

# Healthcare Transformation Collaboratives Cover Sheet



**1. Collaboration Name:** Southwest Hope Collaborative

**2. Name of Lead Entity:** Esperanza Health Centers

**3. List All Collaboration Members:**

- |                                  |                                      |
|----------------------------------|--------------------------------------|
| • Esperanza Health Centers       | • Gage Park Latinx Council           |
| • Rush University Medical Center | • Poder Learning Center              |
| • Sinai Health System            | • Latinos Progresando                |
| • Saint Anthony Hospital         | • Brighton Park Neighborhood Council |
| • Southwest Organizing Project   | • Enlace Chicago                     |

**4. Proposed Coverage Area:**

60608, 60609, 60623, 60629, 60632

**5. Area of Focus:**

Increased access to primary care with the addition of 36 providers on the southwest side of Chicago;  
Increased geographic access to holistic care with the expansion of three community health anchors;  
Expanded behavioral health access; Improved coordination of care across multiple points of care;  
Establishment of an interprofessional workforce training/residency program.

**6. Total Budget Requested:** \$20,000,000



## **Southwest Hope Collaborative**

Prepared by Esperanza Health Centers  
for Department of Healthcare and Family Services Healthcare Transformation Collaboratives

**Primary Contact: Justin Hayford**

**Project Description**

## 0. Start Here - Eligibility Screen

Does your collaboration include multiple, external, entities?

☒ Yes

No

Can any of the entities in your collaboration bill Medicaid?

☒ Yes

No

## 1. Participating Entities

### Contact Information for Collaborating Entities

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

Esperanza Health Centers

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

| Entity Name                                                      | Tax ID #<br>(xx-xxxxxx) | Primary Contact  | Position                                           | Email                      | Office Phone       | Mobile Phone | Secondary Contact     | Secondary Contact Position              | Secondary Contact Email        |
|------------------------------------------------------------------|-------------------------|------------------|----------------------------------------------------|----------------------------|--------------------|--------------|-----------------------|-----------------------------------------|--------------------------------|
| Esperanza Health Centers                                         | 32-0115907              | Dan Fulwiler     | President & CEO                                    | dan@esperanzachicago.org   | 773-584-6130       |              | Heidi Ortolaza-Alvear | VP of Strategy and Business Development | hortolaza@esperanzachicago.org |
| Rush University Medical Center                                   | 36-2174823              | Deborah Edberg   | Director of Graduate Medical Education Development | Deborah_Edberg@rush.edu    | 312-942-5225       |              | Steven Rothschild     | Chair, Department of Family Medicine    | Steven_Rothschild@rush.edu     |
| Sinai Health System                                              | 36-3166895              | Karen Teitelbaum | President & CEO                                    | karen.teitelbaum@sinai.org | 773-257-5364       |              | Rosa Arellano         | Executive Assistant                     | rosa.arellano@sinai.org        |
| Saint Anthony Hospital                                           | 93-0391614              | Guy A. Medaglia  | President & CEO                                    | gmedaglia@sahchicago.org   | 773-484-4300       |              | Ellen Canter          | Campaign Director                       | ercanter@sahchicago.org        |
| Southwest Organizing Project                                     | 36-4090773              | Jeff Bartow      | Executive Director                                 | jbartow@swopchicago.org    | 773-471-8203 x 111 |              | Jessica Biggs         | System of Care Organizer                | jbiggs@swopchicago.org         |
| Gage Park Latinx Council (Resilience Partners NFP, fiscal agent) | 47-3136024              | Antonio Santos   | Executive Director                                 | antonio@gplxc.org          | 708-872-8798       |              | Samantha Martinez     | Outreach Director                       | Samantha@gplxc.org             |
| Poder Learning Center                                            | 36-4251880              | Daniel Loftus    | CEO                                                | dloftus@poderworks.org     | 312-226-2002 x 303 |              | Marc Smierciak        | Program Manager                         | msmierciak@poderworks.org      |
| Latinos Progresando                                              | 36-4355072              | Luis Gutierrez   | Founder and CEO                                    | luis@latinospro.org        | 773-542-7077 x 813 |              | Adrienne Lange        | Chief Advancement Officer               | adrienne@latinospro.org        |
| Brighton Park Neighborhood Council                               | 36-4229387              | Patrick Brosnan  | Executive Director                                 | pbrosnan@bpncchicago.org   | 773-523-7110       |              | Sara Reschly          | Director of Community Partnerships      | sreschly@bpncchicago.org       |
| Enlace Chicago                                                   | 36-3727669              | Katya Nuques     | Executive Director                                 | knuques@enlacechicago.org  | 773.943.7570       |              | Amanda Benitez        | Director of Community Health            | ajbenitez@enlacechicago.org    |

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

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

### Participating Entities

Are there any primary or preventative care providers in your collaborative? Yes

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

- Esperanza Health Centers
- St Anthony Hospital
- Sinai Health System
- Rush University Medical Center



**2. Are there any specialty care providers in your collaborative?** No

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

**3A. Please enter the name of the first entity that provides hospital services in your collaborative.**  
Rush University Medical Center

**3B. Which MCO networks does this hospital participate in?**

- Blue Cross Blue Shield Community Health Plan
- CountyCare Health Plan (Cook County only)
- IlliniCare Health

**3C. Are there any other hospital providers in your collaborative?** Yes

**3D. Please give the name of your second hospital provider here.**  
Sinai Health System

**3E. Which MCO networks does this hospital participate in?**

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

**3F. Are there any other hospital providers in your collaborative?** Yes

**3G. Please give the name of your third hospital provider here.**  
St Anthony Hospital

**3H. Which MCO networks does this hospital participate in?**

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

**3I. Are there any other hospital providers in your collaborative?** No

**4. Are there any mental health providers in your collaborative?** Yes

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

- Esperanza Health Centers
- Sinai Health System
- St Anthony Hospital
- Rush University Medical Center

**5. Are there any substance use disorder services providers in your collaborative?** Yes

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

- Esperanza Health Centers
- Sinai Health System
- St Anthony Hospital
- Rush University Medical Center

**6. Are there any social determinants of health services providers in your collaborative?** Yes

- Brighton Park Neighborhood Council

- Gage Park Latinx Council
- Southwest Organizing Project
- Latinos Progresando
- Poder Learning Center
- Enlace Chicago
- Esperanza Health Centers

**7. Are there any safety net or critical access hospitals in your collaborative? Yes**

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

- St Anthony Hospital
- Mt Sinai Hospital
- Holy Cross Hospital

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

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

- Esperanza Health Centers
- St Anthony Hospital
- Brighton Park Neighborhood Council
- Enlace Chicago
- Gage Park Latinx Council
- Latinos Progresando
- Poder Learning Center
- Southwest Organizing Project

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

- |                                             |               |
|---------------------------------------------|---------------|
| • Esperanza Health Centers                  | 32-0115XXXXXX |
| • St Anthony Hospital                       | 51-0217XXXXXX |
| • Mt Sinai Hospital (Sinai Health System)   | 36-1509XXXXXX |
| • Holy Cross Hospital (Sinai Health System) | 36-2170XXXXXX |

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

- Safety Net Hospital Partnerships to Address Health Disparities
- Cross-Provider Care Partnerships Led By Minority Providers, Vendors, or Not-For-Profit Organizations
- Workforce Development and Diversity Inclusion Collaborations

## 2. Project Description

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

Southwest Hope Collaborative

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

The Southwest Hope Collaborative is an initiative of four healthcare providers and six community organizations whose vision is to eliminate health disparities on the southwest side of Chicago. The Collaborative will achieve this audacious goal through investing in people, organizations and systems to drive sustainable change by providing access to primary and behavioral healthcare services, creating real pathways for patients to access services to address the social determinants of health, and building health professionals training programs that are designed to deliver the type of team-focused, socially engaged community health workers, medical assistants, care coordinators, nurse practitioners, and physicians that are crucial to the care of underserved communities.

### Detailed Project Description

**Provide a narrative description of your overall project, explaining what makes it transformational. Specify your service area, identify the healthcare challenges it faces, and articulate your goals in addressing these challenges; explain your strategy and how it addresses the causes of these challenges, and lay out the expected timeframe for the project.**

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

The Southwest Hope Collaborative (the "Collaborative") shares the HFS vision for transforming Medicaid by reorienting the healthcare delivery system around people and communities. The Collaborative will drive systemic change and advance health equity through a community-centered approach to care.

#### About the Collaborative

The Collaborative is grounded in the belief that it takes the entire community to drive health equity. Traditional healthcare providers, including hospitals and primary care providers, cannot by themselves make the changes that are needed in under-resourced communities to effect true change. The Southwest Hope Collaborative recognizes this and was designed to correct it. The Collaborative consists of not just healthcare partners, but devotes equal or greater resources to community partners to make these changes happen. These partners include Southwest Organizing Project (SWOP), Latinos Progresando, Brighton Park Neighborhood Council, Enlace Chicago, Poder Learning Center, Gage Park Latinx Council, Esperanza Health Centers, Sinai Chicago, Saint Anthony Hospital, and Rush University Medical Center.

The Collaborative will be led by Esperanza Health Centers (Esperanza). Esperanza has a track record as a "first mover" and innovator with demonstrated success in improving health outcomes. Esperanza's commitment to offering care of the highest quality is made clear by its designation as a National Quality Leader by HRSA during four of the past five years, ranking Esperanza among the top 3 percent of health centers in the nation, and the top two in Illinois for quality of care. This ranking is based on the measures that truly count in terms of improving life expectancy, including management of diabetes and hypertension; colorectal, cervical and breast cancer screening; childhood and adult vaccinations; and screening and treatment of depression, among many others.

In addition, Esperanza has made its motto to "put the community back in community health." This means that it sees its role in the community as far more than simply making clinicians available, and waiting for patients to come to it to access care. Rather, Esperanza works to be deeply engaged in the communities it serves, partnering with social service providers, community organizations, schools and others to create programs that can drive health outcomes for their entire service area, not just their own patients.

The Southwest Hope Collaborative builds on Esperanza's strength of working in partnership to address systemic barriers in order to improve health outcomes, but Esperanza is not the sole driver of this work. Instead, the ten partners in the Collaborative have existing multi-year relationships built among members by their work in community

participatory processes to define and prioritize shared health goals. This work has gone far beyond typical community engagement strategies, which often serve merely as communication tools between large healthcare partners and small community agencies. Rather, our approach has been to actively participate in the creation and implementation of community plans for health that drive real health outcomes. The vision, or “Big Hairy Audacious Goal,” is to actually change measurable health outcomes for the southwest side through carefully structured partnerships between people, organizations, and systems that can drive health outcomes.

This work came from the frustration of many Collaborative partners with maps created by Chicago Department of Public Health epidemiologists that for decades have looked the same, no matter what health impact was being examined or what time period was looked at: these maps have glowed white with good health on the affluent north side of Chicago, while the rest of the City languished in darker colors, indicating increased morbidity and mortality from almost all disease states: hypertension, diabetes, overdose, infectious disease, asthma, poor birth outcomes, and many others.

With the Covid-19 pandemic, the partners in this proposal saw an opportunity to make significant inroads on reducing a health disparity that had hit the area harder than almost any other. Three of our five target area zip codes were the hardest hit in the State, and the partners knew they had to do something. Because of the trust and knowledge that had been built over many years, they were well placed to do so.

The first investment was in creating equitable access to testing. The three hospitals and Esperanza provided tens of thousands of tests in the part of the City with the highest positivity rates and the fewest number of testing sites. Because of the high morbidity of patients tested, this service was not offered in isolation, however. It included high-quality primary care follow-up for positive patients, warm hand-offs to partner hospitals for patients receiving testing who were in acute respiratory distress, and many, many programs to address the social determinants of health. Together, the partners offered distribution of food, diapers, masks, and other supplies that were in critical need. The partners created access to housing assistance programs when they became available, and helped with access to free internet and computers for distance learning as schools were closed.

When vaccines became available, the partners knew that they had the opportunity to really “change the map,” producing a more equitable outcome. Vaccines were the exit strategy from the pandemic, but a vaccination rate high enough to meet the need would not be easy to achieve.

Through a massive effort between multiple community partners, hospitals, and literally dozens of community health workers hired and trained within a matter of weeks, the collaborative partners succeeded. The map for vaccination rates reflected these efforts is included in the attachments to this proposal. It reflects a profound change, as the 60629 and 60632 zip codes in the heart of our service area lit up just like their northside counterparts. They were among the first in the state to achieve a 70 percent vaccination rate, despite the community’s predominantly low-income, medically underserved population.

As the pandemic has waned, the collaborative partners have turned their focus to how they can leverage the lessons that they learned during the pandemic to change the map for other diseases that have plagued the community for decades. Additional partners have been incorporated into the Collaborative and partner organizations have begun to rethink the way that healthcare systems can better deliver the outcomes that should be their goal.

Our model is based on the idea that healthcare transformation that is successful in advancing health equity and eliminating disparities must stem from a deep integration not only among partners, but through a weaving of healthcare practice into the community itself. One of the hallmarks of our Collaborative is the intentionality of the members in centering Latinx community organizations and individuals in all aspects of health care planning, delivery, and assessment.

#### Service Area

The Collaborative will focus on the predominantly Latinx, Medicaid population in neighborhoods on the southwest side of Chicago. This area corresponds with five zip codes: 60608, 60609, 60623, 60629, and 60632. These areas broadly coincide with the Chicago community areas of Lower West Side, South Lawndale, Archer Heights, Brighton Park, Chicago Lawn, McKinley Park, Gage Park, West Elsdon, New City, and West Lawn. There are 422,167 individuals living in these zip codes, 184,862 who have coverage through the Illinois Medicaid program.

The southwest side of Chicago is an often overlooked part of the city. It is not what people traditionally think of as the

“South Side,” nor the “West Side,” which have distinctive cultures built on their long associations with the Great Migration and African American culture in general. The southwest side, in contrast, is a community whose character has been shaped largely by a much more recent influx of Mexican immigrants and Mexican-Americans. The area’s industrial roots, including factories, meat packing plants, and “last mile” distribution centers, has created a landscape of production sites, with interwoven affordable neighborhoods which initially attracted European immigrants, and over the past decade have drawn a predominately low-income, Latinx population seeking similar opportunity. These neighborhoods don’t have vast tracts of empty lots and boarded up businesses that characterize the South and West Sides, and yet the fragile nature of the social and economic bonds of the area are evident in how drastically the Covid pandemic hit the area, and in the way that so many other health disparities have affected its working-poor residents.

#### Transformational Approaches

The hallmark of the Southwest Hope Collaborative’s approach to transformation is to invest in people, organizations, and systems in order to change the poor health outcomes that have plagued our community for decades.

We will do this through three major initiatives:

**Investing in primary care** through the creation of three community-centric health anchors, including the construction of a new 30,000 sq. ft. health center facility, to expand the geographic availability of primary medical and behavioral health services, and foster community connections with safety net hospitals as vital health care assets.

**Investing massively in pre-primary care** (often called preventive care or population health) through a re-envisioned healthcare team that includes community health workers and care coordinators in addition to clinical staff. These CHWs will work across Collaborative partner settings and leverage in-person and telemedicine to provide care grounded in culturally relevant practices, address social determinants of health that result in poor health outcomes, mitigate barriers to care, assist patients in navigating healthcare transitions, and provide the optimal level of care in the appropriate setting. Most of these community health workers will be physically located at community partner agencies, but will still be a critical part of the primary care team, with access to medical records and specific knowledge of patients on their panels.

**Investing in health professionals training**, including an interdisciplinary training model that centers health equity, and trains family medicine residents, nurse practitioner fellows, medical assistants, care coordinators, and community health workers collectively and by discipline on the intersection of clinical practice; team-based care that incorporates care coordination, insurance enrollment, and other supports to address social determinants of health; structural barriers to eliminating health disparities; and tools to maximize health outcomes for both individuals and the entire community. In order to have health professionals that are invested in the outcomes of underserved communities, they must be trained there.

The Southwest Hope Collaborative’s transformation model centers on setting a higher standard of care by creating new spaces for health, both within the community and virtually, for local residents to share, plan, and address their health needs through relevant medical and nonmedical programs and services. These efforts will deepen neighborhood trust, increase the number of patients served, and improve health outcomes in the area. The Collaborative will transform how health system partners interact in these spaces to address the root causes of inequities for a predominantly Latinx population, and train interdisciplinary teams to sustain this community-centric approach.

The Collaborative’s transformational approach will be actualized through the following strategies:

**1. Increased access to primary care with the addition of 36 providers on the southwest side of Chicago.** The Collaborative will add 20 primary care physicians and 16 nurse practitioners to provide care in community settings. Providers will be bilingual/bicultural, with training specific to the needs of a predominately Latinx Medicaid population.

**2. Increased geographic access to holistic care with the expansion of three community health anchors.** The three sites will establish points of care at strategic locations within the five zip code area. All three sites will offer in-person as well as telemedicine visits to further expand our reach.

Expanded access will be available with establishment of the following health anchors:



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**Esperanza Brighton Park Phase Two:** The launch of Esperanza Brighton Park Phase Two, a 30,000 square foot building that will complement the existing 26,000 square foot health center on the Esperanza Brighton Park Campus, will more than double the size of the facilities on the health campus, and significantly expand healthcare resources for the target area. The plans for the newly constructed facility include 34 exam rooms, consultation space, a community activity area, and dedicated program space. In addition to formal programming, the building will serve as a “third space” - in addition to home and work - for community members by creating a healthy environment for social connection, health promotion, and a forum for addressing social determinants of health with community partners.

**Latinos Progresando Community Center:** The co-located site will serve as a behavioral health hub, home to four licensed clinical social workers providing behavioral health services in a trusted community setting separated from the sometimes clinical feeling clinic setting. Services will be aligned with other community programming that focuses on wellness.

**Gage Park Latinx Council Community Center:** As with Latinos’ Progresando, behavioral health services will be offered here by two licensed clinical social workers to augment existing other health resources such as a community *Mercadito*, a market that provides fresh, culturally appropriate foods at no charge.

**3. Increased initiation and engagement in care using a Community Health Worker strategy to center “community” in health.** Thirty (30) Community Health Worker (CHW) positions will be created, based at Collaborative partner organizations and also embedded in primary care teams. CHWs will serve as concierges, public health ambassadors, community educators and more, thus driving real health outcomes for patients and communities.

CHWs will reflect the bilingual/bicultural population that call Chicago’s southwest side home. They will play a critical role in connecting community members to a medical home, and addressing social determinants of health and systemic barriers that prevent care initiation and ongoing engagement. CHWs will also be critical to deploying population health strategies in the community, including engaging one-on-one with patients, and creating a community of patients to support wellness and health outcomes in high-incidence conditions such as diabetes, obesity, and cardiovascular health.

Community health workers will also be integrated virtually into the primary care teams, with full access to the primary care medical record, and the responsibility to work with clinicians on care gaps that are drivers of key health outcomes.

**4. Improved coordination of care across multiple points of care.** The Collaborative will add 18 care coordinators to support transitions of care from primary, specialty, diagnostic services, and hospital discharge. Hospital-based transitions will be supported with the addition of 6 hospital concierges. These care coordinators and concierges will also collaborate with the CHWs on the team to address social determinants of health.

**5. Expanded behavioral health access across the continuum of care.** The Collaborative will add 8 licensed clinical social workers (LCSWs) and 2 psychiatrists to create a continuum of care from community settings, primary care, and hospital based services, including from the comprehensive mental health crisis stabilization unit at Sinai Holy Cross Hospital.

**6. Integration of social determinants of health as a fundamental part of the care model, improving individual- and population-health by addressing systemic barriers to achieving health equity.** The Collaborative will focus its efforts on food insecurity, with a pilot to address the specific cultural needs of patients experiencing high rates of diabetes, obesity, and cardiovascular illness. We will also address social isolation and the effects of immigration.

**7. Establishment of an interprofessional workforce training/residency program that integrates role- and team-based learning, and incorporates community context and social determinants of health in clinical care team education.** The training program will draw on interactive, experiential, and participatory approaches and address the need for healthcare workers at all levels, including community health workers, medical assistants, counselors, nurse practitioners, care coordinators, and physicians. In addition to learning skills specific to their own area of work, we also plan to provide these learners interdisciplinary training, to advance our holistic model of patient care and to create upward career mobility.

There is a workforce crisis within the safety net at all levels of healthcare delivery. The dearth of health care providers cannot be addressed simply through recruitment strategies; it must be addressed further upstream through training

programs that specifically prepare individuals to address the health inequities, cultural context, and linguistic backgrounds of patients, and that take into account the interconnected roles of care team members.

Esperanza has already created pathways in two of these areas (MAs and NPs), and now plans to expand those programs and add programs for each of the other named professions, including the launch of a family medicine residency program in partnership with Rush University Medical Center in 2023.

The Collaborative will build on these foundations in partnership to expand and augment these community-centered training programs to achieve high quality, team-based care in safety-net and other institutions serving a large Medicaid population.

The training program will include a longitudinal social justice curriculum that explores issues regarding health inequities, social determinants of health, historical oppression, bias, and experience of oppressed communities in society and the health care system. The goal of this curriculum is to equip health professionals with the tools to promote improved health equity. The educational component of this curriculum will include facilitated workshops, narrative readings, podcasts and videos, case presentations, and discussion groups.

The Collaborative will provide integrated training for clinical team members within the community health center setting. Innovative aspects of the curriculum include:

*Centering social justice in health care:* Southwest Hope Collaborative partners have long been focused on dismantling health inequities in Chicago. Team based training will focus not only on the intersection of health and justice in program curriculum, but health professionals will be immersed in care delivery systems that prioritize an understanding of the social, political, economic, and cultural context within which patients live and work.

*A focus on patient-centered care:* Training will be provided in a HRSA-approved Patient Centered Medical Home (PCMH). Health professionals will learn first-hand the systems and processes that make community-based health care genuinely responsive to patient needs.

*Culturally and linguistically competent care:* Training will focus on the importance of culturally and linguistically informed care in working with our patient populations. Residents will be expected to possess or gain fluency in Spanish

*Integration of mental health and substance abuse treatment:* Stigma, clinical integration, and community resource considerations will be addressed to result in better patient outcomes.

*Understanding value-based care:* Training will highlight the critical issues that must be considered when delivering healthcare in a value-based environment.

*Incorporation of wraparound services:* Given the Collaborative's keen understanding of the key role that social determinants of health play in patient wellness, we devote significant resources to providing wraparound services (most notably care coordination and public benefits enrollment assistance) to ensure that the barriers to care so many patients face are reduced or eliminated. Participants will learn the key role that wraparound services play in improving patient outcomes.

*Leadership in community health care:* Program curriculum will include modules on leadership within the communities the health system serves, including outreach, education, and policy advocacy.

The interprofessional training program will increase the pipeline of nurse practitioners, family medicine physicians, medical assistants, and community health workers prepared to provide high quality, bilingual, culturally relevant care. A total of 32 physicians, 24 nurse practitioners, 60 medical assistants, 43 care coordinators, and 30 community health workers will be trained through the program.

The Southwest Hope Collaborative will bolster the community's health care infrastructure over the next five years with support from IL HFS; the lasting effects on the Medicaid beneficiaries living in our community will extend far beyond this initial investment.

### 3. Governance Structure

#### Structure and Processes

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

The governance structure of the Southwest Hope Collaborative will include a Coordinating Council and issue area committees that will provide a framework for policy, practice, and operations of the Collaborative. The Coordinating Council will serve as the decision making body of the Collaborative, with representation from each collaborating partner.

Esperanza will serve as the fiscal agent for the Southwest Hope Collaborative, and as the backbone organization for the Collaborative. As a federally qualified health center organization with \$41 million in annual revenue from third party insurers, public funds, and philanthropic sources, Esperanza is adept at managing complex financial arrangements. Esperanza also serves as the fiscal sponsor for the Chicago Safety Net Learning Collaborative, a collaboration of 21 Chicago-area FQHCs. Esperanza's CEO, Dan Fulwiler, recently served as president of the Medical Home Network Accountable Care Organization, overseeing policy for the ACO's shared savings, quality bonus arrangements, and member contracting.

The Coordinating Council will be co-chaired by the Collaborative's backbone organization (Esperanza) and a Collaborative member representative, who is approved by the Coordinating Council. The body will review and approve all policies for the Southwest Hope Collaborative.

The Coordinating Council will be responsible for:

- Adopting, monitoring, and reviewing the Collaborative mission, strategies, and priorities to meet transformation goals
- Setting a regular meeting schedule for governance committees to set policy, review data and assess progress towards Collaborative goals
- Review and approval of the Collaborative's quality plan
- Monitoring of the Collaborative's performance goals, including individual partner contributions
- Advising on the financial viability and sustainability of the Collaborative, key investments
- Providing guidance to the backbone organization on contracts, financial agreements, and vendor relationships
- Monitoring job creation, including BEP/WBE and other equity, diversity and inclusion goals
- Recommending distribution of transformation funds in alternative payment models

The Coordinating Council will be informed by a committee structure addressing healthcare system transformation issue areas. Committees will include:

- Access & Community Integration
- Quality
- Education & Training
- Finance & Sustainability

The Access & Community Integration Committee will address:

- Coordinated processes for benefits enrollment
- Operational processes for initiation of care
- Social determinants of health pilot
- Healthcare utilization monitoring

The Quality Committee will support:

- Creation of annual quality plans
- Quality plan monitoring towards transformation goals
- Development of integrated quality improvement strategies
- Documentation review of clinical and social support systems

The Training & Education Committee will provide recommendations on the following:



- Collaborative training plan, including content and timeline
- Interprofessional curriculum design
- Monitoring of training plan in line with Collaborative's quality goals

The Finance & Sustainability Committee will address:

- Collaborative investments with the potential for the greatest return on health system efficiency, quality, and value
- BEP/MBE goal monitoring
- Alternative payment models
- Joint operating agreements for Collaborative members

All governance entities will maintain a regular meeting schedule to promote active participation, communication, and proactive identification of integration opportunities. Each committee will provide regular reports to the Coordinating Council. The Coordinating Council will review committee recommendations and set policy based on review of committee guidance, organizational needs, and operating guidelines.

### Accountability

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

The Southwest Hope Collaborative builds on established, multi-year relationships built among members working towards shared health goals. This history sets a foundation for trust, ethical engagement, and continued participation across the Collaborative's membership. Members were identified based on (1) their commitment to improving the health of the southwest side; (2) established collaborative work with measurable impact; (3) flexible operating systems to support integration; (4) organizational capacity to scale and transform; and (5) an ethical orientation that centers decision making in the interest of the community's predominately Latinx population.

The Collaborative will codify this shared accountability in a legally binding operating agreement. Members will agree to shared terms across the Collaborative, with terms set forth by the Coordinating Council. The operating agreement will address the following terms:

- Membership commitment and duration
- Governance structure and decision making authority
- Delineation of Coordinating Council and backbone organization roles
- Policy creation, review, and adherence
- Ethics and compliance terms
- Commitment to Equity, Diversity and Inclusion
- Training plan requirements to support the integration of the Collaborative's partners to achieve transformation goals
- Performance standards, monitoring, and risk mitigation
- Fund distribution policies

In addition to the operating agreement, each Collaborative member will sign a legally binding contract that outlines their organization's specific commitments:

- Authorized representative to the Southwest Hope Collaborative Coordinating Council
- Scope of the member organization's involvement in the Collaborative
- Staffing commitment to achieve the scope, including titles and job descriptions
- Staff weekly hourly commitment
- Attestation to policy adherence, including organization policies that address non-discrimination, sexual harassment, diversity, training, ethics, and record keeping and reporting
- Attestation to financial audit requirements

### New Legal Entity

**Will a new umbrella legal entity be created as a result of your collaboration? No**

### Payments and Administration of Funds

**How will you ensure direct payments to providers within your collaboration are utilized for your proposed**

**program's intended purpose? If the plan is to use a fiscal intermediary, please specify.**

The proposed Collaborative does not require the creation of a new legal entity, and instead builds on established relationships and aligned community efforts. Our aim is to re-envision care delivery to a community centric model by leveraging HFS investments to seed practice changes, while also strategically aligning organizational investments to achieve system transformation.

Direct payments will be channeled to Esperanza as the Collaborative's managing entity. Direct payments in support of the Collaborative will be sequestered in a separate account, with separate management and auditing. Esperanza's CFO will provide regular written reports to the Finance & Sustainability Committee on the Collaborative's budget, cash flow, and contracts. The Finance & Sustainability Committee will also review fund disbursements administered by Esperanza.

All members will be legally bound to use funds for the purposes outlined in the individual organizational contract. The Coordinating Council will provide oversight of individual members' performance goals.

## 4. Racial Equity High-Level Narrative

### Racial Equity Impact Assessment Questions

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

The Southwest Hope Collaborative was created to fundamentally address the health disparities that stem from racial inequities. Our belief that it takes the entire community to drive health equity is supported by the intentionality of the members in centering Latinx individuals in all aspects of health care planning, delivery, assessment, and decision making.

The Collaborative's focus on racial equity is evidenced in the following:

- Inclusive, immersive planning processes such as user-centered design research to truly center the needs of Latinx individuals;
- A governance structure with 73 percent of decision making entities being minority-led organizations;
- Equal or greater investments to community partners within Latinx communities in relation to traditional health care systems, with the recognition that the majority of health is driven by factors outside of the health care system itself and that investments should be made commensurate with this, while also rectifying historic disinvestment from both private and public entities;
- Hiring bilingual/bicultural Latinx staff, including those with relevant lived experience, to provide point-of-care services that are responsive to the cultural, social, economic, and linguistic factors that impact the health of patients;
- Strategies that address both care delivery and the systemic changes in the delivery system to transform and sustain improvements that result in better health of Latinx patients; and
- Engagement of MBE/WBE firms to support the Collaborative's goals, and a prioritization of minority-led contracting for ongoing operating needs identified by the Collaborative.

All members of the Southwest Hope Collaborative have a deep commitment to racial equity that is demonstrated in their long histories of community partnerships, as well as their operating principles. Collaborative members prioritize hiring from the community in order to understand and address the lived experiences of those they serve, engage in racial equity training, assess operations for their impact on various racial/ethnic groups, and seek out cross-racial opportunities for collaboration to advance shared equity agendas.

### Racial Equity Impact Assessment Questions

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

Low-income, Latinx individuals living in under-invested communities of Chicago's southwest side are most affected by the issues outlined in the proposal.

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

The genesis of the Southwest Collaborative's plans stems from community members themselves; the resulting proposal is informed by strategies identified and prioritized by local residents. Years of coordination across community residents, neighborhood organizations, minority-led/resident-driven community providers have formed consensus around the most pressing health care challenges facing the predominantly Latinx population on the southwest side, which are reflected in community health data and codified in neighborhood plans.

True to our belief in equitable decision making, the Collaborative has engaged those most affected in informing not only the priorities of the Collaborative, but in shaping the structure of a transformed system. Three of the Collaborative members represent the interests of hundreds of engaged, local residents, through three neighborhood networks. Their ongoing role in governance will ensure that the Southwest Hope Collaborative sustains meaningful involvement beyond proposal submission.

To ensure that all vulnerable populations are meaningfully engaged, a racial equity assessment completed in August 2021 by Esperanza and the Morten Group sought perspectives from racially diverse constituents. It focused on the participatory assessment of knowledge, experiences, and opinions related to diversity, equity, and inclusion (DEI) strategies, policies, and next steps. The assessment engaged nearly 700 patients and community members. Recommendations based on the assessment include explicitly addressing anti-Blackness and colorism within the Latinx community. The Collaborative will build on this work to foster its values of inclusivity, diversity, and equity for all racial groups. Potential strategies include developing an explicit organizational statement on anti-Blackness, addressing medical racism, anti-Blackness, and implicit bias in the inter-professional training curriculum, and fostering opportunities for Black and Brown dialogues.

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

The predominantly low-income, Latinx residents living in the five target zip codes who are the groups most affected by the issues related to this proposal are also the racial/ethnic group most disadvantaged. Latinx individuals experienced more barriers when attempting to seek health care than non-Latino Whites, despite access to care being recognized as a concern (Agency for Healthcare Research and Quality. (2017, October). *2016 National Healthcare Quality and Disparities Report* (AHRQ Pub. No. 17-0001). Rockville, MD: Author. Retrieved from <https://www.ahrq.gov/research/findings/nhqrdr/nhqrdr16/index.html>). Disparities in access to primary care services such as preventive care have been shown to contribute to concentration of health disadvantages among Latinx and other non-White racial/ethnic groups ([Addressing Barriers to Primary Care Access for Latinos in the U.S.: An Agent-Based Model](#), Hyunsung Oh, Mai P. Trinh, Cindy Vang, and David Becerra *Journal of the Society for Social Work and Research* 2020 11:2, 165-184).

Qualitative research conducted by Duo Development provides evidence of existing inequities. Language, immigration status (even among U.S. residents/citizens living in blended immigration-status households), degree of acculturation, and structural racism result in unequal access to healthcare. Generational unfamiliarity with the U.S. healthcare system, and methods of navigating its complexity, equate to delayed care, decreased use of primary care, increased use of hospital emergency departments, and inadequate follow-up care (Escarce JJ, Kapur K. Access to and Quality of Health Care. In: National Research Council (US) Panel on Hispanics in the United States; Tienda M, Mitchell F, editors. *Hispanics and the Future of America*. Washington (DC): National Academies Press (US); 2006. 10. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK19910/>).

The Latinx population makes up 66 percent of the neighborhood. African-Americans make up a smaller percentage of the target zip codes (17 percent) than the Latinx population though often face similar barriers. Though there are some differences in root causes, the effects of oppression can manifest in similar ways. The Collaborative is committed to intentional inclusion, building awareness of shared history and experiences of oppression across Black and Brown communities, and fostering Black and Brown unity. A smaller percentage of Whites also reside in the area. Because of the historical roots of the neighborhood and ensuing White flight, they are less likely to experience community disinvestment and racial biases in healthcare systems in the same manner as the large - and growing - Latinx population that make up the community.

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

The effect of immigration policy is a key factor that has produced and perpetuated inequities for the Latinx population. Explicit anti-immigrant policies over the last few years compounded inequities. Increased anxiety and fear led many immigrant families to forgo assistance to meet basic needs, despite the ravaging impacts of the pandemic. A nationally representative survey showed that nearly 30 percent of low-income immigrant families with children avoided accessing public benefits to meet basic needs in 2020 because of immigration-related concerns ([Many Immigrant Families with Children Continued to Avoid Public Benefits in 2020, Despite Facing Hardships](#) Jennifer M. Haley, Genevieve M. Kenney, Hamutal Bernstein, Dulce Gonzalez). Half of adults in immigrant families with children reported someone in the family lost work due to the pandemic, and 30 percent experienced food insecurity.

The lack of generational wealth building because of recent entry into the U.S. economic system also limits healthcare options. Limited economic opportunity, coupled with lack of investment in healthcare infrastructure in the largely immigrant community, have made accessing healthcare resources difficult, and at times, impossible.

Nearly all southwest neighborhoods are designated by HRSA as Medically Underserved Areas and Health Professional Shortage Areas. These issues are further exacerbated by structural bias against those whose first language is not English, and who experience the effects of racism. Together, these root causes perpetuate health inequities.

The Southwest Hope Collaborative addresses these root causes in its transformation approach. By investing in culturally and linguistically relevant primary care, deploying a comprehensive pre- primary care strategy, and investing in health professionals training that is explicitly rooted in social justice and anti-racism values the Collaborative will advance health equity.

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

Our aim is two-fold: (1) to reduce disparities that stem from lack of access and result in poor health outcomes; and (2) to create a sustainable healthcare system that addresses the root causes of these disparities. In affirming the cultural heritage and norms of patients, we will also reduce discrimination through the healthcare system that we create. Our emphasis on interprofessional training program and its social justice emphasis will be a factor in both reducing disparities and training in anti-racist systems of care.

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

A positive opportunity for equity is that IL HFS transformation funds will spur additional investment in healthcare resources in the community, as providers recognize opportunities in the vibrant and growing communities of the southwest side. The Southwest Hope Collaborative would welcome investment that continues meaningful engagement of community residents, and see this involvement as the pathway for any adverse effects to be minimized. A potential negative consequence as a result of this proposal is that public investment will be made at a level that only addresses the symptomatic effects of disinvestment in healthcare serving vulnerable populations. Our vision is big and bold, and investment at significantly lesser amounts will result in deepening already entrenched inequities.

**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?**

All members of the Southwest Hope Collaborative, within their individual organizations and collectively, recognize the multiplicity of factors that create and perpetuate racial disparities and inequities. The Southwest Hope Collaborative represents a path forward to “change the map” and improve the health of Medicaid beneficiaries. In addition to this transformation, we are committed to evolving this work over time to also examine aspects of healthcare payment reform, healthcare and other benefits policies, as well as investment in healthy neighborhood infrastructure to support community wellness. HFS transformation funds will provide a significant step forward in realizing our vision of a healthier, more equitable healthcare system for our patients, and will provide a basis for further expansion of this work.

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

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

The Collaborative’s vision is big, and yet practical in its approach to achieving transformation. The proposal builds on strong and long standing partnerships, trust, and knowledge the group has gained over the years. The governance structure ensures appropriate oversight and public accountability. Reporting on our progress, and ongoing participation in evolving the healthcare system, will be achieved in established community forums via the three neighborhood convening groups.

The addition of new staff, including a Director of Collaboration & Integrative Services will provide leadership to the project. Additional positions will support data collection, population health initiatives and management support. As the backbone organization, Esperanza is well positioned to provide leadership and in-kind staff support to support data collection with its population- health management tools, quality dashboards, and community health tracking systems.

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

**assessed?**

The ultimate success of the Southwest Hope Collaborative will be in achieving our “Big Hairy Audacious Goal” of “changing the map” on community health indicators in the five target zip codes on the southwest side. Our goal is nothing less than making marked improvements in the overall health of the community. Illinois Medicaid beneficiaries comprise a significant portion of our population. Our ability to not only improve but to be the pace setters for healthcare excellence on the quality indicators outlined in our quality plan will be a factor in demonstrating our success.

Along with our demonstrated quality indicators, the Collaborative will leverage the three represented neighborhood networks and the teams of CHWs across the partner organizations to ensure ongoing stakeholder input and qualitative data to inform our assessment of the Collaborative’s success.



## 5. Community Input

### Service Area of the Proposed Intervention

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

Southwest side of Chicago

**Select counties:**

Cook

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

60608, 60609, 60623, 60629, 60632

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

The members of the Southwest Hope Collaborative share a passion for community engagement as a means to achieve health equity. The Collaborative is steeped in community listening and engagement of residents. Through direct engagement with community members, the Collaborative has learned about the unique needs in the service area, and has listened to community input around how these needs can best be addressed.

Three Collaborative members - Latinos Progresando, and Brighton Park Neighborhood Council and SWOP - are organizers of the three large, collective impact neighborhood networks in our service area: the Little Village Neighborhood Network, the Brighton Park Neighborhood Network, and the Southwest Action Council. Each of these organizations brings together community stakeholders from multiple sectors – schools, churches, social service organizations, health care, local government, small businesses, etc. – to create collaborative action plans to improve quality of life and redress inequities. These three networks have a combined membership of over 125 organizations, as well as numerous local residents. Collectively, they provide an important mechanism for engagement and connection with a wide array of local stakeholders focused on community wellness and improvement.

The Southwest Hope Collaborative's proposal is a response to a multi-year process of neighborhood and hyper-local input sessions driven by the three networks, resulting in the Chicago Southwest Quality of Life Plan, Brighton Park Neighborhood Network Community Plan, and the Little Village Neighborhood Network Community Plan priorities. The plans share the following themes:

- The need to expand access to medical care, including outreach to residents and bilingual assistance;
- An equal need to increase the availability of mental health services, and specifically services that are bilingual/bicultural;
- A recognition that stigma can affect whether residents access medical, behavioral health, and other services;
- The need for more fresh foods, and systems that support the affordability of these foods;
- The power of collective impact on changing community attitudes, beliefs, and systems to address health.

The Collaborative also has drawn insights from user-centered design research gathered through conducted by Duo Development in February 2021. User research focuses on understanding user behaviors, habits, needs, tensions and motivations through various methodologies such as in-home and on-site interviews, observation techniques and immersive studies. After conducting various research sessions, findings were analyzed and synthesized to discover and generate insights. Based on ethnographic field work, a method of research developed in the field of anthropology that relies on immersion in a local context to understand and uncover real needs and root causes, this method is particularly well aligned for identifying opportunities to address social determinants of health and advance health equity.

Community input from this process focused on understanding how individuals perceive their and their families' health needs, access, and barriers to health; how the neighborhood's assets and needs reveal a path to access and understanding local health, and what is missing. A range of community perspectives gathered through 250 immersion hours, 32 resident/patient interviews, and 12 interviews with organizational leaders working in the area informed our model. Six themes emerged from this work:



1. *Instability is an obstacle to long term planning and prioritizing health.* Instability is both a stressor and a reason people don't seek services. The predominantly low income, immigrant residents often assume services are beyond their means of access and hesitate to approach or attempt to navigate them.
2. *Family units are the microcosm of cultural knowledge and representation.* A significant value is placed on safeguarding health at home. Health is communicated first across generations, then across families interacting with each other. Leveraging this shared knowledge holds potential to improve health outcomes.
3. *Time, proximity, and convenience are central to the engagement equation.* This makes the role of a care coordinator hold special value.
4. *Individual experiences and cultural practices form foundations of health.*
5. *Shared and passed-on experiences inform future attitudes and actions.* Knowledge is primarily passed down through the family.
6. *Mutually beneficial relationships revolve around trust and shared values.* Residents' relationships with organizations impact access to services.

The Southwest Hope Collaborative has also engaged with institutional partners as part of the community input process. Through our close partnerships with community groups in the area we have also identified opportunities, challenges and resources in the healthcare landscape. Several of the Collaborative's organizational leaders live in and/or have familial ties within the service area. All entities devote a great amount of time, talent, and energy to true community engagement, including prioritizing the hiring of local residents, so that the lived experiences of staff reflect those of local residents. Organizational partners cite the lack of healthcare resources in the community, and the need to attract external investment to create institutional anchors.

### **Input from Elected Officials**

**Did your collaborative consult elected officials as you developed your proposal? Yes**

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

- Gonzalez Jr., E. - Ill. Representative - 21st State Representative District
- Guerrero-Cuellar, A. - Ill. Representative - 22nd State Representative District
- Mah, T. - Ill. Representative - 2nd State Representative District
- Muñoz, A. - Ill. Senator - 1st State Senate District
- Ortiz, A. - Ill. Representative - 1st State Representative District
- Villanueva, C. - Ill. Senator - 11th State Senate District

## 6. Data Support

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

The Southwest Hope Collaborative's proposal is informed by both qualitative and quantitative data sources. The multiple sources provide insights into the healthcare landscape affecting Chicago's southwest side, healthcare resources and gaps, community plans and resident views, community health indicators, Medicaid enrollment, healthcare utilization, and quality markers.

#### *Community perspectives gathered through user-centered design research*

Data was gathered through ethnographic fieldwork employing user-centered design principles by Duo Development in 2021. A range of community perspectives gathered through 250 immersion hours, 32 resident/patient interviews, and 12 interviews with organizational leaders working in the area was aggregated to identify key themes.

#### *Community Profile: Demographics, Healthcare Access and Health Indicators*

Several sources were used to identify the population to be served, community health indicators, and healthcare access gaps/opportunities:

- U.S. Census, American Community Survey, 2015-2019
- Health Professional Shortage Area data, accessed via [data.hrsa.gov](http://data.hrsa.gov)
- Uniform Data System indicators related to federally qualified health center reach and penetration
- Healthy Chicago 2025, including Data Compendium

#### *Comprehensive Community plans*

Collaborative members have conducted and participated in several community planning processes addressing health. Both the Quality of Life Plans and Neighborhood Network plans are created by a diverse group of residents, organizations, and businesses to identify neighborhood priorities. The following plans were used to identify community priorities for health:

- Chicago Southwest Quality of Life Plan
- 2017 Brighton Park Neighborhood Network Community Plan 2020
- Little Village Neighborhood Network Community Plan, 2020

#### *Community Health Needs Assessments*

Hospital Community Health Needs (CHNAs), as well as reports produced by community health collaboratives were used to identify significant health needs and community priorities.

- Saint Anthony Hospital Community Health Needs Assessment & Implementation Strategy, 2019-2021
- Mount Sinai Community Health Needs Assessment, 2019
- Holy Cross Hospital Community Health Needs Assessment, 2019
- Rush Medical Center Community Health Needs Assessment, 2019
- Roots to Wellness. *Assessing the Mental Health Needs of the Latinx Community on Chicago's Southwest Side*, 2017.

#### *State of Illinois Medicaid and Hospital Data*

Data from HFS and IDPH were used to identify the number of Medicaid beneficiaries in the service area, and assess quality and availability of health care resources.

- IL HFS Enrollment Data, 2020
- IL HFS Medicaid Claims Summary, 2019 and 2020
- IDPH Hospital Report Card

#### *Managed Care Data*

Provider data related to quality, hospital admissions follow-up, and cost were used to set quality goals and establish baselines.

## 7. Health Equity and Outcomes

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

### *Access to Care*

The most significant health disparities facing the Latinx Medicaid patient base are related to access to care. For these morbidities, we see elevated rates in our service area relative to non-Latinx, White populations and relative to other parts of the city of Chicago.

Disparities in preventive care suggest that racial/ethnic disparities are found in many preventive care practices (e.g. cancer screening) offered by primary care providers (Racial and Ethnic Disparities in the Quality of Health Care. Kevin Fiscella and Mechelle R. Sanders. Annual Review of Public Health 2016 37:1, 375-394). This also leads to a reliance on more expensive points of care. For example, on the southwest side, preventable hospital conditions are higher than in the city of Chicago as a whole. In one of the five target zip codes, the rate is as high as 263.2 per 100,000, a rate considerably higher than the citywide rate of 198.6. Addressing the underlying disparity in access to care will have positive impacts on a host of health conditions.

### *Diabetes*

Diabetes is a significant health disparity for our Latinx population. Nationwide, one in two Latinos will develop diabetes over their lifetime (Martha Hostetter. Klein, Sarah. In Focus: Identifying and Addressing Health Disparities Among Hispanics. December 27, 2018. Accessed at: [https://www.commonwealthfund.org/publications/2018/dec/focus-identifying-and-addressing-health-disparities-among-hispanics?redirect\\_source=/publications/newsletter-article/2018/dec/focus-identifying-and-addressing-health-disparities-among](https://www.commonwealthfund.org/publications/2018/dec/focus-identifying-and-addressing-health-disparities-among-hispanics?redirect_source=/publications/newsletter-article/2018/dec/focus-identifying-and-addressing-health-disparities-among)). While the fact that 50 percent of Latinos will develop the disease is striking, what is salient is that Latinx are at a 66 percent greater risk of developing type 2 diabetes, and once diagnosed, have worse outcomes than non-Latinx Whites (*Ibid*).

These trends are evident on the southwest side of Chicago, where residents experience diabetes at some of the highest rates in the city. Diabetes-related hospitalization rates highlight this disparity, with hospitalization rates escalating to 38.1 per 100,000, a significantly higher rate than the benchmark of 25 per 100,000 across all Chicago zip codes. While diabetes alone is a crucial health challenge, the associated comorbidity of depressive symptoms in one in five diabetics further escalates the need to address the diabetes disparity (Diapression: An Integrated Model for Understanding the Experience of Individuals With Co-Occurring Diabetes and Depression. Paul Ciechanowski. Clinical Diabetes Apr 2011, 29 (2) 43-49; DOI: 10.2337/diaclin.29.2.43).

### *Mental Health*

The need for access to mental health care is particularly acute. However, Latinx are less likely to receive treatment for depression, anxiety, and other behavioral issues than Whites.

Experiences on the southwest side bear this out. A recent study from Roots of Wellness, entitled “Assessing the Mental Health Needs of the Latinx Community on Chicago’s Southwest Side,” reveals nearly 50 percent of Latinx individuals on the southwest side report living with depression, 36 percent report anxiety, and 34 percent report acculturative stress (*Assessing the Mental Health Needs of the Latinx Community on Chicago’s Southwest Side*. Simone Alexander, Benitez, Amanda, Gutierrez, Livier A., Mendez, Eddie. Roots to Wellness Collaborative, 2017). These sobering findings are replicated in a 2018 Collaborative for Community Wellness report, entitled “Uplifting Voices to Create New Alternatives: Documenting the Mental Health Crisis for Adults on Chicago’s Southwest Side.”

Neighborhoods in our service area severely lack mental health providers. The Collaborative for Community Wellness 2018 report found only 63 licensed mental health professionals located on the entire Southwest side, a ratio of 0.17 clinicians per 1,000 residents. By contrast, better resourced areas just north of our service area, namely Oak Park and the Near North Side, have ratios more than 2,600 percent higher. It’s important to point out that the study authors did not comment on how many of the 63 licensed mental health providers on the southwest side are bilingual in Spanish, and it’s likely that not all are. Considering that nearly a quarter of Southwest side residents surveyed in the study reported the unavailability of culturally and linguistically appropriate services as a significant barrier to accessing behavioral health care, it’s especially important to the Southwest Hope Collaborative to expand access to ensure that all of our therapists and psychiatrists are bilingual.

### *Cervical Cancer*

Cervical cancer is diagnosed at higher rates in our target zip codes than in the city as a whole. Four of the five zip codes have diagnosis rates higher than the city of Chicago benchmark of 15 per 100,000 residents. This incidence points to the need for primary care services to support routine screening.

### *Chronic Liver Disease*

Chronic liver disease is a leading cause of death in the Southwest Hope Collaborative geography. This reflects nationwide data that indicates chronic liver disease is a leading cause of death among the Latinx population, with a chronic liver disease rate twice that of the non-Latinx, White population (U.S. Office of Minority Health, accessed at: <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=62>). Information based on CDC, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) <http://www.cdc.gov/injury/wisqars/fatal.html> ). This is a significant disparity, with Latinx men and women 1.6 times more likely to die from liver cancer than non-Latinx individuals.

Rates of chronic liver disease in the target zip codes reflect this nationwide disparity. These communities have some of the highest mortality from the disease in Chicago. Notably, Latinos in Chicago are more likely to die from chronic liver disease than any other group. The mortality rate among Latinx population is 22.6 per 100,000, compared to 10.6 for the general population. Latinx individuals experience greater mortality from chronic liver disease relative to non-Latinx Whites (8.6) and non-Latinx Blacks (8.4).

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

Addressing underlying access issues is a key strategy for the Southwest Hope Collaborative to eliminate these health disparities. Access will be provided not only to primary care services, but to upstream solutions to mitigate risk factors. Our emphasis on addressing food insecurity and mental health services are a direct response to the greatest health disparities facing our communities. Team-based care that includes care coordinators and community health workers to support patient education and foster trust will also serve to mitigate the effects of these health conditions.

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

Our emphasis on primary care and pre-primary care will ensure that individuals are engaged in care, receive necessary routine screenings to identify and address risk factors, and are supported through a network of prevention resources.

## 8. Access to Care

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

The Southwest Hope Collaborative has identified several barriers to healthcare access on Chicago's southwest side: population characteristics, health care availability, and responsive systems of care.

### *Population Characteristics Affecting Access to Care*

There are several economic, social, and cultural factors that limit access to care and utilization of health services in the community. Individuals living on Chicago's southwest side experience higher rates of poverty, unemployment, and limited English proficiency relative to other communities. High rates of poverty within the Collaborative's service area is a critical factor that limits access to healthcare, with 55 percent of residents (216,888 individuals) classified as low-income, representing 51 percent of the total population (U.S. Census Bureau. (2020). *2015-2019 American Community Survey Five Year Data Estimates*). This is reflected in the high rates of Medicaid enrollment: 184,862 individuals in the Collaborative's five zip codes rely on Medicaid for insurance coverage IL HFS Medicaid Enrollment Data, 2020. Accessed online at <https://www2.illinois.gov/hfs/info/factsfigures/Program%20Enrollment/Pages/FY2020ZipCodeSearchEnrollment.aspx>).

### *Health Care Availability*

All five zip codes targeted by the Collaborative are located within federally designated Health Professional Shortage Areas (HPSAs) for both primary care and mental health. While a majority of low-income residents receive primary care from federally qualified health centers, the dominant source of primary care on the southwest side, 66,000 low-income individuals remained unserved through these systems.

In addition, the area has no academic medical center. While the South Side is served by the University of Chicago and the West Side is served by Rush, there is no large academic hospital within the five zip codes or indeed across the larger southwest side. While community hospitals could normally fill many of the needs that this type of provider might offer, each of the three hospitals in the service area (Sinai, Holy Cross, and Saint Anthony), are safety net providers and among the most financially challenged hospitals in the state. The type of cost shifting that an academic medical center can engage in is not possible for these hospitals, who have very few commercially insured patients. This means that access to critical specialty and diagnostic services is extremely limited, and none of these three hospitals supports a primary care network, as most non-safety nets do. This continues to exacerbate access to primary and specialty care.

### *Access to Systems of Care Responsive to a Medicaid, Latinx Population*

While the lack of providers alone makes accessing services difficult, accessing a system of care that is culturally responsive to the needs of the predominantly Latinx Medicaid population on the southwest side is even more difficult. Access is further limited by the lack of linguistically and culturally appropriate services for the 66 percent of residents who are of Latinx origin; nearly one-third of service area residents (29 percent) have limited English proficiency, as defined by the U.S. Census as speaking English less than "very well." (U.S. Census Bureau. (2020). *2015-2019 American Community Survey Five Year Data Estimates*). In the absence of readily available systems, individuals may choose to not engage in health care because of fear, distrust, and linguistic barriers. This lack of initiation into care, and ensuing engagement, results in poor community health outcomes.

Language is a major barrier to appropriate medical care for our target population. Considering the importance of successful communication to the provision of health services, overcoming language barriers in the clinical setting is essential to high quality care. A national study conducted by the University of California Irvine found that when patients and providers do not speak the same language, patients were less likely to receive counseling on health, diet and nutrition. The barrier was only partially overcome when interpreters were used (University of California - Irvine (2007, November 14). *Language Barriers Adversely Impact Health-care Quality*. ScienceDaily. Retrieved from <http://www.sciencedaily.com/releases/2007/11/071113132304.htm>). There is still a lack of Spanish-speaking providers and cultural sensitivity generally in Chicago, both at the primary care level and in hospitals. Echoing this sentiment are key findings of focus groups representing the immigrant community that participated in the recent Health Impact Collaborative of Cook County (*Collaborative CJNA in Chicago and Cook County*, [www.healthcareimpactcc.org](http://www.healthcareimpactcc.org). Updates and Preview of Next Steps, May 25, 2016). Convened by the Illinois Public Health Institute, they noted in part:

- A lack of cultural sensitivity has been a barrier to accessing healthcare facilities and services
- Additional culturally and linguistically competent providers are needed
- Linguistically isolated individuals were identified as being at increased risk for not having their health



needs met

- Services are needed to help individuals understand the complex US healthcare system

Community feedback on mental health access provides additional insights into the complexities of access within the community. In a survey of 2,878 southwest side residents, four broad categories affecting mental health service engagement/utilization were identified: (1) perceived need, (2) structural factors, (3) quality of care, and (4) cultural/attitudinal factors (Roots to Wellness. *Assessing the Mental Health Needs of the Latinx Community on Chicago's Southwest Side*, 2017). These responses indicate that availability alone is not the obstacle to overcome; rather, the issue of access is multi-faceted, and as such requires a multi-pronged, integrated solution.

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

The Southwest Hope Collaborative has designed approaches to expand the availability of care. First, the increase in primary care and behavioral health providers will significantly address the health care professional shortage which exists within the service area. Second, the addition of three new community health hubs will provide broader geographic access across the five zip code geography. Third, the Collaborative will expand telehealth, connecting patients across the geography with members of their care team at times/locations convenient to them. Fourth, community health workers will be instrumental in connecting individuals with a patient-centered medical home, and supporting ongoing engagement and access to care. Finally, the Collaborative's interprofessional training program, with its curriculum addressing social factors, trauma-informed care, multi-disciplinary resources, and cultural/systemic factors influencing health, is designed as a structural response to address the health care professional shortage.

Through these activities we expect to achieve the following, immediate, measurable impacts:

- An increase in the number of family practice physicians and nurse practitioners providing care within the service area.
- An increase in the number of Medicaid beneficiaries in the five target zip codes with an established medical home.
- The establishment of three new health hubs, providing care to meet the physical, social, and behavioral health needs of patients.
- An increase in available appointments via telehealth services.

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

Our activities will build community capacity to address deeply rooted issues of access for Medicaid beneficiaries by addressing both the symptoms and root causes of unequal access. The addition of new providers, community health workers integrated into the care model, access points, and appointment availability address the pressing issues facing patients now. This alone will not result in ending health disparities, however. By creating a pipeline of highly qualified health professionals who are steeped in evidence-based practices specific to a Medicaid, Latinx population, we will significantly advance health equity.



## 9. Social Determinants of Health

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

The Southwest Hope Collaborative transformation model is built on community-centric approaches, and addressing social determinants of health is fundamental to our approach to improving health outcomes.

The Collaborative will specifically target the following social determinants of health through evidence-based approaches designed for the service area's majority-Latinx population. These three social determinants were selected as areas for intervention as they are both a consequence of social determinants, as well as social determinants in their own right, and are shared issues for the majority of our Medicaid population. Evidence also indicates that these social determinants have impacts beyond healthcare access, and play an outsized role in determining health outcomes. Intersecting issues of household poverty, systemic neighborhood disinvestment, racism, and integration barriers have joined to create and reinforce these social determinants on the southwest side.

1. **Immigration:** Immigration is increasingly recognized as an important, and often overlooked, social determinant of health (Castañeda H, Holmes SM, Madrigal DS, Young ME, Beyeler N, Quesada J. Immigration as a social determinant of health. *Annu Rev Public Health*. 2015 Mar 18;36:375-92. doi: 10.1146/annurev-publhealth-032013-182419. Epub 2014 Dec 10. PMID: 25494053). Documentation status alone shapes access to employment, care and housing. Fear of deportation contributes to toxic stress and has long term implications for physical and mental health. Among children, research shows that chronic fear of parental deportation impacts cognitive development, mental health, and academic progress and learning.
2. **Social Isolation:** Among Medicaid beneficiaries on Chicago's southwest side, social isolation stems from a variety of factors: difficulty in integrating because of linguistic, cultural differences; fear of families living in mixed-immigration status households; trauma associated with community violence; and a lack of community institutions relative to other neighborhoods. There is robust evidence illustrating that social isolation is associated with a significant increase in mortality and morbidity.
3. **Food Insecurity:** While the predominantly Latinx population has a vibrant food culture with intergenerational knowledge about healing foodways, the lack of private investment in culturally relevant foods across the southwest side, along with high rates of poverty, contributes to food insecurity. Among children, food insecurity is demonstrated to lead to adverse outcomes such as asthma, depression and anxiety, and suicide ideation. Similarly, among adults, research shows that food insecurity is associated with increased rates of diabetes, hypertension, and depression.

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

The Southwest Hope Collaborative has defined the following approach to addressing social determinants and resulting health disparities:

1. Routine screening for social determinants of health, using the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool, designed specifically for use in community health settings;
2. Hiring, training, and deploying community health workers who are integrated into the community, with residency in community- and minority-led organizations who work in partnership with patients to identify and address the range of social determinants that impact an individual's health including economic conditions, job access, housing assistance, transportation, and other barriers to care; and
3. Leveraging Southwest Hope Collaborative partnerships, expertise, and investments to meet population health needs by addressing immigration effects, social isolation, and food insecurity through targeted interventions.

The Collaborative will adapt the National Academies' framework for integrating social care into clinical practice, which includes awareness, adjustment, assistance, alignment, and advocacy by the healthcare system (National Academies of Sciences, Engineering, and Medicine. 2019. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. Washington, DC: The National Academies Press). This approach will be applied to each of the three social determinants prioritized by the Collaborative. The activities outlined below provide a brief overview of how the framework informs activities.

### *Immigration*

CHWs will be hired by Southwest Hope Collaborative members who have intersecting immigration and health

programming: Poder Learning Center, SWOP, Latinos Progresando, Enlace, Esperanza Health Centers, and the Brighton Park Neighborhood Council. This intersectionality is critical to addressing the particular health needs of Medicaid patients within immigrant communities, including implications on patient's health outcomes due to limited healthcare access, behavioral/mental health care access, high-quality, culturally- and linguistically relevant health care, economic opportunity and its resulting negative impact as a determinant of health, and enrollment into entitlement benefits for which they qualify. (e.g., SNAP). This intersectional lens will also be incorporated into the interdisciplinary training curriculum.

Collaborative partners share an emphasis on immigrant inclusion and integration, economic stability, and upward mobility as a means to improving the social, economic, and health conditions of patients. CHWs will leverage cross-organizational resources that include an Immigrant Welcome Center, supported by the Illinois Department of Human Services, to help immigrant families through connections to affordable credit, financial counseling, health, and job training, as well as benefits enrollment and other supports.

#### *Social Isolation*

Recognizing the importance of social isolation on health outcomes, the Collaborative will use a multi-pronged approach to address the issue at both the individual- and population level. Transformative strategies include: (1) designing curriculum to educate the health care team about the impact of social needs on health; (2) screening for social connection/isolation by the health care team, with documentation in the patient's electronic health record; (3) "social prescribing", as appropriate, as an element in the patient's plan of care; (4) building trusting, one-on-one relationships between patients and resident community health workers who provide coaching support to patients in day-to-day life to achieve their health care goals; (5) creating a community of peer support in small group settings for personal health goals, with support from community health workers; (6) integrating health/wellness services into multiple community cultural hubs, or "third spaces" - spaces beyond home and work - including at the Gage Park Latinx Council, the new Latinos Progresando Community Center, the new Poder Learning Center headquarters, and Esperanza's Brighton Park expanded campus, to create a healthcare ecosystem that supports patients where they live, work, and play; and (7) expanding access to behavioral health services that employ evidence-based practices such as Cognitive Behavioral Therapy (CBT) to address maladaptive social cognition, empower patients, and decrease incidence of mild to moderate mood disorders that lead to poor physical health outcomes.

#### *Food Insecurity*

The Southwest Hope Collaborative will address food insecurity by building beyond the concept of "food as medicine" to also address the structural issues that have created a food desert on Chicago's southwest side by increasing the availability of culturally-relevant, nutritious foods. Our focus will be on patients with diet-related illnesses who are also food insecure.

The Collaborative will pilot efforts, with focus at both the individual level (food "prescriptions" to patients) and population level (partnerships expanding food access; dietary education). We anticipate that our approach will have a greater impact over food distribution alone, as the Collaborative reaches further upstream to impact systemic factors that contribute to poor health outcomes, and with greater potential to be sustained as a long-term solution to underlying issues of food access.

The pilot will leverage Collaborative members' work in addressing food insecurity, building on Gage Park Latinx Council's *El Mercadito*, a community pantry targeted towards the Latinx immigrant community, and Windy City Harvest's Veggie Rx program. The pilot will provide food access options to Medicaid patients through expansion of *El Mercadito*, expanding a stand-alone, free market that makes accessible, fresh culturally-reflective foods to Medicaid patients served under this transformation proposal as well as increase the availability of fresh produce boxes through Windy City Harvest. Patients will partner with nutritional education customized to their medical dietary needs, and that is informed by the health care team with a cultural understanding of Latinx populations.

Patients will also have the opportunity for hands-on instruction and community building around healthy foodways through cooking/education classes at the kitchen classroom on Esperanza's Brighton Park campus. The combination of access to these foods and nutritional education will have a direct impact on the health of Medicaid patients who experience high rates of diabetes, high blood pressure and heart disease.

The following immediate, measurable impacts that stem from these activities that will show progress towards mitigating barriers include:

- An increase in the number of patients identified for social determinant interventions
- An increase in the number of patients who connect to social and food supports

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

In addition to these immediate impacts, the Collaborative also expects to realize improvement in several quality indicators over the five year project period. The application of the National Academies framework that the Collaborative will adopt has resulted in improved health outcomes in several health systems (National Academies of Sciences, Engineering, and Medicine. 2019. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. Washington, DC: The National Academies Press).

Social isolation in particular is a significant contributor to morbidity and early mortality (*Social Isolation and Health*, Health Affairs Health Policy Brief, June 22, 2020). Evidence indicates that our focus on these three priority areas will address root causes of morbidity and early mortality for a number of disease conditions that affect residents of Chicago's southwest side. Poor social connection, for example, increased the risk of heart disease by 29 percent and stroke by 32 percent (*ibid*). It is also linked to diabetes prevalence.

Food insecurity has been shown to consistently be associated with negative health outcomes (Gundersen C, Ziliak JP. Food Insecurity And Health Outcomes. *Health Aff (Millwood)*. 2015 Nov;34(11):1830-9. doi: 10.1377/hlthaff.2015.0645. PMID: 26526240). The relationship between food insecurity and obesity, hypertension, and diabetes has been widely established (Te Vazquez, J., Feng, S.N., Orr, C.J. et al. Food Insecurity and Cardiometabolic Conditions: a Review of Recent Research. *Curr Nutr Rep* (2021). <https://doi.org/10.1007/s13668-021-00364-2>). Our intervention seeks to prevent these conditions, as well as to intervene to improve the health of Medicaid beneficiaries who suffer with these chronic conditions.

Addressing these interwoven social determinants of health will have the greatest power to dramatically reshape the health and associated quality of life of individuals who receive care through the Southwest Hope Collaborative, as well as the wellbeing of the community as a whole.

## 10. Care Integration and Coordination

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

The Southwest Care Collaborative will improve the integration, efficiency, and coordination of care using the following approach: (1) risk stratification of all patients to identify both medical and social risks, and alignment of resources based on the patient's needs; (2) use of community health workers to support medical home engagement and social determinant of health needs, with scheduling access and documentation in the patient's health record; (3) expansion in the number of care coordinators by 18 to support care transitions; (4) integration of care coordinators in a team-based model of care, supported by the Collaborative's interprofessional training program; and (5) addition of hospital concierges at two high-frequency safety net hospitals to support discharge planning.

A key component of the Southwest Care Collaborative model is the expansion of care coordination to support transitions of care from primary, specialty, diagnostic services, and hospital discharge. The 18 new care coordinators, along with six hospital-based concierges, will support patient navigation, service integration, and efficiency by facilitating connections for patients across points of care, while also ensuring support for the optimal level of care in the appropriate setting.

Using a team based approach, care coordinators will act as a resource to patients and health care staff to ensure patients receive all the care and services they require. They will be responsible for providing support to a defined panel of patients and assisting in prevention efforts to help patients achieve and maintain their optimal level of health.

Care coordinators will support population health outreach (e.g., identifying care gaps around clinical quality measures and bringing patients in to care), patient education (e.g., face to face in the clinic and in health education programs around self-esteem, nutrition, diabetes management, healthy pregnancy, breast feeding, and physical activity), and addressing social determinants of health in coordination with community health workers (e.g., food insecurity, utilities assistance). Care Coordinators will commit a significant amount of time to: monitoring and following up when patients are discharged from the emergency room (e.g., ensuring a 7 day follow up with Esperanza); completing health risk assessments; and providing targeted chronic care management (e.g. remote self-monitoring blood pressure cuffs).

A key component of this work will be facilitating communication among the patient, providers, nurses, medical assistants, and community health workers, related to the care of patients. Specifically, care coordinators will:

- Utilize screening and assessment results, along with provider input, to refer patients to community resources, e.g. transportation, child care, employment, nutrition and exercise classes, and ensure services are received.
- Assist patients in connecting to primary care, specialty, and ancillary services (e.g., labs, diagnostics) by identifying an appropriate resource (i.e., medically appropriate and accessible), providing information, and scheduling support.
- Encourage patients to become actively engaged in their own health by utilizing motivational interviewing techniques.
- Coordinate with hospital concierges to identify pending hospital discharges, and coordinate a plan of care for community based services for individuals leaving the hospital.

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

Yes

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

The Collaborative will hire a total of 18 care coordinators (CCs) and 30 community health workers (CHWs). The care model assumes that each CC will carry an average caseload of 75 low to moderate risk patients per month. In year one, with a starting annual salary of \$38,400 and an average monthly caseload of 75, the cost per case is \$42. CHWs will carry an average caseload of 60 patients per month. CHW caseloads are smaller to ensure adequate capacity for outreach to initiate care and follow up to support successful medical home engagement, as well as to support education and access to community-based services. In year one, with a starting salary of \$34,560 and an average monthly caseload of 60, the cost per case is \$48.

### **Are there any managed care organizations in your collaborative? No**

### **If no, do you plan to integrate and work with managed care organizations? Yes**

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

The Collaborative will leverage the Healthcare Transformation Collaborative initiative's catalytic investment and Medicaid encounter revenue to demonstrate value through outcomes. Beginning in year one, the Finance and Sustainability Committee will address collaborative investments with the potential for the greatest return on health system efficiency, quality, and value. They will also monitor Collaborative goals and, as outcomes are realized, begin to identify value-based payment opportunities for long-term sustainability. Initially, the Collaborative will build on existing shared savings and quality incentive payment arrangements with Medicaid managed care organizations. However, by year five, we will be well-positioned to explore alternative payment arrangements with Medicaid managed care organizations to help sustain our efforts and drive quality and value.

## 11. Minority Participation

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

IL BEP-certified firms:

- Urban Works (MWBE)
- McNitt Consulting LLC (WBE)
- Terra Engineering (WBE)
- GDA Landscape Architecture (WBE)

Non-profit entities, minority managed and controlled:

- Brighton Park Neighborhood Council
- Duo Consulting
- Enlace Chicago
- Esperanza Health Center
- Gage Park Latinx Council
- Latinos Progresando
- Poder Learning Center
- Saint Anthony Hospital
- Southwest Organizing Project (SWOP)

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

The Southwest Hope Collaborative and its individual member organizations have a deep commitment to supporting BEP-certified firms, and entities that are majority-controlled and managed by minorities. This commitment stems from our goal of addressing social determinants of health such as economic security, not only in how healthcare is delivered, but in how health care institutions operate.

The Collaborative has engaged the following Illinois BEP-certified entities for the initial planning phases that led to the submission of this proposal:

- Urban Works, a WBE architectural firm committed to producing socially and environmentally responsible designs for civic, community-based, private and commercial sector clients. Urban Works has engaged in initial design planning for the planned 30,000 sq. ft. health center included in this proposal.
- McNitt Consulting LLC, a WBE Owner's Representative firm responsible for project managing procurement and project management for the new health facility.

Both will serve in their respective architectural/project management roles through the duration of the \$20 million building project. In addition, the following IL BEP-certified entities will join the construction team:

- Terra Engineering (WBE)
- TGDA Landscape Architecture (WBE)

Additional BEP-certified companies will be added to the project as subcontractors as the construction project launches.

This proposal was also informed by the planning work of minority-led, minority controlled Duo Development. The non-profit, user-centered design research firm's work provided key community insights through its community engagement and ethnographic research strategies.

The operations of our transformed delivery system will be guided largely by minority-controlled entities, who comprise 73 percent of the Southwest Hope Collaborative's Coordinating Council. Each of the following minority-controlled/managed entities - Esperanza Health Center, Gage Park Latinx Council, SWOP, Latinos Progresando, Enlace Chicago, Brighton Park Neighborhood Council, Saint Anthony Hospital and Poder Learning Center - will be responsible for setting policy and overseeing implementation of the Collaborative's work. Each entity will also be engaged in implementation directly, with responsibility to hire staff, execute transformation projects, and respond



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to patient needs.

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## 12. Jobs

### Existing Employees

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

The Southwest Hope Collaborative will build on the existing excellence of staff who have advanced high quality, bilingual care, and tirelessly work to improve the lives of patients. Our dedication to staff is borne out by a commitment to pay livable wages (e.g., starting community health worker, medical assistant, and other ancillary salaries at starting levels above the \$15 minimum wage) as a statement of our commitment to the predominantly Latinx staff, many of whom call the southwest side home.

Our emphasis on interprofessional training also reflects a commitment to improving the knowledge and skills of both our existing and new workforce. The Collaborative's interest is in developing the skills among staff for the jobs they are in, while creating pathways for further growth. Our aim is to retain and expand our staffing in order to meet our plan's access goals.

The following existing employees will be retained and trained as part of the Collaborative:

#### Nurse Practitioners

|   |       |
|---|-------|
| 1 | 38237 |
| 1 | 60008 |
| 1 | 60108 |
| 1 | 60302 |
| 1 | 60304 |
| 2 | 60402 |
| 1 | 60491 |
| 1 | 60516 |
| 1 | 60605 |
| 1 | 60608 |
| 2 | 60647 |
| 1 | 60653 |

#### Care Coordinators

|   |       |
|---|-------|
| 1 | 60031 |
| 1 | 60074 |
| 2 | 60402 |
| 1 | 60453 |
| 1 | 60459 |
| 1 | 60482 |
| 1 | 60544 |
| 3 | 60608 |
| 1 | 60609 |
| 1 | 60617 |
| 1 | 60620 |
| 2 | 60623 |
| 4 | 60629 |
| 1 | 60632 |
| 1 | 60639 |
| 1 | 60646 |
| 1 | 60652 |
| 1 | 60804 |

#### Licensed Clinical Social Workers

|   |       |
|---|-------|
| 1 | 60452 |
| 1 | 60605 |
| 1 | 60609 |
| 2 | 60623 |
| 3 | 60632 |
| 1 | 60638 |
| 1 | 60707 |

#### Community Health Workers

|   |       |
|---|-------|
| 1 | 60608 |
| 1 | 60609 |
| 2 | 60623 |
| 1 | 60639 |

#### Family Medicine Physicians

|   |       |
|---|-------|
| 2 | 60302 |
| 1 | 60459 |
| 1 | 60605 |

### New Employment Opportunities

**Please estimate the number of new employees that will be hired over the duration of your proposal. 112**

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

The Southwest Hope Collaborative will add 112 new jobs to the community, adding significant resources to achieve better health outcomes. Our focus on hiring bilingual staff, with lived experiences shared with the Medicaid beneficiaries to whom we provide care, will also serve to positively affect the economic vitality of the community as a social determinant of health.

Our proposal outlines the following key new employment:

- 36 primary care providers, including 20 family practice physicians and 16 nurse practitioners
- 35 community health workers and community health worker team leads
- 18 care coordinators
- 8 licensed clinical social workers
- 6 hospital concierges
- 7 professional staff to support the Collaborative's operations, training, and data collection
- 2 psychiatrists

Our emphasis on hiring healthcare professionals at all levels along the care continuum will create entry-points for a diversity of individuals, while also creating ladders to further growth.

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

The development of an interprofessional training program is a key aspect of the Southwest Hope Collaborative's plan. The training program will include a longitudinal social justice curriculum that explores issues regarding health inequities, social determinants of health, historical oppression, bias, and experience of oppressed communities in society and the health care system. The goal of this curriculum is to equip health professionals with the tools to promote improved health equity. Training will be provided upon hire, and augmented with the launch of the interprofessional training program once developed

## 13. Quality Metrics

### Alignment with HFS Quality Pillars

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

The Southwest Hope Collaborative will advance IL HFS' mission of improving lives by addressing social and structural determinants of health, empowering patients, and maintaining high standards of the Illinois Medicaid program. Our Collaborative provides a vehicle to make significant improvements in the quality of care for residents of the Southwest side of Chicago, close gaps in health disparities, and advance health equity over the long term.

The proposed model directly supports the achievement of the IL HFS Quality Goals shared across all quality pillars.

| HFS Quality Goals                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Southwest Hope Collaborative Alignment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Better Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <ol style="list-style-type: none"> <li>1. Improve population health</li> <li>2. Improve access to care</li> <li>3. Increase effective coordination of care</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                   | <ul style="list-style-type: none"> <li>• Improve access to a national quality leader in community health care</li> <li>• Increase system capacity to see 40,000 Medicaid beneficiaries</li> <li>• Increase access through three new community health anchors to expand geographic coverage</li> <li>• Increase effective coordination with the expansion of 18 care coordinators and 6 hospital concierges</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Healthy People/Healthy Communities</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <ol style="list-style-type: none"> <li>4. Improve participation in preventive care and screenings.</li> <li>5. Promote integration of behavioral and physical healthcare.</li> <li>6. Create a consumer-centric healthcare delivery system.</li> <li>7. Identify and prioritize reducing health disparities.</li> <li>8. Implement evidence-based interventions to reduce disparities.</li> <li>9. Invest in the development and use of health equity performance measures.</li> <li>10. Incentivize the reeducation of health disparities and achievement of health equity.</li> </ol> | <ul style="list-style-type: none"> <li>• Improve the number of patients with routine, preventive health visits by ensuring 80 percent of patients have an annual health visit</li> <li>• Promote integration of behavioral health services with the addition of 8 LCSWs and 2 psychiatrists, expansion of behavioral health services into community health anchors and primary care, and coordination of transitions from hospital-based crisis stabilization unit to outpatient behavioral health treatment services</li> <li>• Create a patient-centered healthcare delivery system by partnering with patients to create a plan of care that reflects their goals, building trust with resident-led entities, and providing care that is responsive to linguistic, cultural, social, and economic factors that shape patients' lives</li> <li>• Reduce health disparities through bold, evidence-based population health initiatives</li> <li>• Invest in community care infrastructure that will advance health equity over the long term</li> </ul> |
| <b>Affordable Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <ol style="list-style-type: none"> <li>11. Transition to value- and outcome-based payment.</li> <li>12. Deploy technology initiatives and provide incentives to increase adoption of electronic health records (EHRs) and streamline and enhance performance reporting, eligibility and enrollment procedures, pharmacy management, and data integration.</li> </ol>                                                                                                                                                                                                                    | <ul style="list-style-type: none"> <li>• Establish value-based contracts that incorporate the full range of community-based services, primary and hospital-based care necessary to improve health outcomes</li> <li>• Incorporate SDOH and community based providers into the EHR to coordinate scheduling and care management to streamline and provide more efficient care.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

The Collaborative's work further aligns with the specific pillars of HFS's Quality Plan: (1) Maternal and Child Health, (2) Adult Behavioral Health, (3) Child Behavioral Health, (4) Equity, and (5) Community Based Services and Support. The Collaborative envisions improving health by focusing on the following metrics, and looks forward to working with IL HFS to finalize performance metrics.

| HFS Quality Pillar                   | Outcome Measures                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Maternal and Child Health<br>•       | <ul style="list-style-type: none"> <li>• Timeliness of Prenatal Care</li> <li>• Child and Adolescent Well-Care Visits (WCV)</li> </ul>                                                                                                                                                                                                                                       |
| Adult Behavioral Health<br>•<br>•    | <ul style="list-style-type: none"> <li>• Follow-Up After Hospitalization (Inpatient) for Mental Illness: 7-Day</li> <li>• Follow-Up After Hospitalization (Inpatient) for Mental Illness: 30 Day</li> <li>• Follow-Up After Emergency Department Visit for Mental Illness: 7-Day</li> <li>• Follow-Up After Emergency Department Visit for Mental Illness: 30-Day</li> </ul> |
| Child Behavioral Health<br>•<br>•    | <ul style="list-style-type: none"> <li>• Follow-Up After Hospitalization (Inpatient) for Mental Illness: 7-Day</li> <li>• Follow-Up After Hospitalization (Inpatient) for Mental Illness: 30 Day</li> <li>• Follow-Up After Emergency Department Visit for Mental Illness: 7-Day</li> <li>• Follow-Up After Emergency Department Visit for Mental Illness: 30-Day</li> </ul> |
| Equity<br>•<br>•                     | <ul style="list-style-type: none"> <li>• Diabetic control</li> <li>• Controlling High Blood Pressure (CBP)</li> <li>• Breast Cancer Screening (BCS)</li> <li>• Cervical Cancer Screening (CCS)</li> <li>• Adults' Access to Preventive/Ambulatory Health Services (AAP)</li> </ul>                                                                                           |
| Community Based Services and Support | <ul style="list-style-type: none"> <li>• Reduction in preventable hospital admissions</li> </ul>                                                                                                                                                                                                                                                                             |

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

**Maternal and Child Health? Yes**

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

- Timeliness of Prenatal Care
- Child and Adolescent Well-Care Visits (WCV)

**Adult Behavioral Health? Yes**

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

- Follow-Up After Hospitalization (Inpatient) for Mental Illness: 7-Day
- Follow-Up After Hospitalization (Inpatient) for Mental Illness: 30 Day
- Follow-Up After Emergency Department Visit for Mental Illness: 7-Day
- Follow-Up After Emergency Department Visit for Mental Illness: 30-Day

**Child Behavioral Health? Yes**

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

- Follow-Up After Hospitalization (Inpatient) for Mental Illness: 7-Day
- Follow-Up After Hospitalization (Inpatient) for Mental Illness: 30 Day
- Follow-Up After Emergency Department Visit for Mental Illness: 7-Day
- Follow-Up After Emergency Department Visit for Mental Illness: 30-Day

**Equity? Yes**

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

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

**Community-Based Services and Supports? Yes**

**Community-Based Services and Supports: Propose measurable quality metrics you propose to be**

**accountable for improving. You should choose at least one metric from the quality strategy.**

- Reduction in preventable hospital admission

**Will you be using any metrics not found in the quality strategy? No**

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#### 14. Milestones

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

There are four phases to our proposed five-year health care system transformation:

1. **Project launch** (*Year 1, Months 1-3*), including initiation of subcontracts, construction, staff hiring, initial training, and SDOH pilot.
2. **Transformation foundations** (*Year 1, Months 4-12*), including implementation of team-based care model, with community health workers, care coordinators, and hospital concierges; initial expansion of primary and behavioral health care; establishment of two community health anchors; SDOH pilot monitoring, and interprofessional curriculum development; launch health outcome data collection and monitoring.
3. **Transformation growth** (*Years 2-4*), with the completion of the third community health anchor integrated primary care will expand the interprofessional training program; health outcomes monitoring.
4. **Transformation optimization** (*Year 5 and beyond*), by maximizing healthcare systems to achieve health outcomes.

The Southwest Hope Collaborative will achieve the following calendar of milestones outlined in the attached table.

**15. Budget****Number of Individuals Served**

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

|                            |       |
|----------------------------|-------|
| Year 1 Individuals Served: | 22000 |
| Year 2 Individuals Served: | 28000 |
| Year 3 Individuals Served: | 32000 |
| Year 4 Individuals Served: | 38000 |
| Year 5 Individuals Served: | 40000 |
| Year 6 Individuals Served: | 42000 |

**Alternative Payment Methodologies**

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

The Southwest Hope Collaborative proposes to utilize pay for performance based on improving HEDIS scores, as well as shared savings with health plans. Our value-based model is well positioned to improve health outcomes, and these mechanisms will allow us the opportunity to more flexibly invest in resources outside of a fee-for-service environment.

## 16. Sustainability

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

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

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

The Southwest Care Collaborative model was designed to impact the areas with the greatest potential to improve the health of patients through value-based care: community-based services, supported by strong transitions to- and from- higher levels of care when medically necessary. The five-year runway will allow time to demonstrate the model's effectiveness and recoup these initial investments.

Transformation funds will support capital investments and operational start-up. These costs include construction at Esperanza Brighton Park, seed funding for personnel, and curriculum design of the interprofessional training program.

Interprofessional training costs will be sustained through GME payments, additional federal training dollars, and fee-generated revenue. Existing training costs for care coordination, community health worker, and other professional staff are currently borne by healthcare institutions; the ongoing cost of this component of training is cost neutral; currently budgeted revenue for these purposes will be applied to the interprofessional training program.

The focus on using Transformation funds for one-time and start-up costs sets the foundation for the Collaborative to cover operating costs beginning in Year 6. The proposed budget decreases reliance on Transformation funding after Years 1 and 2 with construction completion. Year 3 marks an increase in personnel costs aligned with the opening of the new federally qualified health center site, as primary care and care coordination expands. The expansion of primary care billed at FQHC rates after Year 5 will generate operating income at increased levels to support the ongoing Collaboration.

While Medicaid encounter revenue is a key part of our financial model, the Collaborative views the greater sustainability opportunity in shared savings arrangements and quality payment incentives from Medicaid managed care organizations. Esperanza, Sinai Health, and Rush Medical Center, for example, have demonstrated experience from their participation in the Medical Home Network ACO in achieving the aim of value-based care by improving patient health through cost-effective strategies.

In the Collaborative's experience, substantiated in evidence-based practice, community health workers are key to addressing social, economic, and cultural conditions that impact health. Esperanza, for example, has made sizable investments in non-medical patient support services, which has positioned the organization as a national quality leader, while also generating significant financial returns via shared savings. Transformation funds will provide a necessary investment to demonstrate and scale this approach through broad, systematic implementation. In the Southwest Care Collaborative model, these efforts will be sustained through contracts between Esperanza and community providers employing community health workers beyond the five year funding period as a key strategy to maximizing shared savings and quality incentives.

The Southwest Hope Collaborative is also interested in exploring additional opportunities to apply alternate payment methods in conjunction with HFS and health plans.



Department of Family Medicine  
Rush University Medical Center  
Suite 302, Westgate Building  
1645 W. Jackson Boulevard  
Chicago, IL 60612

Tel: 312.942.7083  
Fax: 312.942.7086  
www.rush.edu



Steven K. Rothschild, MD  
Professor and Chair  
Department of Family Medicine

November 9, 2021

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

Dear Director Eagleson:

Rush University Medical Center (RUMC) is laser-focused on reducing health disparities and increasing health equity on the South and West sides of Chicago. We share HFS's appreciation for community engagement as a means to achieve health equity. Thus, we are enthusiastic supporters of the proposed Southwest Hope Collaborative, spearheaded by Esperanza Health Centers.

RUMC is an academic medical center that includes a 671-bed hospital serving adults and children, the 61-bed Johnston R. Bowman Health Center and Rush University. For more than 180 years, the Medical Center has been leading the way in developing innovative and often life-saving treatments. Rush's 2025 System Strategy calls for leading the transformation of health care through critical strategies, including innovating and improving primary care delivery, developing and retaining a diverse workforce, and improving the health of communities by challenging health inequity through educational opportunities based in the communities we serve. In May of 2021 we launched the Rush BMO Institute for Health Equity, with a mission of eliminating health inequities and helping people live longer and healthier lives.

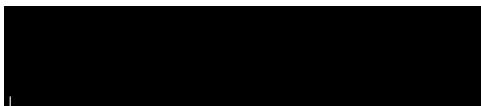
As a member of the proposed Southwest Hope Collaborative, RUMC will be the sponsoring institution for the Rush – Esperanza Family Medicine Residency, the first family medicine residency program on Chicago's Southwest side, housed at Esperanza's expanded Brighton Park campus. This residency will train the next generation of physicians to deliver care within a community health center, with an emphasis on understanding the necessity of addressing social determinants and structural inequities in order to maximize health outcomes for both for individual patients and entire communities. Towards this end, our program centers the role of family physicians as members of an interdisciplinary healthcare team that includes other health professionals as well as neighborhood residents. We will therefore also contribute curriculum development to Esperanza's current Nurse Practitioner Postgraduate Training Program, which has been training advance nurse practitioners since 2019.

With support from HFS, the Southwest Hope Collaborative will help transform the healthcare delivery system across Chicago's Southwest side and significantly improve the health and wellness of the communities we serve. We look forward to being part of that transformation. If you have any questions, you are welcome to contact either of us at [Deborah\\_Edberg@rush.edu](mailto:Deborah_Edberg@rush.edu) or [Steven\\_Rothschild@rush.edu](mailto:Steven_Rothschild@rush.edu).

Sincerely,



Deborah Edberg, MD  
Director of Graduate Medical Education Development  
Associate Professor, Department of Family Medicine



Steven K. Rothschild, MD  
Chair, Department of Family Medicine  
Professor, Depts of Family Medicine and  
Preventive Medicine

November 9, 2021

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

Dear Director Eagleson:

I am pleased to offer this letter of support for the Southwest Hope Collaborative, an important step forward in achieving true health on the Southwest side of Chicago. Sinai Health System looks forward to being an active member of this important Collaborative.

Located on Chicago's West and Southwest Side, Sinai Health System is comprised of Mount Sinai Hospital, Holy Cross Hospital, Schwab Rehabilitation Hospital, Sinai Children's Hospital, Sinai Community Institute, Sinai Medical Group, and Sinai Urban Health Institute. Collectively, our sites deliver a full range of quality inpatient and outpatient services, as well as a large number of innovative, community-based health, research, and social service programs. We focus our collective depth of expertise and passion to improve the health of the 1.5 million people who live in our diverse service area. With our team of dedicated caregivers, Sinai Health System is committed to building stronger, healthier communities.

As an anchor healthcare institution on the Southwest side, we welcome the opportunity to work even more closely with members of the Collaborative, with a particular focus on coordinating care from our hospital-based services to community-based providers in the Collaborative. If I can provide any additional information, don't hesitate to contact me at [karen.teitelbaum@sinai.org](mailto:karen.teitelbaum@sinai.org).

Sincerely yours,

A black rectangular box redacting the signature of Karen Teitelbaum.

Karen Teitelbaum  
President and Chief Executive Officer





November 9, 2021

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

Dear Director Eagleson:

Saint Anthony Hospital is happy to lend its support and participation to the Southwest Hope Collaborative. It holds great potential to transform healthcare in our service area on Chicago's Southwest side.

Saint Anthony Hospital is an independent, nonprofit, faith-based, acute care community hospital dedicated to improving the health and wellness of the families on the West Side and Southwest Side of Chicago. We have grown to provide medical care, social services, and community outreach to the residents of several city neighborhoods, including: Little Village, North Lawndale, Brighton Park, Garfield Park, Back of the Yards, McKinley Park, Archer Heights, Pilsen, Austin, and Chinatown, as well as suburban Cicero. Saint Anthony offers quality services close to home, caring for people regardless of their nationality, religious affiliation, and ability to pay.

The Southwest Hope Collaborative provides us an opportunity to work closely with cross-sector partners in a community-wide initiative to drive health outcomes, and to coordinate care from our hospital-based services to community-based providers in the Collaborative. We look forward to initiating this crucial work.

Sincerely,

Guy A. Medaglia  
President and Chief Executive Officer

October 12, 2021

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

Dear Director Eagleson:

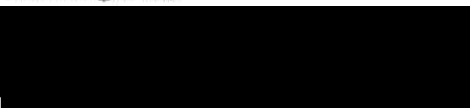
On behalf of the Southwest Organizing Project (SWOP), I write to lend my strong support for the Southwest Hope Collaborative that is being led by Esperanza Health Centers.

Like HFS, SWOP believes that transformation in healthcare delivery must be driven by community-wide efforts. This approach is aligned with SWOP's mission and history. Formed in 1996, SWOP is a broad-based organization of 45 Christian, Muslim and Jewish faith institutions, public and private schools, and other institutions in Southwest Chicago. We are known for our efforts to end predatory lending and foreclosures, reduce violence, win rights and protect the civil liberties of immigrants, and improve achievement in public schools through parent, student and school staff engagement. We have dedicated ourselves to building relationships across racial, ethnic, generational and faith differences and to bringing the common concerns of their institutions into the public life of the community as they develop the capacity to act collectively and "stand for the whole."

As a member of the Southwest Hope Collaborative, we look forward to housing community health workers at SWOP, who will continue the work we have long prioritized, namely to address social determinants of health that limit access to care, and to strengthen connections among primary care, mental health, and social service providers across Chicago's Southwest side.

Everyone at SWOP sees great promise in the Southwest Hope Collaborative. Please don't hesitate to contact me if you need further information.

Best regards,



Jeff Bartow  
Executive Director  
jbartow@swopchicago.org, (773) 471-8208 x 111

**SWOP**  
Recognizing the diversity of our community, we are building a broad-based organization of churches, schools and other institutions in Southwest Chicago, which will enable families to exercise common values, determine their own future and connect with each other to improve life in our neighborhoods.

11/9/21

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

Re: Support for Southwest Hope Collaborative

Dear Director Eagleton:

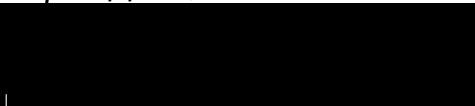
I write to express my earnest support for the Southwest Hope Collaborative outlined in Esperanza Health Centers' proposal for Healthcare Transformation Collaboratives funding. We are enthusiastic about participating in this project as a full collaborative member, as we believe this model holds great promise to transform healthcare delivery on Chicago's Southwest side.

Gage Park Latinx Council (GPLXC) is a queer, DACA, Latinx organization led by long-time residents of the community we serve. We directly address significant social determinants of health that have long led to health disparities here. To close the gap in access to food, we operate El Mercadito, a free weekly market of culturally reflective food items. To address the lack of green space in our neighborhoods, we offer Reclaiming Our Roots, creating eco-community spaces for healing and gathering using ancestral wisdom. We use our cultural center to establish pop-up health clinics in collaboration with local health providers (through this initiative, we worked with Esperanza to open the first pop-up clinic administering COVID-19 vaccines on the Southwest side). In addition, we offer opportunities for local youth to develop and hone their artistic abilities.

As a member of the Southwest Hope Collaborative, we will establish a community health anchor by 1) co-locating an Esperanza behavioral health counselor at our Cultural Center, 2) establishing telehealth integration with Esperanza, and 3) housing community health workers. Our entire team has first-hand lived experience that helps inform the work that we do as an organization. This collective knowledge is key asset we bring to the Southwest Hope Collaborative.

If you would like further information about GPLXC's participation in the Southwest Hope Collaborative, feel free to contact me at [antonio@gplxc.org](mailto:antonio@gplxc.org) or (708) 872-8798.

Sincerely yours,

A black rectangular box redacting the signature of Antonio Santos.

Antonio Santos  
Executive Director & Co-Founder



November 12, 2021

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

Dear Director Eagleson:

I am pleased to write as Founder and CEO of PODER in support of Esperanza Health Centers' application to the proposed Southwest Hope Collaborative.

PODER is a 501(c)(3) immigrant integration center whose mission, consistent since opening in 1997, is to provide the necessary academic tools to promote human dignity, increase employment potential, and facilitate participation in the larger community. After serving primarily the Pilsen community for our first eighteen years, we have spent the last six years operating satellite sites to better serve the first generation Latinos residing in Chicago's southwest side communities of West Lawn, Gage Park, Chicago Lawn, and Brighton Park. For all of our twenty-four years, PODER has worked tirelessly to identify and expand transformative windows of opportunity for Chicago's Latino immigrant community. We have celebrated the educational accomplishments of over 13,000 students and have continued to strategically design and refine adult education and job training programs to adapt to the changing needs of employers and our constituents. And while our target population is primarily the Latino immigrant communities of the southwest side, PODER is committed to helping all community members regardless of background.

There are formidable barriers facing southwest side Latino immigrants. PODER's answer is a literacy + job skills + placement strategy that offers multiple pathways to learn English and gain marketable job skills while providing wrap-around support services from a growing community partner network. With this approach, each graduate from PODER takes a step towards his or her own American Dream, which in turn results in a more just and prosperous Chicago for all. Through the Southwest Hope Collaborative, we will be able to forward our mission by providing additional wrap-around support to our program participants, housing community health workers at PODER who will link participants to high quality primary care and help address any obstacles to care they may encounter.

Esperanza Health Centers has been a valued community partner for many years, and I look forward to strengthening that partnership, as well as enriching the lives of southwest side residents, through our participation in the Southwest Hope Collaborative.

Sincerely,

A solid black rectangular box used to redact the signature of Daniel Loftus.

Daniel Loftus  
CEO



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Chicago Police Department

**LUIS GUTIERREZ**

*Founder and CEO*

Latinos Progresando

Theresa Eagleson, Director

Illinois Department of Healthcare and Family Services

401 South Clinton

Chicago, Illinois 60607

Dear Director Eagleson:

I am writing to offer my support for Esperanza Health Centers' proposal seeking support for the Southwest Hope Collaborative. Latinos Progresando, the organization I founded and for which I serve as Chief Executive Officer, is eager to participate in the Collaborative to enhance our impact on health and quality of life on Chicago's Southwest side.

Latinos Progresando first opened its doors in 1998. Today we provide myriad services to improve and enrich the lives of residents in our predominantly Latinx community. We offer programming in three broad areas -- immigration, culture, and community -- providing direct client services, educational forums, and cultural enrichment experiences. We also coordinate the Marshall Square Resource Network, a place-based coalition of more than 45 institutional partners that advances bold, integrated solutions in health, education, peace, and community response.

We have had a long and fruitful partnership with Esperanza Health Centers for many years. With the proposed Southwest Hope Collaborative, Latinos Progresando will create a behavioral health community anchor, with an Esperanza mental health clinic co-located within our new community center. We will also develop telemedicine integration between Latinos Progresando and Esperanza, so that our two organizations can efficiently serve our mutual clients/patients.

After the devastation that the COVID-19 pandemic has wrought on our communities, we greatly look forward to broadening and strengthening our ability to drive health outcomes for local residents as part of the Southwest Hope Collaborative. I welcome discussing our plans further with you. You can contact me at [luis@latinospro.org](mailto:luis@latinospro.org) or (773) 542-7077 Ext: 813.

Sincerely yours,

Luis Gutierrez

Founder and CEO



## **Brighton Park Neighborhood Council**

**4477 S. Archer Avenue \* Chicago, IL 60632 \* (773) 523-7110 \* fax: (773) 523-7010**

11/12/21

Director Theresa Eagleson  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Second Street  
Springfield, Illinois 62763

Re: Southwest Hope Collaborative

Dear Director Eagleson:

I write to voice my support for the Southwest Hope Collaborative's application for Healthcare Transformation Collaboratives funding. The Collaborative is an impactful model to advance health equity on Chicago's Southwest site.

Brighton Park Neighborhood Council (BPNC) is a community based, nonprofit organization committed to serving the residents of Brighton Park - a working class neighborhood on Chicago's Southwest side. BPNC's mission is to create a safer community, improve learning, preserve affordable housing, provide a voice for youth, protect immigrant rights, promote gender equality, and end all forms of violence in our communities. Central to our mission is our Brighton Park Neighborhood Network (BPNN), a coalition of 40 local organizations, as well as community residents, dedicated to dramatically improving outcomes for every resident through comprehensive support in education, health, and employment. This way we can connect community members to resources that promote physical, emotional, academic, and economic well-being; develop and implement initiatives to enhance our neighborhood's social service infrastructure; and advocate for local, state, and national policies that dismantle structural inequities in our community.

As a member of the Southwest Hope Collaborative, BPNC will bring on Community Health Workers to connect Brighton Park residents to primary care services, and to help them navigate across barriers erected by social and economic disparities in the community. This work will complement the work of our current Parent Health Promoters, who work with local parents and schools to address family health and nutrition, women's health, and understanding health care system and campaigns for reform.

The Southwest Hope Collaborative aligns perfectly with BPNN's community-generated strategic plan, which includes our "bold goal" to improve the physical health and emotional wellness of community residents by increasing access to and use of preventative health care services and mental health services. We think the Collaborative is an investment worth making.

Sincerely yours,

Patrick Brosnan  
Executive Director





2759 S. Harding Ave  
Chicago, IL 60623  
Phone: 773.943.7570  
Fax: 773.644.3263

[www.enlacechicago.org](http://www.enlacechicago.org)

Chicago, November 17 2021

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

Dear Director Eagleson:

The Southwest Hope Collaborative, outlined in Esperanza Health Centers' application for Healthcare Transformation Collaboratives funding, holds great promise to transform healthcare and improve health outcomes for residents of our Little Village service area. That's why we're a proud partner in the Collaborative, and why I write to express my heartfelt support.

Enlace Chicago was founded in 1990 as the Little Village Community Development Corporation. Enlace convenes, organizes, and builds the capacity of Little Village stakeholders to confront systemic inequities and barriers to economic and social access. Currently, our four areas include education, health, immigration, and violence prevention. Within and across each of these areas, Enlace engages four key strategies: 1) organizing and advocacy, 2) program implementation and service delivery, 3) convening and community planning and 4) individual and community capacity building. We also operate the Enlace Leadership Academy, a training program designed to challenge participants to consider their role as change agents and to analyze power dynamics within their community.

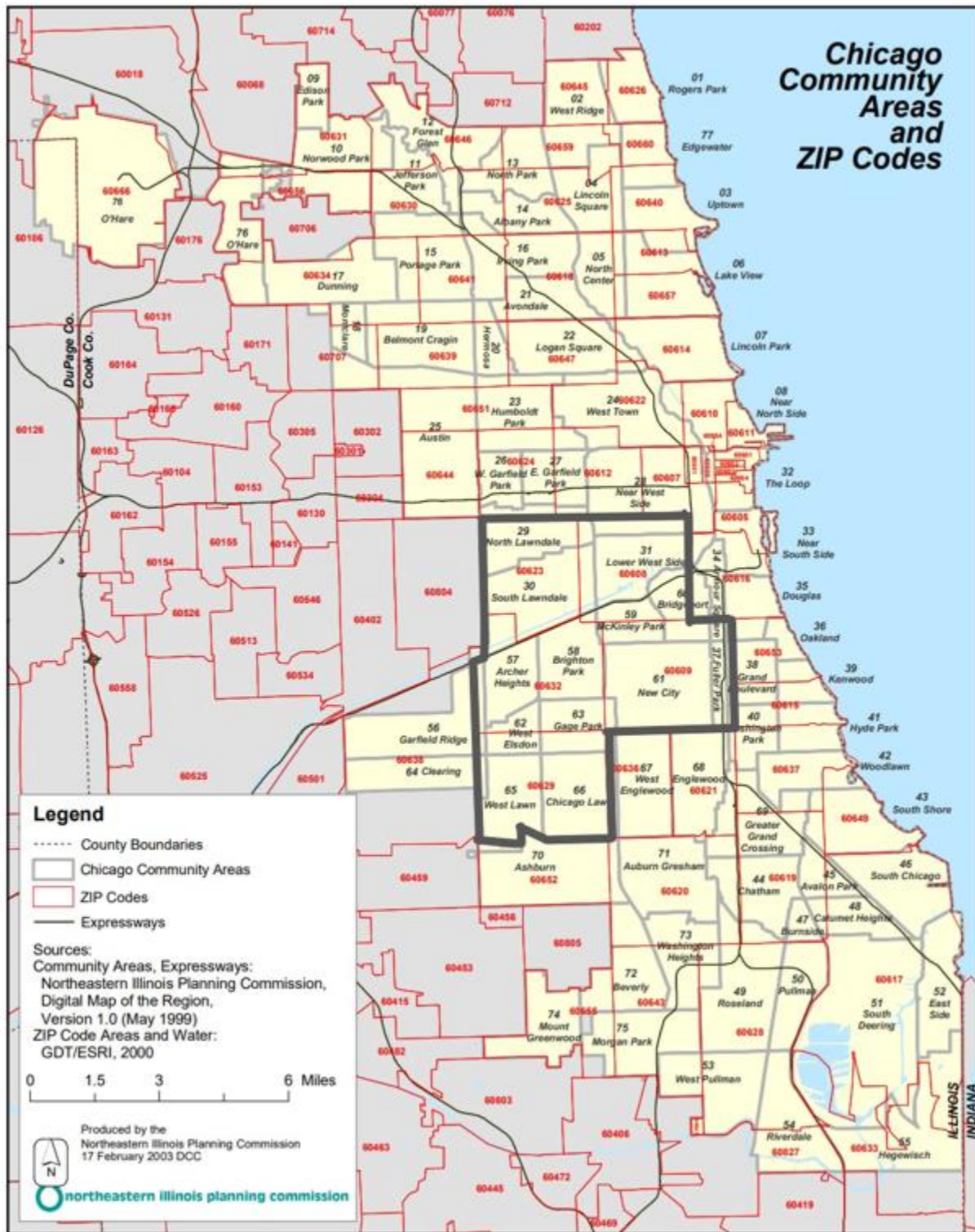
Our participation in the Southwest Hope Collaborative will allow us to grow our team of community health workers (*promotorxs de salud*) in order to connect more local residents to care, and to ensure that we deepen our ability address the social determinants of health that often prevent people from leading their healthiest, most productive lives.

Sincerely,

  
Katya Nieves  
Executive Director



## Southwest Hope Collaborative



## "Changing the Map"

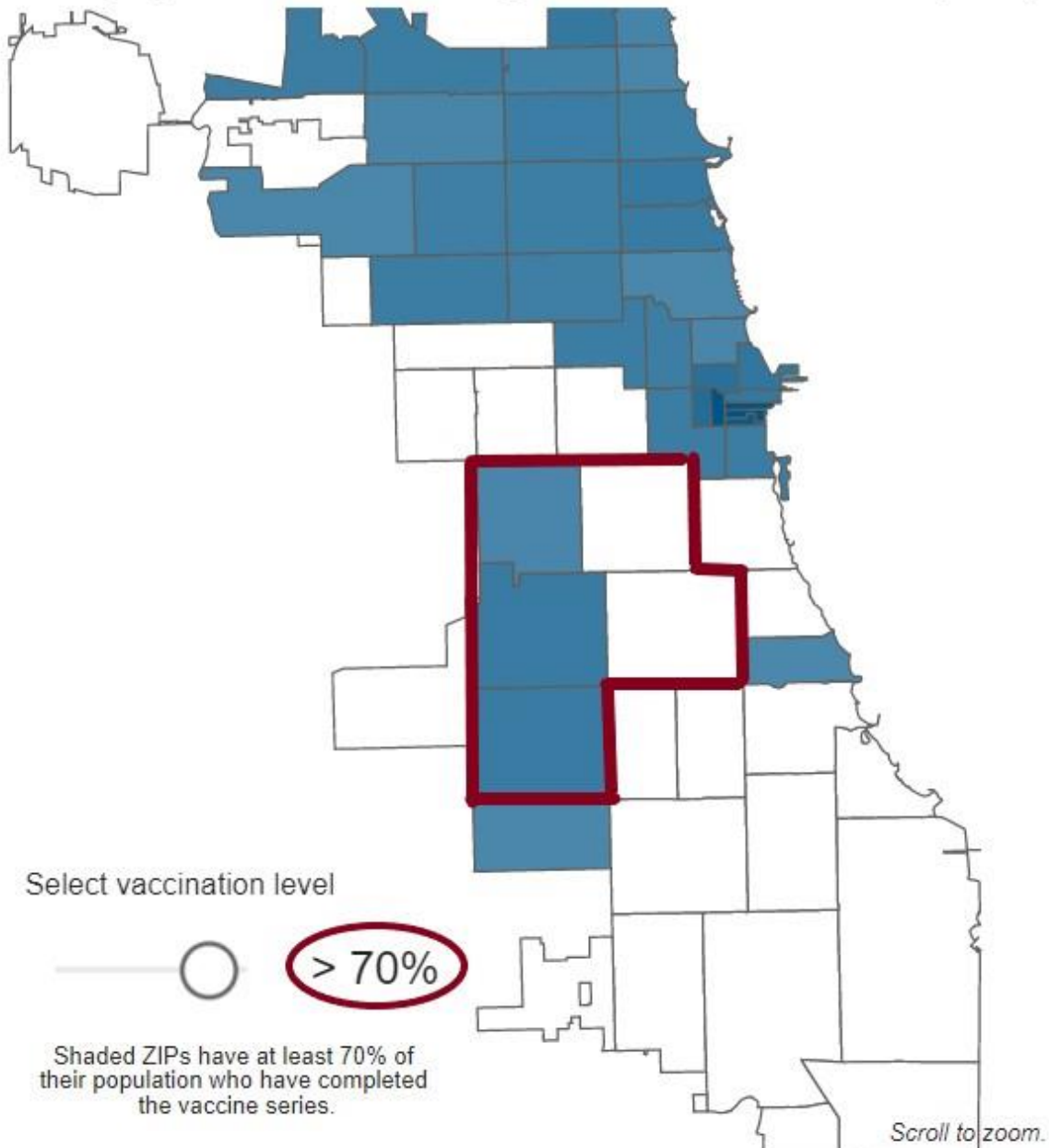
**Data current as of Nov 16, 2021.**

Data are updated M-F at 5:30 p.m., except for City holidays.  
All data are provisional and subject to change.

[? Learn how to use this dashboard.](#)

At least one dose **Completed vaccine series** Total doses Vulnerability Index

### % of population with completed vaccine series (12+)



## Southwest Hope Collaborative

| Participating Entity                      | Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Transformation Elements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Brighton Park Neighborhood Council</b> | Brighton Park Neighborhood Council (BPNC) is a community-based nonprofit organization committed to serving the residents of Brighton Park, a working class neighborhood on Chicago's Southwest side. BPNC's mission is to create a safer community, improve learning, preserve affordable housing, provide a voice for youth, protect immigrant rights, promote gender equality, and end all forms of violence in our communities. Central to their mission is the Brighton Park Neighborhood Network (BPNN), a coalition of 40 local organizations, as well as community residents, dedicated to dramatically improving outcomes for every resident through comprehensive support in education, health, and employment. | <ul style="list-style-type: none"> <li>• Five (5) on-site Community Health Workers, with in-person and virtual integration into the primary care team</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Esperanza Health Centers</b>           | Esperanza Health Centers is a Federally Qualified Health Center (FQHC) operating on Chicago's Southwest side. With five sites and a staff of over 300, Esperanza serves more than 40,000 patients a year, providing preventive and primary care, behavioral health, psychiatry, substance abuse treatment, and a wide range of wellness programs. Esperanza was designated a National Quality Leader by HRSA over the past four years, ranking among the top 3 percent of health centers in the nation, and the top two in Illinois for quality of care.                                                                                                                                                                 | <ul style="list-style-type: none"> <li>• Lead health care partner for the Southwest Hope Collaborative</li> <li>• One of the three community health anchors in the Collaborative, expanded with the construction of a new 30,000 sq. ft. health center</li> <li>• Expansion of primary care with hiring of 36 new providers</li> <li>• Provider of integrated behavioral health care by 8 LCSWs and 2 psychiatrists</li> <li>• Five (5) on-site Community Health Workers, with in-person and virtual integration into the primary care team</li> <li>• Site host/collaborating partner for interdisciplinary health care training program that centers health equity.</li> </ul> |

| Participating Entity            | Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Transformation Elements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Enlace Chicago</b>           | Founded in 1990, Enlace Chicago convenes, organizes, and builds the capacity of Little Village stakeholders to confront systemic inequities and barriers to economic and social access. Their four focus areas include education, health, immigration, and violence prevention. Within and across each of these areas, Enlace engages four key strategies: 1) organizing and advocacy, 2) program implementation and service delivery, 3) convening and community planning and 4) individual and community capacity building.                         | <ul style="list-style-type: none"> <li>• Five (5) on-site Community Health Workers, with in-person and virtual integration into the primary care team</li> </ul>                                                                                                                                                                                                                                                                                                                                                           |
| <b>Gage Park Latinx Council</b> | Gage Park Latinx Council (GPLXC) is a queer, DACA, Latinx organization led by long-time residents of the community. GPLXC directly addresses significant social determinants of health that have long led to health disparities here. GPLXC operates <i>El Mercado</i> , a free weekly market of culturally reflective food items; Reclaiming Our Roots, creating eco-community spaces for healing and gathering using ancestral wisdom; and a cultural center, used to establish pop-up health clinics in collaboration with local health providers. | <ul style="list-style-type: none"> <li>• One of three community health anchors</li> <li>• Co-location of behavioral health services in GPLXC community center</li> <li>• Telemedicine integration at community health anchor</li> <li>• Five (5) on-site Community Health Workers, with in-person and virtual integration into the primary care team</li> <li>• Pilot site for an expanded <i>Mercadito</i>, a market that provides fresh, culturally appropriate foods at no charge to address food insecurity</li> </ul> |
| <b>Latinos Progresando</b>      | Latinos Progresando provides myriad services to improve and enrich the lives of residents in the predominantly Latinx community of Little Village/Marshall Square, including immigration legal services, educational forums, and cultural enrichment experiences in addition to serving as the backbone organization for the Marshall Square Resource Network, a place-based coalition of more than 45 institutional partners that advances bold, integrated solutions in health, education, peace, and community response.                           | <ul style="list-style-type: none"> <li>• One of three community health anchors</li> <li>• Co-location of behavioral health services in the Latinos Progresando community center</li> <li>• Telemedicine integration at community health anchor</li> </ul>                                                                                                                                                                                                                                                                  |



| Participating Entity                  | Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Transformation Elements                                                                                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Poder Learning Center</b>          | Poder serves as an immigrant integration center, with five levels of Integrated English and Workforce Development programs that include Customer Service training tied to an industry-recognized credential, Bilingual Insurance Licensing, and Latinos in Finance. Digital literacy and financial literacy are incorporated into all of PODER's programs                                                                                                                                                                                                                                                                                                                                    | <ul style="list-style-type: none"> <li>• Three (3) on-site Community Health Workers, with in-person and virtual integration into the primary care team</li> </ul>                                                                                                                                                                                                                                                          |
| <b>Rush University Medical Center</b> | Rush University Medical Center is an academic medical center that includes a 671-bed hospital serving adults and children, the 61-bed Johnston R. Bowman Health Center and Rush University. For more than 180 years, the Medical Center has been leading the way in developing innovative and often life-saving treatments. Rush's 2025 System Strategy calls for leading the transformation of health care through critical strategies, including innovating and improving primary care delivery, developing and retaining a diverse workforce, and improving the health of communities by challenging health inequity through educational opportunities based in the communities we serve. | <ul style="list-style-type: none"> <li>• Interprofessional curriculum development and delivery</li> <li>• Establishment of a community-centric Family Medicine Residency Program, which will be the only such residency program on Chicago's southwest side</li> <li>• Integration of community health workers, medical Assistants, nurse practitioners and care coordinators into interprofessional curriculum</li> </ul> |
| <b>St Anthony Hospital</b>            | Saint Anthony Hospital is an independent, nonprofit, faith-based, acute care community hospital dedicated to improving the health and wellness of the families on the West Side and Southwest Side of Chicago. St. Anthony provides medical care, social services, and community outreach to the residents of several city neighborhoods, including: Little Village, North Lawndale, Brighton Park, Garfield Park, Back of the Yards, McKinley Park, Archer Heights, Pilsen, Austin, and Chinatown, as well as suburban Cicero. Saint Anthony offers quality services close to home, caring for people regardless of their nationality, religious affiliation, and ability to pay.           | <ul style="list-style-type: none"> <li>• Coordinate transition of care from hospital-based services to community-based providers in the Collaborative with the addition of 2 hospital concierges.</li> </ul>                                                                                                                                                                                                               |
| <b>Sinai Health System</b>            | Located on Chicago's West and Southwest Side, Sinai Health System is comprised of Mount Sinai Hospital, Holy Cross Hospital, Schwab Rehabilitation Hospital, Sinai Children's Hospital, Sinai Community Institute, Sinai Medical Group, and Sinai Urban Health Institute. Collectively, their sites deliver a full range of quality inpatient and outpatient services, as well as a large number of innovative, community-based health, research, and social service programs.                                                                                                                                                                                                               | <ul style="list-style-type: none"> <li>• Coordinate transition of care from hospital-based services to community-based providers in the Collaborative with the addition of 4 hospital concierges.</li> </ul>                                                                                                                                                                                                               |

| Participating Entity         | Description                                                                                                                                                                                                                                                                                                                                                                                                                                              | Transformation Elements                                                                                                                                         |
|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Southwest Organizing Project | Southwest Organizing Project (SWOP) is a broad-based organization of 34 Christian, Muslim and Jewish faith institutions, public and private schools, and other institutions in Southwest Chicago. SWOP is known for their efforts to end predatory lending and foreclosures, reduce violence, win rights, and protect the civil liberties of immigrants, and improve achievement in public schools through parent, student, and school staff engagement. | <ul style="list-style-type: none"> <li>Seven (7) on-site Community Health Workers, with in-person and virtual integration into the primary care team</li> </ul> |

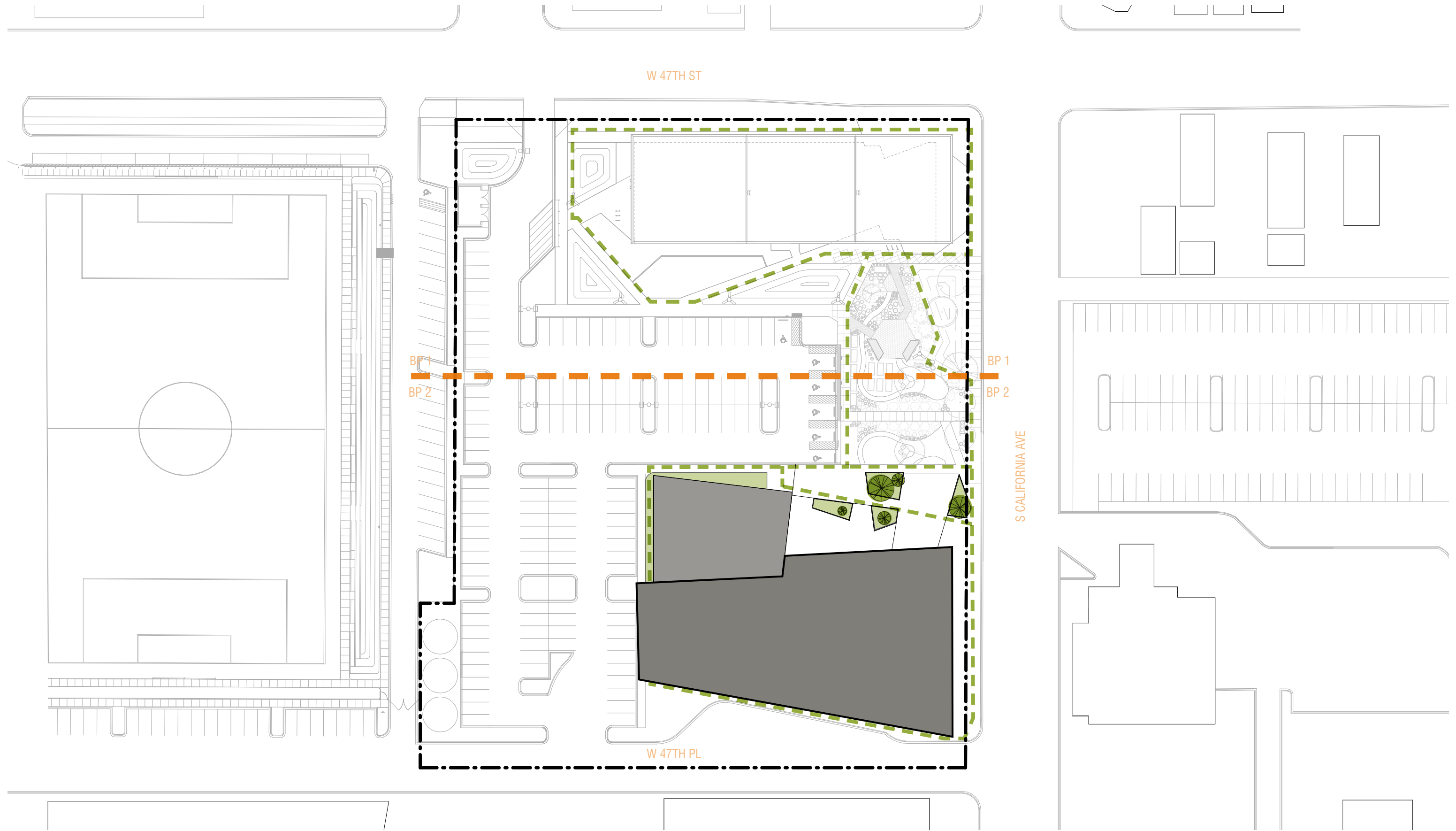


Brighton Park Phase Two



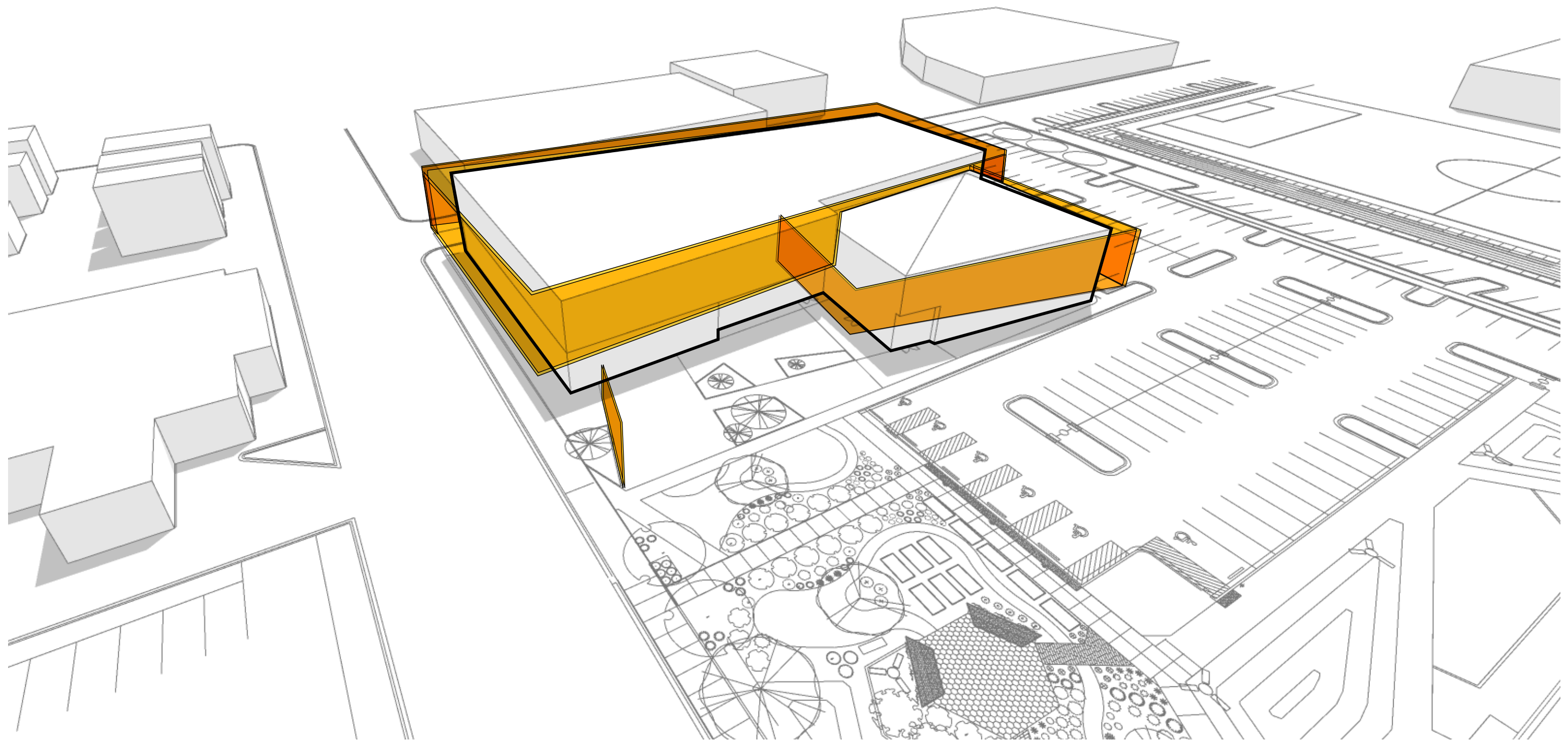
Esperanza Health Center / W 47th St + S California : Brighton Park : Chicago

Esperanza Health Centers  
McNitt Consulting, LLC

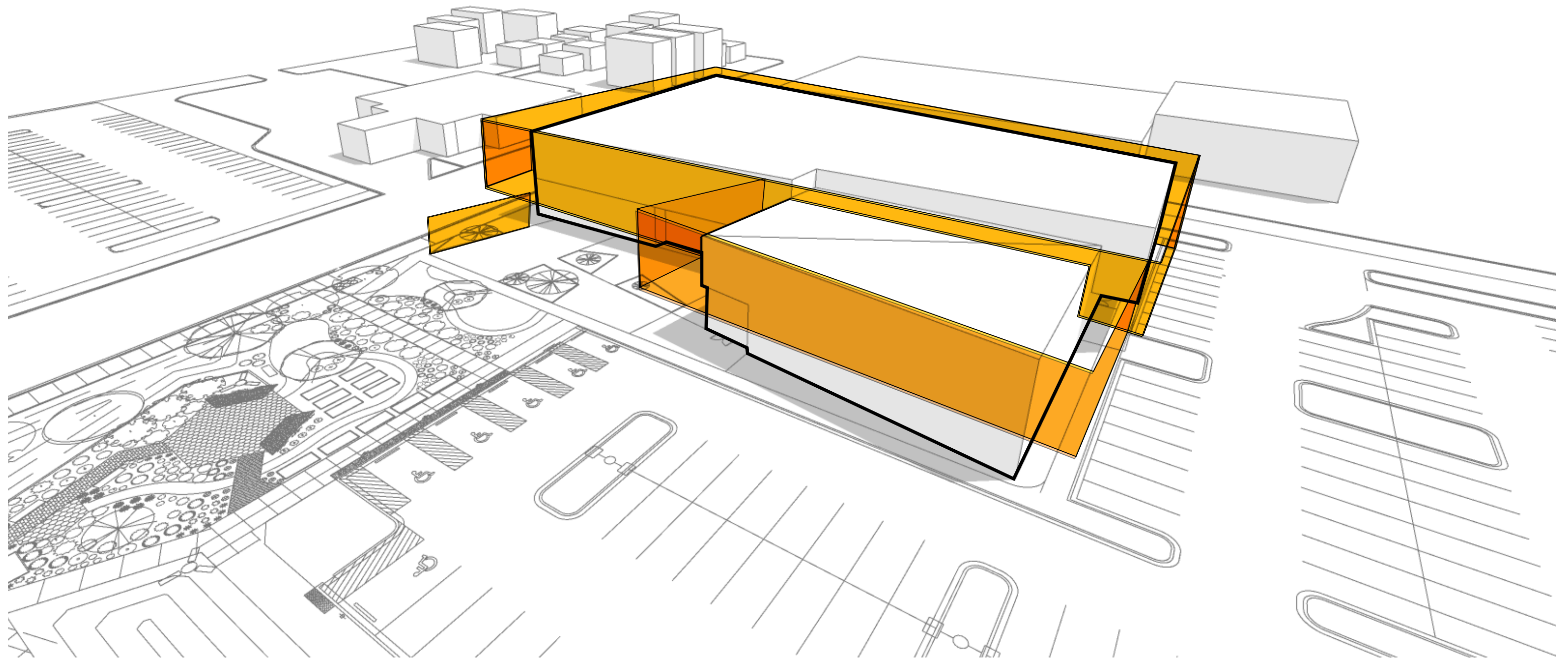




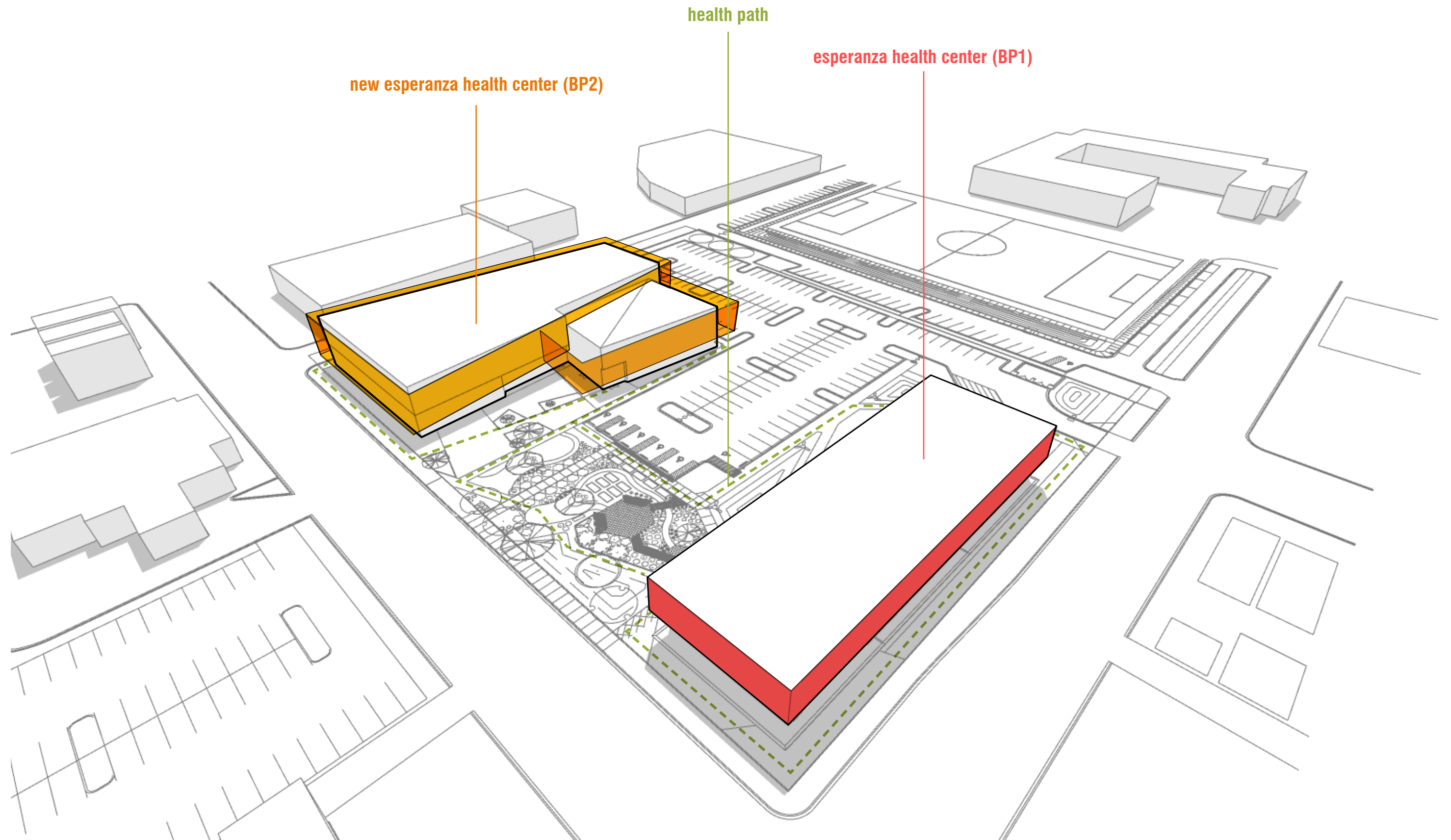




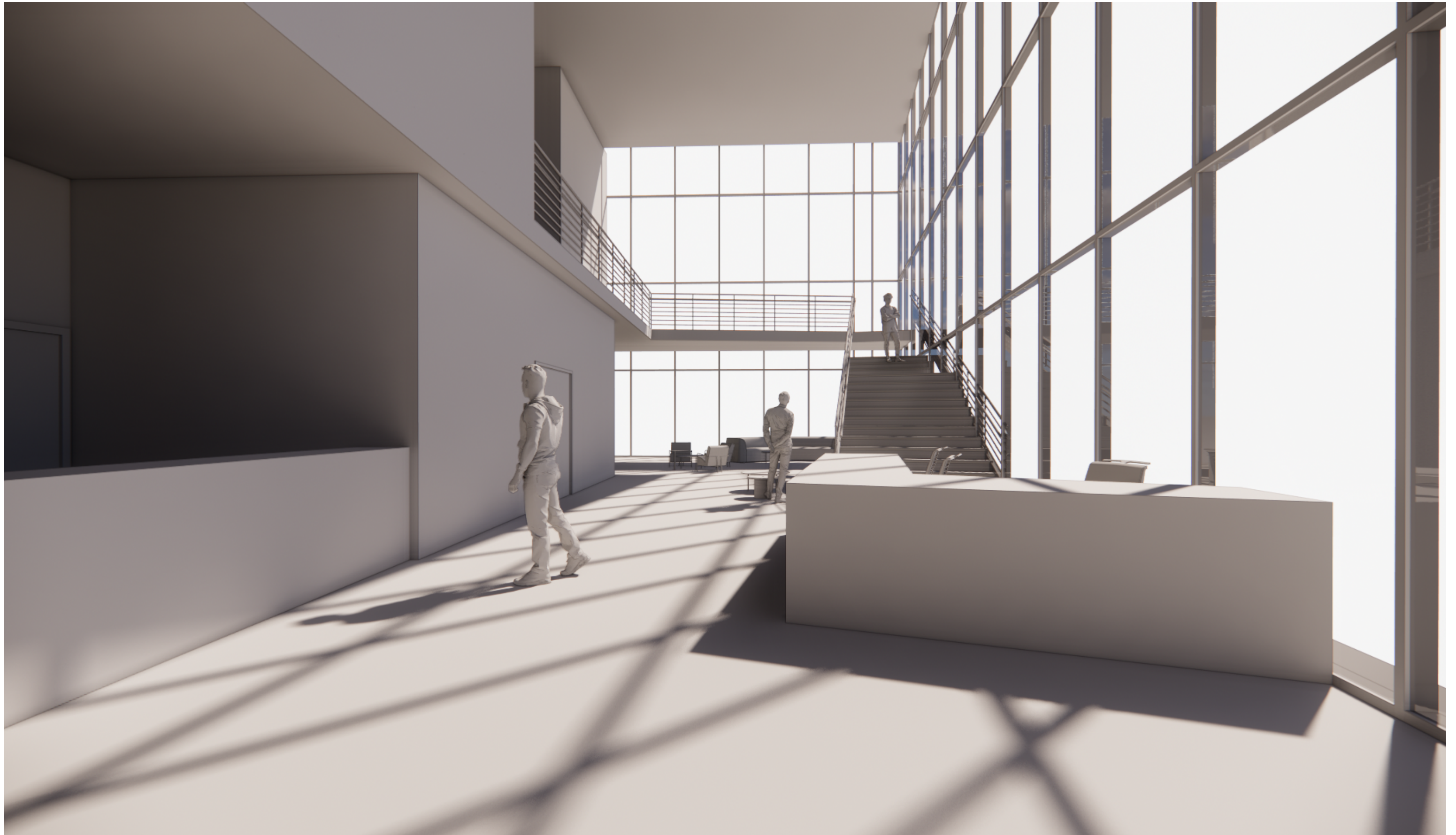














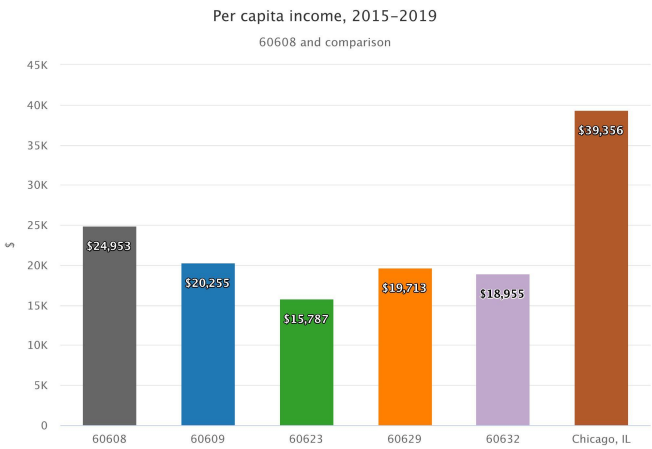


# Southwest Hope Collaborative

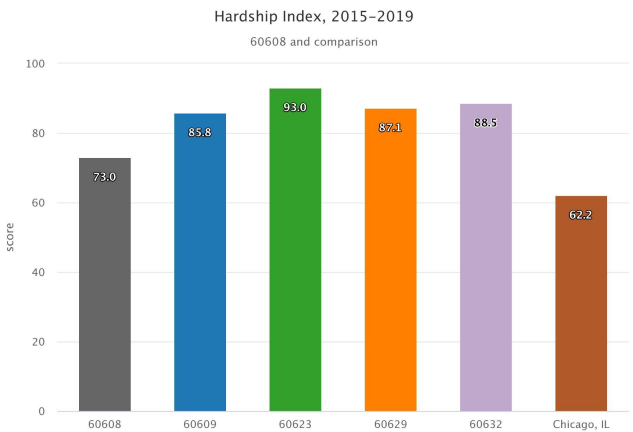
## Data Insights

The Southwest Hope Collaborative gained insights from numerous quantitative and qualitative sources. Following are select indicators.

### 1. Five Zip Code Service Area Poverty Indicators

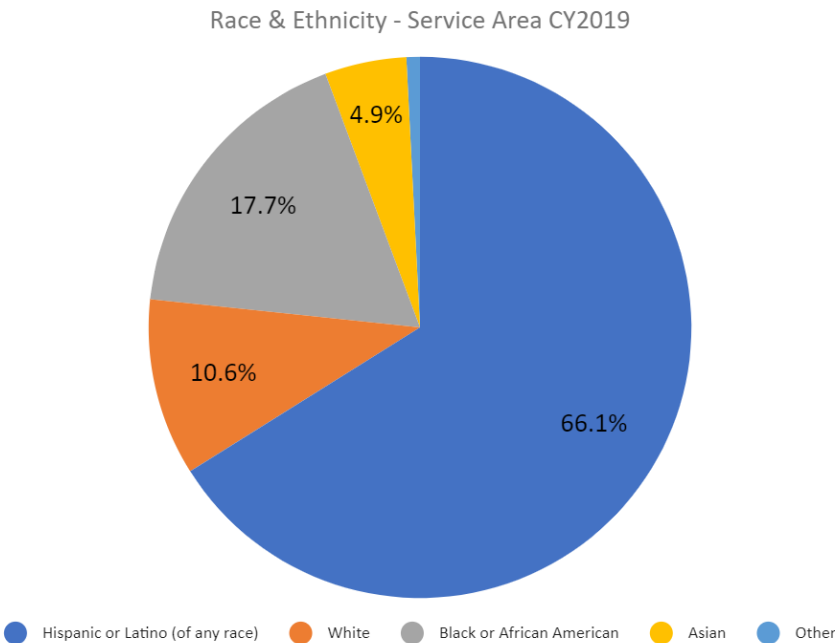


Created on Chicago Health Atlas | [chicagohealthatlas.org](http://chicagohealthatlas.org) | Data source: American Community Survey (Table B19001)  
Per capita income: Income in the past 12 months.



Created on Chicago Health Atlas | [chicagohealthatlas.org](http://chicagohealthatlas.org) | Data source: American Community Survey (Calculated by Metrosol)  
Hardship Index: The Hardship Index is a composite score reflecting hardship in the community (higher values indicate greater hardship). It incorporates unemployment, age dependency, education, per capita income, crowded housing, and poverty into a single score that allows comparison between geographies. It is highly correlated with other measures of economic hardship, such as labor force statistics, and with poor health outcomes. See technical notes for details.

### 2. Five Zip Code Service Area - Race/Ethnicity Data







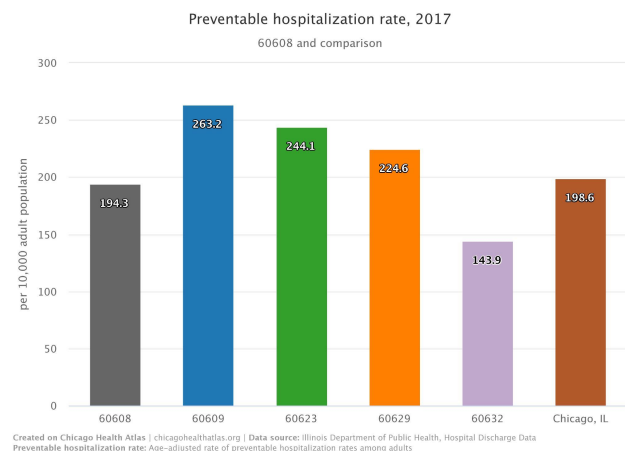
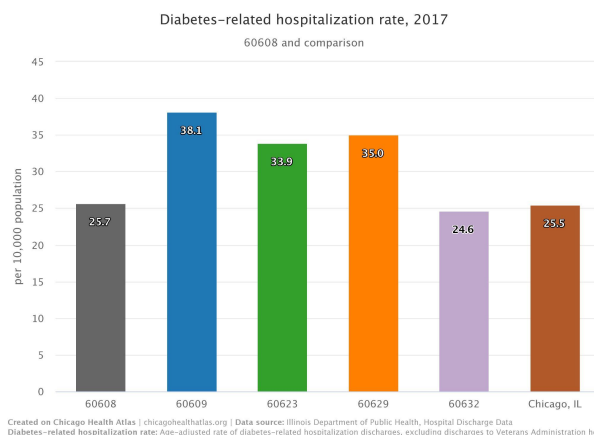
## 5. Five Zip Code Population & Healthcare Care Access Opportunity

| Community Area             | Zip Code | Total Population (2015 - 2019) | Low Income Population (2015-2019) | Health Center Population Served (2020) | Health Care Access Opportunity Population |
|----------------------------|----------|--------------------------------|-----------------------------------|----------------------------------------|-------------------------------------------|
| Lower West (Pilsen)        | 60608    | 80,059                         | 30,889                            | 18,519                                 | 12,370                                    |
| Back of the Yards          | 60609    | 60,939                         | 33,403                            | 20,461                                 | 12,942                                    |
| S. Lawndale/Little Village | 60623    | 81,283                         | 50,820                            | 37,488                                 | 13,332                                    |
| Chicago Lawn/West Lawn     | 60629    | 110,029                        | 56,180                            | 39,501                                 | 16,679                                    |
| Brighton Park              | 60632    | 89,857                         | 45,596                            | 34,890                                 | 10,706                                    |
|                            |          | 422,167                        | 216,888                           | 150,859                                | 66,029                                    |

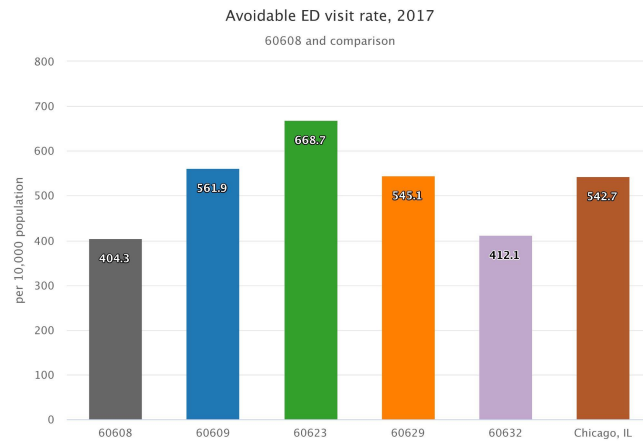
## 6. Medicaid Enrollment

| Medicaid Enrollment for Service Area Zip Codes, 2020 |                 |                                  |                                   |                      |               |                  |                  |
|------------------------------------------------------|-----------------|----------------------------------|-----------------------------------|----------------------|---------------|------------------|------------------|
| Zip Code                                             | Children (0-18) | Adults with disabilities (19-64) | ACA Newly Eligible Adults (19-64) | Other adults (19-64) | Seniors (65+) | Partial Benefits | Total Enrollment |
| 60608                                                | 10,270          | 1,596                            | 5,763                             | 3,631                | 2,481         | 407              | 24,148           |
| 60609                                                | 14,654          | 2,094                            | 5,666                             | 4,304                | 2,081         | 386              | 29,185           |
| 60623                                                | 23,215          | 3,083                            | 8,580                             | 6,583                | 2,469         | 536              | 44,466           |
| 60629                                                | 27,601          | 2,643                            | 8,601                             | 7,734                | 2,889         | 552              | 50,020           |
| 60632                                                | 21,484          | 1,317                            | 5,764                             | 5,783                | 2,310         | 385              | 37,043           |
| Total of 5 zip codes                                 |                 |                                  |                                   |                      |               |                  | 184,862          |

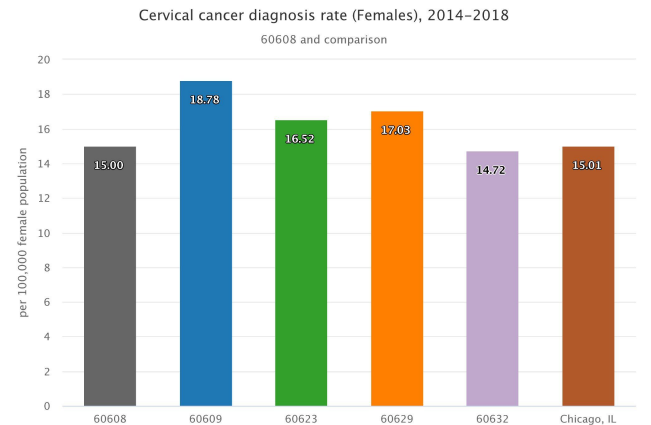
## 7. Select Health Indicators





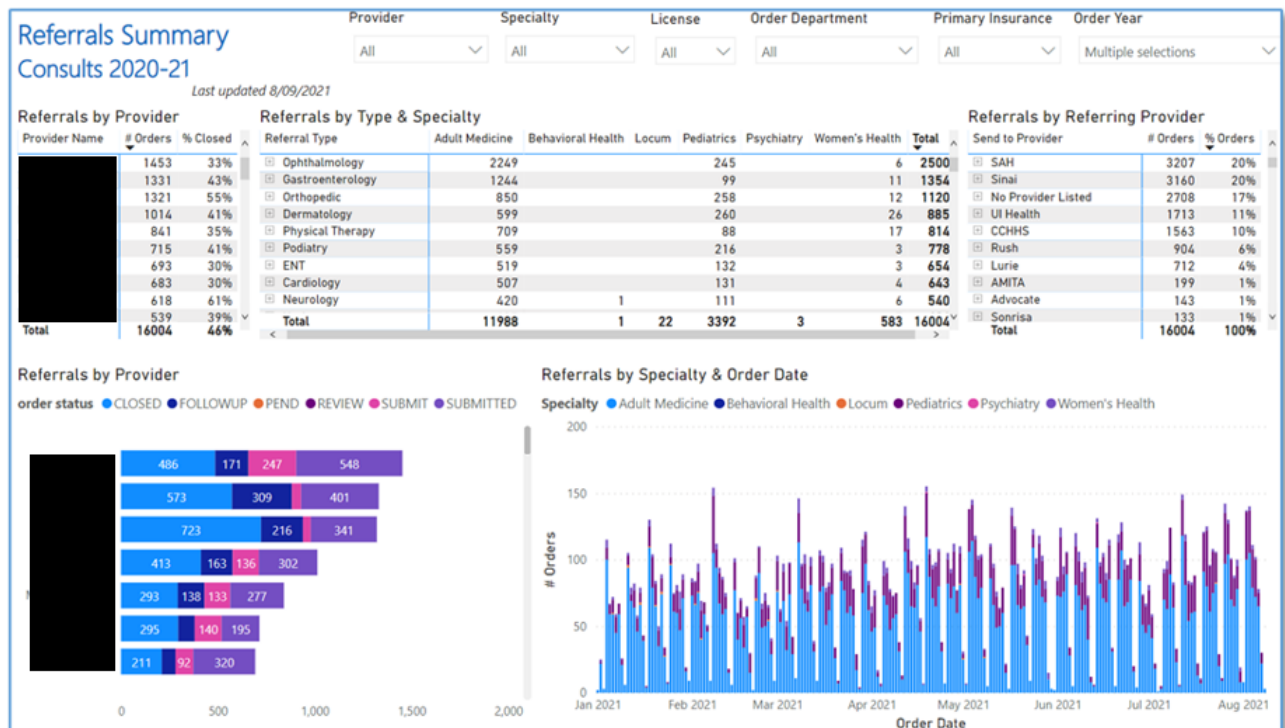


Created on Chicago Health Atlas | [chicagohealthatlas.org](http://chicagohealthatlas.org) | Data source: Illinois Department of Public Health, Hospital Discharge Data  
Avoidable ED visit rate: Age-adjusted rate of emergency department (ED) discharges that are non-urgent or primary care treatable, excluding discharges to Veterans Administration hospitals.



Created on Chicago Health Atlas | [chicagohealthatlas.org](http://chicagohealthatlas.org) | Data source: Illinois Department of Public Health, Illinois State Cancer Registry (Calculated by Metos)  
Cervical cancer diagnosis rate: Annual diagnosis rate for cervical cancer, Ages 15 and over, age-adjusted.

## 8. Hospital and Specialty Referrals



## 9. Behavioral Health Personas and Insights

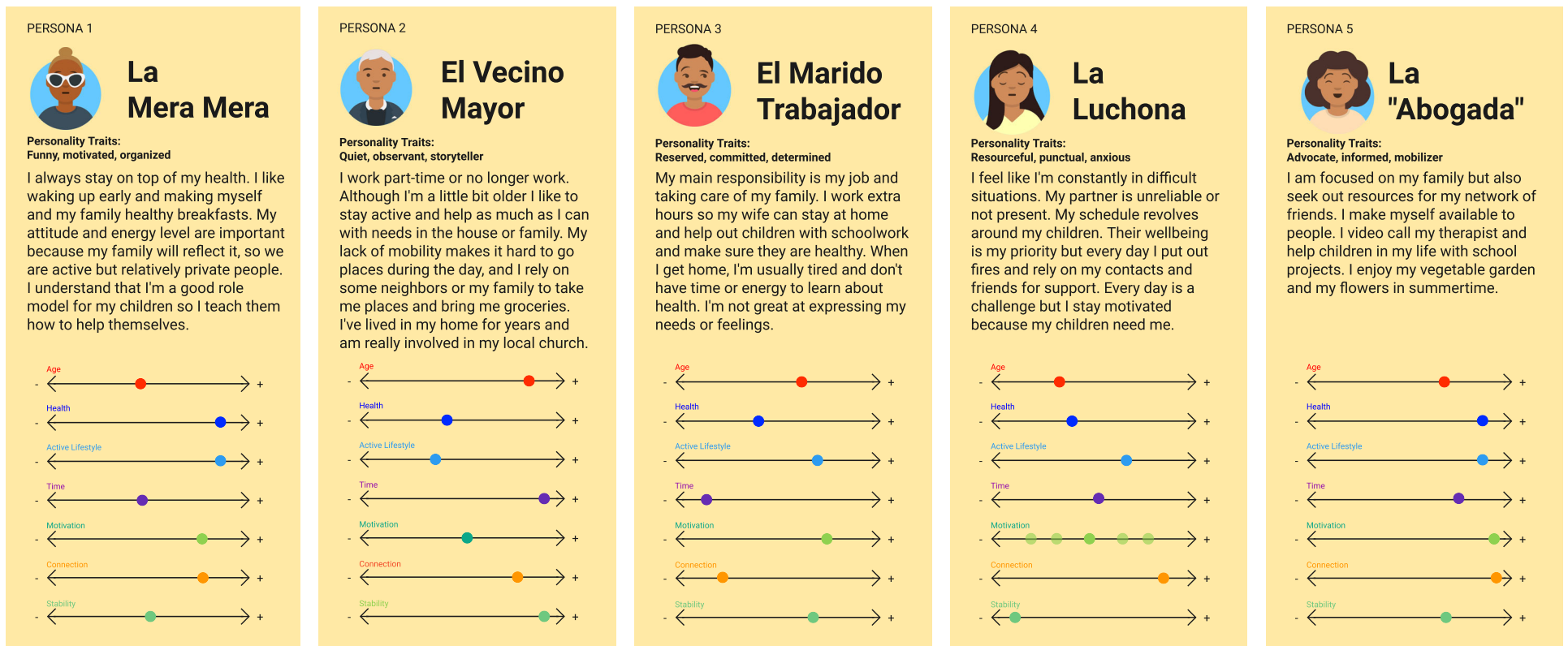
The following personas and insights were compiled by Duo Development using data generated from user-design qualitative methods.

# Personas

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# Personas.

Behavioral personas are not generalizations, but patterns of behavior identified in a local context. They help us remain user-centric and know who we are designing for.



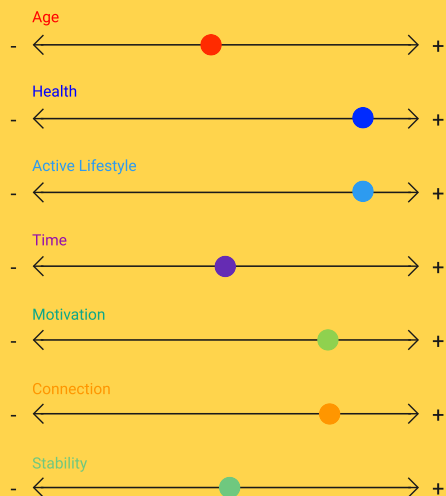
## PERSONA 1



# La Mera Mera

### Personality Traits: Funny, motivated, organized

I always stay on top of my health. I like waking up early and making myself and my family healthy breakfasts. My attitude and energy level are important because my family will reflect it, so we are active but relatively private people. I understand that I'm a good role model for my children so I teach them how to help themselves.



Duo/.

## Who they are.

### Goals and aspirations.

Las meras meras want to be seen as leaders in their families. They often guide others to a better lifestyle and lead by example. They enjoy being motivated, and like participating in activities that benefit them. They have a positive outlook and know that things will always get better regardless of the difficulties at hand. They truly aspire to be the best they can be, and this can lead them to seek self-help, more than medical help.

### Might be seen.

- Taking my kids for a walk
- Meeting up with a group of parents at the park
- Making my mom's recipe but with less salt because it's better for me
- Meeting new people and inviting them to social events
- Driving to other parts of the city to find a nice park or ways to enjoy the weekend

### Behaviors.

- I don't proactively go to the doctor because I like staying on top of my health in my own way
- I always show up to work early
- I try to skip that extra tortilla
- I make appointments to the doctor for my family and make sure they go
- I work hard because that's the only way to go

## What they need.

### Individual.

- Someone to make me go to the doctor because I always forget
- Help talking to someone when I'm stressed
- Help organizing my finances

### From Esperanza.

- Something to do while I'm waiting for my kids
- Workshops and events
- Places to go on a regular basis

### From the neighborhood.

- Activities for my family (e.g., tennis courts, gym, skating)
- Safe environments to be in after dark
- Places where I can remember and celebrate my culture

### Pain points.

- I don't have time to make friends and my schedule is out of control because I'm always working
- I have too many people and things to care for, and I might take on responsibility if others around me are not doing well

### La Neta

*Her resilience stems from her belief as a role model and positive impact on others. If people around her struggle she might internalize responsibility or she may place the blame on others and ignore systemic barriers affecting their behaviors.*

*"It would be nice if Esperanza did something to break the daily routine"*  
-Mari, 36

## How to work with them.

### A Their way or the highway.

Ensure that you listen to the way they like to address their health as individuals. They may be skeptical of medical interventions and prefer natural or cultural ways to heal.

### B Remind them.

It sounds counter-intuitive, but they often care for others and forget to care for themselves. Giving them reminders that work with their schedule ensures their participation.

### C Motivate them.

Motivate and teach them in practical ways. Always remember that they will teach others so make this easy for them.

## PERSONA 2

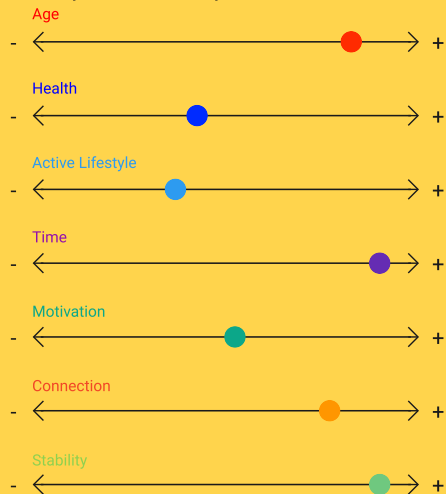


# El Vecino Mayor

### Personality Traits:

**Quiet, observant, storyteller**

I work part-time or no longer work. Although I'm a little bit older I like to stay active and help as much as I can with needs in the house or family. My lack of mobility makes it hard to go places during the day, and I rely on some neighbors or my family to take me places and bring me groceries. I've lived in my home for years and am really involved in my local church.



**Duo/.**

## Who they are.

### Goals and aspirations.

El Vecino Mayor has a slower pace to their daily lives but are still quite engaged. They are approachable and like telling stories. They want to be involved in things that have a high degree of certainty but are also flexible. They want to continue to be independent and aspire to be leaders in their neighborhood. They like to get the youth involved and teaching others.

### Might be seen.

- Sitting in my stoop or front porch
- Walking my dogs for exercise
- Leading a prayer at church on Sundays
- Going to the supermarket because my kids don't know how to pick the right vegetables
- Cooking for the family
- Taking care of my grandchildren after school
- Asking neighbors for help with house chores or groceries in the winter

### Behaviors.

- I like to stay active and go on walks if it's nice out
- I teach others how to have good values and to help others
- I try to keep up with my medicine but sometimes forget
- I like eating traditional food even if it's not the healthiest
- I don't like asking for help

## What they need.

### Individual.

- Help with mobility and transportation
- Resources to be able to teach others
- A sense of belonging in their families and communities

### From Esperanza.

- Reminders and ways to receive care in simple ways
- Help achieving basic needs, more than complicated medical needs
- Spanish-first customer service

### From the neighborhood.

- Street Festivals and mingling opportunities
- Amenities at walking distance
- Visible and reliable local orgs
- Places to "be" without having to "do"

### Pain points.

- I don't speak perfect English
- I can't get to the places I need to go on my own
- I struggle with technology
- I have a sense of grief but don't want to burden the family with it
- I struggle with loneliness

### La Neta

*There is social tension around aging in a culture that values hard-work. This can lead to feeling like a burden while wanting to contribute. You'll often hear "Yo puedo! No estoy viejo!"*

*"Intergenerational events are great places to interact and see young people becoming involved"*  
- Pablo, 63

## How to work with them.

### D Keep it simple.

Enable the development of routines that are easy to follow. When giving directions, avoid medical jargon and complement medicine with alternative forms of health.

### E Enable independence.

Make sure they can handle their own care to the extent possible. Offer ways to enable self-reliance.

### F Make space for them.

Flip the script: from "they need to be served", to "how they serve us". View them through their inherent value while creating spaces and programs that are accessible, and welcoming to an adult audience.

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## PERSONA 3

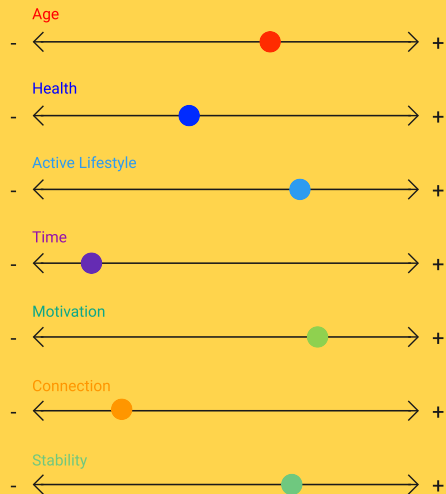


# El Marido Trabajador

### Personality Traits:

**Reserved, committed, determined**

My main responsibility is my job and taking care of my family. I work extra hours so my wife can stay at home and help out children with schoolwork and make sure they are healthy. When I get home, I'm usually tired and don't have time or energy to learn about health. I'm not great at expressing my needs or feelings.



**Duo/.**

## Who they are.

### Goals and aspirations.

El Marido Trabajador keeps a low-profile and hands-off parenting style, yet is involved in their children's endeavors. They are focused and determined to provide for their family. Does not remember the last time he visited the doctor because his wife and mother tend to his aches with *remedios*. Time off work is time with family and they make sure there is enough food on the table and to set a good example.

### Might be seen.

- Might NOT be seen at home in the mornings because I'm already at work
- Watching TV after work
- Working on the house on the weekends
- Talking to my friends or organizing a carne asada
- Attending my kids school events

### Behaviors.

- I wake up early and head to work
- I avoid seeking services that require paperwork (due to my legal status)
- I help at home with physical tasks
- I make sure my family has shelter, clothing, and food on the table
- I'm confused by formal settings like school, or the doctor
- I like hanging out with the family on weekends
- I go to church and have a deep sense of duty for my elders

## What they need.

### Individual.

- Help understanding formal paperwork
- Clear directions to follow relating to personal health issues
- Recommendations that fit my schedule

### From Esperanza.

- Ad-hoc services and appointments
- Quick stops during lunch or weekends
- Affordable services and minimal paperwork

### From the neighborhood.

- Natural spaces and fresh air
- Places to go on a date with my wife
- Safe spaces and activities to connect to my children
- Places to hang out with my friends

### Pain points.

- "Nothing is wrong with me"
- I struggle to find motivation to get organized
- I can't always find a job in the neighborhood
- I don't have time for anything but work!

### La Neta

*They believe that they should not need support. Their difficulty with accepting their own struggles might lead to difficulty accepting the struggles of their wife and kids. This can cause health issues that go unchecked and passed down generationally.*

*"Meetings and appointments are managed by my wife"*  
*-Saúl, 47*

## How to work with them.

### G Slow and steady wins the race.

Understand that progress will be made in small steps, and outline a path to make incremental progress visible and clear.

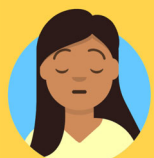
### H State the obvious and be direct.

Be direct! Make outcomes of services and treatment clear and obvious (E.g., smoking will kill you).

### I Reduce the rules and time.

Too much complexity will dissuade them to participate. Make sure there is enough guardrails while maintaining a level of flexibility for participation.

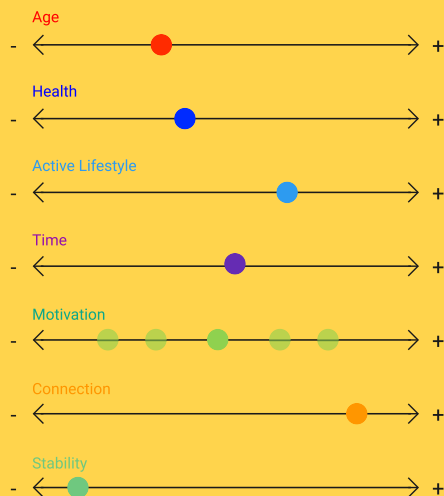
## PERSONA 4



# La Luchona

## Personality Traits: Resourceful, punctual, anxious

I feel like I'm constantly in difficult situations. My partner is unreliable or not present. My schedule revolves around my children. Their wellbeing is my priority but every day I put out fires and rely on my contacts and friends for support. Every day is a challenge but I stay motivated because my children need me.



Duo/.

## Who they are.

### Goals and aspirations.

Luchonas have a high resiliency yet are never fully caught up or recovered before another emergency or obstacle is demanding their attention and priority. They have exhausted local options for social assistance and relies heavily on social services. They're constantly stressed, and work incredibly hard to keep their family afloat. They know they need more organization but feel that they can't get to a point of stability to allow for it.

### Might be seen.

- On Facebook looking for local orgs
- Taking GED or English classes
- Waiting for the bus with children
- On time for her next appointment
- Cooking for her kids after work
- Organizing bills on the fridge
- writing reminders on pieces of paper

### Behaviors.

- I have a network of close friends with whom I share resources
- Based on the season I figure which bills I may need to skip this month
- I keep myself busy to avoid my stress
- I take my kids to school, and as many activities as possible
- I take one day at a time and am afraid of things going wrong
- I am collaborative and understanding but also impatient

## What they need.

### Individual.

- Financial and legal assistance
- Free mental health resources that don't just "end"
- A source of knowledge for work, health, and personal topics

### From Esperanza.

- Practical incentives for attending programs would be much help
- After school programming for my kids
- Guidance on how to sign up for medical insurance

### From the neighborhood.

- Places for kids to learn new things that their schools don't provide
- Safe spaces and places to seek help
- A place to connect to others and feel a sense of community

### Pain points.

- Constant stress is deteriorating my health
- I need legal help because of my husband's absence
- I struggle to keep a job and balance my duties at home due to childcare needs

### La Neta

*Seeking semblance of control, they may feel overly responsible for their difficulties. This may lead them to struggle gaining independence and confidence in their roles, and promote cycles of ever-present crises and comfort prioritizing others rather than themselves.*

*"The cost and fear of not being able to pay keep me from going to the doctor."  
-Adriana, 32*

## How to work with them.

### J Respect their time and trust.

Be efficient with their time. Explain how one thing will help another, but make no guarantees that could break her trust.

### K Help them prioritize themselves.

Go beyond helping them navigate resources by helping them prioritize themselves. Be patient if your support is rejected, they may feel uncomfortable prioritizing themselves.

### L Have empathy.

Have empathy for their situation but do not assume that you know their full story.

## PERSONA 5

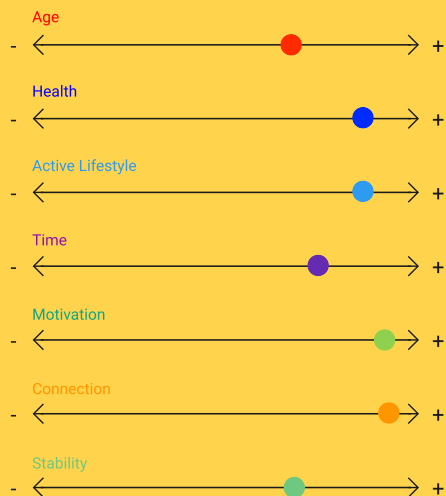


# La "Abogada"

### Personality Traits:

**Advocate, informed, mobilizer**

I am focused on my family but also seek out resources for my network of friends. I make myself available to people. I video call my therapist and help children in my life with school projects. I enjoy my vegetable garden and my flowers in summertime.



**Duo/.**

## Who they are.

### Goals and aspirations.

La "Abogada" is aware of where to get resources but because of that she has high expectations and a lack of trust in new services. She communicates information to and from friends and relatives and is sought out for their knowledge and experience. She wants to make sure her neighborhood receives the services they deserve and participates in community initiatives.

### Might be seen.

- Catching up with people at the laundromat
- Updating Whatsapp groups with links
- Meeting parents at school pickups
- Tending to my plants while chatting with my neighbor
- Joining parent groups at schools
- Going to neighborhood events

### Behaviors.

- I'm not afraid to speak up for myself
- I'm aware of injustice toward Latinx people and will fight for justice
- I leverage resources from local organizations for friends that need it
- I am selective in where I go and send people as not everywhere is welcoming or understands the needs of immigrants
- I'm sensitive to condescending service providers especially if they're Latinx

## What they need.

### Individual.

- A sense of connection to others
- Understanding and organizing my finances
- Parenting guidance as I'm helping raise teenagers

### From Esperanza.

- Multi-lingual and multi-generational service for my family
- Materials I can share with others
- Local events to attend and promote

### From the neighborhood.

- A safe place for my teens to go after school
- Quality leisure services like in other neighborhoods
- Open public spaces, we need safe parks

### Pain points.

- I need time to disconnect and recharge
- There are too many organizations and it's hard to know which is right for me
- I'm afraid of systemic challenges

### La Neta

*They might struggle to see their value outside of the support they bring to their community, given the deep sense of accountability to them. The constant assaults to their communities may be distressing or disheartening.*

*"I'm proud to see Latinx people in leadership roles but disappointed when they don't treat us well"-  
María José, 52*

## How to work with them.

### M Make them "famous."

They are the local *señora influencer* so personal invitations to workshops will be taken as a gesture of trust as you are recognizing their value among others.

### N Encourage Leadership.

They're already advocating for others so giving them the proper tools and training will only motivate them and better equip them.

### O Affirm their knowledge.

If you were to have a suggestion box, they would be leaving pages. When appropriate, ask for their opinion or advice on services.

# Insights

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# Insights.

THEME 1



## El hombre pone, Dios dispone, llega el diablo y todo descomponse.

*We cannot fixate on the future as many outcomes can alter our plans. Present focused mentality.*

Instability is an obstacle to longterm planing and prioritizing health.

### The Individual

Individual instability is both a stressor and a reason why people don't seek services.

### The Place

Perceived cost poses a barrier for residents to access services.

### The Ecosystem

Local businesses thrive under informal and subsistence economy models.

THEME 2



## El que a buen árbol se arrima buena sombra le acobija.

*Central to our wellbeing is the influence and commitment to family where roots and shelter can always be found.*

Family units are the microcosm of cultural knowledge and representation

### The Individual

A significant value is placed on safeguarding health at home.

### The Place

Culturally-informed interactions are key to promote engagement with patients.

### The Ecosystem

The neighborhood creates the need for resourcefulness to find connection.

THEME 3



## No se puede chiflar y comer pinole al mismo tiempo.

*There is an order in which things should be done, doing them all at once can be counterproductive.*

Time, proximity, and convenience are part of the engagement equation.

### The Individual

Prioritizing and coordinating are harder than working.

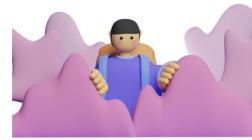
### The Place

Frequency and volume of health visits hinder intended impact of services.

### The Ecosystem

Brighton Park's industrial corridor physically inconveniences residents.

THEME 4



## Solo la cuchara sabe lo que hay en el fondo de la olla.

*Only the spoon knows what's inside the pot (because it's immersed in it).*

Unseen inner dynamics inform outsiders' behaviors and engagement patterns.

### The Individual

Individual experiences and cultural practices form foundations of health.

### The Place

All eyes on Esperanza given its ongoing positive impact and success.

### The Ecosystem

The neighborhood contends with the impact of historic disinvestment.

THEME 5



## Más sabe el diablo por viejo, que por diablo.

*The devil owes his knowledge more to old age than to being the devil.*

Shared and passed-on experiences inform future actions and attitudes.

### The Individual

Knowledge is primarily passed down through the family.

### The Place

Administrative tasks take space from opportunities to connect with patients.

### The Ecosystem

The neighborhood's offerings and shared knowledge guide behaviors.

THEME 6



## Dando y dando, pajarito volando.

*Giving and giving (not taking) let's the birdie fly away.*

Mutually beneficial relationships revolve around trust and shared values.

### The Individual

Residents' relationships with organizations impact access to services.

### The Place

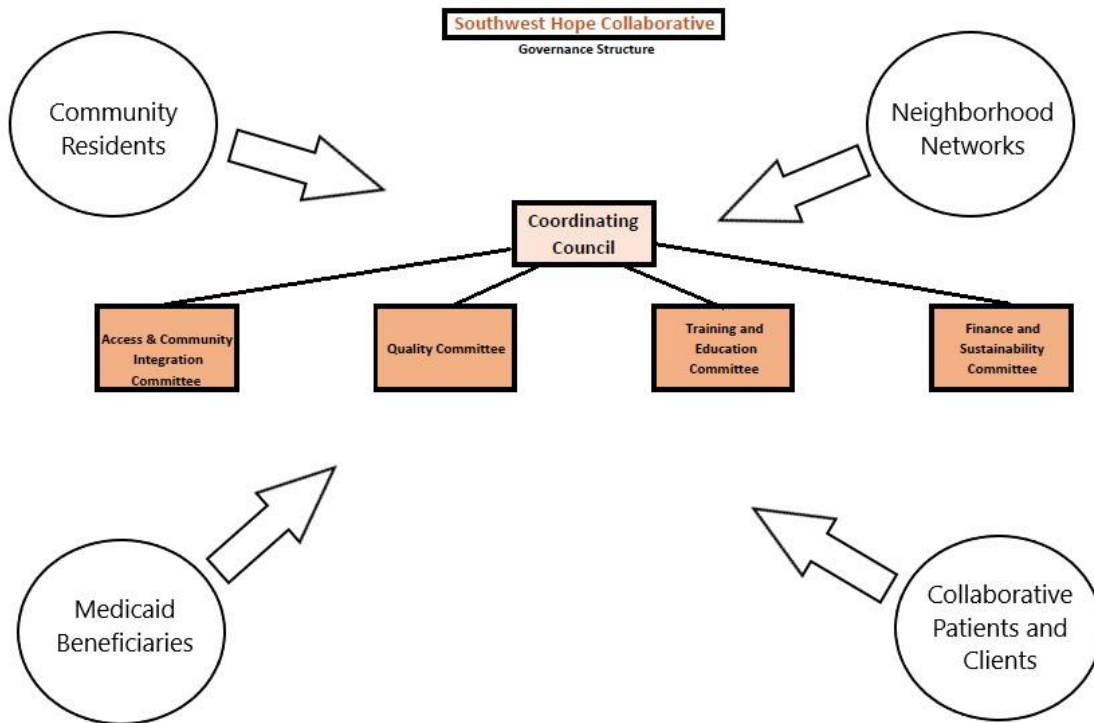
Esperanza's relationships with its stakeholders rely on trust.

### The Ecosystem

Socio-economic forces shape relationships and behaviors.

Duo/.





## Southwest Hope Collaborative

### Project Phases, Milestones and Timeframes

| Project Phases & Milestones                                                                                                                                                                               | Timeframe                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| <b>Project Launch (Year 1, Month 1-3)</b>                                                                                                                                                                 |                               |
| Collaborative Kick Off Meeting                                                                                                                                                                            | Month 1                       |
| Governance meetings commence with Coordinating Council                                                                                                                                                    | Month 1                       |
| Management and support roles hired: <ul style="list-style-type: none"> <li>- Director Collaboration &amp; Integrative Services</li> <li>- Senior Financial Analyst</li> <li>- Clinical Analyst</li> </ul> | Month 1<br>Month 2<br>Month 2 |
| Collaborative operating agreements executed                                                                                                                                                               | Month 2                       |
| CHWs Team Leads Hired                                                                                                                                                                                     | Month 2                       |
| CHWs Hired                                                                                                                                                                                                | Month 3                       |
| Construction design process initiated                                                                                                                                                                     | Month 3                       |
| SDOH pilot subcontracts executed                                                                                                                                                                          | Month 3                       |
| SDOH pilot launch                                                                                                                                                                                         | Month 3                       |
| IT updates & data framework established                                                                                                                                                                   | Month 3                       |
| Integration workflows complete                                                                                                                                                                            | Month 3                       |
| <b>Transformation Foundations (Year 1, Months 4-12)</b>                                                                                                                                                   |                               |
| Initial training of new care team staff completed                                                                                                                                                         | Month 4                       |
| Governance committee meetings commence                                                                                                                                                                    | Month 4                       |
| Construction design complete                                                                                                                                                                              | Month 5                       |
| Construction begins                                                                                                                                                                                       | Month 6                       |
| Care team staff hired: <ul style="list-style-type: none"> <li>- PCPs</li> <li>- Care coordinator</li> <li>- LCSW</li> <li>- Hospital concierges</li> </ul>                                                | Month 6                       |
| Launch community health anchor site at GPLX Council                                                                                                                                                       | Month 6                       |
| Interprofessional curriculum developed                                                                                                                                                                    | Month 12                      |

### **Transformation Growth (Years 2-4)**

- Launch second and third community health anchors
- Expand integrated primary care capacity with additional hiring
- SDOH pilot monitoring
- Launch interprofessional health training program
- Add learning and development coaches to support training application and attainment of health indicator goals
- Population-health interventions
- Monitor health outcomes

### **Transformation Optimization (Year 5 and beyond)**

- Model refinement to achieve highest level of value-based care
- Patient growth
- Health outcomes at established goals
- APM payment structure finalized