 4 Project Care Managers for Chronic Disease Management, 2 outreach coordinators, 15 outreach specialists. We will also hire 3 drivers to provide transportation services to members of our community referred to the Hub or associated care.

In addition, funds will be used to support direct workforce at our partner agencies to staff our pathways and interventions. We will use funds to invest in a dedicated Doula Program Director, Medical Director, Advance Practice Psychiatric Nurse, Family Practice Physician, Quality Control Director, and Executive Director who will all serve through The Link & Option Center. We will also invest in Care Coordinator, Navigator, Discharge Planning Social Worker, and 4 Quality Control Managers at our key partner organizations Aunt Martha's, Hartgrove Hospital, Franciscan Health Olympia Fields, and Garfield Hospital.

Other Direct Costs our Hub will incur will include capital costs associated with purchasing, equipping, and furnishing the Hub facility, including dental supplies. We will also lease 3 vans to support transportation and include costs associated with repairs, maintenance, insurance and fuel for the vehicles. We also propose additional mileage, and transportation costs. We will provide needed technology to our staff including cell phones, office phones, tablets, printers, and software licenses. We will also purchase telemonitoring equipment to support remote patient monitoring including portable teleclinic equipment, a patient assessment portal system, and teledentistry services. We will also invest in telecommunications services, including crisis hotline support.

To support our shared data collection and population health management goals, we will invest in Electronic Health Records (EHRs) platforms and integration support, including the HealthEC platform across our collaborative partners. We will invest in training across our collaborative, including training and certification in Pathway HUB, Doula services, CHW, cultural sensitivity, and opioid and naloxone administration. We will also invest in community outreach and engagement activities to make individuals aware and connect them with enhanced service offerings. Additional direct administrative costs include liability insurance, worker's compensation insurance, employee signing bonuses to support recruitment, and other administrative costs.

We also expect to invest in the use of Subject Matter Experts and consultants to support the design and implementation of our proposed model. We will engage the expertise of our medical director, who is a surgeon, an adult psychiatrist, and general psychiatrist to provide supervision and psychiatrist services at the Hub. We will also engage Specialty Physicians of Illinois and So-Well Dental to provide specialty physician and dental services. We will engage JLP consulting to provide chronic disease management consulting support and our pharmacy partners, Victory Pharmacy and South Suburban Pharmacy, for pharmacy health education with visual aids.

Additional subcontractor support will include legal counsel services from the Stuttley Group, fiscal agent support from Benford Brown & Associates, and communication support from Kyu Systems. We will also incur cost for printing and distribution of educational and outreach collateral and Martin Brandin to provide signage and an unidentified firm to provide cleaning/janitorial services at our physical Hub location. We will also hire two security guards who will secure the facility and coverage for 24/7 crisis triage services. We will engage an IT consultant, Access One, to assist with our EHR and population health integration activities. We also plan to engage Health Management Associations to support our implementation. TDG and Associates will provide Doula program implementations support activities. We will engage a search firm to assist with recruitment for key positions and PALS International to provide critical interpretation services for our non-English speakers.

Governance Structure

Structure and Process: 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?

A Partnership Agreement between the Key Collaborative Partners, including The Link & Option Center, Inc., Aunt Martha's Health & Wellness, Hartgrove Behavioral Health System, Garfield Park Behavioral Hospital, Elite Houses for Sober Living, Victory Pharmacy, South Suburban Pharmacy, Together We Cope, So-Well Dental Associates, TDG & Associates, and Franciscan Health Olympia Fields Hospital will drive all elements regarding the execution, management, accountability, and inter-reliance of the participating members of our collaboration. Collaborative member's Boards of Directors (including the TLOC Board of Directors) will give authority to enter into necessary agreements to execute the collaborative's goals and vision, including steps to appropriately govern the work, including: developing governance committees; designing new workflows, policies and procedures; identifying priorities for the collaborative's effectiveness; and approving goals set by the Advisory Council (see description below) based on the needs assessed for our population. All partners will meet face-to-face to develop the initial partnership agreement and define policy and procedures for the collaboration.

Our Partnership Agreement will provide a formal structure that details priorities, and decision-making functions to hold partner organizations accountable to each other and provide direction to the lead entity, TLOC. A Leadership Council will be formed, and one seat will be appointed by each key member organization with authority to act on behalf of their organization. Each organization will be required to name a proxy in the event the executive appointment cannot participate.

The following standing committees will be formed:

- **Leadership Council:** receives input from governance committees and approves decisions granted to the Leadership Council by the Partnership Agreement. For powers reserved to the lead entity agreed to in the Partnership Agreement, the Leadership Council will develop recommendations to be submitted to, TLOC. Types of Leadership Council recommendations that could flow to TLOC for final approval, include but are not limited to partnership Agreement and governance structure changes, amendments to the Partnership Agreement and other agreements, termination agreements, contracts and financial arrangements between TLOC and partners. Decisions we anticipate remaining with the Leadership Council include process for addressing partner performance, addition or removal of partners to or from the initiative, reporting requirements of partners/initiative to monitor mutual accountability, approval of policies and procedures, and process for enforcing policy and procedure adherence.
- **Finance Committee:** provides oversight of how directed payments flow and monitors overall financial sustainability of the initiative. Chair of the finance committee will be from the entity receiving direct payments. The committee will transparently report directed payments received, funds flow, and reporting/accountability of how partners have used funds. The fiduciary agent will support this committee and will provide reports on disbursements approved by the committee and Leadership Council.
- **Quality Improvement Committee:** approves goals and monitors effectiveness and results of interventions, recommends continuous quality improvement initiatives,

and reports results to the Leadership Council. This committee will review reports and inputs received from the Collaborative's Quality Control team.

The Leadership Council will meet monthly with the Collaborative for the first year, in order to set the agenda and establish the role of the MyCorCare Hub™ South Cook Regional Community Health Home Collaborative Hub Advisory Council.

The Advisory Council will include 10-15 community stakeholders who are racially and ethnically representative of the populations our Hub serves, representatives from our partnering entities, managed care organizations serving our population, key CBOs serving our population, local Township leaders and other public health and welfare leaders. They will be trained in collective impact and supported by the Hub Director and the Leadership Council to advise the Hub's goal setting in their role of advancing as a broader collective, based on the Hub's data and collaborative planning, by aligning their respective organizational agendas with the shared Hub agenda. The Advisory Council will identify and make recommendations on systemic changes that will be necessary to improve care delivery, expedite access, and support achievement of shared goals for population health. Members of the Advisory Council will also be engaged in advocating for additional resources from complementary grants and service contracts to support the population and expand to integrate new partners.

New Legal Entity:

N/A

Accountability:

Partner accountability will be governed at several levels: in the Partnership Agreement established with partners; through contracts entered into for funds flow; and through policies and procedures established through our committee structure. Any partner that fails to meet performance standards and expectations will receive notice from TLOC and the Leadership Council. The notice will provide a process for partners to submit a plan of correction within 30 days. If a plan of correction is not submitted timely or the plan of correction is insufficient, the Leadership Council reserves the right to make a recommendation to the lead entity to terminate a partner's participation in the collaborative.

Our collaborative will also establish clear standards around conflict of interest. In the case of TDG & Associates, Inc., TDG is a separate entity from TLOC, however, they share in common a CEO, Dr. Twin Green. Contracting with TDG will allow Dr. Twin Green to provide oversight and doula services, as in-kind matching service to the contract. TDG will be subject to the same accountability and oversight requirements as other key partners and the Leadership Council will govern the operation of activities and services of TDG & Associates, Inc.

Payment and Administration of Funds:

The party receiving the Directed Payment will be contracted to direct funds to the fiduciary agent who in turn will monitor, report and disperse funds while also collecting reports regarding how funds have been used. Hartgrove Behavioral Health System has agreed to receive payments on behalf of the collaborative. Directed Payments will be distributed according to contractual agreement with the collaborating partners. A base payment with a pay for performance mechanism will be included within the fund distribution agreed to by the partners and included in partner contracts. The fiduciary agent

will provide finance reports and manage expenditures as agreed to by and on behalf of the Leadership Council. The agent will participate on and provide reports directly to the Finance Committee. Our Fiduciary Agent is Benford Brown and Associates, a BEP that has prior experience working with grantees under the Healthcare Transformation Program and has established similar fund distribution mechanisms.

Racial Equity

High level description of how the design of your proposal incorporates racial equity:

Our MyCorCare Hub: South Cook Regional Community Health Home Collaborative incorporates racial equity in every facet of its design. To start, our backbone entity is a Black Female led organization, and our key partners are longstanding collaborators. Together, our shared agenda is rooted in dismantling the systems of oppression that contribute to and sustain racial health disparities in our target area. Our approach involves activating our local network to improve access to care for the highest risk populations facing health disparities in our community. To do this, we will recruit, hire, and train local representatives who racially reflect our community demographics to reach out and proactively make comprehensive connections to needed mental health and substance use/opioid addiction treatment, medical care, and services that address the social indicators of health. These local leaders will have the capacity to motivate and ease patient's entry into services, based on our collaborative planning effort in combination with their lived experiences navigating within our community's system of care and overcoming barriers to health and wellness.

As well, our collaborative is entirely comprised of organizations that are Black led/owned and majority comprised of providers and workforce who are culturally and racially congruent with our target population. The Hub will be led by **The Link & Option Center, Inc.**, a Joint Commission accredited outpatient Community Mental Health Center (CMHC) and pillar in the Southland region with locations in South Holland and Hazel Crest Illinois. TLOC was founded in 1995 by Dr. Twin Green, a local Black leader who remains our President & CEO, in response to struggles her teenage son was having due to negative forces in the community. TLOC's leadership and staff reside in our local region and are predominantly African American (32 staff), with the exception of two Indian clinicians and two staff (a biller and a staff member for its Living Room program) who are Caucasian. Guided by a seven-member Board of Directors that also reflect the area's local Black community, TLOC's mission is to empower people with quality prevention and intervention services coordinated within a network of local community resources. Since the start of the pandemic, TLOC has served over 7,000 clients, 98% of whom are black and 2% Hispanic.

Initially, the agency focused on stimulating and supporting the education and knowledge of African American and other minority young adults between the ages of fourteen and twenty-one by strengthening academic skills, promoting post-secondary education, and supporting career development. The nationally known Scholarship America's *ScholarShop* college prep and career development transition program was the initial flagship program offered by TLOC. Today, TLOC provides a suite of prevention, mental health and addiction treatment, recovery support, and other public safety and human services for adults, seniors, children, and adolescents, as well as their families. TLOC integrates medical, mental health and substance abuse treatment, provides medication management, Mobile Crisis Response Services, conducts Emergency Department Triage Assessments, and offers Comprehensive Follow-up after Hospitalization for mental health (FUH MH) Hospital Discharge Planning,

Opioid Addiction Treatment, Medicated Assisted Treatment (MAT), Crisis Triage Living Room Program, Dementia Care, Mental Health First Aid, Integrated Care Coordination, Case Management, Domestic Violence Counseling, and DUI Evaluation and Education. We also provide Cook County Adult Probation Treatment Services, IDOC Reentry Transitional Services, 6th District Family Court Reunification, Emergency Services for Homeless Prevention and Housing Stabilization, and Certified Medicaid and SSI/SSDI Benefit Application Services, Medicaid application assistance, housing and credit counseling, Child Welfare -IL Department of Child and Family Services Continuity of Care, Cook County Court-Community Service, and Workforce Development.

Our minority-led partner organizations, who share the Hub's health equity goals and all provide services that are highly cultural responsive to our community include:

Aunt Martha's FQHC, under the leadership of President and CEO Raul Garza, is a high performing Federally Qualified Health Center that specializes in integrated team-based care and local access for our highest need populations, including a special focus on families, children and youth involved in the child welfare and foster care system. Aunt Martha's provides health, dental care, mental health and substance abuse treatment, foster care placements, as well as education and life skills, employment training, family and youth crisis services, supportive emergency and transitional housing, and juvenile justice services. In 2020, despite the pandemic, Aunt Martha's over 12,000 new patients received care in the targeted region for the first time due to the FQHC's rapid transition to a telehealth model. Aunt Martha's is also engaged in an array of value-based initiatives with managed care partners that are aimed at addressing the social determinants of health.

Franciscan Health Olympia Fields Hospital is an acute care community hospital located in the far south suburban region. It provides Behavioral and Mental Health Services; Cancer Care; Children's Health; Dermatology; Diabetes & Endocrinology; Diet & Nutrition; Ear, Nose & Throat; Emergency Medicine; Eye & Vision; Gastroenterology & Colorectal; Heart Care; Home Health; Hospice & Palliative Care; Hospital Based Care; Imaging & Radiology; Infectious Disease; Kidney, Liver & Urinary Tract Care; Laboratory Services; Medical Spa & Massage Services; Neurology (Brain & Spine); Obstetrics & Gynecology (OB/GYN); Orthopedics; Pain Management; Pharmacy; Physical Therapy & Rehabilitation; Podiatry; Primary Care; Pulmonary & Respiratory Medicine; Rheumatology; Sleep Medicine; Sports Medicine; Surgical Services; Urgent Care; Vascular Care; Weight Loss and Bariatric; and Wound Care. It also provides the CareLinks program, which bridges care for those who have been discharged from the hospital or ED by offering a convenient location to receive a quick "check up" to keep conditions from worsening—not by replacing the primary care provider but by serving as a link at a critical time in care. CareLinks is open Monday through Friday, 7:30AM - 4PM, and offers transportation support up until 3:30 p.m. This program will serve as our Hub's key collaboration link to support hospital transitions of care for our shared population.

Under the leadership of Chief Medical Officer, Dr. Sanjay Dharmapuri, **Hartgrove Behavioral Health Center and Garfield Park Hospital** provide inpatient, outpatient, partial hospitalization, and specialized programming for adults, adolescents, and children. Hartgrove Behavioral Health has a trauma program that the Joint Commission awarded their Disease-specific Certification for Trauma-informed Care, the first in the nation and currently the only hospital to hold this certification. Garfield Park has the first-of-its-kind, inpatient psychiatric unit (18-bed) for sexual and gender minority youth (ages 12 to 17), a specialized program for adolescents who are at risk of being sex trafficked, and a program for youth who

display sexually problematic behavior. In total, the two facilities have served 7,000 patients since 2019, 40% of whom are African American, 15% are LatinX, 35% are Caucasian, and 10% are Other.

Elite Houses of Sober Living was established in 2003 to provide structured living environments to facilitate growth and civic responsibility for those who struggle to recover from alcohol/drugs, criminal lifestyles, and homelessness. Its structured, affordable recovery housing is designed to facilitate individual growth and civic responsibility for adult men who are homeless, recovering from addiction, and re-entering the community after incarceration. **Elite Treatment Center** is a substance use addiction treatment facility established in 2008 to strengthen individuals and families in the South Suburban communities we serve by treating addiction through counseling, education, advocacy, and prevention. It provides Medication-Assisted Treatment (Methadone) and Level I & Level II Outpatient addiction treatment and recovery services, and programming for those who have DUI or require domestic violence or sex offender counseling. Elite has served 2,000 individuals since 2019, 80% of whom are African American, 15% are Caucasian, and 5% are Hispanic.

Victory Pharmacy is led by Pharmacist and CEO Wole Adeoye who established this pharmacy, staffed entirely by people of color, based on the realization that local community members were unaware of the lack of care they were receiving from large corporation pharmacies. Victory is committed to ensuring the access and care that larger corporate pharmacies offer, but with more competitive pricing, little to no wait time, and services designed to specifically support people disenfranchised from mainstream healthcare. As described above, Victory Pharmacy interventions and medication management protocols do more than just provide medication. Pharmacists and technicians also add a personal touch and work with our network partners to help the neighborhood get better.

RxLink South Suburban Pharmacy, is a Black-owned pharmacy located on the campus of the South Suburban HealthCare Center and Hospital.

Together We Cope is a local community-based organization led by Executive Director Kathryn Straniero. It was founded in 1982 to bridge the gap for south suburban residents in 27 communities by supplying food, shelter, clothing and referrals and empowering them to self-sufficiency. They provide shelter for those who are experiencing homelessness, assist victims of fire or flood, help people obtain needed medication, address domestic violence, operate a food pantry and a resale shop, provide transportation support, and help with housing and utility support. They purchase food from the Greater Chicago Food Depository and receive some food at no cost from the U.S. Department of Agriculture to serve 5,000 individuals monthly.

So-Well Dental Associates is a Woman and Minority Owned business Led by Dr. Zenobia Sowell, a recognized local leader who employs a well-trained multi-ethnic team. Dr. Sowell grew up in Chicago, loves taking care of patients in her community, and was previously a dental provider for local nursing homes and homebound community residents. Dr Sowell has served as a dental provider for numerous Head Start schools in the city of Chicago, Easter Seals, Catholic Charities, and the Veterans Administration. She has also participated in global mission outreaches in Africa, Haiti, Trinidad, Jamaica and Israel over the past 28 years. Dr Sowell and So-Well Dental Associates has been featured in numerous magazines and articles, including Chicago Magazine and N'DIGO and continues to enjoy discovering new and better means of providing excellent oral health care for the patients they serve. Dr. Sowell has a kind heart for serving and giving back to her community and is a featured motivational and

business speaker in Chicago. She is also involved in the CHAMPS program, mentoring youth and young adults wanting to pursue a career in the healthcare industry.

TDG & Associates, Inc. is a certified Minority-Owned Business Enterprise (“MBE”) and Woman-Owned Business (“WBE”) by the City of Chicago. TDG & Associates, Inc., is a for-profit professional business consulting and development group specializing in creating government and private agency procurement networks driven by equitable economic opportunity, and community wellness and enrichment. TDG’s healthcare transformation response to racial equity transforms values and culture for minority-owned human services organizations to build agency wage-earning health workers with certification opportunities and influence community well-being.

Together, within our community, our collaborative partners all share in the struggle to coordinate care that maximizes our resources on behalf of those we serve. Each organization is predominantly staffed by an African American and Hispanic workforce.

In response to racial barriers experienced by Black and Hispanic residents in our targeted South Suburban region, TLOC will recruit, hire, and train a cadre of community health workers who are locally based and demographically reflect the populations experiencing racial health disparities, particularly in terms of accessing local mental health, substance use disorder, opioid addiction, primary care, and social determinate of health services and resources. Recruitment and hiring will deliberately engage local leaders who racially and linguistically represent those residing in our neighborhoods. Our outreach and engagement strategy will be data informed with a focus on undoing local disparities.

To begin, the most significant barriers to care that our partners indicate have been reported by patients include: transportation, availability of bilingual staff, support to utilize telehealth services and the need for greater flexibility in scheduling appointments during non-standard hours. These social indicators are an initial focus for our proposed Hub, as described below.

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

The racial/ethnic groups most affected by the barriers to care and services addressed by our proposed Hub are predominantly those who are Non-Hispanic Black and those who are Hispanic or Latino. In the targeted region, the total population is 566,756.¹ The predominant racial group is non-Hispanic Black (54.13% of the population), a rate significantly higher than Non-Hispanic Black population in Cook County (23.7%) or in Illinois (13.97%)². The Hispanic population comprises 14.42%, Asian or Pacific Islander comprises 1.18% and Non-Hispanic Whites comprise 28.29% of the population.

According to The Transformation Data and Community Needs Report for South Cook County.³ The 7 highest need zip codes in our targeted region include the following predominantly Non-Hispanic Black communities and one predominantly Hispanic or Latino community:

¹ Metop.io. American Community Survey (ACS: Table B01001; Decennial Census: Table P012)

² Metop.io. American Community Survey (Table B01001)

³ Giles, W., Hershow, R., Musick, H., Gibellina, E., & Messmore, L. (2021). (rep.). *Transformation Data & Community Needs Report: South Cook County*. Illinois Department of Healthcare and Family Services. Retrieved November 17,

- 60419 (Dolton) where 92.26% of residents are Non-Hispanic Black
- 60472 (Robbins) where 86.05% of residents are Non-Hispanic Black
- 60428 (Markham) where 78.57% of residents are Non-Hispanic Black
- 60426 (Dixmoor, Harvey, Phoenix) where 68.37% of residents are Non-Hispanic Black
- 60466 (Park Forest, University Park) where 65.49% of residents are Non-Hispanic Black
- 60411 (Chicago Heights, Ford Heights, Sauk Village) where 50.25% of residents are Non-Hispanic Black and 27.60% of residents are Hispanic or Latino)
- 60445 (Midlothian) where 19.9% are Non-Hispanic Black and 18.36% of residents are Hispanic or Latino

In our region, Non-Hispanic Black residents comprise the greatest percentages of the population in 60419 (Dolton), where 92.26% of residents are Non-Hispanic Black and 60472 (Robbins), where 86.05% of residents are Non-Hispanic Black. Hispanic or Latino residents comprise the greatest percentage of the population in 60469 (Posen) where 54.93% of residents are Hispanic or Latino. Percentage concentration is less segregated for Hispanic or Latino populations, however, dropping to 27.6% in 60411 (Chicago Heights) and then 14.42 in 60633 (Chicago).

The South Cook County area is regarded as one of the country's most disadvantaged communities with high rates of health disparities. Based on an analysis conducted using a subscription to a marketing data base available through Esri, the percentage of adults who did not visit a doctor in the last 12 month period for all of these zip codes ranges from the high percentage of 68% in Harvey to the very high outlier of 79% in Midlothian. Despite the prevalence of Serious Mental Illness, SED, and SUD, the percentage of self-reported adults who have used a prescription drug to treat depression is very low in our region. The highest percentage is in Midlothian (6.7%) and Chicago Heights (5.5%). Chicago Heights also has the highest density of people using prescription depression medication.

Overall within this catchment, we have a higher percentage of families whose income is less than half of the federal poverty level, in past 12 months income than in both Illinois and the United States. The percentage of families whose income is less than half of the federal poverty rate is 7.8%, whereas Illinois and the United States is 5.1% and 5.5%, respectively. As well, 17.95% of adults lack health insurance,⁴ 20.1% of the population experienced food insecurity at some point in 2020,⁵ and nearly 18.3% of adults smoke.⁶ Based on Census data, the two zip codes in our catchment with the greatest percentage and greatest density of households with no vehicle are Robbins at 21.1% of households and Harvey at 15.9% of households. Our catchment area has a lower college graduation rate than both Illinois and the United States, with a rate of 25.7%, whereas Illinois has 35.8% and the United States has a 33.1% college graduation rate.

2021, from

<https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226TransformationReportSouthCookDigitalCMP.pdf>

⁴ Metop.io. Behavioral Risk Factor Surveillance System (BRFSS) (County and state level data)

⁵ Feeding America. (2019). (rep.). *Map the Meal Gap 2019*. The Howard G. Buffett Foundation. Retrieved November 17, 2021, from <https://www.feedingamerica.org/sites/default/files/2019-05/2017-map-the-meal-gap-full.pdf>.

⁶ Metop.io. Dwyer-Lindgren, Mokdad, et al. (Population Health Metrics, 2014) (Data modeled from BRFSS for 1996-2012), PLACES

Our area has a higher percentage of residents who have low access to food, which is defined as more than 0.5 miles from the nearest supermarket in the urban area or further than 10 miles in a rural area, than both Illinois and the United States. Approximately 62.9% of residents have low food access in our catchment area, whereas the rest of Illinois is 48.4% and the United States is 50.4%. Approximately 5.1% of residents in the catchment are living in food deserts. The demand for grocery stores exceeds the local supply of available grocery stores in Midlothian, Park Forest, and Robbins. Robbins has the most adverse circumstances, suggesting a food desert.

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?

Our collaborative convened multiple listening sessions specific to help us shape our transformational design, beginning in March and April of 2021 and included two public forums on the 16th and 30th of October. An array of predominantly Black stakeholders were engaged including over 140 local community members recruited through a combination of robust outreach through public channels, via our network partners, and via postings from our elected officials. These sessions, called “Coffee, Tea With Me” were held at our Hazel Crest location, drawing participants from the communities of Hazel Crest, Robbins, Markham, South Holland, Riverdale, Dolton, Country Club Hills, Lansing and Harvey. Additional meetings were held with elected officials representing 20 communities.

Missing stakeholders include other local medical professionals, law enforcement, Mayors and Managers, Cook County Department of Public Health, local churches, local chambers of commerce and business associations, and municipalities. To engage missing municipal stakeholders, we have recruited Tyrone Ward to be a member of our Community Advisory Council. Mr. Ward is a lifelong resident of the Village of Robbins who has a rich history working with the community. He is the past president of the Southland Regional Mayoral Black Caucus of Cook County, which represents fifteen Southland mayors and was also the past president of the Southland Mayors and Managers Association, which represents forty-five mayors.

Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address?

This proposal seeks to improve access to health and behavioral health care for our area’s Black and Hispanic populations who are currently most disadvantaged by the access-oriented health disparities we seek to address. Case examples help to illustrate the issue, for example:

A case of Racial Disparity in Treatment/Services from The Link & Option Center

A 37y/o African American male patient who suffers from Bipolar I disorder presented to The Link & Option Center for mental health and substance abuse treatment. RW resides in a recovery home shelter and is employed. He has met many hurdles trying to keep up with his medication and still be able to function on his job. Due to the side effects of the multiple medications that he is currently taking, he often finds himself in the ER for symptoms of nausea, headaches, and dizziness. During an ER visit, RW reports not having a PCP but sees a doctor associated with the recovery home. When RW is symptomatic and cannot get an appointment to see the assigned doctor he is often told to go to the hospital. Because of the

number of times that he has been to the ER, hospital staff has repeatedly told him that he needs to stop coming to the ER and provides no further assistance. According to RW, the ER Physician Assistants have refused to adjust his medication and the only option they give him is to be admitted. This option is not suitable for RW for fear of losing his job. RW says it is his impression that ER staff assume he has ulterior motives for seeking support with his medication regimen from the ER, and he is discharged with his symptoms unaddressed.

If it were not for the care management services provided at The Link & Option Center, RW would continue to have a hard time getting stable on his medications with this kind of treatment experience. We have had similar cases where white patients present to us for similar treatment requests and it is evident that *they have gotten better care and treatment than RW has during ED visits.*

A case of Racial Disparity in Pain Management from Victory Pharmacy:

MT is an African-American male customer, middle-aged who fills his pain medication prescription at Victory Pharmacy. He said he felt intimidated at the larger retail pharmacy. His prescription was for a 5 day supply of Tramadol 50mg. After MT came several times to refill the 5-day supply, the pharmacist at Victory asked what kind of pain he was having. MT told the pharmacist that he was waiting for surgery for a knee replacement. Given the severe level of pain MT was experiencing, the pharmacist recognized that a five day supply of medication was insufficient, creating the likelihood that MT will require the Emergency Room or Urgent Care when the renewals were exhausted. In contrast, *Victory pharmacists have filled prescriptions for a white customer, for the same Tramadol 50mg # 90 to 120 tablets, without severe pain symptoms.*

Our planned approach includes universal screening and connections to care across our network of culturally aligned organizations, plus shared population health planning to maximize our impact, and targeted outreach from locally recruited and racially representative CHWs to identify and engage those at highest risk not connected to care. In this way, our collaborative will identify unmet needs that are inequitably represented across racial categories by residents of the targeted area for appropriate linkages to the existing community resources and for targeted advocacy to address these gaps in the system of care. Our stakeholders advising our Hub will be trained and empowered for the advocacy necessary to undo the systematic oppression affecting our community.

How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

Black and Hispanic populations face significant disparities in accessing mental health, substance abuse, primary care, dental care, and social services supports.

Mental Health Need and Disparities. Limited access to mental health care is a challenge that pre-existed COVID-19 and has been significantly exacerbated by the pandemic, across the country and in our targeted zip codes. In 2015, South Cook County reported the highest percentage of individuals with symptoms of chronic depression (2+ years) of all the sub-areas of Cook County. South Cook County

reported that 31.2% of individuals reported symptoms of chronic depression. This is higher than the rest of Cook County by 4.1%.⁷

South Cook County was reported to have the lowest percentage of individuals diagnosed with depression that are seeking help-- nearly 30% of individuals with depression are not seeking care.⁸

Nationally, the CDC reported that the percentage of U.S. adults with recent symptoms of anxiety or a depressive disorder increased from 36.4% to 41.5% and the percentage reporting an unmet mental health need increased from 9.2% to 11.7%, with the largest increase seen among young adults (18-29) during August 2020 to February 2021.⁹ Nationally, only 65 percent of adults who require mental health services receive care.¹⁰ Although one in five children have a mental, emotional, or behavioral disorder¹¹, only about 20% receive care.¹²

Racial disparities are profound. Barriers to care are disproportionately experienced by Black and Hispanic populations. Nearly 60% percent of Black and African American young adults 18-25 and 50 percent of Black and African American adults ages 26-49¹³ or Latinx young adults ages 18-25 with

⁷ Professional Research Consultants, Inc. (2015). (rep.). *2015 Community Health Needs Assessment: Cooke, DuPage & Lake Counties, Illinois*. Metropolitan Chicago Healthcare Council (MCHC). Retrieved November 18, 2021, from https://cdn2.hubspot.net/hubfs/3003156/files/pdfs/2015_PRC_CHNA_Report_-_MCHC_Region_1_.pdf.

⁸ Professional Research Consultants, Inc. (2015). (rep.). *2015 Community Health Needs Assessment: Cooke, DuPage & Lake Counties, Illinois*. Metropolitan Chicago Healthcare Council (MCHC). Retrieved November 18, 2021, from https://cdn2.hubspot.net/hubfs/3003156/files/pdfs/2015_PRC_CHNA_Report_-_MCHC_Region_1_.pdf.

⁹ Vahratian A, Blumberg SJ, Terlizzi EP, Schiller JS. Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic — United States, August 2020–February 2021. *MMWR Morb Mortal Wkly Rep* 2021;70:490–494. DOI: <http://dx.doi.org/10.15585/mmwr.mm7013e2>external icon

¹⁰ Centers for Medicare & Medicaid Services. (2018, November 13). *CMS Announces New Medicaid Demonstration Opportunity to Expand Mental Health Treatment Services*. Retrieved November 17, 2021, from <https://www.cms.gov/newsroom/press-releases/cms-announces-new-medicare-demonstration-opportunity-expand-mental-health-treatment-services>.

¹¹ National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions; O'Connell ME, Boat T, Warner KE, editors. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Washington (DC): National Academies Press (US); 2009. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK32775/> doi: 10.17226/12480

¹² American Academy of Child & Adolescent Psychiatry. (2012). (rep.). *Best Principles for Integration of Child Psychiatry into the Pediatric Health Home*. American Academy of Child & Adolescent Psychiatry. Retrieved November 17, 2021, from https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatic_health_home_2012.pdf.

¹³ Artiga, S., Orgera, K., & Damico, A. (2019). (rep.). *Changes in Health Coverage by Race and Ethnicity since Implementation of the ACA, 2013- 2017*. Henry J. Kaiser Family Foundation. Retrieved November 17, 2021, from <https://files.kff.org/attachment/Issue-Brief-Health-Coverage-by-Race-and-Ethnicity-Changes-Under-the-ACA>.

serious mental illness did not receive treatment in 2018.^{14,15,16} These issues are compounding in the wake of the pandemic. A recent Kaiser Family Foundation (KFF) poll found that nearly half (45 percent) of adults in the United States reported that their mental health has been negatively affected by worry and stress over the virus,¹⁷ and a poll conducted by the Census found that one-fourth of Americans, 18 and older, report feeling nervous, anxious and on edge nearly every day.¹⁸ Heightened mental health risks and needs are apparent among youths who had pre-existing mental health conditions, due to increased stress during COVID-19 as well as potential disruptions in mental health care.^{19,20,21} In our catchment, based on the population numbers alone, an estimated 15,723 adults have a serious mental illness and 14,182 children have a serious emotional disturbance, and even greater numbers experience moderate mental health challenges that impact their functioning. However, our network is reaching only a slim fraction of those in need because we have not had the resources to effectively coordinate our outreach or promote our collective's comprehensive services and cultural alignment with the community.

Substance Use Disorder and Opioid Treatment Access. Between 2015 and 2017, Fentanyl-involved deaths quadrupled in Suburban Cook County.²² In 2017, heroin accounted for over 60 percent of opioid-related overdose deaths. In Hispanics, fentanyl was the most common opioid-drug involved in overdose deaths.²³ Since 2016, 1,576 people have died from opioid overdoses. Approximately 82.9% of the opioid fatal overdoses involved heroin or fentanyl. Similar to national trends, there has been a sharp increase in opioid overdose mortality rate among middle-aged Black/African-American residents. Nearly 22% of the opioid fatal overdoses were Black or African American. In comparison to national trends,

¹⁴ National Alliance on Mental Illness. (n.d.). Hispanic/Latinx. Retrieved November 18, 2021, from <https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Hispanic-Latinx#:~:text=Hispanic%2FLatinx%20communities%20show%20similar,illness%20may%20not%20receive%20treatment.22>.

¹⁵ National Alliance on Mental Illness. (n.d.). LGBTQI. Retrieved November 18, 2021, from <https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/LGBTQI>.

¹⁶ Mental Health America. (n.d.). *Racial Trauma*. Mental Health America. Retrieved November 18, 2021, from <https://www.mhanational.org/racial-trauma>.

¹⁷ Panchal, N., Kamal, R., Cox, C., & Garfield, R. (2021). (issue brief). *The Implications of COVID-19 for Mental Health and Substance Use*. Kaiser Family Foundation. Retrieved November 17, 2021, from <https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>.

¹⁸ US Census Bureau. (2021, October 8). *Week 14 household pulse survey: September 2 – September 14*. Week 14 Household Pulse Survey: September 2 – September 14. Retrieved November 18, 2021, from <https://www.census.gov/data/tables/2020/demo/hhp/hhp14.html>.

¹⁹ Golberstein E, Wen H, Miller BF. Coronavirus Disease 2019 and Effects of School Closure for Children and Their Families—Reply. *JAMA Pediatr*. 2021;175(2):211–212. doi:10.1001/jamapediatrics.2020.35

²⁰ Lee J. (2020). Mental health effects of school closures during COVID-19. *The Lancet. Child & adolescent health*, 4(6), 421. [https://doi.org/10.1016/S2352-4642\(20\)30109-7](https://doi.org/10.1016/S2352-4642(20)30109-7)

²¹ Cui, Y., Li, Y., Zheng, Y., & Chinese Society of Child & Adolescent Psychiatry (2020). Mental health services for children in China during the COVID-19 pandemic: results of an expert-based national survey among child and adolescent psychiatric hospitals. *European child & adolescent psychiatry*, 29(6), 743–748. <https://doi.org/10.1007/s00787-020-01548-x>

²² Cook County Government. (n.d.). Opioids in Suburban Cook County. Retrieved November 18, 2021, from <https://maps.cookcountyil.gov/opioidstory/>.

²³ Cook County Government. (n.d.). Opioids in Suburban Cook County. Retrieved November 18, 2021, from <https://maps.cookcountyil.gov/opioidstory/>.

hospitalization and mortality rates were more than two times lower among Hispanic/Latinx residents compared to Black/African-American and white non-Hispanic residents.²⁴

Chronic Disease and Primary and Specialty Care Access Barriers.

Black and Hispanic populations experience disproportionately high rates of chronic disease, as well as barriers to primary and specialty medical care access.

Obesity. Our area has a higher percentage of adults age 18 and older who are obese (have a body mass index (BMI) $\geq 30.0\text{kg/m}^2$). In 2018, approximately 34.8% of adults were obese in the catchment area. In comparison, approximately 31.8% of adults in Illinois and 30.9% of adults in the United States are obese.

In 2015-2016, Hispanic (47.0%) and non-Hispanic Black (46.8%) adults had a [higher prevalence of obesity](#) than non-Hispanic White adults (37.9%)²⁵. In 2011-2014, the [prevalence of diabetes pdf icon\[PDF-176KB\]](#) was 18.0% in non-Hispanic Black adults, 16.8% in Hispanic adults, and 9.6% in non-Hispanic White adults²⁶.

Hypertension. Throughout our catchment area we have a higher percentage of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have high blood pressure (hypertension). In 2012, approximately 36.5% had high blood pressure in the catchment area. In comparison, approximately 30.5% of adults in Illinois and 30.9% of adults in the United States have high blood pressure.

Diabetes. Approximately 12.3% of resident adults aged 18 and older report having been told by a doctor, nurse, or other health professional that they have diabetes. This is higher than both in Illinois and the United States. Approximately 9.5% of adults have diabetes in Illinois and 10.0% of adults in the United States have diabetes. In our targeted area, some of the highest rates of diagnosed diabetes are in the 60827 zip code where 89.79% of residents are Non-Hispanic Black and 15.4% of adults have diabetes, the 60419 zip code where 92.26% of the population is Non-Hispanic Black and 14.7% of adults have diabetes, the 60643 zip code where 72.31% of residents are Non-Hispanic Black and 14.3% have diabetes, 60406 zip code where 48.22% of residents are Hispanic. These disparities have been starkly illustrated during the COVID-19 pandemic. Indeed, our targeted zip codes are among the top 10% for COVID-19 fatalities in the state²⁷ and for infection rates, averaging 5.9 % positive infections^{28,29}.

²⁴ Friedman, L., Holloway-Beth, A., & Nguyen, N. (2020). (rep.). <https://cookcountypublichealth.org/wp-content/uploads/2021/10/Opioid-Epidemic-in-Suburban-Cook-County-Report.pdf>. Cook County Department of Public Health. Retrieved November 18, 2021, from <https://cookcountypublichealth.org/wp-content/uploads/2021/10/Opioid-Epidemic-in-Suburban-Cook-County-Report.pdf>.

²⁵ Hales CM, Carroll MD, Fryar CD, Ogden CL (2017). Prevalence of obesity among adults and youth: United States, 2015–2016. NCHS data brief, no 288. Hyattsville, MD: National Center for Health Statistics. Retrieved November 18, 2021, from <https://www.cdc.gov/nchs/products/databriefs/db288.htm>

²⁶ Centers for Disease Control and Prevention. (2017). (rep.). *Table 40. Diabetes prevalence and glycemic control among adults aged 20 and over, by sex, age, and race and Hispanic origin: United States, selected years 1988–1994 through 2011–2014*. Retrieved November 18, 2021, from <https://www.cdc.gov/nchs/data/hus/2017/040.pdf>.

²⁷ Metopio. UIC School of Public Health (Sage Kim, PhD)

²⁸ Metopio.io. Various state health departments (COVID dashboards)

²⁹ Metopio.io. Chicago Department of Public Health

Asthma. In 2018, approximately 10.8% of residents indicated that they have been told by a healthcare professional that they have asthma and currently still have asthma. This is both higher in both Illinois and the United States.

Maternal and Infant Health. Pregnancy related needs require special attention in our communities. Our catchment area has a higher percentage of women age 15-19 with a birth in the past year, per 1,000 women age 15-19 than both Illinois and the United States. The teen birth rate in the catchment area is 14.1%, whereas Illinois and the United States have a teen birth rate of 9.9% and 10.6%.

Between 2000 and 2007, the average rate of infant mortality in Suburban Cook County (SCC) was very close to the U.S. rate (7.2/1,000 and 6.8/1,000 respectively). Due to small numbers of infant deaths, there was great variation between years and between districts. From 2000 to 2007, on average, the South district had the highest infant mortality rate, 10.8/1,000, which was double the infant mortality rate of the North district, 4.8/1,000. During 2005-2007, the infant mortality rate for SCC was 15.1 per 1,000, slightly higher than the Illinois and U.S. rates (14.5 and 14.1/1,000 respectively). The infant mortality rate in the South district was 11.3/1,000 which was more than double that of the North district, which was 4.4/1,000. In all regions, the rates of infant mortality for African Americans was approximately double that of Whites and Hispanics. The West district had the highest rate of infant mortality for African Americans (17.8 per 1,000), followed by the South district (14.3 per 1,000).³⁰

Dental Needs and Access Barriers. According to the latest report by the Surgeon General on oral health oral health in the U.S. population. Among Hispanics, there is variability depending on the subgroup (e.g. Mexican, Puerto Rican, Cuban American), but, in general, this population has higher rates of untreated oral health issues and higher incidents of oral diseases. As well, Non-Hispanic Blacks have a higher percentage of dental caries in their primary teeth, and caries that go untreated, than Whites.³¹ Dental conditions are the top avoidable ambulatory care sensitive conditions (ACSCs) in the emergency department and the most frequent in terms of inpatient hospitalization in South Cook County. South Cook County reported that 63.9 per 10,000 Medicaid enrollees end up in the Emergency Department and Hospitalized due to dental conditions.³²

Social and Recovery Support Needs and Barriers. Our area also falls in the top quartile statewide for both deep poverty (income less than half of the federal poverty level)³³ and for the percentage of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits, formerly known as food stamps, over the past 12 months³⁴. Nonetheless, food insecurity is as high as 22.2% of residents in the 60472 zip code where diabetes rates are also concentrated.

³⁰ Cook County Department of Public Health. (2010). (rep.). *Community Health Status Report 2010: Maternal Child Health*. Cook County Department of Public Health. Retrieved November 18, 2021, from <https://cookcountypublichealth.org/wp-content/uploads/2018/12/CHSA-Section-4.pdf>.

³¹ Ibid.

³² Musick, H., Kauth, A., Freeman, V. L., Basu, S., Wang, H., Hershow, R., Gotiwale, K., Flax-Hatch, J., Schneiderman, J. Gao, Y. (2021). Transformation Data & Community Needs Report (South Cook). Illinois Department of Healthcare and Family Services. Retrieved from <https://www.illinois.gov/hfs/Pages/default.asp>

³³ Metop.io. American Community Survey (Table C17002)

³⁴ Metop.io. American Community Survey (Tables B22003, B22005, and S2201)

HFS has noted that “some communities are structurally disadvantaged from benefitting from the transformation model” due to a historic lack of community resources³⁵; however, this is not the case in our area. Our partners have the capacity to improve access to medical, mental health, substance use disorder, dental and services to address the social indicators of health. However, to build community trust, streamline access and facilitate effective coordination we require: additional CHW outreach and engagement support to reach those in need, clinical supports to meet immediate needs within the community setting, and integration infrastructure. As utilization volume increases, in response to our efforts, within our partner organizations, the increased revenue from those billable services will enable us to expand our staffing to meet the expanded need over time and beyond the life of the grant.

Data will be systematically gathered to track which needs can be met through local resources and for which needs resources do not exist, require enhancement, or could be expanded. This project’s collaborative will be organized to collectively advocate with local service providers and with governmental and private funders to address local gaps.

What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise?

Racial inequities are being produced and perpetuated by the lack of proactive local outreach, public health information, and support addressing social influencers of health for those who need it most in our community. Our siloed and segregated system is not adequately resourced to reach out to those who we know most need our care. Instead, we serve the population most able to access and engage in available services. The continued impact of the pandemic only exacerbates and compounds the inequitable access and increases the divide between those needing and receiving our services. These inequities arose due to the systemic racism that has traditionally established healthcare as a privilege versus a right and advantages those whose resources and socioeconomic circumstances facilitate utilization and hid the evident impact on racial groups, even in areas such as ours, where the majority of the population is Black and Hispanic.

Local Black and Hispanic populations have experienced difficulty accessing and navigating care that has left them feeling that the health care system does not work for them—in many cases they have lost hope that their needs will or can be addressed. Too often, the combined impact of poverty’s competing demands and frustration with a system built to treat rather than prevent illness limits tolerance for the challenges of identifying providers, securing needed appointments, arranging technology for telehealth or accessing transportation, obtaining medications, and following recommendations for diet and lifestyle changes.

These inequities are rooted in systemic racism. Chicago has been identified as one of the most segregated cities in America. According to an analysis conducted by Racial Residential Segregation and Exclusion in Illinois, 9 of our communities are listed among the 15 most segregated areas in the Chicago Metro Area, based on their dissimilarity Index scores which measure their lack of racial diversity,

³⁵ Musick, H., Kauth, A., Freeman, V. L., Basu, S., Wang, H., Hershow, R., Gotiwale, K., Flax-Hatch, J., Schneiderman, J.Gao, Y. (2021). Transformation Data & Community Needs Report (South Cook). Illinois Department of Healthcare and Family Services. Retrieved from <https://www.illinois.gov/hfs/Pages/default.asp>

including East Hazel Crest, Blue Island, Alsip, Chicago Heights, Matteson, Lansing, Markham, Chicago, and Dixmoor.

Concentrated Black and Hispanic populations such as those in our targeted communities have resulted from the accumulated effects of many factors rooted in historic and modern-day racism. Over 500 communities in Illinois have been documented as probable Sundown Towns, in which non-whites are excluded via discriminatory local laws, intimidation, or violence. Of these, 218 have been confirmed, and only half of these towns have formally shed their status even today. In these “whites only” communities, violence was threatened and used to expel the Black population. The earliest riot, in Springfield in 1908, became the prototype for at least 12 similar attacks on African Americans in which they were literally driven from the towns. In addition to violence, other techniques included threats of violence documented in ordinances passed to prohibit Blacks from being in the town after sundown, even having whistles sound to indicate the 6 pm curfew by which Blacks need to leave or be escorted out by the police. Suburbs such as ours in South Suburban Chicago used intimidating acts such as local governmental officials refusing to turn on utilities and restrictive deed covenants that prohibited the sale of property to blacks and established private associations to permit exclusion of certain group members. Local, state, and federal policies created segregation by restrictive zoning ordinances and federal policies on public housing, transportation, and redlining in home loan programs.

These statewide practices were then compounded by the Great Migration during the period from 1916-1970, during which 6 million African Americans fled to urban cities in the north to escape racist Jim Crow laws enacted in the rural South. Despite the Fair Housing Act of 1968, housing discrimination persists in practice because enforcement has been low and because practices such as racial steering – the act of showing minority clients neighborhoods where their group predominates—persist. Black home buyers are also more often steered toward predatory lenders and face difficulty obtaining property insurance³⁶.

Consequently, Black residents are heavily concentrated in segregated areas of Chicago, especially in projects managed by the Chicago Housing Authority. The CHA was sued for racial discrimination in 1968 and entered a 20-year period of receivership during which conditions deteriorated and crime increased. Ultimately, in 2000 a Plan for Transformation led to the high rises being demolished one by one to provide shoreline access for wealthier Chicagoans. Alternatives were slow to be developed which pushed many Black residents into suburbs such as ours.

The South Suburban landscape was a predominantly white industrial center, until the area was devastated by the downsizing and eventual closure of several plants, including the Allied Tool Manufacturing Corporation and the Ingalls-Shepard Division of the Wyman Gordon Steel Mill in Dixmoor in the 1980s. Although a majority of the manufacturing buildings have been demolished, the Environmental Protection Agency has listed the location as a brownfield in need of cleanup before development can continue. As one local observer commented: “The long-abandoned Wyman-Gordon Power & Manufacturing plant, formerly located in Harvey Illinois-So sad to see the extreme deterioration of what was once a thriving Chicagoland spot....This town was once filled with jobs, grocery stores, clothiers, pharmacy stores, bakeries & restaurants, even movie theaters....Now it’s all gone, the main street(154th), closely resembling images of some vast & virtual post-apocalyptic

³⁶ Krysan, M. (2009). (rep.). *Racial Residential Segregation and Exclusion in Illinois*. Institute of Government & Public Affairs. Retrieved November 17, 2021, from <https://igpa.uillinois.edu/sites/igpa.uillinois.edu/files/reports/IR09-Ch4-Segregation.pdf>.

nightmare....The last time I made a trip down that street, it was really hard for me to hold back tears, remembering what it once was....”³⁷

The resulting layoffs led whites to leave and provided affordable housing for displaced African Americans who were pushed into the suburbs. Although resources were promised, they were not provided and this created the current situation, in which large numbers of Black residents live in poverty, cut off from employment opportunities because the area lacks adequate opportunities or transportation to reach employment elsewhere. The southern Chicago suburb has three expressways, four national highways, four freight railroads and the Chicago Metra lines running through it. PACE buses in our community run at limited hours and connect to city buses at only a few times, which can leave residents stranded in the City overnight. The Metra commuter rail line’s cost exceeds what many can pay and it doesn’t even effectively penetrate the community.

Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

Racism and segregation remain prevalent, however our Hub does address several key root causes in terms of renewing fractured community linkages for a displaced population, supporting access to available community-based resources, and beginning to establish vital connections to the care and services necessary to undo racial health disparities, including empowering active local participation in community-led population health planning.

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

This proposal seeks to unite a network of Non-Hispanic Black and Hispanic/Latino- run and staffed health and human service organizations to establish an integrated network that truly promotes culturally congruent and ethnically and linguistically responsive outreach and engagement by utilizing CHWs recruited from our targeted communities. In this way, we will improve care engagement and begin to better understand how best to adapt and respond to the highest need populations whose health inequities most need attention from the providers who are best suited to guide the broader system changes necessary to improve health outcomes. We will also be identifying and engaging community leaders in our Advisory Council to empower their leadership in the ongoing advocacy that our Hub’s data will drive. Our united partnership will be dedicated to facilitating access to care and to identifying, and quantifying, the very real gaps in our local system of care. As well, the increased utilization of our organizations’ services will drive demand and support our own capacity building to better match the true level of local need.

Additionally, The Link & Option Center is pursuing National Commission for Health Education and Credentialing (NCHEC) 'Designated Provider' status to offer continuing education activities for Certified Health Education Specialists (CHES®) and Master Certified Health Education Specialists (MCHES®). This certification offers professional development opportunities of interest to health education professionals seeking to be designated CECH providers. The U.S. Department of Labor defines health educators as those that provide and manage health education programs and that help individuals, families, and their communities maximize and maintain healthy lifestyles. The benefits of The Link & Option Center, Inc. becoming such a provider include:

³⁷ Vanished Chicagoland: <https://www.facebook.com/groups/vanishedchicago/permalink/3825602810839783/>

- Increasing the visibility of The Link & Option Center by attracting more health education professionals to our activities,
- Elevating our organization's credibility by being a nationally recognized provider of continuing education for health education specialists, and
- Enhancing the health education profession by providing a valuable service to our South Cook County Region.

The Hub will strengthen the workforce by encouraging its CHW's to pursue the healthcare industry as a career path and consider becoming a Health Education Specialist and ultimately become a Certified Health Specialist (CHES).

What are negative or unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal?

We recognize that the demand for culturally competent and readily accessible care is literally overwhelming. Our ambitious scale seeks to leave no one out and must maintain equitable guardrails to assure that we are able to maintain access without creating delays. Screening to filter our intakes into the HUB and then stratifying the population to assure intensive and immediate supports are targeted to those with the greatest and most immediate needs will both help to streamline who we serve and how effectively we operationalize our model. However, we do anticipate that we will receive more referrals than our own providers can reasonably be expected to serve right away. While this is a negative consequence of our robust outreach plan, we do see an opportunity in that our network will attract patients who are already empaneled with PCPs who are not in our network. While this could be negative in that those patients, if they choose to retain their current assigned PCP, will not benefit from the full array of integrated care coordination we will establish among our participating providers, it is also an important opportunity for the CHWs to serve as cultural brokers. As our local CHWs support access to these non-Hub providers they will be able to share insights and build these providers' capacity for improved engagement in the future. In this way we can both limit the burden to our own network while assuring access for all to more culturally competent care throughout the health and human service system more broadly.

In addition, we recognize the challenges involved in hiring workers at this point in our country's labor history. To overcome this potential barrier, the focused recruitment support that our partners can collaboratively generate will be coupled with a recruitment campaign that leverages interest in addressing racial health disparities within our community as part of a culturally responsive network.

Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized?

Our network of providers is predominantly Non-Hispanic Black which matches the demographics for the largest percentage of the communities we serve. However, the population we serve is also heavily Hispanic. To help to balance this potential inequity, we will be recruiting bi-language, bi-cultural, and Hispanic staff for the project. As well, our partners are committed to adopting shared practice standards, such as alignment with CLAS standards that guide organizations in their practices related to recruitment, hiring, training, and care delivery to ensure that the workforce and the services provided are culturally and linguistically responsive to the local populations served.

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?

It would be ideal if every local provider, organization, hospital, and managed care plan were fully aligned to assure racial equity and inclusion... or even if our network of Black and Hispanic-led organizations were limited to entities that are already fully CLAS aligned. Instead, to ensure that the ideal does not become the enemy of progress and remain dedicated to achieving positive impacts on racial equity and inclusion, our network of willing entities will strive toward racial equity and inclusion goals. Our Partnership Agreement and governance structure will be grounded in CLAS-alignment and in data tracking, monitoring, and reporting to guide our continued attention to our shared goals for racial health equity and inclusion.

Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement?

Our proposal was initially far more expansive. Based on feedback from our stakeholders and data from our partners, we distilled and focused our approach to ensure implementation success.

Our budget is robust and realistic, recognizing that this seed funding for our eventual financing through managed care contracting, must be targeted toward demonstrating our cost-effective impact on outcomes for the highest need populations where cost savings is most possible. We also recognize that many people in our communities are not receiving routine care. While we expect health care costs to rise initially, we have created a program and model that over time will reduce the total cost of care as preventative and routine care becomes more accessible in our communities.

Mechanisms such as stratifying our Hub participants based on their level of risk for hospitalization or ED use is designed to target inequities as well as appeal to payers. Our enforcement of the network's commitment to shared goals for contracting with managed care with an emphasis on reducing health disparities in our region is integral to our governance structure and to the powerful role that stakeholders will play in keeping our program accountable to those it is intended to serve.

Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

The Collaborative will contract with the African American Family Research Institute who will have the responsibility of collecting data monthly from all collaborative partners, solicit stakeholder participation through survey, and submit quarterly reports to the Leadership Council for review and approved reports will be uploaded on the HUBs website for public viewing

Our model is designed to promote shared accountability to our local community across our network via transparent data sharing, activated stakeholder engagement, and routine progress reporting.

Our goal is to leverage our Hub Advisory Council to inform our efforts and the information that we disseminate to the community. The Hub will deploy a "Community Care Campaign" about our Hub and its CHWs and services, local health, how to access services, and where to go to access community-based care. We will promote the campaign via local media, including PSAs, monthly community newsletters, social media, radio, TV, and print materials.

The campaign's intent will be to reduce unnecessary emergency department visits by educating patients on the proper usage of the ER, drive patient education, and promote community-based primary care and behavioral health engagement to reduce reliance on the emergency department. This information will be provided on partner websites and at physical office-based locations and throughout the community.

What are the success indicators and progress benchmarks? How will impacts be documented and evaluated?

Our success indicators will include the volume of new clients we reach who have not been previously connected to needed care and services, the volume of risk factors (pathways) that we identify and complete (mitigate), the increased engagement we measure across our community-based care sites, and the impact on local health indicators-- as described below --related to HEDIS. Our success will also be indicated by how racially/ethnically representative our workforce and Advisory Council is, and by the successful development of groups and workflows necessary to effectively implement the Hub. Our Advisory Council will be tasked with setting goals and benchmarks for the Hub. Accordingly, our successful generation of the hub's data, to identify local needs, and recruitment of the correspondingly relevant stakeholders (respective to sector, geography, impacted community members, etc.) will be crucial success indicators, in addition to the Hub needs assessment, policies and procedures, and aligned strategy. The Hub strategy and targeted evaluation efforts respective to specific highest risk groups will also be important in documenting and evaluating our impact.

How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

Stakeholder engagement, level of participation in the project, and the diversity of participant makeup will be assessed through recordkeeping of the Advisory Council meeting attendance and level of input and recommendations made to the Leadership Council.

Community Input:

Service Area of Proposed Intervention:

- **Region:** South Suburban Cook County Region
- **Counties:** Cook County and Will County
- **Zip Codes:** 60803, 60406, 60633, 60409, 60643, 60411, 60478, 60445, 60426, 60419, 60429, 60422, 60425, 60426, 60429, 60430, 60438, 60428, 60411, 60475, 60443, 60445, 60452, 60461, 60462, 60466, 60426, 60469, 60471, 60827, 60472, 60411, 60473, 60476, 6047, 60466

Community Input:

Community input was first sought in February 2021 through interviewing and surveying current clients to assess the need for triage center services in the South Suburban region. Input was also gathered to better understand the mental health disparities that exist in the community, identify gaps in services and gain a clear understanding of how Black and Brown ethnic groups view wellness and being well. Our

partners met weekly to design a draft model, based on local data and this initial input, that was both responsive to local need and complementary to our existing services.

We then convened listening sessions on October 16th and 30th with an array of predominantly Black community members recruited by staff of our partner organizations and our local legislators. We conducted direct outreach by phone and in-person, plus electronic emails and texts, website notices, and public flyers. Together, we engaged 140 new and established network clients, as well as local residents receiving other community supports; our October 16th session included 75 attendees and our October 30th session included 65 attendees.

We called these sessions “Coffee, Tea with Me” and held them at The Link & Option Center.

Findings from the Listening Sessions identified the following:

- After being presented with a handout illustrating how to access care, 75 attendees shared responses that indicated that they do not know when to use the ER, After Hours Clinic or Community Mental Health Center for their care. These attendees reported long wait times of 2 hours or more when seeking care in the community.
- 65% indicated that having someone to assist them in navigating the healthcare system would be helpful.
- 100% indicated that either they or others will need rental assistance after the Eviction Moratorium is lifted.
- 35% indicated that MCOs should facilitate connections to school-based mental health services to assist in supporting more rapid access to care
- 50% endorsed the importance of having Specialty Physicians’ offices nearer to their home to eliminate having to travel to places far outside of their community to access services.
- 100% agreed that a follow up phone call after ER discharge would be helpful.
- 100% indicated that either they or a family member has been diagnosed with hypertension or diabetes.
- 25% stated that they do not trust that medication prescribe by ER doctors is right for them and indicated that they would like to have pharmacists to educate them regarding proper medication management.

Input from Elected Officials:

Did the collaborative consult elected officials as you developed the proposal?

The following elected officials participated in the development of the proposal.

- Senator Michael Hastings (Majority Caucus Whip, State Senator, 19th District)
- State Senator Napoleon Harris (State Senator, 15th District)
- Senator Elgie Sims (State Senator, 17th District)
- Senator Kimberly Lightford (State Senator, 4th District)
- State Representative Debbie Myers-Martin (State Representative, 38th District)
- State Representative Thaddeus Jones (State Representative, 29th District)
- State Representative Marcus Evans (State Representative, 33rd District)
- State Representative Anthony Deluca (State Representative, 80th District)

- Congresswoman Robin Kelly (US Representative, 2nd District)
- Commissioner Donna Miller (County Board Commissioner, 6th District)
- Commissioner Debora Sims (County Board Commissioner, 5th District)
- Senator Mattie Hunter, (Majority Caucus Chair, State Senator, 3rd District)
- State Representative Camille Lilly (State Representative, 78th District)

Data Support

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

To design our proposed approach, we leveraged multiple data resources and tools, including:

- The **Transformation Data and Community Needs Report for South Cook County**³⁸ that was prepared by the University of Illinois at Chicago School of Public Health and Institute for Healthcare Delivery Design for the Illinois Department of Healthcare and Family Services. It details the findings and methods for a study conducted to understand health outcomes and community needs in South Cook County.
- **Metopio** software, which uses data and visualizations to reveal valuable, interconnected factors that influence health in our targeted area.
- **Health Management Associates' Community Health Needs Assessment (CHNA) Data Tool** which facilitates assessment of demographics and health status for a defined geographic region, including variations in demographics and status within or across the service area. The data tool utilizes federally approved extrapolation techniques to “drill down” on small units of geography (e.g., one or a few zip codes) to create statistically significant geographic variation of demographic and health status prevalence or rate data compared to benchmark indicators, as well as identification of service gaps.
- **Stakeholder input** from local residents was collected via a survey of 75 community residents and in-person listening sessions with 140 community members recruited by our partners. Below is a copy of the survey administered at our community input sessions to collect data to inform our initiative.

Health Equity and Outcomes

Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity.

Our partnership aims to improve access to health, mental health, substance use and opioid use disorder and other social care and services in the community in order to increase the proportion of Prior and Subsequent Outpatient Care among Patients Who Received Hospital-Level Care for Mental Disorders 3 months prior to their inpatient care. This rate, in South Cook County, according to the Transformation Data and Community Needs Report for South Cook County,³⁹ is currently 12.3%, and 18.6% are

³⁸ Musick, H., Kauth, A., Freeman, V. L., Basu, S., Wang, H., Hershow, R., Gotiwale, K., Flax-Hatch, J., Schneiderman, J.Gao, Y. (2021). Transformation Data & Community Needs Report (South Cook). Illinois Department of Healthcare and Family Services. Retrieved from <https://www.illinois.gov/hfs/Pages/default.asp>

³⁹ Musick, H., Kauth, A., Freeman, V. L., Basu, S., Wang, H., Hershow, R., Gotiwale, K., Flax-Hatch, J., Schneiderman, J.Gao, Y. (2021). Transformation Data & Community Needs Report (South Cook). Illinois Department of Healthcare and Family Services. Retrieved from <https://www.illinois.gov/hfs/Pages/default.asp>

connected to care within 3 months following an inpatient or ED admission, including hospitalization related to injury or illness. We also seek to improve the Proportion of Prior and Subsequent Outpatient Care among Patients Who Received Hospital-Level Care for Psychoactive Substance Use Disorders, which is 23% prior and 44.7% after inpatient in South Cook County⁴⁰ at present. We also seek to improve the proportion of Prior and Subsequent Outpatient Care among Patients Who Received Hospital-Level Care for Ambulatory Care Sensitive Conditions (ACSCs), health conditions or diagnoses for which timely and effective outpatient care can help to reduce the risks of hospitalization by either preventing the onset of an illness or condition, controlling an acute episodic illness or condition, or managing a chronic disease. In South Cook County, only 19.3% of individuals had care prior to their ED or inpatient visit and only 32.8%⁴¹ are connected to care within the 30 days post inpatient hospitalization.

We specifically aim to improve these rates among our targeted region's Black and Hispanic population.

South Cook contains zip codes with particularly low facilities accessibility combined with high rates of disease. In fact, one contiguous area in our South Cook region includes Blue Island, Robbins, Midlothian, Crestwood, and Palos Heights, which has the highest rates of hospital-level care for bipolar, depression, and substance use disorders and the lowest rate of facilities accessibility⁴².

Access to primary care is a key component of preventing and managing a variety of ambulatory care sensitive conditions (ACSCs), so we will be seeking to connect every client with a PCP⁴³, support their transportation to attend appointments, accompany them when necessary, and educate each client regarding the importance of engaging in their care.

Large portions of South Cook are food deserts as defined and identified by the USDA,⁴⁴ so our proposal seeks to ensure that each person has secure access to healthy food via our pantry partners and our collective impact efforts.

Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes.

Our stakeholders reported that the causes of these disparities relate to difficulty accessing and navigating the service system. Challenges mentioned as priorities related to transportation barriers, language barriers, providers' hours of operation, and difficulty accessing telehealth care due to lack of a device. These findings complement those shared by stakeholders convened to inform the

⁴⁰ Musick, H., Kauth, A., Freeman, V. L., Basu, S., Wang, H., Hershow, R., Gotiwale, K., Flax-Hatch, J., Schneiderman, J.Gao, Y. (2021). Transformation Data & Community Needs Report (South Cook). Illinois Department of Healthcare and Family Services. Retrieved from <https://www.illinois.gov/hfs/Pages/default.asp>

⁴¹ Musick, H., Kauth, A., Freeman, V. L., Basu, S., Wang, H., Hershow, R., Gotiwale, K., Flax-Hatch, J., Schneiderman, J.Gao, Y. (2021). Transformation Data & Community Needs Report (South Cook). Illinois Department of Healthcare and Family Services. Retrieved from <https://www.illinois.gov/hfs/Pages/default.asp>

⁴² Ibid.

⁴³ Ibid.

⁴⁴ Ibid.

Transformation Data and Community Needs Report for South Cook County, ⁴⁵ which are excerpted in the following italicized sections, as they track very directly to our planned approach.

In those Stakeholder sessions, respondents reported a lack of knowledge about diet and exercise best practices, not knowing how to cook for health, and lack of awareness of the signs and symptoms of prevalent chronic diseases (such as diabetes, hypertension, depression, etc.). Our South Cook residents specifically described a particular lack of knowledge about mental illness and described neither knowing how to prevent mental illness or help someone who is in crisis, or about what resources are available for those in need. Residents expressed interest in learning mental health first aid (MHFA) to help friends and family members in crisis TLOC, the lead entity for our network conducts MHFA training and will therefore leverage that existing capacity to support outreach, while simultaneously recruiting stakeholders who can in turn be trained to share this training in their own networks.

Community members' suggestions for how to address health information and health service navigation barriers, included pairing preventive health information with community-based programs to teach the skills needed to shift behavior and offer social support, health fairs, healthy cooking classes, farmers markets, and exercise programs offered through local schools, community centers, and the park district. Residents recommended that messaging about available health resources be culturally tailored to communities and appropriate channels identified to ensure reach and penetration. Our CHWs will not only directly provide health education using the Pathways health education learning modules, but they will also leverage these ideas as both service settings and to recruit new collaborators into our network.

In South Cook, the cost of healthy food, transportation, health insurance premiums, and co-pays was particularly highlighted. Residents managing chronic illnesses faced barriers being able to afford specialty care, medications, and healthcare supplies, such as test strips for diabetics and blood pressure monitoring devices for those with high blood pressure. Our CHWs will be able to identify these risk factors for individuals and families to identify options and support planning that is specifically designed to meet their unique needs, via their Medicaid coverage, referrals to local support, and targeted community-level advocacy to address systemic economic challenges.

Several residents described shifting from employer-provided insurance to public insurance due to job layoffs, some associated with the COVID-19 pandemic, and as a result, not being able to see a provider who they had seen in the past. Such changes forced some to seek care outside of their community and others to delay care. Residents also spoke of providers who seemed rushed or appeared to lack time to field questions or ensure that they understood the patient's needs, being provided with a prescription but not addressing options or available resources to help manage a condition, and feeling they were being treated as a number and not a person. South Cook residents sought relationship-based care with healthcare providers but instead experienced care that was rushed and impersonal. A number of residents noted that repeated negative encounters with the healthcare system influenced their decisions to not engage with it at all. Our plan is designed to establish a system of integrated care from providers who reflect our community and are committed to developing the relationships with their clients that are necessary to improve outcomes. The need for culturally competent and representative care providers was consistently expressed across the community conversations. Residents seek providers who

⁴⁵ Musick, H., Kauth, A., Freeman, V. L., Basu, S., Wang, H., Hershow, R., Gotiwale, K., Flax-Hatch, J., Schneiderman, J., Gao, Y. (2021). Transformation Data & Community Needs Report (South Cook). Illinois Department of Healthcare and Family Services. Retrieved from <https://www.illinois.gov/hfs/Pages/default.asp>

understand their local cultural and behavioral norms, especially with regard to mental health services in the Black communities of South Cook. Latinx residents of South Cook described disappointing care experiences when interpreters were not available to communicate with the provider, so our budget includes costs for interpreters. The Link & Option Center has engaged the interpretation services of Pals International for On-the-Phone and Video Remote Interpretation.

Many residents spoke of being socialized in their families to not go to the doctor for preventive care. Others described their families passing down beliefs in home remedies and prayer over medical intervention. Similarly, cultural beliefs in both the Black and Latinx communities about men needing to be self-reliant contribute to males not seeking care. Unethical scientific experimentation on the Black community in the past casts a long shadow and continues to fuel mistrust of the medical establishment. Our plan includes expedited access to a trusted local leader who is Black or Hispanic and can broker connections to a racially, culturally, and linguistically responsive provider network prepared and able to address these care barriers with individuals and at the community level via public education and health information sharing. Our planned approach to CHW convenings on a monthly basis and to the Hub Advisory Council quarterly will help to ensure that issues such as these are proactively addressed at every level of our Hub.

Residents spoke of the emotional, physical, and economic strain that chronic illnesses can put on individuals as well as on their family and friends. Caregiving becomes an additional job that can be part driver, counselor, advocate, care coordinator, cook, interpreter, and nurse. These additional responsibilities can become a source of stress that in turn can affect the caregiver's health. Chronically ill residents without strong support systems spoke of social isolation as well as delayed care due to lack of logistic and emotional support. COVID-19 has exacerbated both the strain on support systems and social isolation. Our approach involves comprehensive risk assessment for every member of the family when a high-risk individual is identified or located during our community outreach. We will use data to systematically track progress addressing every risk factor for every assessed person, coordinating care in a shared care plan across the involved sectors (i.e. medical, behavioral health, dental and social care), and facilitated development of trusted relationships with a local CHW and with the person's providers.

Environmental barriers mentioned by residents across all community input sessions include living in a resource desert (food, recreation, green space, transportation, healthcare facilities, etc.), the presence of unhealthy food options in communities, prevalence of drugs and alcohol in the community, poor air quality and exposure to ongoing crime, street violence, domestic abuse, neglect, and discrimination. For South Cook in particular, residents' top concerns in terms of staying healthy and accessing healthcare were a lack of resources, specifically food, transportation, and safe recreational resources. There's a lack of full-service grocery stores in the most distressed areas of South Cook and, at the same time, a prevalence of unhealthy food options. Each person will be supported to develop a highly individualized care plan that engages both formal and informal services in our local community. CHWs will support access to needed providers, employment resources, local services, and to our program's transportation and food resources—whatever they and their family identify as their needs. For issues related to the local environment, our network may recommend resources that are “off the radar” for non-local providers and MCO care managers and may identify specific needs that require a community response from our stakeholders' collective impact efforts.

Transportation options are limited for many residents. Transportation is a primary component of our plan. We will assist each person in need of transportation, to make a plan that leverages their available resources, including identifying plans for maximizing public transportation, each person's MCO resources, with our vans available as a backup when necessary or for a short term as longer-term solutions are developed.

Finally, residents felt that there was a lack of safe recreational options in the area. While there are trails and parks in many areas of South Cook, residents often don't feel safe using them. Our plan will engage a CHW and the primary and specialty care providers supporting each high need person to develop a plan that reduces their risk factors and maximizes their health. Weight loss and exercise plans will leverage local gyms and public resources, potentially including the data-informed development of group exercise and nutrition programming that leverages programming from our pharmacy partners, input from our nutritionist, and health coaching from our CHWs and is planned in targeted geographies where we identify concentrated levels of chronic disease and difficulty completing fitness related "Pathways".

The COVID-19 pandemic has heightened barriers to staying healthy and accessing care and contributed to increased violence, addiction, mental health issues, and difficulty managing chronic conditions. Community residents saw impacts of COVID-19 in unemployment and the sudden loss of insurance; isolation exacerbating mental health issues; suspension of in-person 12-step programs; postponement of needed care for fear of going into healthcare facilities; friction with telehealth, due to lack of equipment, internet access, or technical knowledge or dissatisfaction with past telehealth appointments; stress and depression as a result of losing friends and family members to the virus. In addition, several residents described the closure of local pharmacies in the aftermath of George Floyd's death and the subsequent social unrest which prevented them from obtaining medications to manage chronic conditions. Our network includes addressing the full array of needs each person presents via a relationship with a local person who has also experienced similar issues. It addresses telehealth access, mental health and SUD treatment access, and employment needs, and will assist people to maximize available COVID-19 related resources while gathering data and engaging local partners to ensure that our on-going response, at the community level, remains aligned with true local needs and priorities.

According to The Transformation Data and Community Needs Report for South Cook County,⁴⁶ transformation efforts need to concentrate on clinic-community linkages that provide primary and secondary care and community-based wraparound services to help people manage chronic illnesses, mental illnesses, and substance use disorders. Clinic-community linkages leverage the treatment expertise of healthcare systems, the on-the-ground knowledge of community-based organizations, and the trust that residents have in those organizations to support an active approach to chronic disease management, to restore trust in the healthcare system in socially vulnerable communities and increase engagement in healthcare. Our Hub embodies this guidance.

What activities will your collaborative undertake to address the disparities mentioned above?

Our partnership will recruit, hire, train and employ a cadre of local culturally competent community health workers to conduct outreach, find and proactively engage the highest need populations, and

⁴⁶ Musick, H., Kauth, A., Freeman, V. L., Basu, S., Wang, H., Hershow, R., Gotiwale, K., Flax-Hatch, J., Schneiderman, J.Gao, Y. (2021). Transformation Data & Community Needs Report (South Cook). Illinois Department of Healthcare and Family Services. Retrieved from <https://www.illinois.gov/hfs/Pages/default.asp>

coordinate care via our proposed MyCorCare Hub™. Our collaborative network of clinical care partners will include those mentioned above, plus the Olympia Fields-based providers of Specialty Physicians of Illinois, and community-area dialysis centers. Our collaborative team will be led by our Medical Director Dr. Syed Khadri and Consulting Psychiatrist, Dr. Anjum Mujahid. Our APN Prescriber, Kathryn Robinson-Peoples will guide care provided by a team of 48 Community Health Workers (CHWs) to serve as Case Managers, 12 CHWs to serve as Recovery Support Specialists, 24 CHWs to serve as Doulas, 4 Substance Abuse Counselors (CADC), 8 Mental Health Clinicians, 2 Licensed Clinical Social Workers, 4 Project Care Managers for Chronic Disease Management, 2 outreach coordinators, 15 outreach specialists.

What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

We will assess the impact of our collaborative, most immediately based on collecting metrics that will demonstrate the number of appointments made, attendance rate at appointments, HEDIS outcomes (see below), and assessments which will be administered every six months to monitor client improvement from baseline at time of admission. We will collect baseline data on each patient at the time of referral and will administer standardized assessments including the PHQ-9, depression risk screening, domestic violence screening, social determinant of health screening, and substance use and opioid disorder risk screening. This will be facilitated through the Pathways comprehensive risk assessment model.

Our planned approach includes universal screening, comprehensive risk assessment, development of a single care plan, and support to facilitate access to quality care across our network of culturally aligned organizations.

Each family member onboarded will also receive the standardized and comprehensive assessment of modifiable risk factors to inform whole-person, holistic care planning. The risk assessment process comprehensively identifies interrelated risk factors associated with medical, behavioral, dental, and social indicators of health.

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

We will use the baseline assessment to measure and assess progress at six month intervals. This will give us quick feedback on an individual's outcomes as a result of our interventions. We will also be collecting claims-driven HEDIS metrics to assess outcomes according to the services an individual receives. This will all be centrally tracked through our partners EHRs which will feed into our population health tool, HealthEC. To ensure rapid risk reduction, our team will highlight which people and families present the greatest combined risks and where, in the community, concentrated risks or delays/barriers in accessing care or services requires attention due to geographic, subpopulation, or systems issues. This population data will inform our collaborative efforts with our partners and at the community level to address local health disparities. At the community level, our Hub will provide an access point for referrals, coordination, and community-led planning to reduce disparities. We will convene a Monthly CHW Meeting with our team to coordinate service planning, expediate access to needed care, and resolve any barriers or issues that might jeopardize a person's outcomes within our network of clinical and community-based partners. Findings from this meeting will inform our messaging, education, outreach, and service delivery approach and be reported to our quarterly Hub Advisory Council, which will address broader systemic needs and issues related to needed service improvements.

Access to Care

Name the specific obstacles or barriers to healthcare access you are targeting in your service area. Describe the causes of these obstacles that your project specifically seeks to address and explain why you have chosen to address these causes. What activities will your collaborative undertake to address the disparities mentioned above?

Access to and willingness to access existing primary care is a key component of preventing and managing a variety of ambulatory care sensitive conditions. South Cook contains zip codes with particularly low facilities accessibility combined with high rates of disease. In fact, a contiguous area in South Cook that includes our targeted region's communities of Blue Island, Robbins, Midlothian, Crestwood, and Palos Heights has the highest rates of hospital-level care for bipolar, depression, and substance use disorders and the lowest rate of facilities accessibility. A review of HRSA's primary care shortage data shows that portions of South Cook and the other 4 study areas have primary care shortages. For this reason, our partners will take immediate steps to improve local access to care for Medicaid Enrolled clients with mental health, substance use disorder, opioid use disorder, dental and human service needs, primary and specialty care needs. Our approach is focused on clinic-community linkages that provide primary and secondary care and community-based CHW services designed to comprehensively support the identification and connections to care and services needed by each high risk person and their family members.

To reduce stigma, educate, and empower people to make use of the health care system, we will be leveraging our collaborating partners' cultural congruence, combined with the racially and ethnically aligned CHW workforce, to maximize our systems' capacity to and promote access to our system of care's community-based organizations. Our Hub will provide trained CHWs who are trusted by the residents in our targeted local communities. Our relationship-focused design will, in this way, help to restore trust in the healthcare system for our socially vulnerable communities and increase their engagement in healthcare.

To overcome a lack of facility access in some areas of our region, our CHWs will be trained and resourced to bring health education and the technology necessary to access prompt care right into the homes of our highest need populations. These immediate connections, plus support for ongoing engagement, are hallmarks of our plan. As well, our network will ramp up its provider workforce, as the volume of patients grows over time, based on our targeted campaign to find, reach, and engage those at highest risk.

To identify areas for targeted interventions, the Hub will convene monthly CHW meetings for team input and routinely survey participants about their experience of the Hub's services and the services provided by our network member entities. Participants will be surveyed after 3, 6, and 12 months and/or discharge from the Hub, whichever occurs first.

Many chronic conditions like diabetes, hypertension and heart disease are diet related ACSCs and large portions of South Cook are food deserts as defined and identified by the USDA. Our nutritionist will work with clients whose dietary needs require customized planning to leverage their local resources and maximize our Hub's food pantry support.

Social Determinants of Health

Name the specific social determinants of health you are targeting in your service area.

We recognize that every person is impacted by a unique array of social determinants that do not fit into discrete categories. Our planned approach is therefore rooted in comprehensive assessment of SDOH needs. For example, a housing need could be for rental assistance, emergency shelter, home repairs, or for the recovery housing our network partner Elite Housing for Sober Living can offer, as described below. For this reason, we will use the Pathways comprehensive risk assessment model. This approach identifies the full array of social determinant of health needs presented by each individual and supports the care planning necessary to help each person prioritize their needs--whether social, medical, or behavioral-- that matter to them. We will also utilize Now Pow, the personalized electronic community referral platform that, similarly, is responsive to each need, for every person. The SDOH supports that our network will also directly address will initially, during the grant period, include the following:

Transportation. We are specifically targeting access to care barriers such as transportation, via our Hub. Limited transportation is a significant care barrier, especially in the winter. Handicapped accessible hospitality will be leased to transport clients to medical appointments, and those discharging from ER and referral to the Hub for crisis triage. We will advocate and coordinate with MCOs, when indicated to secure and speed access to available transportation supports, as well as contract with Uber Health to be a backup source of transportation to make their in-person PCP appointments or specialty care doctors' appointments and BH appointments when the van is unavailable during peak hours of the day. We anticipate assisting approximately 300 people per quarter. An arrangement will be made with Uber Health to certify our workers to be Uber Health drivers using their own vehicles, and to only serve our Hub clients when and if the van service is not available. Clients in need of transportation to their appointments will call the designated Concierge Line created specifically for transportation purposes and a Transportation Care Coordinator will secure the transportation.

Technology for Telehealth. To address the gap in accessing telehealth by people who lack an appropriate device, our hub will bring telehealth technology and support directly to the homes of those who need it, as our CHWs will carry telehealth enabled tablets and arrange visits to accommodate appointments, as needed for those who require such access.

Housing. Our network will customize the support for needed housing assistance based on each person's needs. Additionally, we will facilitate access to recovery housing from Elite Housing for Sober Living, which provides recovery housing for adult men. EHSL provides sober housing for employed men who are in recovery from addiction who are over age 18 or those who are receiving SSI or unemployment compensation. Another local resource, Tabitha's House, is a recovery home for women who are suffering with substance use issues and homelessness.

Food. Our network will address food in a variety of ways that are responsive to each person's needs and resources. As well, our partner Together We Cope provides grocery gift cards and operates a food pantry that distributes pre-packed bags. They serve 5,000 people each month. Those who reside in the service area can receive a monthly emergency bag. Their food comes from the Greater Chicago Food Depository, the U.S. Department of Agriculture, and donations (from generous local businesses, restaurants, grocery stores, and community groups)

Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes.

As described above the SDOH needs in our community relate to both the overt and the structural racism of the past century, combined with the community poverty precipitated by the downsizing and eventual closure of the US Steel mill followed by the public housing demolitions which drove Chicago's concentrated, segregated African American population into the area. We are addressing all of the SDOH, plus the needs related to recovery housing, technology for telehealth, and transportation because those are the most concrete and prevalent needs impeding access to care that our partners and stakeholders are advising us are critical to our success. We believe that these supports are responsive to priority needs and will promote wellness while building trust within the community.

What activities will your collaborative undertake to address the disparities mentioned above

In order to undo the racial disparities, we have identified in our community, local people need to be informed and empowered to act as "system influencers". Our Advisory Council will establish a framework for stakeholder engagement and participation that is informed and activated by our wellness goals and efforts. We envision the development of a pipeline of community advocates who are informed by our data and committed to our vision, as they will be true partners in creating it.

As well, our network offers a powerful example of Black and Brown leaders united in service to our own people and our own community. Our Hub will also provide an array of vocational resources for those seeking to serve either as CHWs, doulas, or in other capacities that our partners can support, such as health education specialists, and training for technology, electric automotive, and fabricated house development.

What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

The immediate measurable impacts that we will track to measure our progress will include the identified SDOH risks, or Pathways, that our hub has "completed and closed"; the direct supports we can quantify in terms of people housed, fed, and accessing telehealth and transportation due to our Hub's referrals and direct services; the vocational opportunities that we create and extend to the community; and ultimately, the initiatives and efforts that our Hub participants are afforded based on input and efforts undertaken by our activated and empowered stakeholders, based on what they believe will support community wellness.

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

As a network, we embrace the belief that community is medicine. Our Hub is designed to build community by supporting relationships between care recipients and providers, between local leaders and those in need, and between our network and our local and state governmental representatives. By supporting our community to address needs while simultaneously coming together, with data to demonstrate the gaps that remain despite our efforts, we will establish the accountability necessary to achieve our intended impact.

Care Integration and Coordination

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

To improve the integration, efficiency, and coordination of care across provider types and levels of care, we will staff and manage a team dedicated to finding those in need, building strong relationships, supporting them to identify their full array of needs, and plan the person-centered and culturally aligned care and services that they need. Our approach will comprehensively address the following areas to facilitate each person's rapid access and coordinated care across provider types and levels of care:

Identification. Medicaid enrolled people of all ages will be pre-screened using a quick screener to identify diagnoses and risk for chronic disease, behavioral health needs, dental needs, lack of current primary or behavioral health provider, and needs related to pregnancy, housing, transportation, food, safety, and other social indicators. Our screening tool will identify their care needs and the reason(s) for not having been able to connect or not sought to connect to care in the community. Our cadre of CHWs will conduct data informed outreach to identify high need individuals and families in our community. Outreach will be conducted to the many hotels housing transient people, local delis, places where substance users are known to gather, IDOC Transitional Housing Vendors, recovery homes, methadone clinics, the several grocery stores, etc. Each core partner will have an assigned CHW Care Coordinator. The CHWs and each of our collaborating partners will use a universal pre-screening form and we will also share this screening tool across an even broader network of community entities, including Townships (Alderman's Offices), municipalities, homeless shelters, police departments, schools, faith-based organizations, community centers and places where people reside such as budget hotels and organizations operating SROs.

The risk screening will help our team to identify each person's level of risk and support individualized care planning and services that address the needs of each person who is served by our Hub.

A shared consent form will be used across our network to improve the ability of providers to coordinate care and reduce duplication in services.

Comprehensive Risk Assessment. The assigned CHW will engage each individual who screens into the Hub in a comprehensive Pathways risk assessment, which identifies their full array of clinical and social service needs.

Individuals served by the Hub will be risk stratified through HEC to identify those whose risks require immediate and intensive engagement, those whose needs are increasing but not imminent whose engagement can be scheduled, and those whose needs are managed but require less intensive engagement to monitor and maintain their connections to care and wellness self-management, once a care plan is in place.

Integrated Care Team. Once a relationship has been firmly established and the individual is connected to care, the team will convene weekly to ensure connectivity to care remains and care is coordinated

Based on the number and types of risks identified, individuals will be sorted into tiers based on risk level; weekly check ins until care connections are made and care is underway. Monthly Interdisciplinary Team (IDT) Case Staffing meetings will be held via Zoom among Case Managers and Key Collaborating

Providers. IDT case staffing's for tier one clients will occur no less than twice per month until their care is stabilized, and others will occur monthly. The CHWs will be available to support home visits to hub service recipients, as needed, to engage them in care, including remotely monitoring their well-being and supporting access to telehealth.

Health Home. The Hub will provide a *designated clinical collaborative care manager*: an RN clinical director and an LCSW for behavioral health who will be overseeing care connections or coordinating with the person's existing primary care provider to ensure a care linkage is made. Our consulting psychiatrist will be available to address immediate behavioral health needs while formal connections are under way. A Primary Care provider will address medical needs for those awaiting access to their own PCP.

Wraparound Enhancements:

Our Wraparound Care Coordinators will develop care coordination face-to-face and phone interaction with clients on a weekly and/or monthly basis based on intensity to reduce use of facility-based care (e.g., inpatient psychiatric hospitalization, residential treatment, emergency room use, etc.). Once the initial phone or home visit screening interview is complete, the care plan will be created with the client and their support team to initiate service delivery and follow through. Home visits from locally representative CHWs are key to our plan to build trust in our system of care and improve outcomes. CHWs will assess comprehensive health, behavioral health, dental and social care needs for all members of the household—targeting those whose risk factors are highest.

An array of supports will be available, for example:

Transportation will be leased to transport clients to medical appointments, and those discharging from ER and referral to the Hub for crisis triage. We will contract with Uber Health and to be a backup source of transportation to our Vans. Clients in need of transportation to their appointments will call the designated Concierge Line created specifically for transportation purposes and a Transportation Care Coordination will secure the transportation.

Doula Support will be provided for our expectant mothers who require care connections when they present in local emergency department, at time of delivery, or are identified through outreach. Our Hub's CHWs some who are doulas will provide home visits and site visits for those residing in DV shelters, treatment centers or recovery homes. TLOC will establish a doula partnership with our local DV family shelter organization "Anew," formerly South Suburban Family Shelter, to offer specialized program services to enhance services to enhance support and safety options for pregnant women. For survivors of abuse residing in a safe shelter, our doulas will be their personal childbirth companion. This partnership will also increase opportunities for cross training between doulas and victim advocates to build professional skills to increase health services capacity for pregnant and new parenting survivors. To fill the need for women in recovery in need of doula services, we have partnered with our community partner Restoration Ministries, who operates Tabatha's House, a recovery home for women who are suffering with substance use issues, as well as homelessness.

Nutritionists. The Hub will employ two nutritionists who will work along with the clinical team for wellness promotion.

Food pantry and Meal delivery. Our collaborative partner Together We Cope, plus partnership with Bremen, Thornton and Rich Townships food pantries, will help our Hub ensure that clients will be assisted to receive food pantry services near to their residence.

Remote patient monitoring: Travel for patient's visits is problematic in our area, especially during winter months when travel is severely restricted due to limited access to public transportation. Remote patient monitoring helps keep high-risk, chronically ill patients, and those who suffer with pain management out of the ER and hospital, decreases no show scheduled visits, while improving health across collaboration care settings to manage population health. The ability to see patients while assessing their clinical condition remotely adds value to clinical decision making. Clients can use the Vivify Health solution for one touch video conferencing with care managers and providers when they want to be seen and on their device of choice (provided tablet or phone). The expected outcomes are improved Access to Clinical Service by increasing psychiatric medication management, chronic disease management, and therapeutic sessions, reducing readmissions at ER and hospitalization.

Fitness Program for Exercise. BCBS MCO through its Health and Wellness - Social Determinant of Health Fund has a fitness program for its members as part of their membership. To take advantage of this offering of free fitness programs our Care Coordinators will connect clients to their MCO Care Manager for enrollment.

Data Collection and Sharing. In our collaborative the Health EC single-platform care coordination solution will be used. It consolidates and analyzes all clinical and social determinants of health (SDOH) data and relevant claims in its CareConnect system, to allow CHW care coordinators to seamlessly coordinate between case management, disease management, utilization, and health and wellness functions. With CareConnect our team will be able to:

- Target the highest-risk patients for outreach and intervention at the right time and place
- Risk-stratify those served into subpopulations
- Identify gaps in care
- Use data to develop customized care coordination strategies by taking a more holistic, 360-degree view of patient care
- Emphasize prevention, patient self-management, continuity of care, and communication between primary care providers, specialists, and patients

It is integrated with analytics, which enables every member of each person's team of providers to proactively identify care opportunities, track interventions and assessments, automatically stratify patients into risk categories, and take actions based on automated alerts.

Approach to Care: Our Hub services will be provided to each person and their family until their presenting needs are met based on their individual care plan, they are connected to a primary care provider they trust, specialty care is available when and where suitable to the patient, and their care is being managed appropriately based on a review by our Medical Director. This will be measured based on appointments made, attendance at appointments, HEDIS outcomes, and assessments which will be administered every 6 months to monitor improvement from baseline.

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

Yes

189 over 5 years (94 to start and increase to 189 every year)

Please submit care coordination caseload numbers and cost per caseload.

CHW-Care Coordinators case load is 80:1; and less if they have more high-risk clients (10:1) Clinical Care Manager per 8-10 CHW-Care Coordinators

Are there any managed care organizations in your collaborative?

No

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

N/A

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

Our collaborative will coordinate with MCO care managers, to minimize duplication of efforts and leverage our services as a local extender for their coordination efforts. We will monitor enrollees to track which plans are accountable for our population and report our success metrics to these MCOs, as indicated, to support continuation funding for our shared population beyond the grant period.

The collaborative will work with all payers in our catchment area. BlueCross Blue Shield Community Health Plan has the greatest penetration in our service area and has a history of contracting and working collaboratively with our key partners. We will leverage this relationship and will build on it to seek opportunities where our expanded service offerings align with the plan's strategic goals for its covered Medicaid population.

We will use this information to inform our partnership's approach to Alternative Payment Models (APMs) and Value Based Payment (VBP) initiatives to support and sustainably fund our enhanced service portfolio for the community.

Minority Participation

Please provide a list of entities that will be part of your collaboration that are certified Illinois BEP and/or nonprofit majorly controlled/managed by minorities that will be used on the project as subcontractors. Only list services of the firms that will be used on this project. To be included these services must increase the entity's volume of work above the level already provided to collaborating members (if members already contract with the firm).

- The Link & Option Center, Inc. – Majorly Controlled and Managed by Minorities
- Aunt Martha's – Majorly Controlled and Managed by Minorities
- So-Well Dental Associates – Majorly Controlled and Managed by Minorities
- TDG & Associates, Inc. - BEP
- Victory Pharmacy - BEP
- Benford Brown & Associates – BEP
- The Stuttley Group - BEP
- Martin Branding - BEP

Please describe respective roles of each entity identified and whether they will only have an implementation role or if they have an ongoing role in your transformed delivery system.

Name	Role Description	Type
The Link & Option Center, Inc.	Lead Agency; Key Collaborative Partner	Ongoing Role
Aunt Martha's	Key Collaborative Partner	Ongoing Role
So-Well Dental Associates	Key Collaborative Partner	Ongoing Role
TDG & Associates, Inc.	Vendor; Key Collaborative Partner	Ongoing Role
Victory Pharmacy	Key Collaborative Partner	Ongoing Role
Benford Brown and Associates	Fiduciary Agent	Ongoing Role
The Stuttley Group	Legal Counsel	Ongoing Role
Martin Branding	Branding/Signage	Implementation

Jobs

Existing Employees

For our collaborating providers, we currently employ more than 700 employees who reside in the following zip codes:

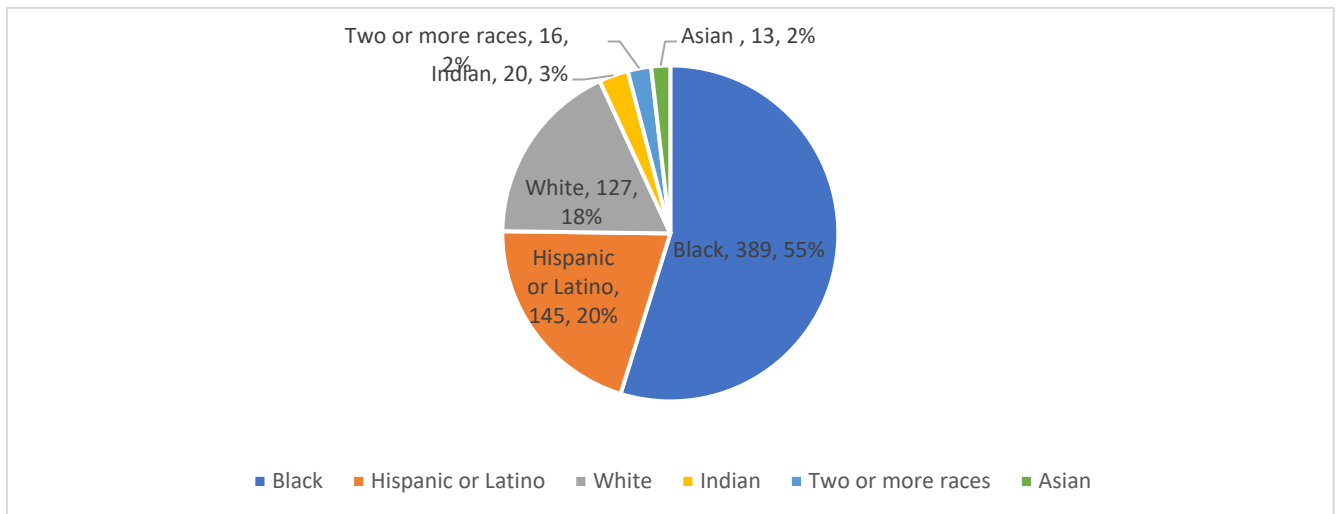
46311	60411	60152	60476	60445	61019	60649	61101
46312	60008	60154	60416	60446	60478	60652	61103
46319	60014	60156	60417	60447	60481	60653	61108
46320	60016	60169	60419	60448	60484	60655	61114
46321	60033	60172	60422	60449	60487	60656	61354
46323	60050	60174	60423	60451	60502	60659	61361
46324	60056	60181	60425	60452	60504	60660	61443
46327	60064	60185	60426	60457	60505	60712	61611
46368	60068	60187	60428	60459	60506	60803	61614
46373	60076	60193	60429	60461	60601	60805	61801
46375	60098	60194	60430	60462	60601	60827	61802
46376	60099	60202	60431	60463	60620	60901	61821
46394	60102	60302	60432	60464	60621	60914	61822
46408	60104	60305	60433	60466	60628	60915	61832
46409	60110	60401	60435	60468	60637	60938	61834

46410	60115	60402	60436	60469	60638	60940	61846
52803	60120	60403	60438	60471	60640	60950	61883
53184	60123	60404	60439	60472	60641	60953	62034
53208	60126	60406	60441	60473	60643	60954	62526
60005	60130	60409	60442	60475	60644	60968	
60007	60137	60412	60443	60477	60647	61073	

These locally hired employees breakdown in the following job roles/categories:

Job Category	Number of Employees
Administration	46
Direct Service Staff, Clinical	545
Leadership	30
Support Staff	77

The racial breakdown of our collaborative member's employees is:



We will use the following metrics to evaluate our collaborative's goal to preserve and grow employment in our service area, to preserve a highly diverse workforce representative of the community we serve, and provide pathways for advancement for individuals employed by our collective organizations:

- Employment rates and percentages by zip code and county
- Racial and ethnic breakdown of employees by job category
- Recruitment and retention rates by agency

New Employment Opportunities

The human services industry comprises the organizations that operate mental health centers for people who have a mental illness, provide assistance to the disabled, facilitate adoptions, operate shelters for the homeless, collect and distribute food to people without food. They employ a workforce of Human Service workers who are not highly paid, and definitely not over-paid. Many who live in poverty

themselves are people who assist seniors, help people reduce drug dependency, and perform thousands of other tasks that promote community well-being.

The Hub proposes a team that will include new hires in our community and use of existing staff and resources to deploy them to our targeted interventions. Our hiring approach will look to preserve and build jobs in our community and provide opportunity for advancement. We will recruit directly from the community to ensure the racial and ethnic composition of our workforce mirrors the population we are serving and the values and goals of our respective organizations.

The Hub will hire 144 new full-time staff across various roles. To ensure appropriate administrative supervision, data collection, and quality oversight, the Hub will hire an overarching project director, a program evaluator/researcher, data analyst supervisor, data collection/integrity specialist, data analyst, quality assurance director, Hub referral specialist, an executive assistant, 2 medical billing specialist, and 2 reconciliation specialists. Each of these individuals will be a 1.0 FTE. For adequate clinical supervision the Hub will hire a project manager for intensive SUD, a project manager for intensive behavioral health, a social work manager, a nutritionist, wellness program coordinator, and project care coordinator. We will also hire several direct care workers including 48 Community Health Workers (CHWs) to serve as Case Managers, 12 CHWs to serve as Recovery Support Specialists, 24 CHWs to serve as Doulas, 4 Substance Abuse Counselors (CADC), 8 Mental Health Clinicians, 2 Licensed Clinical Social Workers, 4 Project Care Managers for Chronic Disease Management, 2 outreach coordinators, 15 outreach specialists. We will also hire 3 drivers to provide transportation services to members of our community referred to the Hub or associated care and 2 security personnel for our 24/7 crisis center.

Quality Metrics

Our initiative will support all pillars of HFS Medicaid Quality Strategy including: Maternal and Child Health, Adult Behavioral Health, Child Behavioral Health, Equity, and Community-Based Services and Supports. We will track our performance using the following metrics:

<i>Metric</i>	<i>Currently Tracked?</i>	<i>HFS Pillar: Adult BH</i>	<i>HFS Pillar: Equity</i>	<i>HFS Pillar: Community Living</i>	<i>HFS Quality Strategy Core Set</i>	<i>HEDIS</i>
1. Follow-Up After Hospitalization for Mental Illness (FUH), 7 day and 30 day	x	x			x	x
2. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA), 7-day and 30-day	x	x			x	x
3. Follow-Up After High-Intensity Care for Substance Use Disorder (FUI), and Pharmacotherapy for Opioid Use Disorder (POD)		x				x
4. Pharmacotherapy for Opioid Use Disorder (POD)					x	x

5. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment			X	X
6. Annual PCP Visit				X
7. Behavioral health ED visits	X			X
8. Behavioral health inpatient hospitalizations				X
9. Behavioral health 30-day readmissions	X			X
10. Acute Hospital Utilization				X
11. Plan All-Cause Readmissions (PCR)	X			X
12. Emergency Department Utilization (EDU)	X			X
13. Hospitalization for Potentially Preventable Complications (HPC)	X			X
14. Adult access to preventive/ambulatory health services (AAP)	X	X		X
15. Successful Transition after Long-Term Care Stay			X	
16. Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions (FMC)	X	X		X
17. Notification of Inpatient Admission. Documentation in the medical record of receipt of notification of inpatient admission on the day of admission or the following day.	X	X		X
18. Receipt of Discharge Information. Documentation in the medical record of receipt of discharge information on the day of discharge or the following day.	X	X		X
19. Patient Engagement After Inpatient Discharge. Evidence of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.	X	X		X
20. Medication Reconciliation Post-Discharge. Medication reconciliation on the date of discharge through 30 days after discharge (31 total days).	X	X		X
21. Cervical Cancer Screening*	X		X	
22. Chlamydia Screening in Women Ages 21 to 24	X		X	

23. Breast Cancer Screening*	x	x
24. Controlling High Blood Pressure*	x	x
25. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control	x	x
26. HIV Viral Load Suppression*		x
27. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H—Adult Version*		x

Sustainability

The Partnership plans to sustain its activities by moving away from traditional fee-for-service and move initially toward pay-for-performance in its agreements with Medicaid MCOs using shared quality and outcome metrics. We will seek financial award under these arrangements for decreasing escalation of Medicaid clients to avoid unnecessary ED visits. We will also pursue Alternative Based Payments/Value Based Payments to fund SDOH interventions and other nonbillable outreach services. At the system of care level, the Hub will serve as a central organizing structure for a local network of providers. In this way, the Hub can provide a methodology for sustainable funding via contracts with Medicaid managed care organizations, as well as other governmental contracts and grants. We will strive to design a payment methodology that will incentivize outreach and engagement of the highest risk patient clusters and facilitates rapid connections to the services necessary to address their full array of health, behavioral health, and non-medical supports to address the social determinants of health. We will also focus on strategies to streamline reimbursement for CHW services based on mitigated risk factors (confirmed outcomes) that are achieved by the CHW for each member of the family.

The Hub will pursue enhanced billable opportunities (perhaps in collaboration with FQHC/hospital partners) with MCOs for payments related to intermediate and final Pathway steps/outcomes using nationally standardized billing codes and Outcome Based Units (OBUs). Our approach will attract payers that are interested in funding evidence-based models of community-based care coordination. We will work to link appropriate billing codes to our identified interventions. Outcomes based payment is a key component of our model, and will promote accountability, quality, equity, health improvement, and value.

The South Cook Regional MyCorCare Hub Health Home Collaborative will begin developing its sustainability plan in year 2 of our initiative and will begin to glidepath toward sustainable funding in Years 4 and 5 of the initiative with full sustainability achieved by Year 6.

Enclosed please find letters of support from the following elected officials and community partners who participated in our planning and engagement efforts to ensure diverse and widespread community input. We are grateful for their support and efforts.

Letters of Support	
From Illinois Elected Officials	
Robin L. Kelly	U.S. House of Representatives, 2 nd District
Kimberly A. Lightford	State Majority Leader, State Senator, 4 th District
Michael E. Hastings	Majority Caucus Whip, State Senator, 19 th District
Napoleon B. Harris III	State Senator, 15 th District
Debbie Meyers-Martin	State Representative, 38 th District
Thaddeus M. Jones	State Representative, 29 th District
Anthony DeLuca	State Representative, 80 th District
Deborah Sims	Cook County Board of Commissioners, 5 th District
From Community Partners	
Kathryn Straniero	Bremen Township Supervisor
Calvin Jordan	Rich Township Supervisor
Frank J. McHugh	Vice President Finance and Chief Financial Officer, Franciscan Health
Marc D. Smith	Director, Illinois Department of Children & Family Services
Carol Gsell	Associate Director, Anew building beyond violence & abuse

ROBIN L. KELLY
2ND DISTRICT, ILLINOIS

2416 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
PHONE: (202) 225-0773
FAX: (202) 225-5681

www.RobinKelly.house.gov

Congress of the United States
House of Representatives

DISTRICT OFFICES:
600 HOLIDAY PLAZA DRIVE
SUITE 505
MATTESON, IL 60443
PHONE: (708) 679-0078

1000 E. 111TH STREET
SUITE 5N
CHICAGO, IL 60628
PHONE: (773) 321-2001

Theresa Eagleson, Director
Illinois Healthcare and Family Services
401 South Clinton
Chicago, Illinois 60607

October 22, 2021

Dear Director Eagleson:

I am writing in support of The Link & Option Center Inc. South Cook Regional Community Health Center Collaborative's HFS Healthcare Transformation application. The request is for \$24 million to be spent over a 5-year period.

The South Cook Regional Community Health Center Collaborative was designed to build "clinic-community linkages" by creating a multidisciplinary team approach of providers to transform community health. Funding from the HFS Healthcare Transformation will create greater access pathways to care via a Medical Home Network Platform which will impact more than 25,000 people. Additionally, it will help the collaborative improve local access to care for primary and specialty care. Finally, funding from the HFS Healthcare Transformation will support the collaborative's effort to address transportation issues in the Suburban Cook County area, which have significantly reduce patients' ability to receive medical care.

For these reasons, I ask that you give this application all appropriate consideration. If you have questions, please contact my Grants Specialist, Adal Regis, at 202-604-7514 or at Adal.Regis@mail.house.gov.

Sincerely,



Robin L. Kelly
Member of Congress

SPRINGFIELD OFFICE:
ROOM 329 CAPITOL BUILDING
SPRINGFIELD, IL 62706
217/782-8505
217/558-2068 FAX

DISTRICT OFFICE:
4415 W. HARRISON STREET
SUITE 550
HILLSIDE, IL 60126
708/632-4500
708/632-4515 FAX



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

COMMITTEES:

ASSIGNMENTS
CHAIRPERSON
EDUCATION
EXECUTIVE
HIGHER EDUCATION
LABOR

October 5, 2021

Illinois Healthcare and Family Services
Theresa Eagleson, Director
401 South Clinton
Chicago, Illinois 60607

Dear Director Eagleson,

I am pleased to provide this letter of support for The Link & Option Center Inc.'s South Cook Regional Community Health Center Collaborative, HFS Transformation Pilot proposal. They are joining to be an integral part of an innovative journey to transform lives through tackling Mental Health and Chronic Disease Prevention. I commend their efforts to introduce new integrated models of care that can transform the outcome for Medicaid recipients in our Southland Region by building "clinic-community linkages", by creating a multidisciplinary team approach of Providers to transform community health.

The goal of this project is to create greater access pathways to care via a Medical Home Network Platform. It will take immediate steps to improve local access to care for primary and specialty care, dental, maternal and child health, and decrease health disparities. This collaborative will also coordinate patients ER access to the appropriate care they need and reduce high rates of utilization for medical and behavioral health hospitalization and Emergency Department visits. Additionally, the collaborative will look to address transportation in the Suburban Cook County areas of Illinois, which continues to be one of the most significant barriers for patients having access to medical care.

I believe that it is very necessary to address the issues of focus identified for this collaborative to begin to alleviate disparities in healthcare. I support his project and a hope you recognize the need as well. If there are additional questions regarding my support, please do not hesitant to contact my office.

Sincerely,

A handwritten signature in cursive script that reads "Kimberly A. Lightford".

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

ILLINOIS STATE SENATE

SPRINGFIELD OFFICE:
111 Capitol Building
Springfield, IL 62706
(217) 782-9595

DISTRICT OFFICE:
20855 South LaGrange Road
Suite 102
Frankfort, IL 60423
(815) 464-5431
www.SenatorHastings.com



Michael E. Hastings
STATE SENATOR · 19th DISTRICT
Majority Caucus Whip

**Committee
Assignments:**
Energy and Public
Utilities (Chair)
Education
Executive
Insurance
Judiciary

October 13, 2021

Theresa Eagleson
Director
Illinois Healthcare and Family Services
401 South Clinton
Chicago, Illinois 60607

Dear Director Eagleson,

I am writing to express my strong support for Dr. Twin Green and her team at The Link & Option Center Inc., in regards to the South Cook Regional Community Health Center Collaborative for their HFS Transformation Pilot proposal. Dr. Green brings more than 25 years of experience in mental health and chronic disease prevention. She focuses on empowering people with quality prevention and intervention services by coordinating and integrating services among systems of care and community resources.

The goal of this collaboration is to create greater access to care via a Medical Home Network Platform, taking immediate steps to improve local pathways to primary and specialty care, dental, and maternal and child health. In addition, the collaborative will help coordinate patients' ER access, while reducing high rates of utilization for medical and behavioral health (mental health, alcohol, substance use and opioid use disorder) hospitalizations and ER visits. The collaborative will also address transportation in suburban Cook County, one of the most significant barriers for patients having access to medical care. The collaborative providers are culturally sensitive and provide person-centered care that addresses clients' individual needs. In all, this collaboration will help decrease health disparities by creating "clinic-community linkages".

I am in full support of this, and I encourage you to consider the benefits that such a collaboration will bring to the broader community. Too many young people and their families are unable to treat the mental health challenges they face. The Link & Option can provide resources and hope for those who are suffering throughout the South Suburbs. The State's participation in this project will help create a unique asset in the Southland. Please let me know if I can provide any additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Hastings", followed by a date "10/13/21" and a flourish.

Michael E. Hastings
Majority Caucus Whip

Illinois State Senate

Springfield Office

Room 413, Capitol Building
Springfield, IL 62706
217-782-8066
www.senatornapoleonharris.com



District Office

1350 E. Sibley Blvd., Suite 403
Dolton, IL 60419
708-893-0552
708-566-4108 (FAX)
senatorharrisdistrictoffice@gmail.com
www.senatornapoleonharris.com

Napoleon B. Harris III

*Majority Caucus Whip
15th Legislative District*

October 28, 2021

Ms. Theresa Eagleson, Director
Illinois Healthcare and Family Services
401 South Clinton
Chicago, Illinois 60607

Dear Director Eagleson:

I am pleased to provide this letter of support for The Link & Option Center's South Cook Regional Community Health Center Collaborative, HFS Transformation Pilot proposal. I commend their efforts to introduce new integrated models of care that can transform the outcome for Medicaid recipients in our Southland Region.

The purpose of the South Cook Regional Community Health Center Collaborative is to build "clinic-community linkages", by creating a multidisciplinary team approach of Providers to transform community health.

Their goal is to create greater access pathways to care via a Medical Home Network Platform. Their Collaborative will take immediate steps to improve local access to care for primary and specialty care, dental, maternal and child health, and decrease health disparities. Their goal is to coordinate patients ER access to the appropriate care they need, and reduce high rates of utilization for medical and behavioral health (mental health, alcohol, substance use and opioid use disorder) hospitalization, and Emergency Department visits. The collaborative will also look to address transportation in the Suburban Cook County areas of Illinois, which continues to be one of the most significant barriers for patients having access to medical care.

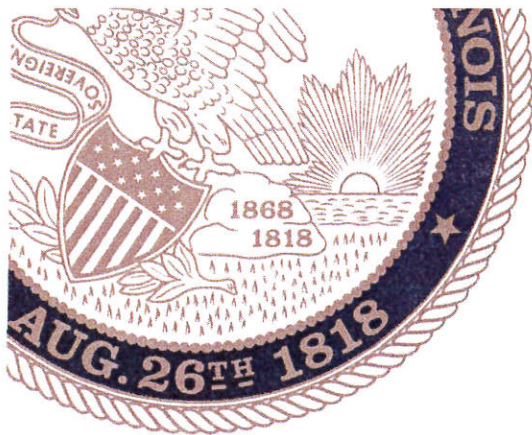
Their collaborative providers are culturally sensitive and provide-person centered care addressing their client's individual needs. Their goal is to transform lives through Mental Health and Chronic Disease Prevention.

Sincerely,

A handwritten signature in blue ink, appearing to be "NBH", written over a light blue horizontal line.

SOYBEAN INKS

Napoleon B. Harris III



DEBBIE MEYERS-MARTIN
STATE REPRESENTATIVE • 38TH DISTRICT

STATEREPDEBBIEMM@GMAIL.COM
REPDEBBIEMEYERSMARTIN.COM

DISTRICT OFFICE:
813 SCHOOL AVE.
MATTESON, IL 60443
P: 708.833.7010
F: 708.248.5346

SPRINGFIELD OFFICE:
237-E STRATTON BUILDING
SPRINGFIELD, IL 62706
P: 217.558.1007

October 6, 2021

Illinois Healthcare and Family Services
Theresa Eagleson, Director
401 South Clinton
Chicago, Illinois 60607

Dear Director Eagleson,

I State Representative Debbie Meyers-Martin am pleased to provide this letter of support for The Link & Option Center Inc.'s South Cook Regional Community Health Center Collaborative, HFS Transformation Pilot proposal. We commend your efforts to introduce new integrated models of care that can transform the outcome for Medicaid recipients in our Southland Region.

As a legislator of this region, I understand the need for and purpose of the South Cook Regional Community Health Center Collaborative is to build "clinic-community linkages", by creating a multidisciplinary team approach of Providers to transform community health at the community level.

I applaud their goal to create greater access pathways to care via a Medical Home Network Platform. Their Collaborative will take immediate steps to improve local access to care for primary and specialty care, dental, maternal and child health, and decrease health disparities. In addition, Coordinate patients ER access to the appropriate care they need, and reduce high rates of utilization for medical and behavioral health (mental health, alcohol, substance use and opioid use disorder) hospitalization and Emergency Department visits. The collaborative will also look to address transportation in the Suburban Cook County areas of Illinois, which continues to be one of the most significant barriers for patients having access to medical care.

Their collaborative providers are culturally sensitive, provide-person centered care addressing their client's individual needs, and delivered through a network trusted of community-based providers.

My Legislative Office will join and be an integral part of their innovative journey to transform lives through these two important issues, Mental Health and Chronic Disease Prevention.

Sincerely,

Debbie Meyers-Martin

ILLINOIS HOUSE OF REPRESENTATIVES

DISTRICT OFFICE:

15525 SOUTH PARK AVENUE
SOUTH HOLLAND, ILLINOIS 60473
708.596.7053 - OFFICE
708.596.7062 - FAX

SPRINGFIELD OFFICE:

241-E STRATTON OFFICE BUILDING
SPRINGFIELD, ILLINOIS 62706
217.782.8087 - OFFICE
217.558.6433 - FAX



THADDEUS M. JONES
STATE REPRESENTATIVE • 29TH DISTRICT

COMMITTEE CHAIRMAN:

INSURANCE COMMITTEE
HEALTH INSURANCE SUBCOMMITTEE

COMMITTEE MEMBER:

APPROPRIATIONS-CAPITAL COMMITTEE
CON JUDICIARY - CIVIL COMMITTEE
LABOR & COMMERCE COMMITTEE
PRESCRIPTION DRUG
AFFORDABILITY COMMITTEE
CONSUMER PROTECTION COMMITTEE
CIVIL PROCEDURE SUBCOMMITTEE
COMMERCE AND INNOVATION
SUBCOMMITTEE
SPECIAL (INS) SUBCOMMITTEE
TORT LIABILITY SUBCOMMITTEE
WAGE POLICY AND STUDY
SUBCOMMITTEE

October 14, 2021

Illinois Healthcare and Family Services

Theresa Eagleson, Director

401 South Clinton

Chicago, Illinois 60607

Dear Director Eagleson,

I am writing to express my support of The Link & Option Center INC.'s South Cook Regional Community Health Center Collaborative, HFS Transformation Pilot proposal. We commend your efforts to introduce new, integrated models of care that can transform the outcome for Medicaid recipients in the Southland Region.

As State Representative of the 29th District, I am aware that the purpose of the South Cook Regional Community Health Center Collaborative is to build "clinic-community linkages," by creating multi-disciplinary team approached providers to transform community health. Your commitment to expanding healthcare services to meet the needs of those within communities that would otherwise be limited to quality healthcare, is more than commendable.

The services that you are seeking to provide to predominantly low-income, and medically underserved communities you target, continue to be in dire need of out-patient health care services. I believe, The Link & Option Center Inc.'s is optimally positioned to fill the gap and improve health outcomes for those with significant need.

We will join and be an integral part of your innovative journey to transform lives through these two important issues, Mental Health and Chronic Disease Prevention. I am proud to align and affiliate with your work and am confident that you will fully implement all efforts embarked upon through this collaboration.

Sincerely,

A handwritten signature in black ink, appearing to read "Thaddeus M. Jones".

Thaddeus M. Jones

DISTRICT OFFICE:

195 W. JOE ORR ROAD
SUITE 201
CHICAGO HEIGHTS, ILLINOIS 60411
(708) 754-7900
FAX: (708) 754-7904
E-mail: repdeluca@sbcglobal.net



Anthony DeLuca

STATE REPRESENTATIVE • 80TH DISTRICT

October 12, 2021

Illinois Healthcare and Family Services
Theresa Eagleson, Director
401 South Clinton
Chicago, Illinois 60607

Dear Director Eagleson:

I am pleased to provide this letter of support for The Link & Option Center Inc.'s South Cook Regional Community Health Center Collaborative, HFS Transformation Pilot proposal. We commend your efforts to introduce new integrated models of care that can transform the outcome for Medicaid recipients in our Southland Region.

The purpose of the South Cook Regional Community Health Center Collaborative is to build "clinic-community linkages", by creating a multidisciplinary team approach of Providers to transform community health.

Our goal is to create greater access pathways to care via a Medical Home Network Platform. Our Collaborative will take immediate steps to improve local access to care for primary and specialty care, dental, maternal and child health, and decrease health disparities. Coordinate patients ER access to the appropriate care they need, and reduce high rates of utilization for medical and behavioral health (mental health, alcohol, substance use and opioid use disorder) hospitalization and Emergency Department visits. The collaborative will also look to address transportation in the Suburban Cook County areas of Illinois, which continues to be one of the most significant barriers for patients having access to medical care.

Our collaborative providers are culturally sensitive, provide-person centered care addressing their client's individual needs, and delivered through a network trusted of community-based providers.

We will join and be an integral part of your innovative journey to transform lives through these two important issues, Mental Health and Chronic Disease Prevention.

Sincerely,

A handwritten signature in blue ink that reads "Anthony DeLuca".

Anthony DeLuca-State Representative, 80th District

COUNTY BUILDING
118 North Clark Street - Suite 567
Chicago, IL 60602
(312) 603-6381

DISTRICT OFFICE
2515 Veterans Drive
Posen, IL 60469
(708) 371-4251



DEBORAH SIMS
COMMISSIONER - 5TH DISTRICT
COOK COUNTY BOARD OF COMMISSIONERS
DEBORAH.SIMS@COOKCOUNTYIL.GOV

**Committee and Subcommittee
Memberships of
The County Board**

CHAIR
Roads & Bridges
Tax Delinquency

VICE CHAIR
Finance

MEMBER
Construction
Contract Compliance
Criminal Justice
Environmental Control
Finance
Health & Hospitals
Labor
Legislation &
Intergovernmental Relations
Rules & Administration
Workforce, Job Development
& Training Opportunities

**COMMITTEES OF THE
FOREST PRESERVE
DISTRICT**

MEMBER
Vice Chair-Capital Development
Finance
Labor
Rules

October 28, 2021

Dr. Twin Green
President & CEO
The Link & Option Center, Inc.
902 E. 162nd St, Suite 102
South Holland, Illinois 60473

Dear Dr. Green:

I am pleased to provide this letter of support for The Link & Option Center Inc.'s South Cook Regional Community Health Center Collaborative, HFS Transformation Pilot proposal. We commend their efforts to introduce new integrated models of care that can transform the outcome for Medicaid recipients in our Southland Region.

The purpose of the South Cook Regional Community Health Center Collaborative is to build "clinic-community linkages", by creating a multidisciplinary team approach of Providers to transform community health.

The Collaborative goal is to create greater access pathways to care via a Medical Home Network Platform. Our Collaborative will take immediate steps to improve local access to care for primary and specialty care, dental, maternal and child health, and decrease health disparities. Coordinate patients ER access to the appropriate care they need, and reduce high rates of utilization for medical and behavioral health (mental health, alcohol, substance use and opioid use disorder) hospitalization and Emergency Department visits. The collaborative will also look to address transportation in the Suburban Cook County areas of Illinois, which continues to be one of the most significant barriers for patients having access to medical care.

The collaborative providers are culturally sensitive, provide-person centered care addressing their client's individual needs, and delivered through a network trusted of community-based providers.

The 5th District of Cook County.
Bringing County Government to the People.



Printed on Recycled Paper

We will join and be an integral part of your innovative journey in the South Cook Region to transform lives through these two important issues, Mental Health and Chronic Disease Prevention.

Sincerely,

A handwritten signature in blue ink, appearing to read "Deborah J. [unclear]".

Cook County Commissioner
5th District



November 8, 2021

Dr. Twin Green
The Link & Option Center, Inc.
900 E. 162nd Street, Suite 102
South Holland, IL 60473

Dear Dr. Green:

I am pleased to provide this letter of support for The Link & Option Center Inc.'s South Cook Regional Community Health Center Collaborative, Healthcare and Family Services Transformation Pilot proposal. We commend your efforts to introduce new integrated models of care that can transform the outcome for Medicaid recipients in our Southland Region.

The purpose of the South Cook Regional Community Health Center Collaborative is to build "clinic-community linkages", by creating a multidisciplinary team approach of Providers to transform community health.

My office understands the goal of the Collaborative is to create greater access pathways to care via an Integrated Health Home Network Platform. Our Collaborative will take immediate steps to improve local access to care for primary and specialty care, dental, maternal and child health, and decrease health disparities. In addition, your strong functionality and reach capacity to coordinate patient's ER access to the appropriate care they need and reduce high rates of utilization for medical and behavioral health (mental health, alcohol, substance use and opioid use disorder) hospitalization and Emergency Department visits. Knowing that the collaborative will also look to address transportation in the Suburban Cook County areas of Illinois, which continues to be one of the most significant barriers for patients having access to medical care, is vital to our region.

Our collaborative providers are culturally sensitive, provide person centered care addressing their client's individual needs, and delivered through a network trusted of community-based providers.

We will join and be an integral part of your innovative journey to transform lives through these important population health issues addressing access to care for Mental Health, Chronic Disease Prevention and Social Determinants of Health.

Sincerely,

A handwritten signature in blue ink that reads "Frank J. McHugh".

Frank J. McHugh
Vice President Finance and Chief Financial Officer

JB Pritzker
Governor



Marc D. Smith
Director

October 20, 2021

Twin Green, Ph.D.
President & CEO
The Link & Option Center, Inc.
902 E. 162nd Street, Suite 102
South Holland, Illinois 60473

Dear Dr. Green:

I am pleased to provide this letter of support for The Link & Option Center Inc.'s South Cook Regional Community Health Center Collaborative, HFS Transformation Pilot proposal. We commend your efforts to introduce new integrated models of care that can transform the outcome for Medicaid recipients in the South Cook Region.

The South Cook Regional Community Health Center Collaborative's multidisciplinary team approach of creating greater access to care via a Medical Home Network Platform will address long standing service voids. The steps to improve local access to primary and specialty care, dental, maternal and child health by increasing service delivery through a network of community-based providers should help to improve health disparities.

The Illinois Department of Children and Family Services looks forward to becoming a collaborative partner as this initiative moves forward.

Sincerely,

A handwritten signature in blue ink, appearing to read "Marc D. Smith".

Marc D. Smith
Director



619 West Jefferson Street • Joliet, Illinois 60453
815-730-4000
www2.illinois.gov/DCFS

BREMEN TOWNSHIP

16361 South Kedzie Parkway Markham, Illinois 60428 708-333-9530 / Fax: 708-333-1958

Kathryn Straniero, Supervisor
John P. Flaherty, Highway Comm.
Carolyn R. Carter, Trustee
John M. "Mike" Tatro, Trustee



John D. Lord, Clerk
Willie A. Jones, Assessor
Mary Catuara, Trustee
Edward Maggio, Trustee

November 3, 2021

Dr. Twin Green
The Link & Option Center, Inc.
900 E. 162nd Street, Suite 102
South Holland, IL 60473

Dear Dr. Green:

I am pleased to provide this letter of support for The Link & Option Center Inc.'s South Cook Regional Community Health Center Collaborative, Healthcare and Family Services Transformation Pilot proposal. We commend your efforts to introduce new integrated models of care that can transform the outcome for Medicaid recipients in our Southland Region.

The purpose of the South Cook Regional Community Health Center Collaborative is to build "clinic-community linkages", by creating a multidisciplinary team approach of Providers to transform community health.

My office understands the goal of the Collaborative is to create greater access pathways to care via an Integrated Health Home Network Platform. Our Collaborative will take immediate steps to improve local access to care for primary and specialty care, dental, maternal and child health, and decrease health disparities. In addition, your strong functionality and reach capacity to coordinate patients ER access to the appropriate care they need, and reduce high rates of utilization for medical and behavioral health (mental health, alcohol, substance use and opioid use disorder) hospitalization and Emergency Department visits. Knowing that the collaborative will also look to address transportation in the Suburban Cook County areas of Illinois, which continues to be one of the most significant barriers for patients having access to medical care, is vital to our region.

Our collaborative providers are culturally sensitive, provide-person centered care addressing their client's individual needs, and delivered through a network trusted of community-based providers.

Bremen Township will join and be an integral part of your innovative journey to transform lives through these important population health issues addressing access to care for Mental Health, Chronic Disease Prevention and Social Determinants of Health.

Sincerely,

A handwritten signature in blue ink that reads "Kathryn Straniero".

Kathryn Straniero
Bremen Township Supervisor



RICH Township

Supervisor
Calvin Jordan
Clerk
Arlene M. "Sugar" Al-Amin
Assessor
Sam Brown, CIAO
Highway Commissioner
Dennis A. White, Esq.
Trustees
Nick P. Bobis
Steven R. Burris
Therese H. Goodrich
Jacquelyn Small

October 19, 2021

Illinois Healthcare and Family Services
Theresa Eagleson, Director
401 South Clinton
Chicago, Illinois 60607

Dear Director Eagleson:

I am pleased to provide this letter of support for The Link & Option Center Inc.'s South Cook Regional Community Health Center Collaborative, HFS Transformation Pilot proposal. We commend your efforts to introduce new integrated models of care that can transform the outcome for Medicaid recipients in our Southland Region.

The purpose of the South Cook Regional Community Health Center Collaborative is to build "clinic-community linkages", by creating a multidisciplinary team approach of Providers to transform community health.

Our goal is to create greater access pathways to care via a Medical Home Network Platform. Our Collaborative will take immediate steps to improve local access to care for primary and specialty care, dental, maternal and child health, and decrease health disparities. Coordinate patients ER access to the appropriate care they need, and reduce high rates of utilization for medical and behavioral health (mental health, alcohol, substance use and opioid use disorder) hospitalization and Emergency Department visits. The collaborative will also look to address transportation in the Suburban Cook County areas of Illinois, which continues to be one of the most significant barriers for patients having access to medical care.

Our collaborative providers are culturally sensitive, provide-person centered care addressing their client's individual needs, and delivered through a network trusted of community-based providers.

We will join and be an integral part of your innovative journey to transform lives through these two important issues, Mental Health and Chronic Disease Prevention.

Sincerely,

Calvin Jordan, Supervisor

November 15, 2021

Dr. Twin Green
The Link & Option Center, Inc.
900 E. 162nd Street, Suite 102
South Holland, IL 60473



Dear Dr. Green:

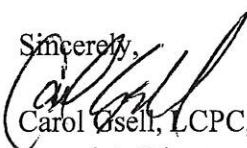
I am pleased to provide this letter of support for The Link & Option Center Inc.'s South Cook Regional Community Health Center Collaborative, Healthcare and Family Services Transformation Pilot proposal. The purpose of this collaborative is to build "clinic-community linkages" by creating a multidisciplinary team approach of Providers and services to transform community health. We are excited by the new integrated models of care that this initiative outlines for Medicaid recipients in our Southland Region.

As a domestic violence organization who works with families facing significant healthcare issues, we support the goal of the Collaborative in creating greater access pathways to care via an Integrated Health Home Network Platform. It is our understanding that the Collaborative will take immediate steps to improve local access to care for primary and specialty care, maternal and child healthcare, and dental services while decreasing health disparities. The capacity to coordinate patients accessing services to obtain the appropriate level of care while reducing high rates of utilization for medical and behavioral health (both mental health and substance abuse disorders) hospitalizations and Emergency Department visits is paramount to the focus of this Collaboration. Knowing that the Collaborative recognizes the need to address transportation in the Suburban Cook County areas of Illinois, which is a significant barrier for access to medical care, highlights that this Collaborative understands the needs of our region.

The collaborative providers included in this project have demonstrated culturally sensitive, person-centered care when addressing their client's individual needs. The spirit of this region's community-based providers ensures that this Collaborative will improve the network of services.

We appreciate the opportunity to support this Collaboration by providing guidance and resources for families impacted by domestic violence. We look forward to an ongoing relationship that will benefit services in the Southland Region of Cook County.

Sincerely,


Carol Osell, LCPC, CDVP, CPAIP
Associate Director

Formerly



P.O. Box 937 • Homewood, IL 60430 • 708.794.2140

HOTLINE: 708.335.3028 • FAX: 708.794.2145 • WEBSITE: www.anewdv.org

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.

Activity	Pre- Implement ation	1 st Quarter			2 nd Quarter			3 rd Quarter			4 th Quarter		
Month		1	2	3	4	5	6	7	8	9	10	11	12
Award Notification	X												
Contract Negotiation with HFS	X												
Execute Agreement with HFS	X												
Secure Hub Space		X	X	X									
Purchase equipment for staff and furnish physical Hub Space			X	X	X	X	X						
Establish community advisory council which will meet regularly to inform the collaborative		X	X	X	X	X	X	X	X	X	X	X	X
Recruit and hire administrative staff, community health workers, and providers to staff Hub and Hub services				X	X	X	X	X					
Develop culturally aware and community-driven recruitment approach for staffing positions		X	X	X									
Establish governance with all Key Partners to Effectuate Collaborative		X											
Establish governance committees and bylaws (as applicable)		X	X										
Policies and procedure and workflow development													
Train staff on award goals and collaborative goals, and evidence-based models				X	X	X	X	X					
Secure necessary agreements/contracts with partners and vendors to ensure provision of services outlined in application		X	X	X	X	X							
Enter into agreement with Fiduciary Agent to manage partner fund flow													
Establish funds flow and payment processes to support first year of operations		X	X	X	X	X	X	X	X	X	X	X	X

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.

Establish cadence of monthly Governance committee meetings to support ongoing work		X	X	X	X	X	X	X	X	X	X	X	X	X
Purchase and configure HealthEC to support the initiative		X	X	X	X	X	X							
Integration of partner EMR and EHRs			X	X	X	X	X	X						
Begin claims data sharing with HealthEC														
Collect historic claims data from HFS to inform population health activity														
Begin formal data collection, including assessment and outcome results						X	X	X	X	X	X	X	X	X
Initiate developing and sharing data reports to key partners						X	X	X	X	X	X	X	X	X
Report program data and milestones to HFS									X					X
Analyze Program Data and Quality Improvement Activities		X			X			X			X			
Review key partner performance data														
Assign initial caseloads and identify attributed population for the Collaborative						X	X	X	X	X	X	X	X	X
Initiate service delivery in the community								X	X	X	X	X	X	X

Years 2-5 Milestones

Milestones	2 nd Year				3 rd Year				4 th Year				5 th Year			
Quarter	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Collect and report program data	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Sharing of partner data and partner performance	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Annual review of				X				X				X				X

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.

P&Ps and workflows																
Analyze program data and quality improvement process	X		X		X		X		X		X		X		X	
End of year performance assessment				X				X				X				X
Regular key partner/governance meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Community stakeholder group																
Develop sustainability strategy	X	X	X	X												
Develop Value Based Payment methodologies					X	X	X	X								
Implement selected Value Based Payment methodology									X	X	X	X				
Implement Sustainability Plan									X	X	X	X	X	X	X	X
Begin negotiation with MCOs to implement VBP arrangements																

Aim/Outcome

Primary Drivers

Secondary Drivers

Change ideas

Decrease inequities and improve outcomes for Ambulatory Sensitive Condition Black and Hispanic population in South Suburban Region

Establish Trust in the System

Locally Trained CHWs and Doulas

Culturally Responsive Health Education

Immediate Access to Care and Crisis Response

Access to Culturally Aligned Comprehensive Network

Home Visits & Telehealth

Needs Assessment and Care Planning

Facilitated Connections to Care

SDOH Interventions Available

Local Knowledge and Experience

Hub supports to address human service needs

Community Planning to address root causes

- Recruit and retain local support team
- Use outcome-based pathways to close gaps in care

- Health Home Care Coordination
- HealthEC, Vivify Health, State ADT Feeds

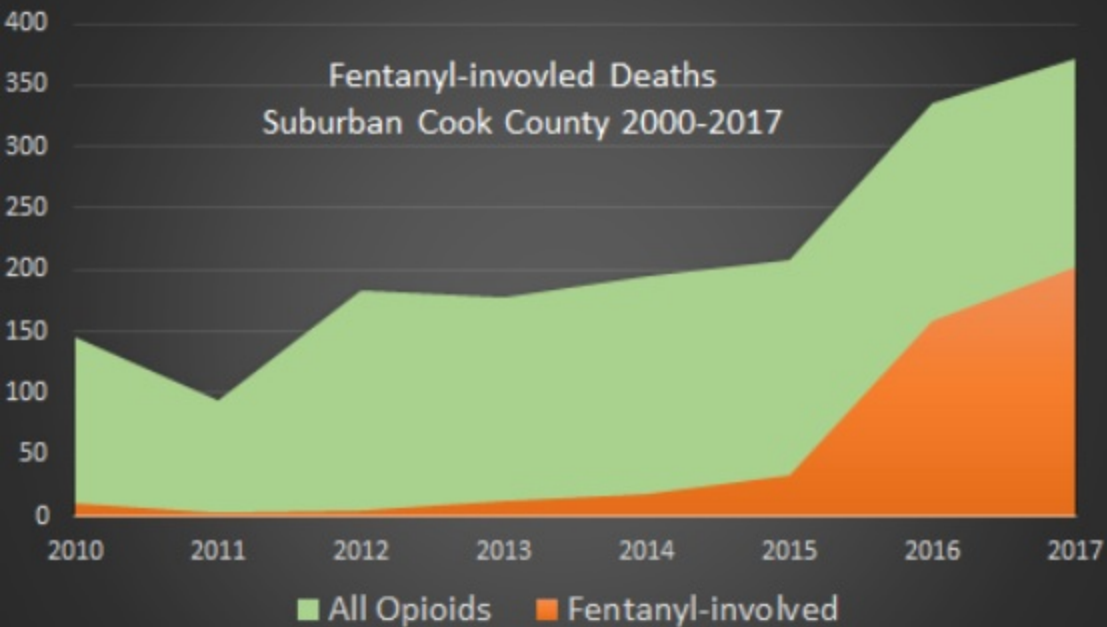
- NowPow
- Metopio to identify gaps in care
- Transportation, Housing, Food
- Provide support for targeted SDOH

Healthcare Access

Topic	Link and Option Center	Illinois	United States	Category
High school graduation rate % of residents,2015-2019	89.38 ± 0.84	89.85 ± 0.47 (2019 data)	88.61 ± 0.12 (2019 data)	Jobs
College graduation rate % of residents,2015-2019	25.69 ± 0.55	35.76 ± 0.28 (2019 data)	33.13 ± 0.07 (2019 data)	Jobs
Food insecurity % of residents,2020	12.1 ± 0.0	15.1 ± 0.0	17.4 ± 0.0	Environmental
Infant mortality deaths per 1,000 live births, 2013	—	6.0 ± 0.3	6.1 ± 0.6 (2018 data)	Health Outcomes, Equity and Disparities
Median household income 2015-2019	\$62,126 ± \$1,110	\$73,388 ± \$621 (2019 data)	\$69,702 ± \$125 (2019 data)	Economic
Life expectancy years, 2010-2015	76.8 ± 0.3	78.7 ± 0.1	78.7 ± 0.0	Health Outcomes
Mortality rate, all causes deaths per 100,000, 2018	—	716.9 ± 3.6	723.6 ± 0.7	Health Outcomes
Population residents,2020	566,756 ± 0	12,812,508 ± 0	334,735,155 ± 0	Demographic
Primary care providers (PCP) per capita physicians per 100,000 residents,2011	60.6 ± 0.0	92.4 ± 0.0 (2018 data)	89.1 ± 0.0 (2018 data)	Access to Health Care
Cigarette smoking prevalence % of adults, 2018	18.3 ± 0.2	17.4 ± 1.1	15.9 ± 0.3	Behaviors
Uninsured rate % of residents,2015-2019	7.74 ± 0.32	7.39 ± 0.14 (2019 data)	9.17 ± 0.03 (2019 data)	Access to Health Care, Equity and Disparities
Deep poverty % of residents,2015-2019	7.79 ± 0.50	5.09 ± 0.19 (2019 data)	5.50 ± 0.04 (2019 data)	Economic, Equity and Disparities
Poverty rate % of residents,2015-2019	15.53 ± 0.70	11.48 ± 0.31 (2019 data)	12.34 ± 0.08 (2019 data)	Economic
Very low food access % of residents,2015	16.32 ± 0.00	18.24 ± 0.00	21.14 ± 0.00	Environmental, Equity and Disparities
Low food access % of residents,2015	62.94 ± 0.00	48.39 ± 0.00	50.38 ± 0.00	Environmental, Equity and Disparities
Individuals living in a food desert residents,2015	30,800 ± 0	556,499 ± 0	18,446,350 ± 0	Environmental
Living in food deserts % of residents,2015	5.08 ± 0.00	4.31 ± 0.00	6.01 ± 0.00	Environmental, Equity and Disparities
Annual food budget shortfall 2019	—	\$657,992,668 ± \$0	\$21,229,676,056 ± \$0	Environmental
Obesity % of adults, 2018	34.8 ± 0.1	31.8 ± 1.3	30.9 ± 0.3	Health Outcomes
High blood pressure % of adults, 2017	36.45 ± 0.10	30.45 ± 0.46	29.70 ± 0.30	Health Outcomes
Diagnosed diabetes % of adults, 2018	12.3 ± 0.1	9.5 ± 0.3	10.0 ± 0.2	Health Outcomes
Newly diagnosed diabetes % of adults, 2016	—	7.4 ± 1.8	6.4 ± 0.8 (2018 data)	Health Outcomes
Current asthma % of residents,2018	10.84 ± 0.05	9.38 ± 0.25	9.10 ± 0.15	Health Outcomes
Drug overdose mortality deaths per 100,000, 2018	—	21.29 ± 0.68	20.71 ± 0.13	Health Outcomes
Diabetes mortality deaths per 100,000, 2018	—	18.6 ± 0.6	21.4 ± 0.1	Health Outcomes
Teenbirth rate Females, Juveniles (5-17 years) Births per 1,000 women, 2015-2019	14.07 ± 11.20	9.91 ± 3.13 (2019 data)	10.57 ± 0.67 (2019 data)	Demographic, Equity and Disparities
Gender inequality	71.7 ± 0.0			Environmental Disparities

Community Need Score score, 2015	76.7 ± 0.0	—	—	Equity and Disparities
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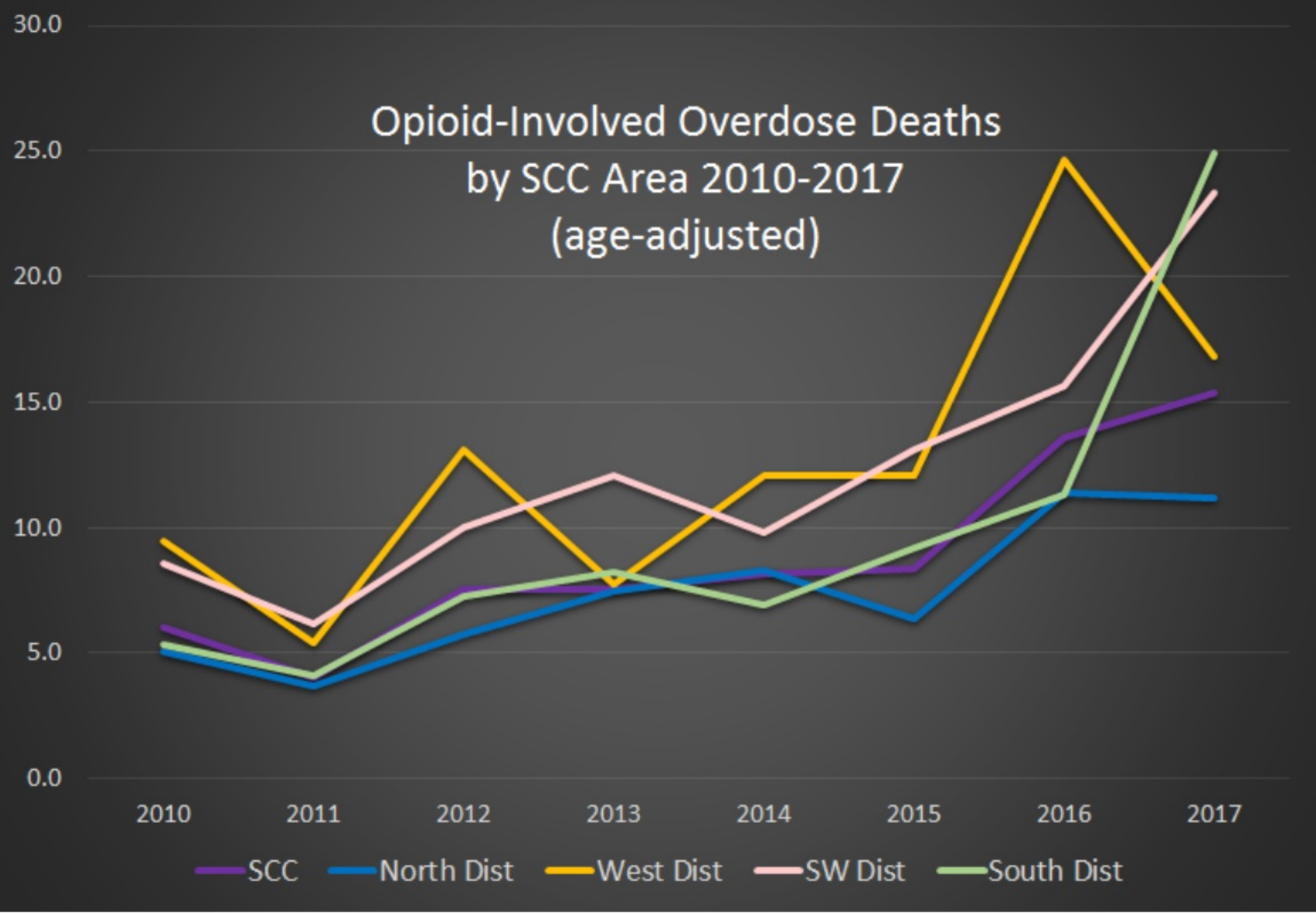
Fentanyl-involved Deaths
Suburban Cook County 2000-2017



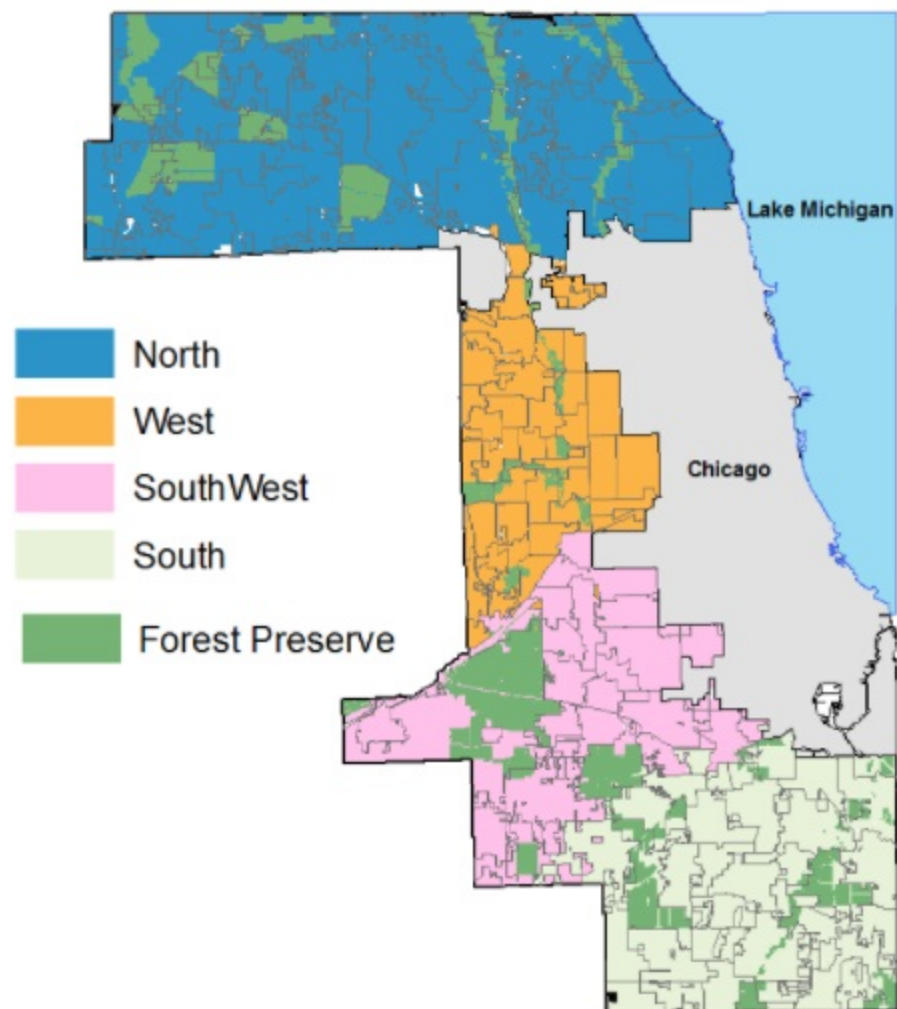
Opioid-Involved Overdose Deaths by SCC Area 2010-2017 (age-adjusted)

2010 2011 2012 2013 2014 2015 2016 2017

— SCC — North Dist — West Dist — SW Dist — South Dist

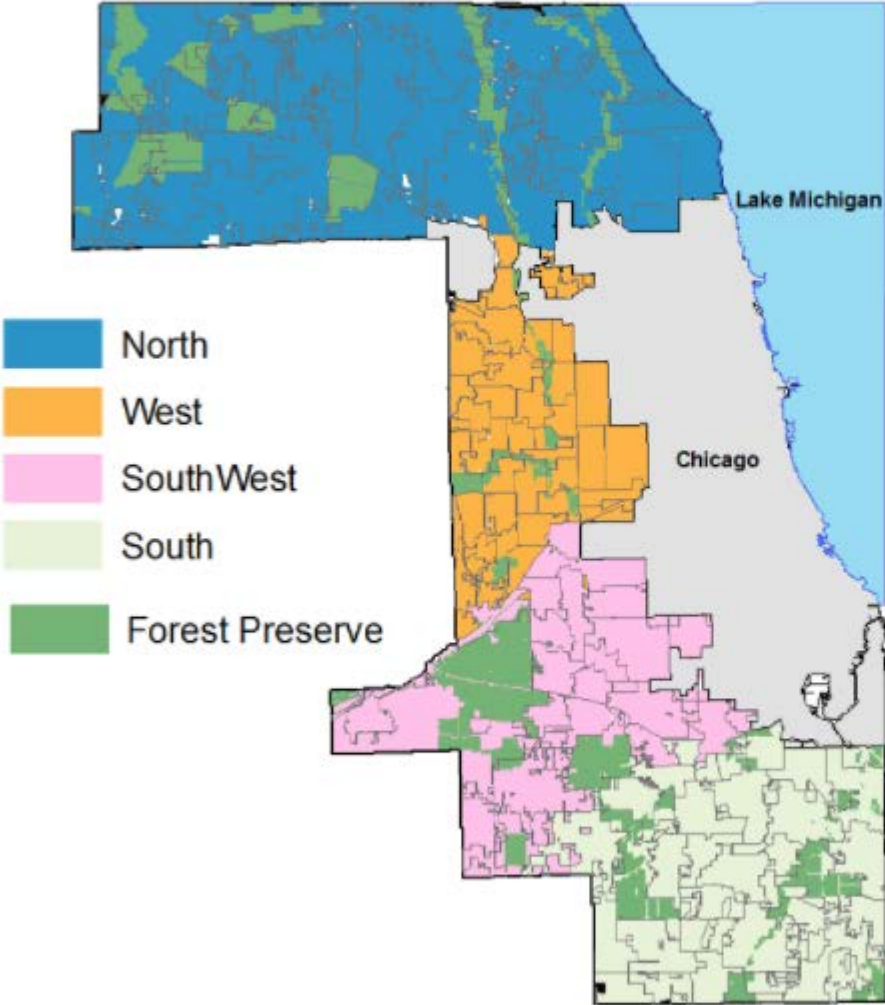


Suburban Cook County Areas



Opioid-related mortality rates increased for all four suburban Cook County districts. The largest increase (over 350%) occurred in the South district.

Suburban Cook County Areas

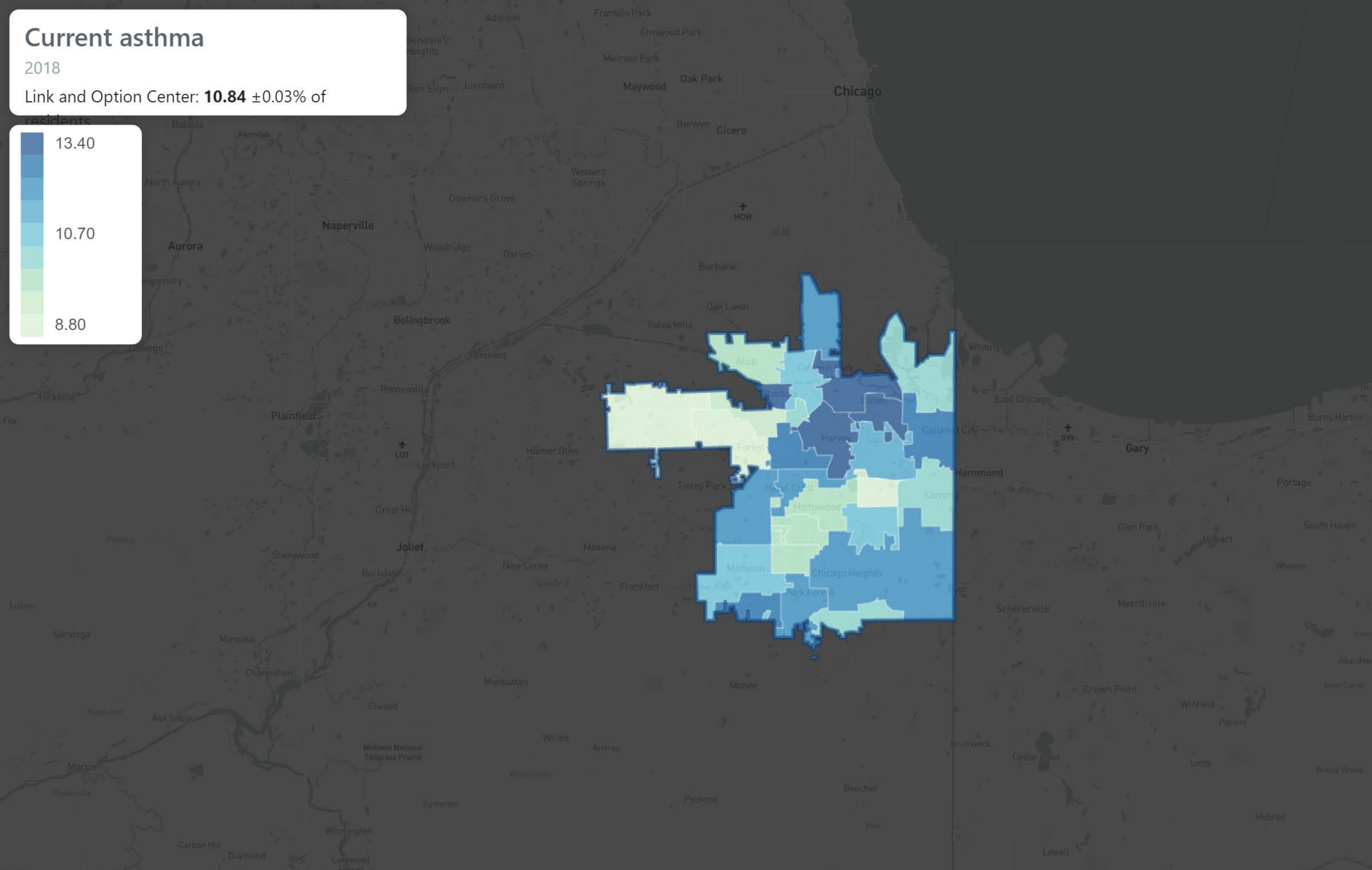
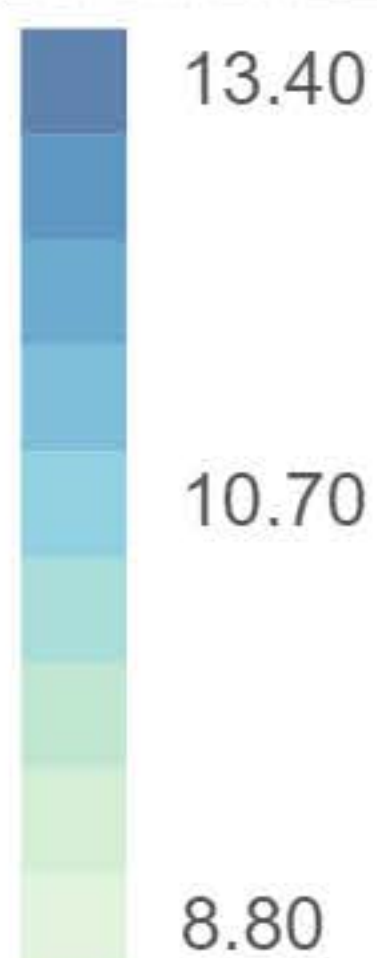


Opioid-related mortality rates increased for all four suburban Cook County districts. The largest increase (over 350%) occurred in the South district.

Current asthma

2018

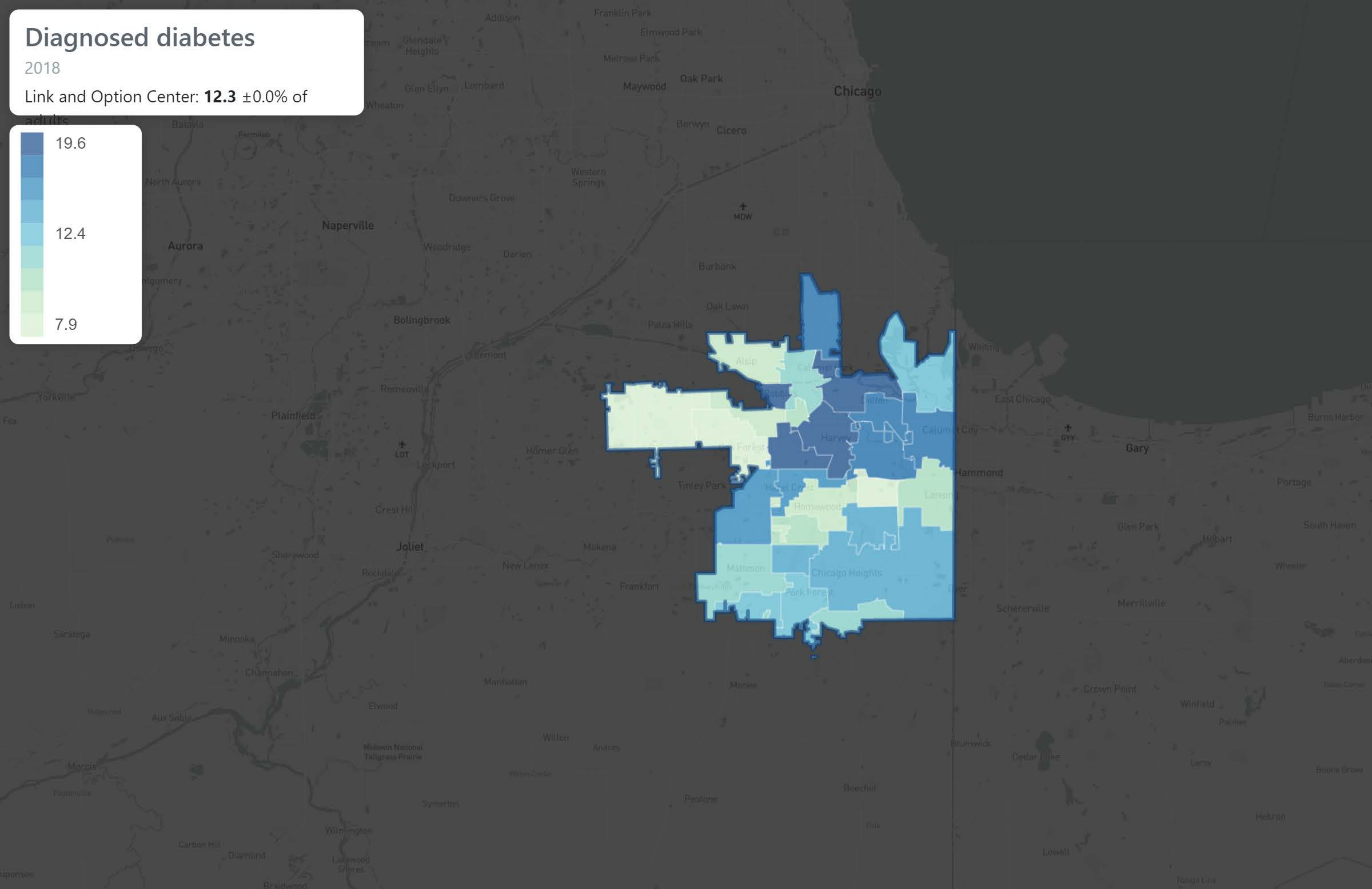
Link and Option Center: **10.84** $\pm 0.03\%$ of



Diagnosed diabetes

2018

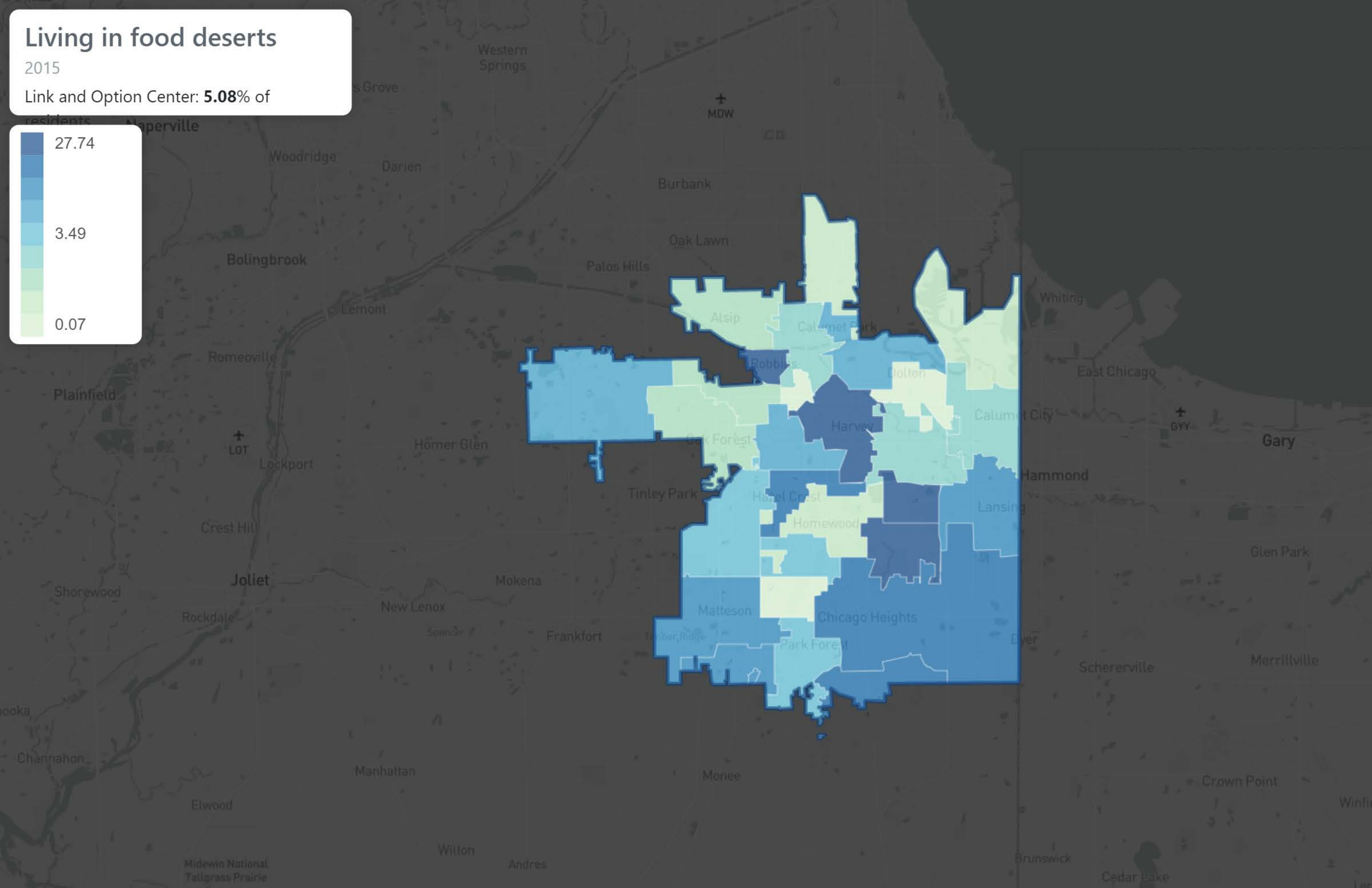
Link and Option Center: **12.3** $\pm 0.0\%$ of



Living in food deserts

2015

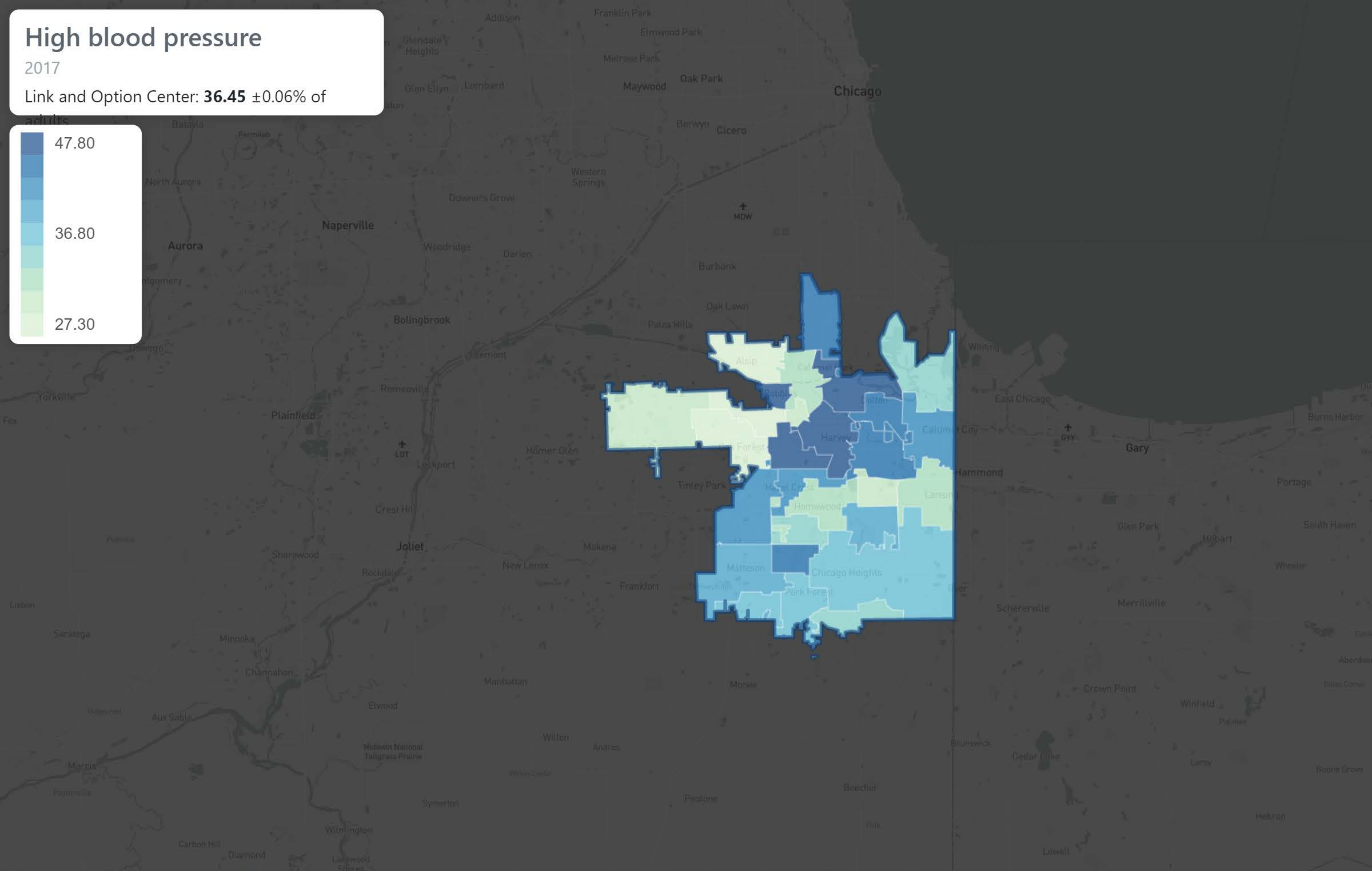
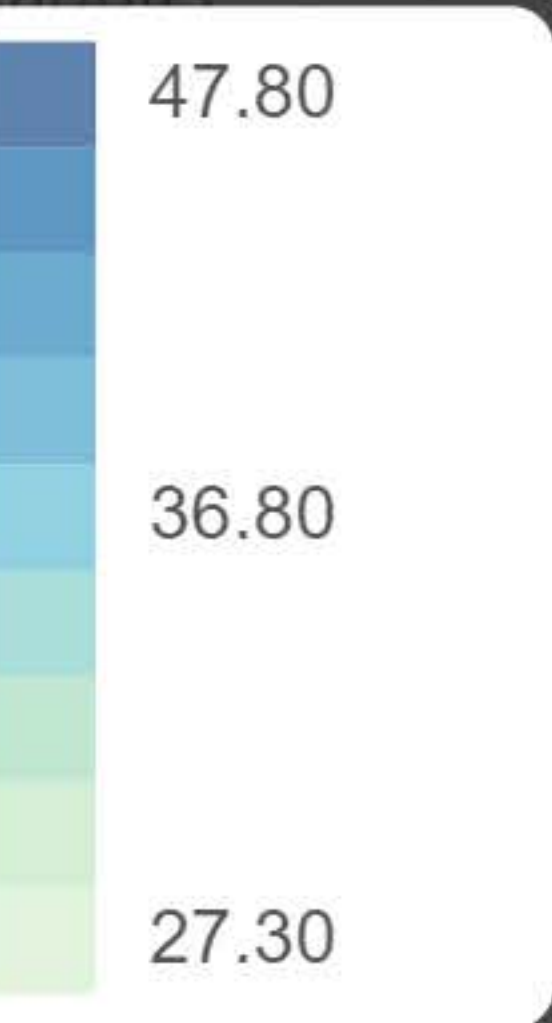
Link and Option Center: **5.08%** of



High blood pressure

2017

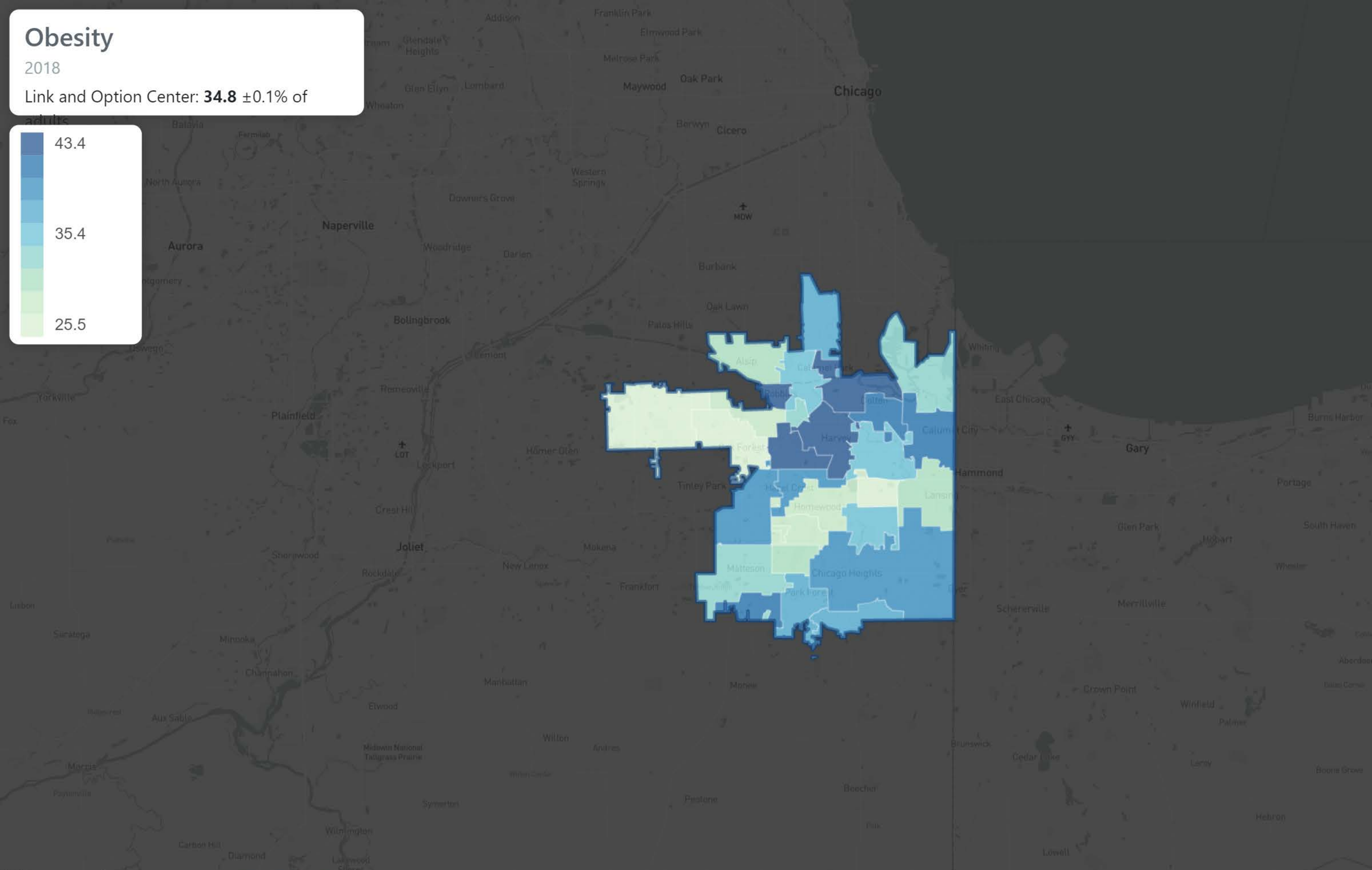
Link and Option Center: **36.45** ±0.06% of



Obesity

2018

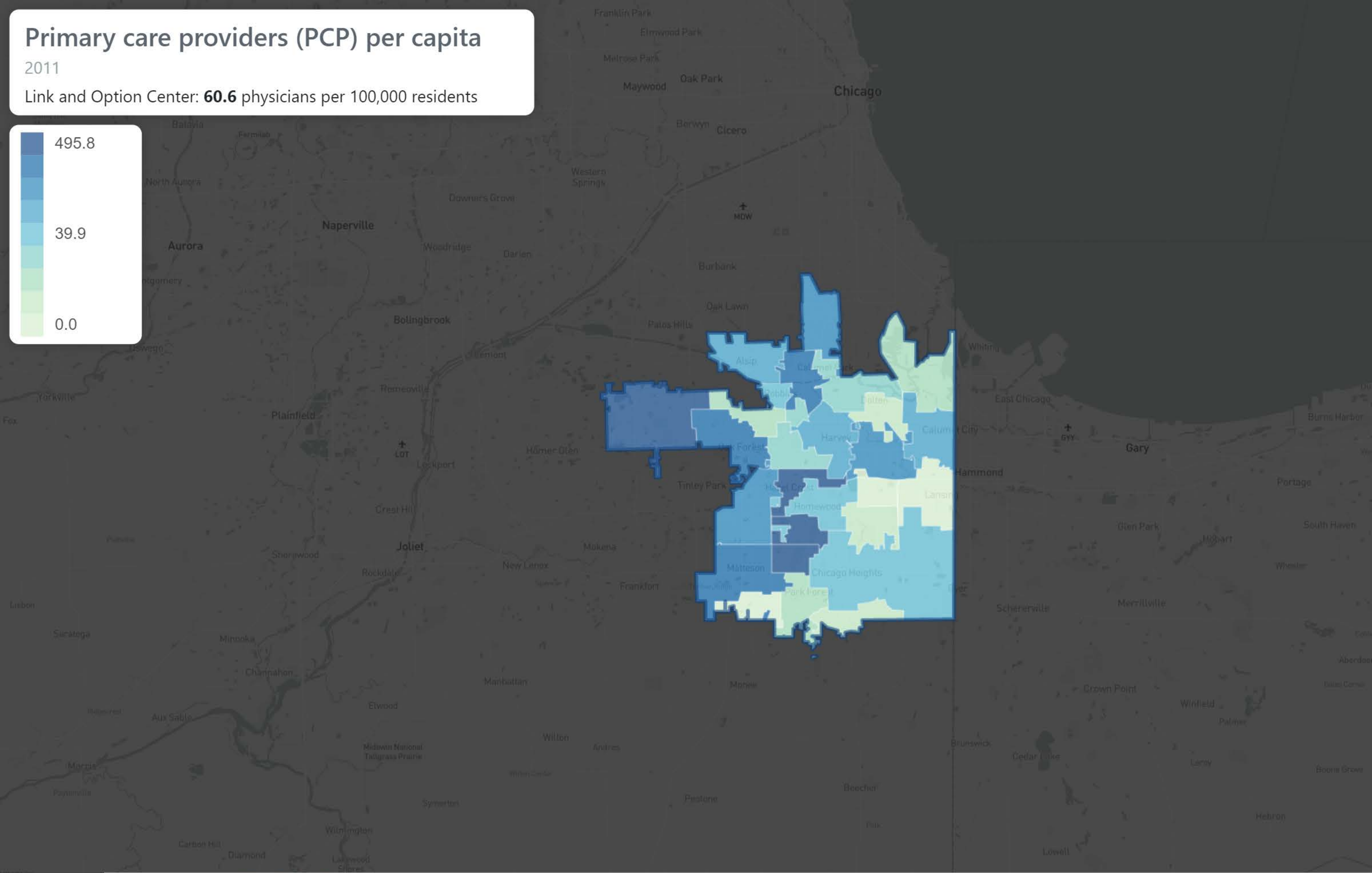
Link and Option Center: **34.8** $\pm 0.1\%$ of



Primary care providers (PCP) per capita

2011

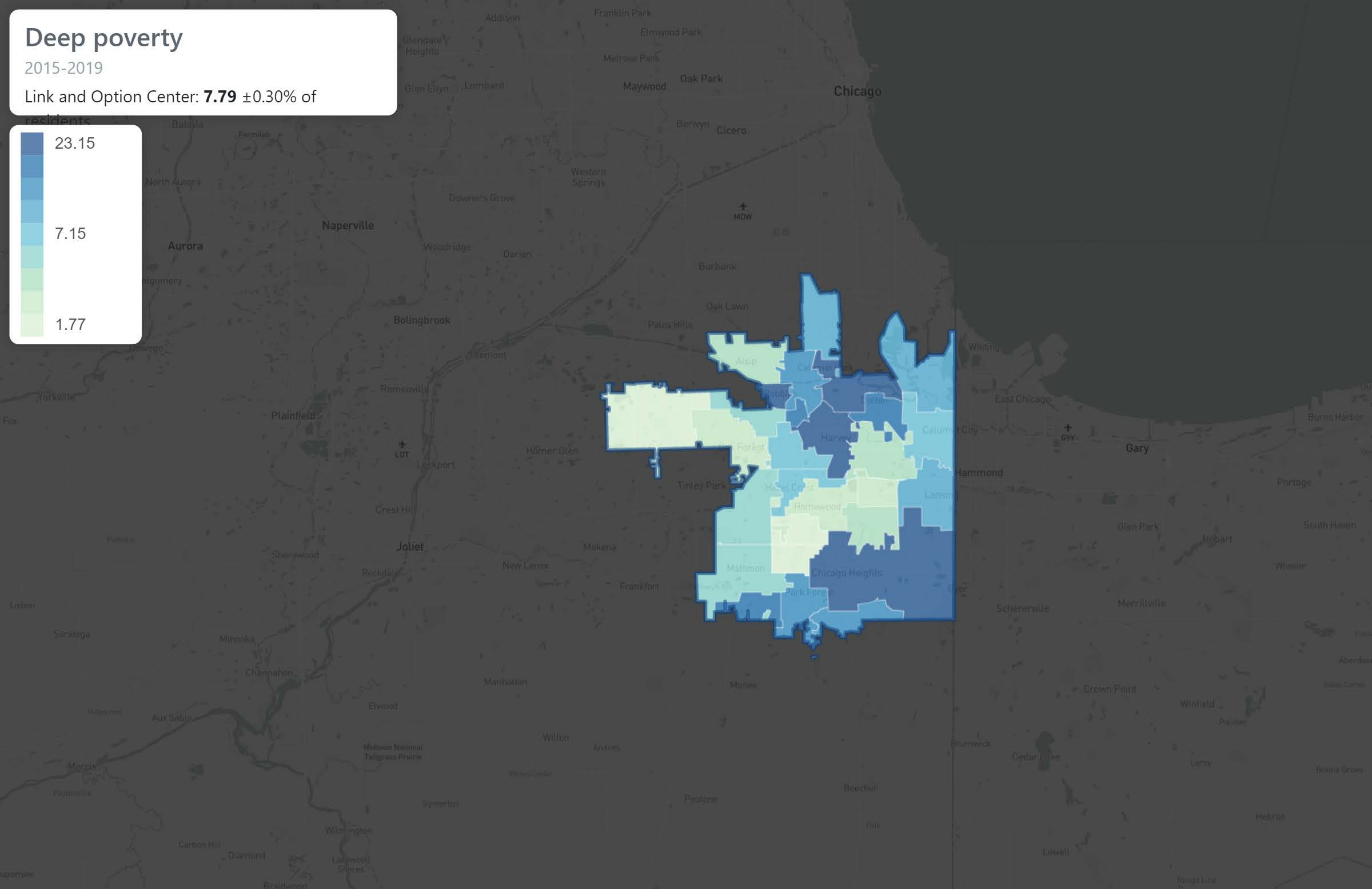
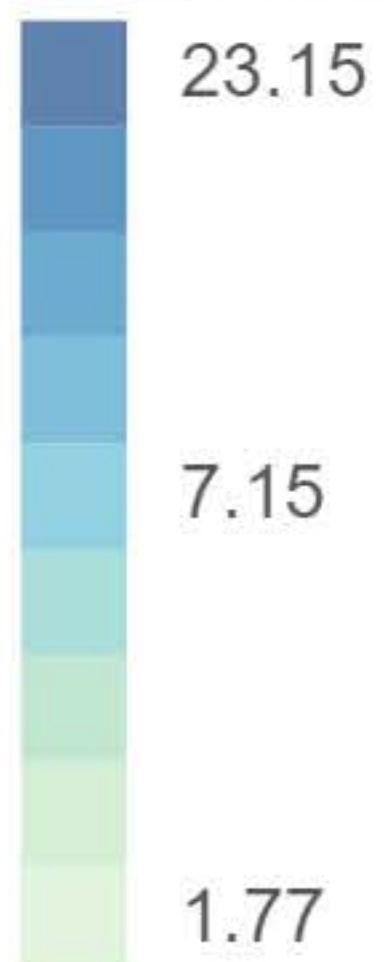
Link and Option Center: **60.6** physicians per 100,000 residents



Deep poverty

2015-2019

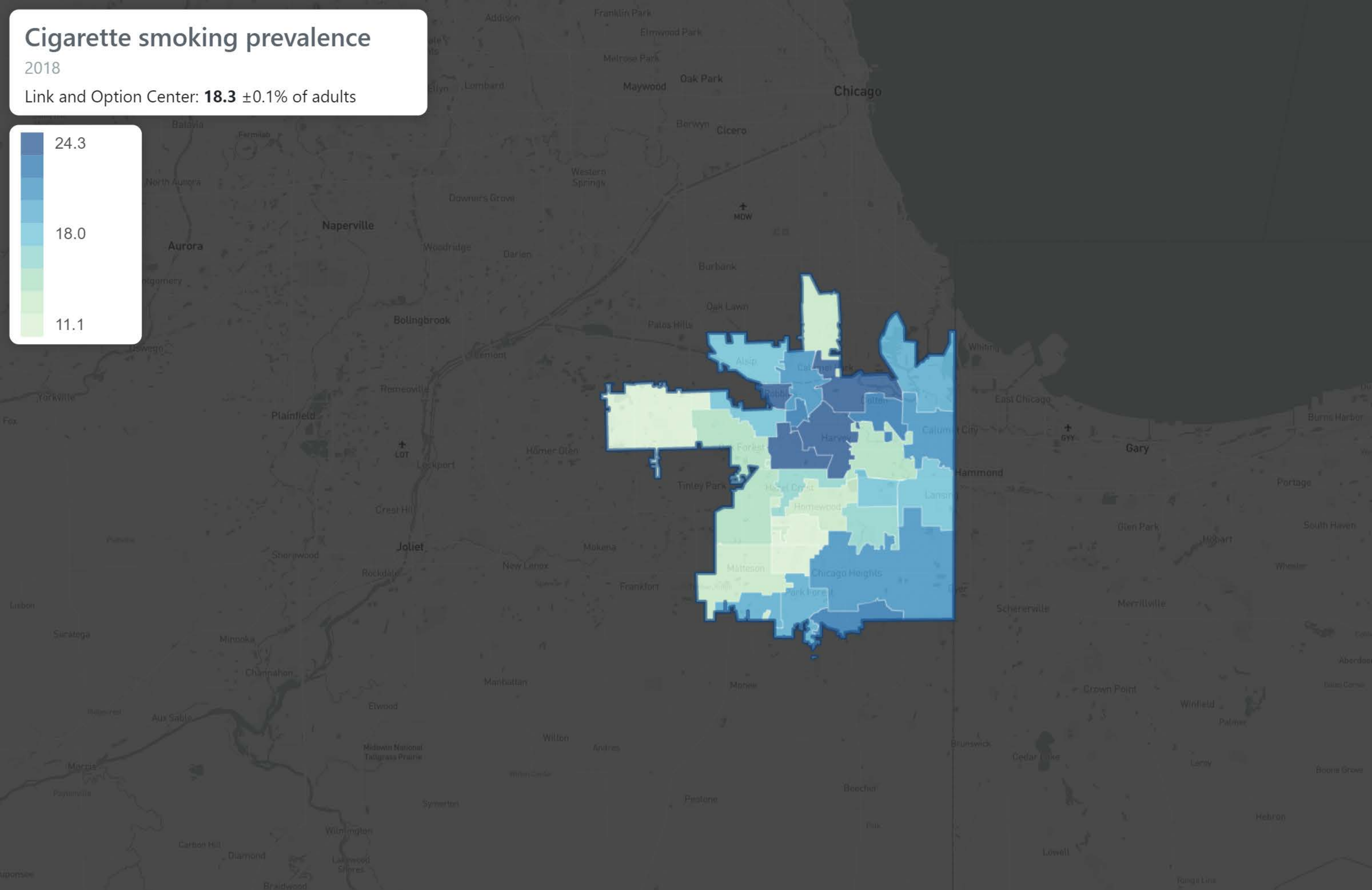
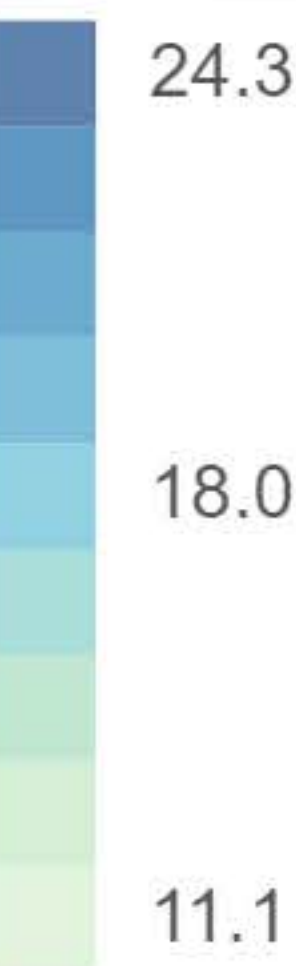
Link and Option Center: **7.79** $\pm 0.30\%$ of



Cigarette smoking prevalence

2018

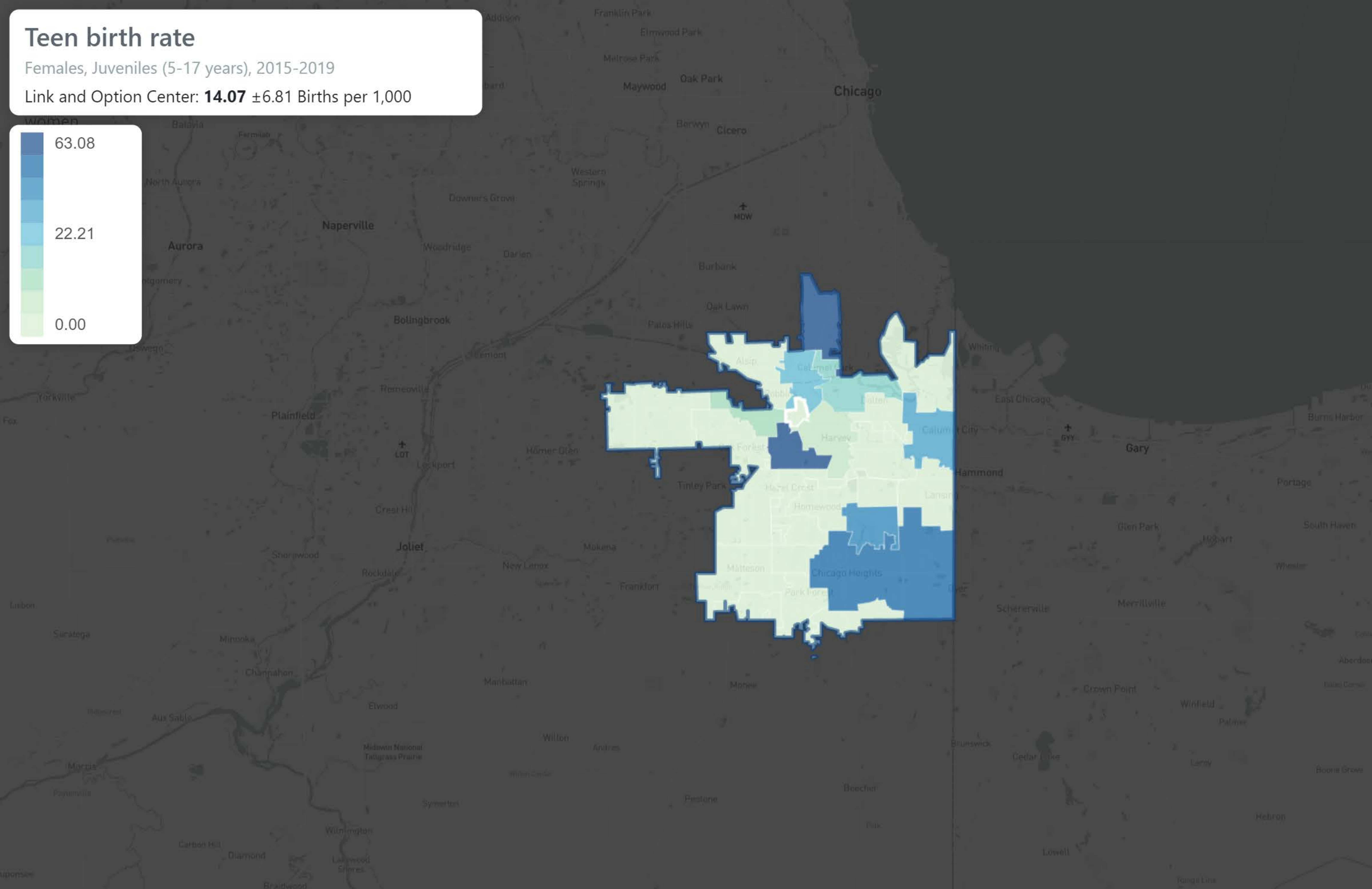
Link and Option Center: **18.3** ±0.1% of adults



Teen birth rate

Females, Juveniles (5-17 years), 2015-2019

Link and Option Center: **14.07** ±6.81 Births per 1,000



Uninsured rate

2015-2019

Link and Option Center: **7.74** $\pm 0.20\%$ of

