Healthcare Transformation Collaboratives Cover Sheet

1. Collaboration Name:

The South Shore Community Behavioral Health System of Care Collaborative (The Collaborative)

2. Name of Lead Entity:

South Shore Hospital

3. List All Collaboration Members:

Chicago Family Health Center
Christian Community Health Center
South Shore Hospital

4. Proposed Coverage Area:

Cook County

5. Area of Focus:

Behavioral Health

6. Total Budget Requested:

$6,156,151.00

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?

South Shore Hospital

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

Entity Name	Primary Contact	Position	Email	Secondary Contact	Secondary Contact Position	Secondary Contact Email
South Shore Hospital	Timothy Caveney	President/CEO	tcaveney@sshcorp.org	Leslie Rodgers	Assistant Administrator	lrogers@sshcorp.org
Chicago Family Health Center	Dr. Melissa Duplantis	Chief Behavioral Health Officer	mduplantis@chicagofamilyhealth.org	Barrett Hatches, Ph.D	Chief Executive Officer	bhatches@chicagofamilyhealth.org
Christian Community Health Center	Lee Madigan	Development Manager	lmadigan@cchc1.org	Melody Chase DNP, RN	Chief Nursing Officer	mchase@cchc1.org

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

☒Yes

☐No

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

Chicago Family Health Center and Christian Community Health

2. Are there any specialty care providers in your collaborative?

☒Yes

☐No

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

South Shore Hospital

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

☒Yes

☐No

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

South Shore Hospital

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

☐YouthCare

☒Blue Cross Blue Shield Community Health Plan

☒CountyCare Health Plan (Cook County only)

☒IlliniCare Health

☒Meridian Health Plan (Former Youth in Care Only)
☒Molina Healthcare

3F. Are there any other hospital providers in your collaborative?
☐Yes
☒No

4. Are there any mental health providers in your collaborative?
☒Yes
☐No

4A. Please enter the names of entities that provide mental health services in your collaborative.
South Shore Hospital, Christian Community Health Center, Chicago Family Health Center

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

5A. Please enter the names of entities that provide substance abuse disorder services in your collaborative.
South Shore Hospital, Christian Community Health Center, Chicago Family Health Center

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

6A. Please enter the names of entities that provide social determinants of health services in your collaborative.
Christian Community Health Center, Chicago Family Health Center

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

7A. Please list the names of the safety net and/or critical access hospitals in your collaborative.
South Shore 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 that are majorly controlled and managed by minorities?
☒Yes
☐No

8A. Please list the names of the entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that that are majorly controlled and managed by minorities.
South Shore Hospital: For all capital purchases, we will be working on identifying BEP vendors.

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

South Shore Hospital, Chicago Family Health Center, and Christian Community Health Center

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

☐Safety Net Hospital Partnerships to Address Health Disparities

☐Safety Net plus Larger Hospital Partnerships to Increase Specialty Care

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

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

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

☐Workforce Development and Diversity Inclusion Collaborations

☐Other

2. Project Description

Brief Project Description

1. Provide an official name for your collaboration.

The South Shore Community Behavioral Health System of Care Collaborative (The Collaborative) represents a partnership between South Shore Hospital, Chicago Family Health Center and Christian Community Health Center.

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

The South Shore Community Behavioral Health System of Care Collaborative (The Collaborative) represents a partnership between South Shore Hospital, Chicago Family Health Center and Christian Community Health Center. The Collaborative transformation project goals include improved outcomes for individuals with co-occurring behavioral health conditions in the areas of penetration in both primary care and outpatient behavioral health, access to acute psychiatric inpatient care for adults between 18 and 64 years of age within the South Shore community, and improved transitions and engagement in outpatient follow-up after psychiatric hospitalization. The Collaborative intends to achieve these outcomes through improved linkage and coordination of care between South Shore providers when level of care needs change, and expanded access to both inpatient and outpatient behavioral health and social support services to strengthen social factors impacting a person's health.

Detailed Project Description

Provide your narrative here:

South Shore Community Behavioral Health System of Care Collaborative Overview

The South Shore Community Behavioral Health System of Care Collaborative (The Collaborative) ensures that individuals in need of behavioral health services have access to treatment at the level of care to meet those needs, including both outpatient and inpatient care. In addition, The Collaborative recognizes the importance of engagement in primary care to ensure optimization of an individual's whole health. Therefore, our project also concentrates resources on ensuring enhanced care transitions between levels of behavioral health care through coordination with, and access to, integrated primary and behavioral health care. In support of these project goals, The Collaborative represents a partnership between South Shore Hospital, Chicago Family Health Center and Christian Community Health Center. Working together, The Collaborative has designed a patient-driven and joint approach to serve people living in the South Side of Chicago who are in need of behavioral health services and supports. In partnership, The Collaborative, with the robust input of community stakeholders, creates strong access and linkage across the continuum of community-based and inpatient health care settings. To close gaps in access to services on the South Side, South Shore Hospital will expand the capacity of adult in-patient psychiatric beds for adults 18-64 years old and develop a long-term plan to build out South Shore's capacity to provide outpatient behavioral health and substance-use disorder services. In addition, The Collaborative will increase screening and linkage to services to address social needs that impact an individuals' health care engagement and subsequent outcomes. FQHC partners will leverage existing relationships with community-based partners, to aid in providing linkage to resources to address these social needs for individuals served.

The Collaborative is focused on serving the areas in the following zip codes: 60628, 60617, 60619, 60649, 60621, 60620, 60636, 60637. These service areas include a population experiencing barriers to accessing healthcare. Further, in addition to experiencing common obstacles and challenges, this community is also disproportionally affected by racial and health disparities. To address these challenges head-on, The Collaborative's goals are to increase access to primary care and behavioral health care in an effort to mitigate healthcare barriers. This will ultimately garner a healthier

population and encourage those who were unable to access health care to gain autonomy in pursuing needed medical care.

The data that was released on November 3, 2021 by HFS, clearly indicated that there is a strong need for stronger linkages post-release from inpatient stays, in addition, the synthesized finding indicate that the objectives that should guide this work are to, 1) Incentivize clinic-community linkages; 2) Promote collaborative care models; 3) Build capacity for clinic-community linkages; 4) Promote care engagement and 5) Reduce Barriers to Care. The Collaborative seeks to address all five of these objectives in this proposal. And seeks to ensure that the significant gap of resources for behavioral health services in the South Side of Chicago will be enhanced and improved through this work. Exhibit 02.01 displays relevant data extracted from the dataset. The extracted information shows South Chicago appears to have the poorest scores for most indicators.

Exhibit 02.01

The major point of the report is highlighted in the following statement:

2: Examined the most frequent and resource-intensive diseases driving Medicaid enrollee hospitalizations in the 5 study areas and discovered a set of disease groups and conditions for which access to quality outpatient care can prevent the need for hospitalization.

Document Location: Page 20

The following sections were specifically focused on study findings related to behavioral health:

hypertensive diseases (see Table 4).

Frequency by Hospital Readmissions: Readmissions within the same disease block were the most common occurrence, compared to early readmissions and lengthy hospital stays. In South Chicago, the 2 disease groups comprising the greatest percentage of readmissions and resource intensive hospitalizations were mental illnesses (mainly mood [affective] disorders and schizophrenia) and substance use disorders. A third grouping from among the largest remaining contributors to readmissions and resource use was organized around a set of chronic illnesses

Document Location: Page 25

3: Investigated levels of outpatient care for patients hospitalized with the identified disease groups and conditions and found low levels of outpatient care, both before and after hospitalization, indicating a crucial lack of access to outpatient care.

Since all of the selected disease groups and conditions can be managed with appropriate outpatient care, an analysis was done to understand outpatient care utilization among Medicaid enrollees who had received hospital-level care (ED visits or inpatient hospitalizations) for these disease groups.

(Note: Outpatient care encounters sit in both the institutional data [outpatient care encounters within hospital/medical center system] and the noninstitutional data [outpatient care encounters with independent healthcare providers]. Encounters from both these data sets were combined for this analysis and all outpatient encounters were used, whether related to the hospitalization diagnosis or not. The results presented in Figures 8–10 can thus be considered a conservatively generous estimate of outpatient care for those with selected and preventable inpatient admissions or ED visits.)

To look for outpatient care evidence prior to hospital-level care, patients who had an initial hospitalization or ED visit for mental disorders, substance use disorders or ACSCs in the last 3 quarters of FY2018 (10/01/2017 to 06/30/2018) were identified. The proportion of these patients who had outpatient care encounters within 3 months *prior* to their hospital admission date or ED visit was then tabulated.

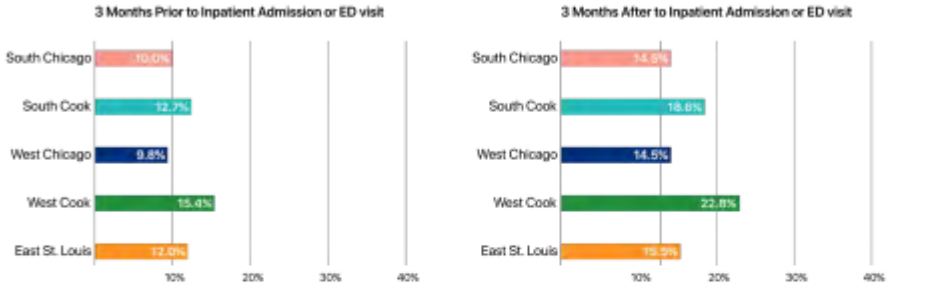
To look for outpatient care evidence subsequent to hospital-level care, patients who had an initial hospitalization or ED visit for mental disorders, substance use disorders or ACSCs in the *first* 3 quarters of FY2018 (07/01/2017 to 03/31/18) were identified. The proportion of these patients who had outpatient care encounters within 3 months *after* their hospital admission date or ED visit was then tabulated.

The result of this analysis shows that *outpatient care prior to or subsequent to hospital-level care is proportionally low in all key disease groups and conditions*, indicating that many patients who were hospitalized for these diseases or disorders did not engage in outpatient care to manage their conditions (see Figures 8–10).

Prior or Subsequent Outpatient Care for Mental Disorder Hospitalizations: For Medicaid patients in the South Chicago area who went to the ED or were hospitalized for mental disorders, only 10.0% received outpatient care within 3 months prior to hospital-level care and only 14.5% received outpatient care within 3 months after hospital-level care (see Figure 8). This second figure, outpatient care within 3 months after hospital-level care, falls well below the national Medicaid benchmark of 56% of discharges receiving follow-up care within 30 days after a hospitalization for mental illness (14, 15).

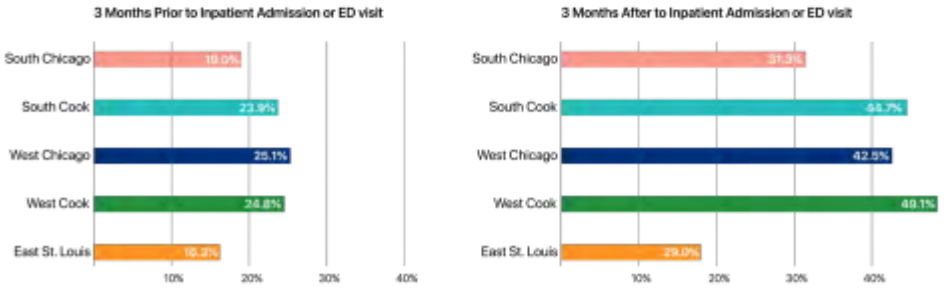
Prior or Subsequent Outpatient Care for Psychoactive Substance Use Disorders Hospitalizations: In comparison to all other study areas, South Chicago was second only to East St. Louis in terms substance use disorder patients who received prior or subsequent outpatient care, with only 19.0%

Figure 8: Proportion of Prior and Subsequent Outpatient Care among Patients Who Received Hospital-Level Care for Mental Disorders



Included in this analysis are ICD-10 principal diagnosis codes from Chapter 5 in the CMS Tabular List of Diseases and Injury, excluding ICD-10s for substance use disorders.

Figure 9: Proportion of Prior and Subsequent Outpatient Care among Patients Who Received Hospital-Level Care for Psychoactive Substance Use Disorders



Included in this analysis are ICD-10 principal diagnosis codes from Chapter 5 in the CMS Tabular List of Diseases and Injury, for the "Mental and behavioral disorders due to psychoactive substance use" disease block.

Document Location: Page 28, Page 30

4: Engaged community members from socially vulnerable areas in conversations and identified barriers to outpatient care, disease prevention and treatment adherence.

The findings above demonstrate that proportionally few of the patients who received hospital-level care for the most frequent and resource-intensive conditions also received outpatient care either before or after hospitalization or an ED visit. These low levels of outpatient care point to the need for resources in communities to help manage bipolar, depressive, alcohol use, and opioid use disorders as well as the most common ACSCs. Recognizing that healthcare data can reveal what is happening, but not explain why, a parallel qualitative study was conducted to understand social factors that contribute to high rates of utilization.

57 community input sessions were held with 252 residents of the Chicago's South and West sides, in South Cook County and in the East St. Louis Metro Area between June and November 2020 (see Figure 17–18). Community residents were recruited from the most distressed zip codes in each study area. In South Chicago, residents were recruited from these zip codes (see Appendix D for information on how zip codes were selected):

- 60621 (Englewood Area)
- 60636 (West Englewood Area)
- 60628 (Roseland and Pullman Areas)
- 60619 (Avalon Park and Greater Grand Crossing Areas)
- 60649 (South Shore Area)

During community input sessions, residents engaged in structured conversations to understand challenges that they face across a simple "healthcare journey" consisting of: staying healthy; recognizing a healthcare need and deciding to get care; arranging and getting to care; receiving care; and managing a condition over time (for those with ongoing health issues). Community residents spoke of multiple barriers (or social determinants) that they face at each point in the healthcare journey. *These community-identified barriers vividly demonstrate the "why" behind the low rates of outpatient-care engagement and high rates of hospitalization for key diseases identified in the quantitative data.* Table 6 lists these barriers.

A summary of findings for each type of social determinant barrier follows. Before moving on to these findings, it's important to note the cumulative impact that these barriers have on residents in communities with high social vulnerability. When people decide to seek care, they make an implicit cost-benefit analysis, trading off time, money and trouble against the value they expect to gain from care. The barriers voiced by community residents tip the balance toward the costs of seeking care and away from the value of getting healthcare. In other words, resident stories about healthcare barriers demonstrate that the cost-benefit calculus applied in deciding whether to seek care would produce a substantially different result if these residents resided in areas with lower social vulnerability.

Document Location: Page 36

Table 6: Community-Defined Barriers to Staying Healthy and Accessing Care

BARRIERS BY SOCIAL DETERMINANTS OF HEALTH	Staying healthy	Recognizing a health need and deciding to get care	Arranging and getting to care	Receiving care (point of service)	
Knowledge & Information (i.e., health literacy barriers – the lack of awareness, information and skills needed to care for one's health and navigate health services)	• Lack of factual and trustworthy health information	• Lack of knowledge of signs and symptoms of prevalent health conditions • Lack of knowledge of what is covered or not covered in insurance plan • Fear about getting healthcare as a result of the lack of knowledge or information (i.e., fear due to unknown costs involved, fear of bad diagnoses, etc.)	• Lack of awareness of healthcare services within community • Lack of awareness of where to seek care that fits one's needs	• Difficulty understanding technical medical terms and physician instructions	• Difficulty personal c • Lack of k manage co
Economic (i.e., inability to access activities, programs, and services due to the associated costs)	• Lack of time for self-care (i.e., exercise, preparing healthy food, preventative care, etc.) • Inability to afford healthy food • Unemployment or economic instability • Housing instability	• Inability to afford health insurance • Inability to afford out-of-pocket care costs (e.g., co-pays) • Inability to afford time off work to seek care	• Lack of insurance or under-insured • Inability to afford transportation	• Inability to afford out-of-pocket care costs (for example, co-pays)	• Inability t equipment
Healthcare Service (i.e., barriers that impede equitable access to, and engagement with, healthcare services)	• Lack of preventive screening or programming in the community	• Previous negative healthcare experience • Fear of going to healthcare facilities due to COVID-19	• Poor quality of local healthcare facilities (self-reported) • Long wait times for appointments • Scarcity of local healthcare facilities (lack of, or limited options due what health insurance is accepted) • COVID-19 closures or reduced appointments	• Long wait times at the point of care • Service quality disparities • "Transactional" experiences with providers (e.g., short facetime, bias towards medication, etc.) • Lack of trained, culturally competent providers • Discrimination due to race, socio-economic status or insurance status (i.e., having Medicaid for insurance) • Care that doesn't fit cultural context (e.g., language and behavioral norms)	• Lack of c manage co
Socio-Cultural (i.e., individual or collective attitudes and beliefs that impact one's ability to maintain health and engage in healthcare)	• Culturally ingrained food and cooking habits	• Hesitancy to seek care (due to historic healthcare system mistrust, cultural issues, immigration status, fear of doctors, stigma, or previous bad experience) • Concealing health issues from family and friends			• Social isc • Strain on physical, e
Environmental (i.e., resource, service, context and infrastructure obstacles in the community that limit one's ability to maintain health and engage in healthcare)	• Lack of resources (i.e., food, recreation, transportation, walking infrastructure, etc.) • Poor air quality due to local polluters • Presence of unhealthy foods • Prevalence of drugs and alcohol in communities • Exposure to ongoing crime, street violence, domestic abuse, neglect and/or discrimination		• Insufficient transportation options		• Lack of re portation, v • Poor air q • Presence • Prevalenc • Exposure domestic a

Note: Community residents spoke of structural inequities such as resource access (including health
generational disinvestment, unethical scientific experimentation, racism, and discrimination based o
contributors to health in their communities. Community residents described these inequities as a ca

Document Location: Page 39

6: Synthesized findings from the data analyses and the community conversations to define transformation opportunities for stimulating outpatient care access and reducing the social barriers to this care and treatment adherence.

What emerges from the combination of the analysis of hospital utilization data, the inventory of concerns expressed by residents in community conversations, and the surveys of available resources is strong indication of a need to improve accessibility to quality primary and specialty care and, in parallel, to address the social determinant of health barriers that make it difficult to prevent disease, access care and adhere to treatment. Doing so will require healthcare systems in South Chicago to reach out beyond the walls of their hospitals and into communities. It will also require community residents in South Chicago to become more engaged in their health and healthcare. In other words, the effort will entail finding a middle ground where healthcare systems and communities work together to prevent disease and promote outpatient care engagement.

To this end, the combined analysis suggests that transformation efforts need to concentrate on *clinic-community linkages* that provide primary and secondary care and community-based wraparound services to help people manage chronic illnesses, mental illnesses, and substance use disorders. Clinic-community linkages leverage the treatment expertise of healthcare systems, the on-the-ground knowledge of community-based organizations, and the trust that residents have in those organizations to support an active approach to chronic disease management, to restore trust in the healthcare system in socially vulnerable communities and increase engagement in healthcare.

Recommended objectives to guide future efforts and interventions toward achieving transformation are:

1. **Incentivize clinic-community linkages** in order to address health, healthcare access, and the social determinants of health.
2. **Promote collaborative care models** for chronic illnesses, including mental illnesses and substance use disorders (for example, health homes and coordinated care models).
3. **Build capacity** for clinic-community linkages and collaborative, relationship-based care models.
4. **Promote care engagement.**
5. Continuously groom clinic-community linkage services to **reduce and eliminate barriers to care.**

There are 2 important issues to note regarding these objectives. First, in regards to care engagement, there are 2 main opportunities to engage people in care: at ED and hospital discharge moments and engaging people in the community who have chronic illnesses, mental illnesses, or substance use disorder (or risk factors for these) well before an emergency. ED and hospital discharge moments represent a key opportunity, given that people have engaged in some form of healthcare. Engaging people out in the community who have not been regularly engaged in care is a second, and in many ways, more complex task. Outreach efforts to do so need to be accompanied by ongoing

efforts to make outpatient care accessible, available, and affordable.

Second, it's important to note that some communities are structurally disadvantaged from benefitting from the transformation model proposed here. Decades-long disinvestment, particularly in predominantly Black communities, has resulted in a lack of basic healthcare infrastructure including facilities that accept Medicaid. This situation means that any transformation activities will need to also include substantive investments to put healthcare structures in place before interventions can be piloted.

(Note: Table 8 is a list of evidence-based examples of interventions that exemplify one or more of the recommended objectives.)

Task-Shifting for Interpersonal Counseling for Depression in Low-Income Areas

Intervention site: São Paulo, Brazil
Target population: *Low-income patients with a current major depressive disorder or dysthymia*
Dates: May 2013 to April 2015

Challenge	Intervention	Outcomes	Addresses	Intervention an example of:
The WHO ranks major depressive disorder (MDD) as one of the most significant challenges of the 21st century because of its consequent disability and loss of function. MDD can be treated early and effectively in primary care but it is often underdiagnosed and under-treated. This mental health treatment gap is more pronounced in low and middle-income areas.	Non-specialist community health workers were trained to provide Interpersonal Counseling (IPC) to treat depressive symptoms in patients receiving treatment at a family health center in São Paulo, Brazil.	Patients receiving the IPC from community health workers showed significant improvement in symptoms. Training non-specialist community health workers in low- and middle-income areas to provide IPC can be a successful strategy for reducing the burden of depression and potentially a low-cost and effective alternative to specialist-led services which might not be available in low- income communities.	☐ ACSCs ☑ Mental Illness ☐ SUD ☐ Condition Agnostic	☐ Clinic-Community Linkage (CCL) ☐ Integrated, coordinated or collaborative care ☑ Capacity building for CCL, coordinated care or other care ☐ Engagement in care (ED/ hospital discharge) ☐ Engagement in care (outside HC system) ☐ Barrier reduction/ elimination

Araya, Ricardo, et al., "Treating depression in primary care in low-income women in Santiago, Chile: a randomised controlled trial." The Lancet 361.9362 (2003): 995–1000.

CA Bridge Model: Developing Hospitals and Emergency Rooms into Primary Care Access Points for Addiction Treatment

Intervention site: 53 hospitals in California
Target population: Patients who present to the ED with Substance Use Disorder
Dates: N/A - currently implemented and operating

Challenge	Intervention	Outcomes	Addresses	Intervention an example of:
Despite evidence that buprenorphine is associated with decreased illicit opioid usage, improved adherence to addiction treatment programs, and cost-savings, 60–80% of people who use opioids do not have access to these medications. Since EDs and hospitals provide 24/7 access to healthcare, they offer a unique opportunity to make treatment for SUD universally accessible. At present, many hospitals do not offer this service.	The CA Bridge model is based on 3 pillars: 1. Provide quick start, low-barrier access to evidence-based medication for addiction treatment for substance use disorder in all hospital departments. 2. Establish pathways to link patients to outpatient care through active support and follow-up. 3. Create a welcoming, non-stigmatizing hospital culture for people who use drugs.	Reduction in the number of emergency department visits from high utilizers who present to the ED with SUD Reduction of SUD-related hospital care Reduction in number and length of psychiatric holds in the ED for patients with co-occurring mental illness and SUD Decreased illicit opioid usage and improved adherence to addiction treatment programs Cost savings (in one study, healthcare savings were $2,074 per patient per year for an intervention group of Medicaid enrollees)	☐ ACSCs ☐ Mental Illness ☑ SUD ☐ Condition Agnostic	☐ Clinic-Community Linkage (CCL) ☐ Integrated, coordinated or collaborative care ☐ Capacity building for CCL, coordinated care or other care ☑ Engagement in care (ED/ hospital discharge) ☐ Engagement in care (outside HC system) ☐ Barrier reduction/ elimination

https://www.bridgetotreatment.org/cabridgeprogram

See also: Busch, Susan H., et al. "Cost effectiveness of emergency department initiated treatment for opioid dependence." Addiction 112.11 (2017): 2002–2010.

Document Location: Page 54 -57

5: Reviewed healthcare resources in the 5 study areas and found gaps that could contribute to greater incidence of hospitalization for key disease groups and conditions.

An examination of Health Resource and Services Administration (HRSA) healthcare shortage area data revealed resource gaps that may contribute to lower rates of engagement with outpatient care and higher rates of hospitalization for mental illnesses, substance use disorders, and ACSCs. More specifically, this examination found that parts of South Chicago and the other study areas have primary care shortages and mental health professional shortages.

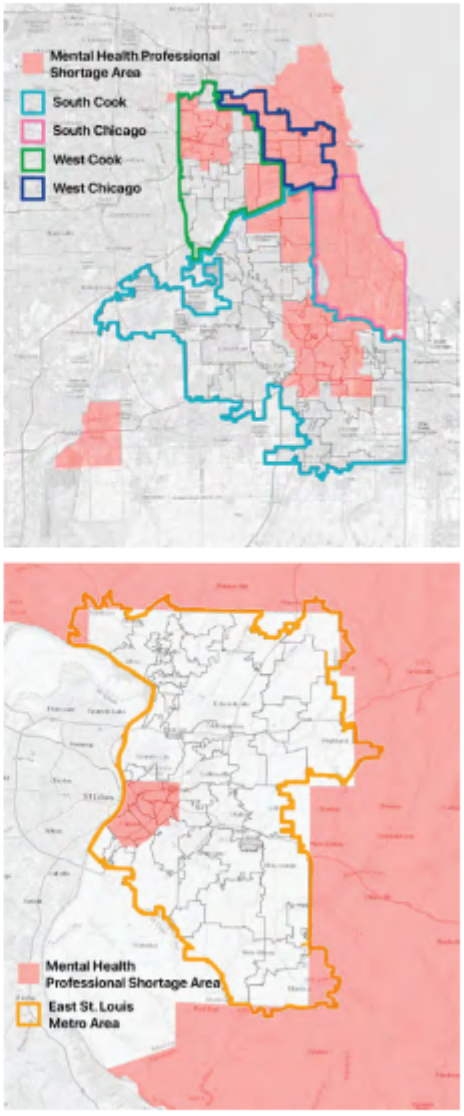
Resource Gaps: Mental Illness and Substance Use Disorders

HRSA provides indices of healthcare resources availability for both primary care and for mental health professionals. HRSA data were reviewed and translated into maps that indicate areas within the 5 study areas where mental health professional shortages exist. HRSA defines mental healthcare shortage areas as either a shortage of providers for the entire population within a defined geographic area or a shortage of providers for a specific population group(s) within a defined geographic area (for example, low income, migrant farmworkers, and other groups). Nearly all of South Chicago is designated as a mental health professional shortage area (see Figure 19).

Resource Gaps: Ambulatory Care Sensitive Conditions

Access to primary care is a key component of preventing and managing a variety of ambulatory care sensitive conditions. A

Figure 19: HSRA Mental Health Professional Shortage Areas

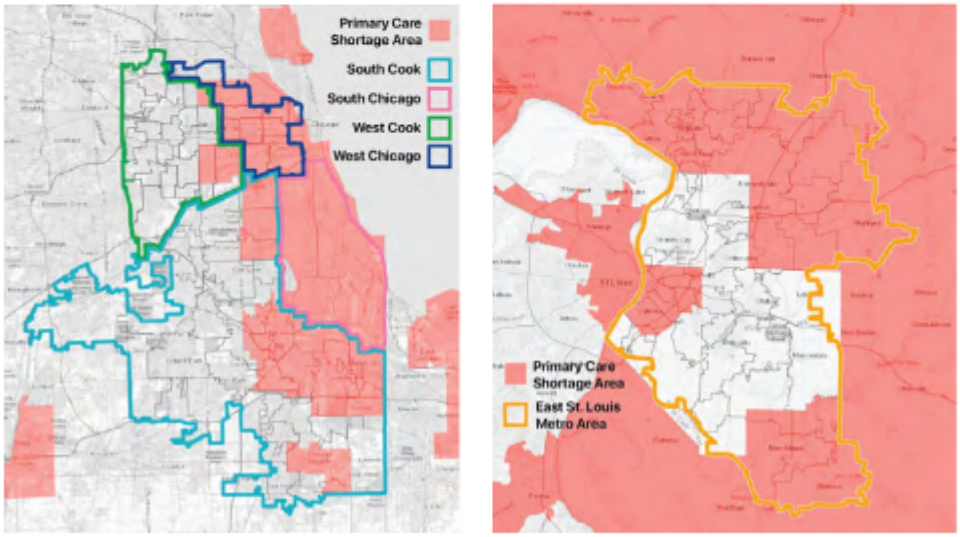


review of HRSA's primary care shortage data shows that portions of South Chicago and the other 4 study areas have primary care shortages (see Figure 19). HRSA defines primary care shortage areas as having either a shortage of providers for the entire population within a defined geographic area or a shortage of providers for a specific population group(s) within a defined geographic area (for example, low income, migrant farmworkers, and other groups).

In addition to primary care shortages, food access was analyzed, given that diabetes, hypertension and heart disease are diet-related ACSCs, and because food access did not factor into community selection for this study (for example, food is not considered in the calculation of social vulnerability scores). Portions of South Chicago are food deserts as defined and identified by the USDA (see Figure 21).

The USDA defines a rural area food desert as census tracts in which a significant number (at least 500 people) or a significant share (at least 33% of the population) lives greater than 10 miles from the nearest supermarket, supercenter, or large grocery store. Lack of access to a full-service grocery store in South Chicago may be a contributing factor to ACSCs in the area.

Figure 20: HSRA Primary Care Shortage Areas in Study Areas



Document Location: Page 51-52

Appendix B:

Additional Analyses and Community Input for Select Disease Groups and Conditions

Bipolar and Depressive Disorders

After identifying the key disease groups and conditions (mental illness, psychoactive substance use disorders and ACSCs), the data analytics team conducted additional analyses to develop a fuller understanding of these conditions. In addition, the team isolated community input information about barriers to mental illness prevention and care.

For mental illness analyses, the research team focused on bipolar and depressive disorders for 2 reasons. First, these disorders represented the bulk of the mood [affective] disorders block, which was the most frequent and resource intensive of the disease blocks in the hospital utilization data. Second, these disorders are responsive to outpatient care treatment that can keep people healthy and out of the hospital.

The data analytics team looked at the frequency distribution of hospitalizations for these disorders across study areas (see Figure 29).

Figure 29: Proportion of Hospitalizations for Depressive Disorders, Bipolar Disorders and Other ICD-10s[1] within the Mood [Affective] Disorders Block across Study Areas

[1] Depression in the above charts includes all "depressive disorder" ICD-10s in the mood [affective] disorders block. Bipolar includes all ICD-10s labeled "bipolar." The "other" category includes cyclothymic disorder, dysthymic disorder, manic episodes with and without psychotic symptoms, persistent mood [affective] disorders, and unspecified mood [affective] disorders.

Multivariate logistic regressions were performed to determine the population characteristics most associated with patients with bipolar and depressive disorders. Significant interaction between age and race groups for bipolar and depressive disorder diagnoses was observed. To minimize this interaction, 3 age categories (12–19, 20–40, >40) were created and separate analyses performed for each age group.

Tables 9 and 10 contain the results of the logistic regressions. Variables highlighted in red represent a population characteristic statistically associated with the diagnosis (meaning the odds ratio and confidence level lower limit are ≥ 1 and the p-value is < 0.05).

Summary of Population Characteristics Most Associated with Patients with Bipolar and Depressive Disorders

Bipolar Disorders:

- Black and white youth (male or female), ages 12–19
- Black and white males, ages 20–40
- Black and white males over ages 40

Depressive Disorders:

- White females, ages 12–19
- White males, ages 20–40
- White males, over age 40, particularly in West Chicago

Table 9: Population Characteristics Associated with Depressive Disorder Patients

Depressive Disorders		Confidence Interval			
	Odds Ratio	Lower Limit	Upper Limit	P-Value	Reference Groups
Age Group: 12 to 19					
Black	0.87	0.79	0.96	0.0039	vs. Other/Unknown
White	1.26	1.15	1.38	<.0001	
Male[1]	0.51	0.47	0.55	<.0001	vs. Female
East St. Louis	0.59	0.52	0.68	<.0001	vs. West Cook
South Chicago	0.70	0.63	0.79	<.0001	
South Cook	0.63	0.55	0.71	<.0001	
West Chicago	0.73	0.65	0.82	<.0001	
Age Group: 20 to 40					
Black	0.83	0.75	0.92	0.0003	vs. Other/Unknown
White	1.59	1.43	1.77	<.0001	
Male	1.97	1.84	2.10	<.0001	vs. Female
East St. Louis	0.79	0.70	0.89	0.0001	vs. West Cook
South Chicago	0.73	0.65	0.82	<.0001	
South Cook	0.82	0.73	0.92	0.0005	
West Chicago	0.89	0.80	1.00	0.0411	
Age Group: Over 40					
Black	1.07	0.97	1.19	0.1628	vs. Other/Unknown
White	1.63	1.47	1.81	<.0001	
Male	1.17	1.10	1.24	<.0001	vs. Female
East St. Louis	0.87	0.77	0.99	0.0285	vs. West Cook
South Chicago	0.92	0.82	1.03	0.1367	
South Cook	0.69	0.61	0.78	<.0001	
West Chicago	1.45	1.31	1.62	<.0001	

[1] Low odds ratio for males in the 12 to 19 group means that females of this age range are associated with depressive disorders.

Table 10: Population Characteristics Associated with Bipolar Disorder Patients

Bipolar Disorders		Confidence Interval			
	Odds Ratio	Lower Limit	Upper Limit	P-Value	Reference Groups
Age Group: 12 to 19					
Black	1.59	1.37	1.85	<.0001	vs. Other/Unknown
White	1.29	1.08	1.53	0.0048	
Male	0.93	0.82	1.07	0.3145	vs. Female
East St. Louis	0.57	0.43	0.75	<.0001	vs. West Cook
South Chicago	0.74	0.60	0.92	0.0056	
South Cook	1.16	0.94	1.43	0.1722	
West Chicago	0.61	0.48	0.77	<.0001	
Age Group: 20 to 40					
Black	1.14	1.00	1.30	0.0471	vs. Other/Unknown
White	1.66	1.45	1.90	<.0001	
Male	2.80	2.59	3.03	<.0001	vs. Female
East St. Louis	0.56	0.48	0.67	<.0001	vs. West Cook
South Chicago	0.93	0.81	1.07	0.3013	
South Cook	1.00	0.87	1.15	9.7804	
West Chicago	0.99	0.86	1.15	0.9241	
Age Group: Over 40					
Black	1.52	1.31	1.76	<.0001	vs. Other/Unknown
White	1.89	1.63	2.21	<.0001	
Male	1.60	1.47	1.74	<.0001	vs. Female
East St. Louis	0.68	0.56	0.81	<.0001	vs. West Cook
South Chicago	1.08	0.93	1.26	0.3364	
South Cook	0.87	0.73	1.02	0.0860	
West Chicago	1.37	1.18	1.59	5.7214	

From Community Input: Barriers Specific to Mental Illness

In community input sessions, residents described specific barriers related to preventing and managing mental illness. Barriers specific to preventing and getting treatment for mental illness included lack of knowledge and coping mechanisms related to signs and symptoms, social stigma, lack of relevant and adequate resources, and strain on the social support system.

Lack of knowledge and coping mechanisms related to signs and symptoms of mental illness: Residents spoke of traumatic stress experienced in their communities due to street violence, domestic abuse, childhood abuse, unemployment, and racial discrimination. Many participants linked trauma to mental illness and recounted personal stories of untreated symptoms due to not knowing what to look for and social stigma associated with labeling a need and seeking help. In these conversations, mental illness was conceived of in narrow terms, characterized as a person experiencing psychosis without reference to behavioral health issues like mood swings, anxiety, and disordered eating/sleeping.

Social stigma associated with mental illness: Latinx and Black residents described social stigma surrounding mental illness in their communities and spoke of it being internalized and perpetuated within the families. Residents of Little Village in West Chicago cited a culture of "machismo" in the predominantly Mexican community as a factor that keeps male residents from acknowledging the need for help or seeking it out. Several church-going residents described the tendency to "pray about it" rather than seek professional support. A pastor from that same community talked about advocating for professional psychological intervention rather than turning solely to "faith" or "prayer."

Racial discrimination when seeking care for mental illness: Residents with mental illness described experiencing racial discrimination from healthcare professionals. Several shared stories of attempts to seek medical support that resulted in arrest.

Lack of adequate and appropriate resources: Residents spoke of the lack of community-based, culturally and linguistically relevant mental health resources especially for those with public insurance. They described it taking a long time to book an appointment at mental health facilities and upon arrival at the facilities, experiencing long wait times before being seen. Perceptions based on these experiences was that the quality of care was sub-adequate. Black residents described a marked service quality disparity between healthcare facilities in Black and white neighborhoods. A repeated recommendation was to build pipelines of therapists and clinicians of color to develop interventions informed by the Black-lived experience and create a foundation for trusting, therapeutic relationships.

Strain on support system: Caring for a loved one with unmanaged advanced mental illness is emotionally exhausting. Caregivers sometimes don't know where to seek help or fear that seeking help will lead to an interaction with the criminal justice system. Multiple conversations included community residents who have family members living with bipolar disorder. They are often frustrated and feel helpless due to an inability to meaningfully intervene through cycles of hospitalization and denial.

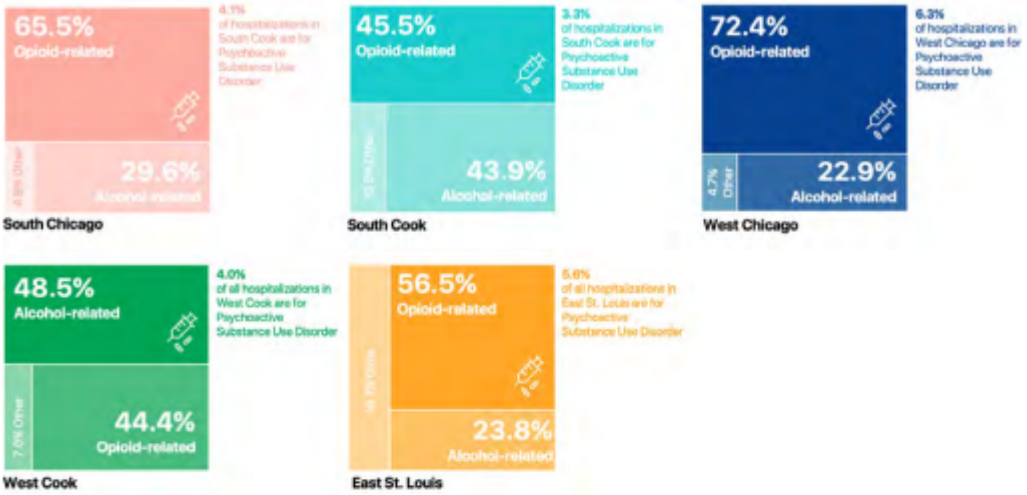
Overall, residents expressed a need to normalize conversations about mental health supported not only by education about available early intervention resources in the community but also by guidance for families, law enforcement, and the community at large on how to handle people when they are having a mental health crisis.

Alcohol and Opioid Use Disorders

For psychoactive substance use disorder analyses, the research team focused on alcohol and opioid use disorders since these represented the majority of the disorders in the psychoactive substance use disorders block and are outpatient-treatable.

The data analytics team looked at the frequency distribution of hospitalizations for these disorders across study areas (see Figure 30).

Figure 30: Proportion of Hospitalizations for Alcohol Use Disorders, Opioid Use Disorders and Other ICD-10s within the Psychoactive Substance Use Disorders Block across Study Areas



(Note: "Other" psychoactive substance use disorders include those for cannabis, cocaine, hallucinogens, sedatives and other psychoactive substances or stimulants.)

Multivariate logistic regressions were done to determine the population characteristics most associated with patients with alcohol and opioid use disorders. Analysts observed significant interaction between age and race groups for alcohol and opioid use disorders diagnoses. To minimize this interaction, 3 age categories (12–19, 20–40, >40) were created and separate analyses performed for each age group.

Tables 11 and 12 contain the results of the logistic regressions. Variables highlighted in red represent a population characteristic statistically associated with the diagnosis (meaning the odds ratio and confidence level lower limit are ≥ 1 and the p-value is < 0.05).

Summary of Population Characteristics Most Associated with Patients with Alcohol and Opioid Use Disorders

Alcohol Use Disorders:

- White youth (male or female), ages 12–19
- Black and white males, ages 20–40
- Black and white males, over age 40

Opioid Use Disorders:

- White males, ages 20–40, particularly in East St. Louis Metro, West Chicago, and South Cook
- Black and white males over age 40, particularly in West and South Chicago

Table 11: Population Characteristics Associated with Alcohol Use Disorder Patients

Alcohol Use Disorders		Confidence Interval		
	Odds Ratio	Lower Limit	Upper Limit	P-Value
Age Group: 12 to 19				
Black	0.98	0.68	1.39	0.9284
White	1.78	1.30	2.43	0.0003
Male	1.16	0.89	1.52	0.2761
East St. Louis	0.51	0.31	0.83	0.0077
South Chicago	0.45	0.30	0.69	0.0002
South Cook	0.75	0.50	1.13	0.1614
West Chicago	0.65	0.43	0.98	0.0399
Age Group: 20 to 40				
Black	1.17	1.03	1.34	0.0169
White	1.73	1.51	1.99	<.0001
Male	4.10	3.78	4.45	<.0001
East St. Louis	0.59	0.50	0.69	<.0001
South Chicago	0.82	0.71	0.94	0.0034
South Cook	0.78	0.68	0.91	0.0009
West Chicago	0.98	0.85	1.12	0.7598
Age Group: Over 40				
Black	1.50	1.34	1.68	<.0001
White	1.95	1.73	2.20	<.0001
Male	4.45	4.14	4.80	<.0001
East St. Louis	0.78	0.68	0.90	0.0006
South Chicago	1.13	1.00	1.27	0.0506
South Cook	1.03	0.91	1.17	0.6619
West Chicago	1.12	0.99	1.27	0.0709

Table 12: Population Characteristics Associated with Opioid Use Disorder Patients[1]

Opioid Use Disorders		Confidence Interval			
	Odds Ratio	Lower Limit	Upper Limit	P-Value	Reference Groups
Age Group: 20 to 40					
Black	0.61	0.50	0.76	<.0001	vs. Other/Unknown
White	3.47	2.88	4.20	<.0001	
Male	4.42	3.97	4.93	<.0001	vs. Female
East St. Louis	1.88	1.56	2.28	<.0001	vs. West Cook
South Chicago	1.06	0.86	1.30	0.5921	
South Cook	1.44	1.18	1.76	0.0003	
West Chicago	1.28	1.05	1.57	0.0164	
Age Group: Over 40					
Black	2.84	2.52	3.21	0.0000	vs. XXXXX
White	1.16	1.00	1.34	0.0456	
Male	3.13	2.92	3.35	0.0000	vs. Female
East St. Louis	0.49	0.40	0.59	0.0000	vs. West Cook
South Chicago	1.26	1.10	1.45	0.0013	
South Cook	0.55	0.46	0.65	0.0000	
West Chicago	2.50	2.18	2.88	0.0000	

[1] Since there were few instances of care encounters for opioid use disorder among patients 12–19 years of age, no associations could be determined for this particular age group.

From Community Input: Conditions and Barriers Specific to Substance Use Disorders

In community input sessions, residents described conditions and barriers related to preventing and managing substance use disorders. Residents referenced general conditions that make communities more vulnerable to substance use disorders, including the omnipresence of drugs and users in communities, high rates of unemployment and a lack of resources for extra-curricular activities, opportunities for personal growth, and professional advancement. Additionally, a marked increase in drug trafficking and consumption throughout the COVID-19 pandemic came up in several conversations.

Specific barriers to preventing and getting treatment for substance use disorders include undiagnosed and untreated mental illness, a scarcity of accessible treatment and rehabilitation facilities, and strain on the social support system.

Undiagnosed, untreated mental illness: Community residents spoke of substance use as a way some people cope with undiagnosed mental illness. The lack of tools to process and manage trauma and chronic stress, and the social stigma associated with seeking help, leads some community members to self-medicate with drugs.

Scarcity of effective treatment and rehabilitation programs: Care access barriers included a scarcity of local treatment options due to facility closures, long wait lists, and providers that don't take one's insurance. Residents with firsthand experience with substance use

commented that such barriers close the window of opportunity to "get clean" and make it more likely for someone to continue to use. Experiences with ineffective interventions due to short program duration and negative responses to methadone (for example, it leading to an increase in using behavior post discharge) were also mentioned. Those in recovery spoke to a lack of local peer support groups (for example, 12-step programs) due to government funding cuts or COVID-19. Multiple residents described being abruptly released after a hospital stay and/or prison time without appropriate follow-up to continue and reinforce rehabilitation. The lack of transition support makes it more likely that residents in recovery will relapse with some ending up back in the criminal justice system.

Strain on social support system: Several resident participants described how addiction isolates individuals and strains families. These conversations point to the need for upstream interventions including workforce development programs, coping resources, community-based treatment centers and rehab programs, and local peer support groups.

Document Location: Pages 77-84.

Underlying Causes

In the 2019 community survey asked residents about top health issues, top needs for a healthy community, greatest strengths in the community, and what needs to be improved. The top five needs identified were diabetes, mental health, violence, substance use, age-related illnesses, and heart disease and stroke. In addition, when asked about the most important factors for a healthy community, the majority of the respondents identified access to care and mental health as the number one factor. Socioeconomic inequities, including community economic investment and development, employment opportunities, quality affordable housing, education opportunities, community safety, and food access were highlighted. These inequities were exacerbated by the catastrophic impact of the COVID-19 pandemic. According to the Chicago COVID-19 Community Vulnerability Index (CVI) , seven out of the eight zip codes in the Collaborative's service area are among the top 20 most vulnerable communities in the state, with 60636 ranked as the community with the highest vulnerability in the state (58 Chicago zip codes reported).

Unemployment, economic stressors, violence, students being educated at home or in hybrid models, and trauma of losses, are only a few of the drivers for the expanding needs in the service area. The loss of income coupled with food insecurity and housing needs only add to the decline in the community's ability to manage chronic conditions such as diabetes and heart disease. These stressors also have a negative impact on overall health outcomes. Other factors affecting the broadening of the inequities include the impact of civil unrest during the pandemic. Looting experienced during the protests last year caused the temporary or permanent closing of businesses such as pharmacies and local stores providing key services to residents. Adolescent mental health and behavioral health in general reached crisis numbers.

Strategy

Aligned with the South Side Community Organization Collaborative, both South Shore Hospital and Chicago Family Health Center are participants within that Health Care Transformation Collaborative. The South Side Community Organization Collaborative is implementing a model that is working across the region to address primary and specialty care needs, but they are initially focusing on maternal and

child health and chronic disease. The leadership of The South Shore Behavioral Health System of Care Collaborative are keenly aware of the time commitment and obligation of participating in multiple collaboratives, but because the need is so great in the region for behavioral health services and stronger linkages to community care, they committed to both of these efforts. Leaders from both South Shore Hospital and Chicago Family Health are on the Board of the South Side Community Organization Collaborative, and they will ensure continued partnership and alignment with both of these efforts to better serve the region. This intentional synergy will allow participating providers to leverage the capacity of both projects, allowing each to compliment a more robust continuum of care for individuals in the South Shore community while creating efficiencies and avoiding duplication of resources and effort. The South Shore Hospital Behavioral Health Collaborative seeks to directly address the significant lack of behavioral health resources by increasing access to services across the care continuum, as well as ensuring continuity of care from inpatient psychiatric care to community behavioral health and primary care.

The South Shore Community Behavioral Health System of Care Collaborative Model (Exhibit 02.02)
According to the 2021 Transformational Data and Community Needs Report,[1] data gathered from community input, coupled with data sets related to disease groups and conditions driving frequent and resource intensive hospitalizations and poor health outcomes show that these could be avoided through outpatient care, coordination of treatment, and community-based supports. These key disease groups and conditions include mental illness, in particular bipolar and depressive disorders, substance use disorders, especially alcohol and opioid use disorders, and a subset of ambulatory conditions including hypertensive diseases, diabetes, and heart disease. The proposed model has been designed with these needs and interventions as the primary focus.

Exhibit 02.02 provides a visual of the System of Care that this proposal seeks to accomplish. Addressing both the patient's primary care and behavioral health needs will lead to the improved quality of care as well as reduced costs. Specific activities for achieving these overarching goals are continuity of care through increased support during transitions, more durable linkage to outpatient behavioral health and primary care, and reduced recidivism for inpatient services. The goals of this proposal are to address the metrics regarding adult behavioral health needs. Specifically, the proposal seeks to improve access to inpatient services with appropriate follow-up, increase timely access to community-based care, improve care transitions, improve the integration of behavioral health and primary care, and address the social determinants of health.

To strengthen the south side of Chicago's capacity to serve those with serious mental illness, South Shore will create 18 new adult psychiatric inpatient beds for individuals between the ages of 18 to 64. There is a considerable number of these adults who enter the emergency department in a behavioral health crisis who are routed to other hospitals across the Chicagoland region due to a lack of psychiatric beds within the South Shore community for this population. The goal of this proposal is to reduce the number of people who need to be transported to hospitals outside of their community to receive inpatient psychiatric hospitalization. The reduction of the transfers of individuals will help to provide better care. This proposal will also reduce the number of individuals in need of inpatient psychiatric stabilization who are held for extended periods of time in the emergency department or are discharged after being treated within the emergency department. The goal of creating the

[1] https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226FinalTransformationReportExecutiveSummary.pdf

additional beds is to resolve the issue of insufficient resources for those in need in the south side of Chicago, but also to provide a more effective continuum of care, linking these and other individuals in need of outpatient behavioral health services, as well as primary care. Additionally, The Collaborative will partner with NAMI Chicago who will help provide ongoing care coordination through their Chicago's Helpline, to support connection and system navigation for individuals connected with the collaborative. The Helpline utilizes a holistic theory of recovery that is flexible and individualized. This provides a supportive complement to traditional treatment models.

Exhibit 02.02

Collaborating Entities – Governance Partners

South Shore Hospital

South Shore Hospital (SSH) is an independent general acute care hospital that has been in existence since 1912. The hospital is currently staffed at a level of 135 beds with licensing for up to 170 beds. In addition, SSH has five primary care outreach facilities. SSH employs over 470, including a medical staff of approximately 104 physicians. The following services are provided on an inpatient and outpatient basis: respiratory care, physical therapy, surgery, nuclear medicine, radiology, laboratory, vascular, diagnostics, pharmacy, non-invasive cardiology, detox services, chemical dependency, transportation, wound and skin care, emergency medicine, geriatric psychiatry, HIV/AIDS services, and gynecological services. SSH is located in the South Shore community area of Chicago and its service area encompasses 17 community areas in the City of Chicago with an estimated population of 411,148 individuals (2016 5-year estimates, American Community Survey). The majority of the population within SSH's service area identifies as African American/black (87%). Nine percent of the population identifies as Hispanic/Latinx and 3% as non-Hispanic white. The majority of the patient population resides in the communities surrounding the hospital. The primary patient population is geriatric with

low to moderate income levels. SSH treats patients regardless of race, color, creed, or their ability to pay.

Chicago Family Health Center

For 44 years, Chicago Family Health Center (CFHC) has provided quality healthcare and support services targeting medically underserved and uninsured people to realize our mission: Chicago Family Health Center will promote health, work to prevent disease and provide treatment through the delivery of quality, accessible primary healthcare that is culturally sensitive, affordable, and responsive to community and individual needs.

CFHC is a Federally Qualified Health Center that provides care for the medically underserved on Chicago's south and southeast sides. CFHC opened its doors in 1977 in a store front office where providers cared for 400 patients that year. CFHC has since grown to a network of six locations in South Chicago, Pullman, East Side, Roseland, Chicago Lawn, and Avalon Park that provided a complete range of high-quality, integrated services, including: primary care, dental, behavioral health, and wraparound services to more than 27,000 patients in 2020.

During the past 44 years, the economic downturn and need for services that led to CFHC opening have only worsened, leaving these communities with few safety-net resources. The communities that CFHC serves are approximately 15 miles south of the city center. CFHC's service area is primarily composed of the Chicago communities of: Avalon Park, Ashburn, Auburn Gresham, Beverly, Burnside, Calumet Heights, Chatham, Chicago Lawn, East Side, Gage Park, Garfield Ridge, Greater Grand Crossing, Hegewisch, Morgan Park, Pullman, Roseland, Riverdale, South Chicago, South Deering, South Shore, Washington Heights, West Elsdon, West Englewood, West Lawn, West Pullman, and Woodlawn.

Last year, CFHC served over 27,000 patients in underserved communities on Chicago's south and southeast sides. Due to environment factors in these communities, many residents in CFHC's service area face barriers to accessing healthcare that residents in more affluent communities don't face. CFHC health centers are located in areas designated as Healthcare Professional Shortage Areas, meaning there is a shortage of providers who will accept patients who are uninsured or underinsured. 67% of CFHC patients have Medicaid, 5% have Medicare, 17% are uninsured, and 11% have private insurance. Almost all of CFHC's patients identify as persons of color; 40% of patients are Hispanic/Latino and 51% are Black/African American. Of patients who reported their income, 91% are living in poverty. In addition to these determinants, other factors impact service area residents' ability to access care. The communities served by CFHC experience high rates of economic hardship and unemployment, low levels of educational attainment, and a lack of access to transportation.

CFHC employs a comprehensive, integrated model of care that allows patients to address all aspects of their wellness at one location. CFHC's model focuses on three central pillars of health: primary care, oral health, and behavioral health. Providers in all three areas work together to care for patients in an integrated way. Behavioral Health Therapists, for example, conduct mental health screenings as part of a doctor's visit, and primary care providers review patients' dental histories at the end of visits and offer walk-in dental exams when appropriate.

Primary care is the first pillar of CFHC's model. Providers offer a wide range of primary care services, including: pediatric care; women's healthcare, including OB/GYNE; senior services and men's healthcare. Dental services are the second pillar in CFHC's model. Providers routinely perform cleanings, exams, x-rays, apply dental sealants, provide fillings and dentures, and provide oral health education. The third pillar of CFHC's model is behavioral health. Behavioral health providers

commonly provide therapy for depression, anxiety, family and marriages issues, smoking cessation, discipline issues for school-age children, domestic violence, and post-traumatic stress disorder. CFHC also offers psychiatric services and medication-assisted treatment. CFHC provides cardiology, endocrinology and psychiatry onsite for patients. Co-locating these services in a patient's primary care home helps to further ensure that CFHC truly is a one-stop location for wellness.
Robust referral partnerships are in place to ensure that patients have access to direct services not provided by CFHC. Mammograms and colonoscopies are provided by Saint Anthony, Mount Sinai, and South Shore Hospitals. Patients who need dental surgeries are referred to University of Illinois – Chicago, Loyola University, Division Oral Surgery, John Stroger Jr. Hospital, or Dr. Karen Nash. Behavioral health refers patients to Metropolitan Family Services and the South East Alcohol, Drug Abuse Center (SEADAC) for detox, outpatient treatment, residential treatment, acute mental health treatment, and non-hospital rehabilitation, St Bernard Hospital for outpatient psychiatry and medical detox; and Mount Sinai/Holy Cross Hospital for crisis stabilization and outpatient psychiatry.

The care that patients receive is buttressed by a variety of wrap-around services, including Care Coordination, the Women, Infant and Children (WIC) program, Illinois Breast and Cervical Cancer program (IBCCP), yoga classes, and health education. CFHC also offers prescription assistance services.

Christian Community Health Center
Christian Community Health Center (CCHC) is a premier network of Federally Qualified Health Centers (FQHC), 501 (C) 3 non-profit organization. CCHC is a Level III National Committee of Quality Assurance (NCQA) Patient Centered Medical Home (PCMH), as well as an Illinois Department of Alcohol and Substance Abuse (DASA) Licensed Level I and II provider of outpatient substance use disorder treatment services for adolescents and adults. CCHC is an African American led FQHC on Chicago's far southside and south suburbs, providing high quality primary care, oral care, behavioral health, and housing supportive services since December 18, 1991. CCHC's mission is to provide high quality primary healthcare and supportive services to the community, regardless of their ability to pay, in the manner that demonstrates in word and in deed, the love of Jesus Christ.
CCHC successfully provides comprehensive integrated primary care and behavioral health care services at three sites of care, all located in Cook County, Illinois. The flagship health center is located at 9718 S. Halsted Street in Chicago and has a full-service 340b Pharmacy that includes home delivery and have agreements with 11 area Walgreens within the surrounding community to increase access to 340b prescription discounts for our health center patients. Also, at this site is a full-service dental clinic that has been outsourced, providing oral care services. CCHC's two additional south suburban health centers are located at 364 Torrence Ave in Calumet City and 901 East Sibley Boulevard in South Holland. CCHC also serves hard to reach patients utilizing the Mobile Health Van, which is a HRSA designated access point.

In addition to health care services, CCHC also provides comprehensive social services, including interim and permanent supportive housing as well as specialized trauma informed re-entry services for commercial sex workers. These services are administered at two additional administrative sites located at the shelter at South Honore Street and housing supportive services at 1701 W. 87th Street, Chicago, IL 60620.
CCHC's clinics are in areas with demonstrated need as defined by the Health Resources and Services Administration (HRSA), designated in 2020 with a Health Professional Shortage Area (HPSA) primary care score of 21, dental care score of 25, and mental health score 19. Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) identify geographic areas and populations

with a lack of access to primary care services. Within our catchments area, there exist multiple MUAs and MUPs primary care, oral care, and behavioral health professional shortage areas.

CCHC's designated catchment areas consists of the following zip codes: In Chicago-60619, 60620, 60628, 60643, 60655, and in the south suburbs-60406, 60409, 60411, 60419, 60426, 60438, 60472, 60473, 60478 and 60827. Our 2019 UDS data indicates that our patients come to us from 59 distinct zip codes in the Chicagoland area. These include the zip codes listed above, along with 23 additional Chicago zip codes, 31 additional South Suburban zip codes and 5 Northwest Indiana zip codes.

Of Chicago's 77 Community Areas, CCHC serves the following: Roseland, the home of CCHC's flagship health center and administrative offices; Auburn Gresham - the location of our Supportive Services Office and our interim housing shelter; Washington Heights, Chatham, Hegewisch, South Chicago, South Shore, Englewood, West Englewood, Chicago Lawn, Woodlawn, Ashburn, New City, Grand Boulevard, Woodlawn, Hyde Park, Kenwood, South Lawndale, West Garfield Park and Austin.

Additional Partners/Supporters

NAMI Chicago
Guided by the experiences of those living with mental health conditions and rooted in equity, NAMI Chicago educates to fight stigma and discrimination, fiercely advocates for our community, and shares hope, connection and expertise with people on their mental health journey. NAMI's vision is a world that embraces and prioritizes mental health and mental illness. Founded in 1979, they are one of the largest, most active affiliates of the National Alliance on Mental Illness, and served more than 30,000 people in the year 2020.
Programs include:

Helpline: A free, confidential resource open 7 days a week. The Helpline answered the call 12,910 times in the year 2020, connecting people to live mental health counselors who provide emotional support and coaching and act as a social service clearinghouse to connect people to vetted resources according to their needs.

Support Groups for individuals on their mental health journeys and their family members. Peer to peer groups and recovery education classes are at the heart of NAMI Chicago's programs, which center on lived experience leadership.

Williams & Colbert Consent Decrees: NAMI Chicago provides support services throughout the state of Illinois for people who wish to move out of institutional facilities and instead live in a community based setting. Outreach Workers, Recovery Support Specialists and peer ambassadors connect with people while they live in institutional facilities, throughout their transition and beyond.

Front Line Wellness: NAMI Chicago provides wellness support and recovery education to first responders and others who work in high-stress and high-trauma professions on the front line of the crisis, court and mental health systems. This includes emergency department staff, non-profit employees, police officers, 9-1-1 call takers, fire department employees, sheriffs, and jail and prison staff.

Community Outreach: Connect with community organizations and health care providers to build a network of resources and support for individuals that serve and provide information about NAMI

Chicago. Coordinate targeted campaigns to spread resource and wellness support in high-need communities.

Community Training efforts provide mental health awareness curriculums widely to the public, trying to increase mental health literacy and utilization of mental health resources in targeted communities. These efforts work alongside Bridges of Hope, an education program for faith-based communities, and workplace trainings, which bring mental health topics into workforce settings.

Education Programming serves elementary, middle and high school students in Chicago, educating and empowering them to recognize the signs and symptoms of mental health challenges and teaching them how to help themselves or a friend. Programming also educates school staff and parents, to create a system of support for youth.

First Responder Training: NAMI Chicago provides training to the Chicago Police Department, 9-1-1 call takers, and interagency sessions with the Chicago Fire Department. These curriculums include teaching the signs and symptoms of mental health conditions and facilitating panels and role plays with individuals and families who have experienced mental health conditions.

Policy and Advocacy in Chicago, Cook County and Illinois for systems changes that improve treatment, collaboration, and access related to mental health services. Provide training to NAMI stakeholders on telling their story for policy change. NAMI Chicago hosts a bi-annual policy priorities survey, as well as frequent stakeholder groups include panel discussions and focus groups, to ensure that our advocacy priorities are shaped by the lived experience of individuals in the community.

Expertise

NAMI Chicago has decades of experience working within the mental health system city- and state-wide. They understand the system as it exists today, as well as the best-practice vision of what equitable, sustainable networks of mental health care should look like on a community level. NAMI Chicago is also a subject matter expert on creating a culture of wellness and sustainability in health care spaces through prioritizing the education and support of front line workers and administrators, smart staffing and infrastructure investments, and more.

NAMI Chicago offers citywide expertise and fluency in the resources and systems surrounding mental health and the social determinants of health. They maintain extensive relationships with direct providers of mental health care, organizations focused on housing and other basic needs, crisis system stakeholders like emergency departments and law enforcement, and more. They actively assist individuals in navigating these systems through the Helpline and Clinical Support programs.

Training Offerings

NAMI Chicago offers a variety of mental health education and training curriculums to the public. They tailor our curriculums to the needs of each partner and community. Some of our training offerings include:

Mental Health Awareness: Provides a foundation of knowledge on mental health & wellness. They will share NAMI Chicago's resources, dive deep into the definition of wellness, learn how to recognize when someone is struggling, and identify ways to be supportive. Attendees will also leave the session

with wellness strategies to better manage stress and engage in self-care. Lastly, to reduce the stigma around mental health, the training will include a NAMI Chicago Ambassador who will share their story of hope and recovery.

Crisis Intervention and De-escalation: Teaches participants how to recognize when an individual is experiencing a mental health crisis and how to utilize verbal de-escalation techniques to build rapport. Participants will engage in specialized role play scenarios in which multiple options for intervention will be discussed. Depending on availability, participants will also hear the recovery story of an individual with mental health experience. Crisis Intervention Team (CIT)-trained police officers and other emergency resources will be discussed, including how to utilize our Helpline in crisis situations.

Practicing & Promoting Self-Care: Highlights the current challenges to mental health in the context of the pandemic and dives into concepts of wellness, individual self-care, and community care. Participants will learn strategies to better manage stress and engage in self-care for themselves and others.

Bridges of Hope: Designed to educate faith communities about mental health. Provides an overview of common mental health warning signs and ways for faith communities to de-stigmatize mental health and create an open, welcoming culture for those who seek guidance. NAMI Chicago's free, confidential mental health resources will also be discussed in detail. To spread hope and provide an opportunity to get real about mental health, the training will conclude with a NAMI Chicago Ambassador who will share their story of hope and recovery.

Exposure to Trauma and Building Resilience: Provides the opportunity to engage in meaningful education, discussion, and activity that addresses each individual's unique life experience. Participants will better understand mental wellness and the impact of exposure to trauma. Participants will learn how to support themselves, their peers, and together will create a space to develop intentional wellness. Lastly, participants will enhance their knowledge of NAMI Chicago as a resource.

Inspirational Leadership: How Leaders Can Create A Culture of Wellness: Leaders have a key role to play in recognizing when an employee may need extra mental health support. In this interactive training, management will learn how to identify the warning signs that someone is struggling with their mental health, communication techniques, and strategies for supporting employees' mental health moving forward. Management will also have the opportunity to practice how they would respond to different workplace mental health-related situations. Option for a Q&A session following the training.

Malcolm X College

Illinois Community College District 508, known as the City Colleges of Chicago (CCC), is one of the largest community college districts in the United States. Serving approximately 70,000 degree-seeking students per year, each of the seven colleges in the district features a Center for Excellence in workforce development and academic programming. On the West Side of Chicago, Malcolm X College (MXC) serves as the City Colleges of Chicago Healthcare Center of Excellence providing a quality healthcare education to enable its students to compete for the 84,000 healthcare jobs that are anticipated in the region over the next ten years. MXC is conveniently located near the Illinois Medical District and offers one of the largest selections of health sciences degrees in Cook County. Malcolm X

College is a minority serving institution dedicated to serving communities facing systemic barriers in the Chicago West and South sides through education and opportunities. 92% of students identify as people of color, 46% identify as Hispanic, and 36% identify as Black, 4% identify as Asian, 2% identify as multi-racial. Malcolm X College is a Hispanic Serving Institution with 46% Hispanic student populations. With an enrollment of nearly 11,800 credit and non-credit students, MXC offers a mix of classroom study, hands-on training and internship at area healthcare facilities. Because many students who attend Malcolm X College also work, they also offer flexible schedules and "stackable" credentials that allow students to continue and expand on their training in the future. Malcolm X College students have access to a host of resources to support them on their path to success, including academic advising, tutoring, wellness center, transfer center, career center, veteran center, disability access center and more. They believe there is no other institution better positioned to become an economic engine for the City of Chicago.

MXC has the necessary resources to complete the proposed grant activities. MXC's Academic Support Center recruits, trains, and coordinates professional tutors with several years of experience and/or a graduate level of education in their subject. The center will administer placement exams, College Level Examination Program (CLEP) tests, and proctored exams assigned by faculty. The Testing Coordinator will work with Insight staff to provide special placement counseling for participants and connect them to tutors based on need and interest. The Career Planning and Placement Center will assist participants in identifying career opportunities that align with their professional goals and advance the SMEV and youth empowerment mission. This office provides workshops in resume writing and job interview skills, and these workshops will be accessible to participants. The library staff will conduct orientation sessions and tours of the library and database. MXC's Student Advising Center will work with students to enhance rates of retention and graduation. The Transfer Center staff will assist students with the transition to a four-year institution, walking students through the college application process and helping them obtain fee waivers. MXC's Office of Instruction oversees efforts across the institution to strengthen academic offerings and outcomes; senior leaders from this office were involved with the project's design and will play an important role in ensuring STEM faculty are engaged and contributing to activities.

MXC's Wellness Center supports students in their transition to college through personal counseling, support groups, stress and time management coaching, and referrals to community resources. In partnership with the Greater Chicago Food Depository, Malcolm X College has opened a food pantry open to students facing food insecurity each week to select fresh and shelf-stable food. The Disabilities Access Center (DAC) makes every effort to integrate students with disabilities into all courses and programs and will provide support services to meet the specific needs of students with disabilities.

The Business Office processes purchase orders, maintains campus budgets, and provides financial services for the campus. The City Colleges of Chicago District Office has committed to drawing down grant funds, maintaining records of drawdowns and expenditures, and supporting the PI and Director in monthly reconciliation of financial records.

MXC has the capacity to comply with the grant conditions stipulated. MXC is strategic and thoughtful about which grant opportunities it pursues, ensuring a portfolio of projects that squarely aligns with the College's mission and vision. MXC is careful to only partner for grants for which it has the institutional capacity and infrastructure to manage and execute efficiently and responsibly. In the last year, MXC recruited and hired its first Director of Grants Development and Compliance. This staff

member is responsible for overseeing grant management efforts and providing technical assistance to PIs and Project Directors to ensure targets and deliverables are successfully met and activities and expenditures comply with funders' regulations and policies. MXC also receives expert support from the City Colleges of Chicago's District Office, which is home to its own grants, compliance, and finance teams whose members work closely with each college's counterparts.

MXC has extensive experience receiving and successfully implementing federal grants from the Departments of Education, Labor, and Health and Human Services. Currently, MXC is implementing a six-year, $3.5 million grant from the Department of Education to increase the number of Black men who study and pursue a career in the field of health sciences. MXC is in its final year of implementation of this program, the funds for which will mostly be expended by December 2022. MXC is also in its first year of a $2 million, four-year program funded by the Department of Health and Human Services' Health Resources and Services Administration. Through this grant, MXC is equipping students with the skills, credentials, and apprenticeship opportunities to serve as community health workers in the Chicagoland area and provide care to families impacted by opioid use. Over the last decade, MXC has successfully applied for and implemented state and federal grants that have grown in both dollar amount and technical complexity.

As a public institution of higher education and one of the seven City Colleges of Chicago, Malcolm X College is held to the highest standards of integrity and business ethics. MXC maintains strict financial controls that ensure that its campuses contract with vendors whose prices and services are competitive. In accordance with City Colleges of Chicago's Board Policy, purchases between $2,500 and $25,000 must be competitively bid. At least three price quotations must be obtained via telephone, fax, and/or email, and at least one of them must be from a currently certified Minority Business Enterprise (MBE) or Women Business Enterprise (WBE). After staff secure three bids, they prepare a bid recapitulation form and compile all supporting documentation (correspondence, quotes, verification of MBE or WBE status) to the CCC District's Procurement Office, which conducts a thorough review, flags any questions or concerns, and approves if all documentation is in order and all requirements have been met. Additionally, all MXC staff is paid in accordance with established and publicly available salary and wage guidelines, which are monitored by the Board of Trustees of the City Colleges of Chicago.

Chicago's South Side Community

Chicago's South Side encompasses 17 community areas in the City of Chicago with an estimated population of 411,148 individuals. The majority of the population within the service area (60628, 60617, 60619, 60649, 60621, 60620, 60636, 60637) identifies as African American/black (87%). Nine percent of the population identifies as Hispanic/Latinx and 3% as non-Hispanic white. Most of the patient population resides in the communities surrounding the collaborative partners' organizations. A significant portion of the patient population is geriatric with low to moderate income levels. There is an extreme disparity in poverty rates among households with children within the collaborative's service area, with over half of children living in poverty in Woodlawn, South Shore, Greater Grand Crossing, and Englewood. Data from the most recent needs assessment identifies diabetes, behavioral health, violence, and substance use as the top health issues, with access to health care and behavioral health services identified as the most important factor in making the South Side a healthier community.

New Interventions – Transformation

A critical element of this proposal is the utilization of community-based care coordinators that will be located in the FQHCs. These care coordinators will do in-reach into the inpatient psychiatric unit to screen patients for social needs, primary care and behavioral health needs. Care coordinators will then work to create a discharge plan in collaboration with the inpatient team that will ensure an effective glide path of care post discharge. The care coordinator will be following the patient to ensure that post-discharge appointments are not only scheduled, but they will monitor to ensure that they aid in removing any barriers for that patient to attend their follow-up appointments.

Community-based care coordinators will travel to meet patients in person at other facilities, provide intensive case management to high-risk patients, review patients in weekly huddles with the medical home, they will help link patients to resources to address social needs, and when needed, will facilitate linkage to a higher level of care.

In addition to the community-based care coordinators, South Shore Hospital will have 3 social workers who will serve as case managers working with individuals who are admitted to the inpatient psychiatric unit. These case managers will coordinate with community-based care coordinators located at the FQHCs to ensure effective linkage to outpatient services and to address social needs.

To ensure effective community engagement, The Collaborative will leverage FQHCs' existing community engagement infrastructure which includes community and patient advisory committees. As well as provide quarterly updates regarding the project to local community organizations and to the community advisory committees, and elected officials. The quarterly updates will be provided via webinars or in-person meetings, The Collaborative will report on key process and program metrics and provide an opportunity for feedback, deploying rapid cycle improvement opportunities to better serve the community.

This collaborative includes a robust group of partners who are committed to: creating a patient driven approach to behavioral health care, increased engagement of these individuals with primary care, building on existing community resources and assets, and filling the gaps with new partnerships to better serve the South Shore community.

Access to Primary Care:

- Partnership with the FQHCs will ensure linkage to primary care
- Goal of Integrated Primary Care-Behavioral Health is to take population-based approach to identify BH needs in primary care panel and aid patients in self-management of chronic BH and medical conditions.
- Population Health data states that at least 60 percent of FQHC medical patients have some underlying or comorbid BH condition that also requires treatment.
- Overlap between physical and behavioral health services has increased 50% over baseline since the pandemic.
- Goal is to match patients with the right level of care at the right time and lower cost, improve quality, patient and provider satisfaction.
- This collaborative will ensure that patients served by South Shore's inpatient psychiatric beds will effectively link to outpatient care upon discharge.
- FQHCs will identify patients who require inpatient care for mental health or substance use services and use SSH as a resource for stabilization.

- FQHCs will continue to improve patients' stability post-hospitalization with engagement in the medical home.

Community Behavioral Health:

- FQHCs and local BH provider will work to provide linkages to care to BH providers who provide specialty services and more intensive levels of care, if needed.
- Community-based Care Coordinators (or CHWs) will:
    - Ensure engagement and linkage to community behavioral health supports
    - Aid in linkage to community-based providers to address social needs
    - Navigate patients to needed services and care
- Utilizing strong connections with community partners, FQHCs will make patient-centered decisions about care for patients.
- To effectively manage the care for patients FQHCs will communicate with community-based organizations serving shared patients to aid in coordination and continuity of care.

Pre-Discharge Care Coordination and Post Release Navigation:

- Community-Based Care Coordinators (CHWs) will:
    - Work to navigate the discharge process pre-discharge.
    - Work with the patient when in the community to navigate and engage in community-based care, including social services, in order to maintain independence.
- CHWs would have a requirement to travel to meet patients in person at other facilities, provide intensive case management to high-risk patients, review patients in weekly huddles with the medical home, they will help link patients to resources to address social needs, and when needed will recommend higher level of care.

Inpatient Psychiatric Care:

- Create 18 new adult psychiatric inpatient beds
    - The creation of these new beds will provide additional capacity in the region to ensure access to adults who meet medical necessity for this level of care.
- FQHC partners can refer patients to South Shore for acute psychiatric stabilization and treatment.
- Patients who are admitted to this unit will have a strong linkage and coordination with outpatient care for both primary care and behavioral health needs.
- FQHCs will refer patients to South Shore for acute substance use needs including medical detox and initiation of medication assisted treatment.

Community Input:

- Build a community engagement process that will advise and guide the leadership of this project.
- Leverage FQHCs existing community engagement infrastructure which includes community and patient advisory committees.
- Provide quarterly updates regarding the project to local community organizations and to the community advisory committees, providing an opportunity for feedback.
- Provide quarterly updates to local community leaders and elected officials.
- Once the project is serving patients, there will be opportunity for patient feedback and input to aid in improving care.

Linkage to Social Needs:

- FQHCs will provide address social needs of patients through existing partners and programs, the resources available are listed below:
    - Health Literacy: Health Educators and Nutritionist services
    - Medication Access: 340b Program, in house pharmacy technicians, patient assistance programs for high-cost meds.
    - Access to Entitlements: Patient Resource Counselors who assist with ABE, SNAP, Sliding Scale, LINK, Medicaid/Medicare
    - Food Insecurity:
        - WIC – On site at South Chicago Clinic (CFHC)
        - Partnership On site with Urban Growers' Collective/Fresh Moves Food Truck (takes WIC, SNAP)
    - Access to Safe Exercise: Partnership On site with YogaCare, referrals to park district via care team.
    - Public Health Crisis Response: COVID – Access to testing and vaccines on site.
    - Public Health Crisis Response: Mental Health/SUD (Public Health crisis): Access on site.
    - Public Health Crisis Response: Overdose Prevention: Access to Narcan through Primary Care Team
    - Help with transportation Insecurity: Care management – (payor specific)
    - Help with utility insecurity: Care Management – patient-specific in care team
    - Help with housing insecurity: Christian Community works to screen individuals utilizing the HMIS screening tool. The completion of the tool aids in the identification of need, and linkage to the appropriate and available housing resources.
        - Link individuals who have immediate housing needs to emergency transitional shelter, where they are also connected to other services they may need, such as behavioral health needs, address domestic violence
        - Link individuals to permanent supportive housing if needed

[1] https://www2.illinois.gov/hfs/SiteCollectionDocuments/20210226FinalTransformationReportExecutiveSummary.pdf

3. Governance Structure

Structure and Processes

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

Membership: South Shore Hospital, Chicago Family Health Center and Christian Community Health Center, as part of the Illinois Department of Health and Family Service's (Department) Healthcare Transformation (HTC) application have agreed to a shared governance structure for the oversight and management of The South Shore Community Behavioral Health Collaborative (The Collaborative).

Meetings: The Collaborative is committed to meet weekly, or as needed as The Collaborative is launched. Monthly meetings will be designated for the regular review of the key measures and milestones to ensure that the project is on track. The Collaborative members' chief executive officer or his/her designee will be required to attend all meetings.

Decision Making: The Collaborative is committed to making decisions by a simple majority 2/3 partners will be necessary for decisions.

Patient Participation: The SSH Patient Advisory Committee is a 5-member group. The advisory committee will designate a member to participate during the monthly Collaborative meetings and represent the voice of patients. A representative from the Collaborate will attend the Advisory Committee meetings to provide updates on project implementation, share upcoming developments and seek input from the group. The Collaborative will subsequently report back to the committee regarding how their input was considered, and how it impacted the decision-making process, when applicable.

Evidence of Authorization: To demonstrate a clear commitment of all partners to fully execute the responsibilities for the successful implementation for this project, each partner received approval from their Board for participation. All partners received support from their Boards to participate in this collaborative, and each have designated staff resources to aid in the development and expected launch of this collaborative. In addition, partners within this collaborative are committed to this project as well as the other collaboratives that they are engaged in across the region. The needs of the South Side of Chicago are vast and creating partnerships across the region with various partners is necessary to ensure that the community and patient needs are met. This collaborative's differentiation amongst others in the South Side of Chicago is focused on addressing behavioral health needs through collaboration, strong linkage across levels of care, and navigation and linkage to resources that address social needs.

Execution: The Collaborative partners participated collaboratively in the development of all areas of the application the roles and responsibilities of the partners are as follows:

- South Shore Hospital will serve as the fiscal agent of The Collaborative and will be responsible for the timely distribution of the funding to the partners. South Shore will also be responsible for the implementation of the planned 18 inpatient psychiatric hospital beds and for hiring the staff that are indicated in the budget.
- Chicago Family Health Center (CFHC) will be responsible for linking patients post-release from the inpatient psychiatric beds to care in the community, either directly with CFHC or with community behavioral health providers, or with designated medical home. Referrals will be made to South

Shore for patients who are identified as needing inpatient psychiatric hospitalization. CFCH will also ensure that the staff required for this project are hired as indicated in the budget.

- Christian Community Health Center (CCH) will be responsible for linking patients post-release from the in from inpatient psychiatric beds to care in the community, either directly to CCH or with community behavioral health providers. Referrals will be made to South Shore for patients who are identified as needing inpatient psychiatric hospitalization. CCH will also aid in linking patients from South Shore to housing needs, if appropriate. CCH will also ensure that the staff required for this project are hired as indicated in the budget.

Accountability

2. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally, and with extensive participation from each participating entity?

The collaborating entities will be made accountable for the milestones established in the proposal. Milestones will be tracked on a monthly basis and will be reported to The Collaborative monthly meetings.

The Collaboration will be made accountable for acting prudently, ethically and legally. Should a problem arise within The Collaborative and outside mediator will be engaged to resolve the issue.

What methods will be used to enforce policy and procedure adherence?

Collaborating entities post-award will execute a binding MOU agreement that will include enforcement of policy and procedure adherence. The Collaborating partners have currently created letters of commitment to demonstrate their engagement in this collaborative and have received approval from their boards to participate.

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

☐Yes

☒No

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

Directed payments will be flagged in South Shore's fiscal systems to ensure that the funds are moved into the appropriate accounting system which will allow for payment for the Collaborating entities and contractors. South Shore is committed to timely payments to all collaborating entities and contractors.

4. Racial Equity

High-Level Narrative

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

Racial equity and addressing health disparities are at the core of this initiative. With a predominantly African American patient and client population, the Collaborative's partners are at the center of the fight for equity and equality. Without access to critical behavioral and physical health services, the ability of South Chicago residents to fully experience equity is significantly hindered. However, addressing the social factors that directly affect behavioral and physical health outcomes needs to be parallel to the former. A hungry child living in a violent home will most likely not succeed in school, which automatically places the child at an educational and future financial disadvantage. A worker experiencing untreated depression or diabetes will not be able to perform well at work, and potentially lose their job. These factors go hand and hand. This coalition understands this well and is positioned to continue to work relentlessly to level the playing field for racial minorities. Racial equality is and will continue to be at the center of every initiative, program, strategy and activity of this collaborative, from planning to implementation, to evaluation.

Racial Equity Impact Assessment Questions

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

As previously established, 87% of those who live in the service area are African American, and 9% identify as Hispanic/Latinx. These groups are also most affected by the racial and health disparities addressed in this proposal.

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

Yes. The collaborative's community engagement strategy was designed to guarantee the meaningful engagement of the South Chicago community. Since most of those impacted by this project are minorities, we feel confident that our efforts to inform and gather information from the community were effective and we utilized a variety of methods to reach a wide variety of patients and community members. Prior to finalizing the proposal, the collaborative conducted community and patient surveys, disseminated informational flyers in plain language, and utilized social media sites from all partners to share information and invite the community to the kick-off webinar. All the informational materials and surveys were made available in English and Spanish. There is more work to do in order to include all the voices as the collaborative moves forward. More community voices are needed at the table, as well as community leaders who represent these communities. The collaborative will continue to work with additional partners to develop strategies to continually seek input and share information as the project is implemented and evaluated. The SSH Patient Advisory Group will be at the center of these conversations and will help implement effective strategies to receive feedback from community members.

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

The community needs assessment demonstrated that African American and Hispanic/Latinx community members are the most affected by the top issues identified in the surveys. Elderly residents are also disproportionally affected by racial and health disparities. Forty-five (45) percent of those who participated in the surveys were 55 years and older. Eighty-four percent (84%) of respondents were African American and eight percent (8%) identified as Hispanic/Latinx. For this reason, these groups will also be those who will benefit the most from this project, as some of the top health and social challenges in the community are directly addressed by the proposed project: diabetes, behavioral health, substance use, and access to care. The Hispanic/Latinx community is affected differently, as in addition to the common barriers and challenges, cultural differences and language barriers, and fear of deportation within sub-populations contribute to their disadvantages. Some of the most serious disparities affecting this community include substance use, access to health care and insurance, violence, and the comorbidities in those affected by housing insecurity, diabetes, heart disease, asthma, food insecurity, unemployment, HIV, and infant mortality. Exhibit 04.01 shows a detailed comparison of how these disparities affect the service area.

Exhibit 04.01

Health Disparities in the Collaborative's Service Area[2]

	FPL< 100%	Children in Poverty	Median Income	% Unemployed Adults 16+	Cost-Burdened Households	No High-School Diploma	Life Expectancy	% Low Birth-weight	Infant Mortality # per 1K	Teen Births
CHICAGO	**19%**	**28%**	**$53,006**	**8%**	**36%**	**16%**	**77**	**10%**	**7**	**25**
Auburn Gresham	29%	42%	$29,285	24%	45%	17%	72	15%	14	40
Avalon Park	21%	18%	$37,208	24%	43%	12%	75	13%	21	32
Burnside	33%	8%	$23,684	18%	50%	19%	70	16%	13	48
Calumet Heights	17%	26%	$46,581	14%	35%	11%	74	15%	20	34
Chatham	29%	37%	$34,612	19%	46%	12%	74	14%	13	41
East Side	20%	34%	$44,079	18%	34%	30%	79	8%	5	35
Englewood	45%	56%	$22,507	35%	56%	25%	71	17%	18	53
Greater Grand Crossing	37%	55%	$28,154	24%	48%	15%	71	15%	14	53
Pullman	25%	32%	$36,777	20%	39%	13%	72	13%	19	32
Roseland	30%	39%	$38,562	26%	43%	15%	72	14%	12	39
South Chicago	31%	45%	$27,692	22%	44%	20%	72	12%	12	42
South Deering	30%	45%	$31,878	25%	37%	20%	75	11%	11	34
South Region										
South Shore	38%	54%	$26,906	21%	53%	12%	72	13%	13	42
West Englewood	36%	49%	$27,911	34%	45%	23%	69	16%	13	61
West Pullman	29%	44%	$37,675	25%	41%	16%	72	13%	12	42
Woodlawn	40%	51%	$25,364	18%	47%	14%	75	14%	11	33

[2] SSH 2019 Community Health Needs Assessment. https://www.southshorehospital.com/wp-content/uploads/2019/12/FINAL-South-Shore-Hospital-Report_13November2019.pdf

For example, in the lowest income community (Englewood) the percentage of individuals living under 100% of the federal poverty level (FPL) is 45%, while it is only 17% in the Calumet Highs community. The life expectancy of a resident of Englewood is eight years shorter than a resident of the East Side community, where 18% of residents live below a 100% of the FPL. Also, a recent study by the Illinois Public Health Institute[3] showed that the number of opioid-related EMS responses exponentially increased in all of the collaborative's service community when comparing numbers from January to June of 2019 to the same period in 2020:

- South Shore – 72-100% increase
- Woodlawn – 101-150% increase
- Avalon Park - 101-150% increase

Currently, there are no regional concerted efforts in place to track the success of SDOH interventions in the service area. The South Shore Hospital Behavioral Health System of Care Collaborative will engage other collaboratives in the area to coordinate data collection efforts, standardize SDOH assessments, and share outcomes to provide additional insight into the effectiveness of the proposed interventions.

[2] https://iphionline.org/wp-content/uploads/2021/04/Landscape-Analysis_Full-Report_121820.pdf

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

The communities in the service area have been disproportionately impacted by social factors such as poverty, violence, poor quality education which is linked to employment and income, trauma, substance use, and behavioral health. The impact of the COVID-19 pandemic has exacerbated these issues further. According to the Illinois Policy Institute[4], a new study found the city of Chicago ranked No. 172 against the 180 largest U.S. cities for unemployment rates recovery after the national economy was shuttered by the COVID-19 pandemic. Unemployment, economic stressors, violence, students being educated at home or in hybrid models, and trauma of losses, are only a few of the drivers for the expanding needs in the service area. The loss of income coupled with food insecurity and housing needs only add to the decline in the community's ability to manage chronic conditions such as diabetes and heart disease. These stressors also have a negative impact on overall health outcomes. Other factors affecting the broadening of the inequities include the impact of civil unrest during the pandemic. Looting experienced during the protests last year caused the temporary or permanent closing of businesses such as pharmacies and local stores providing key services to residents. Adolescent mental health and behavioral health in general reached crisis numbers.

To understand the roots of disparities on the South Side of Chicago, it is important to understand its history. The legacy of segregation has made it hard for poor black families to be part of the economic opportunities in other parts of the city[5]. This segregation forced African Americans to live in areas with limited educational opportunities and less jobs than other people in Chicago. Other causes included disproportionate budget allocations to benefit downtown, and the loss of industrial jobs in factories, steel plants, and logistics companies. These factors have left individuals and families in

[3] https://iphionline.org/wp-content/uploads/2021/04/Landscape-Analysis_Full-Report_121820.pdf
[4] https://www.illinoispolicy.org/chicagos-unemployment-recovery-near-dead-last-for-big-cities/
[5] "Chicago on the Make". Andrew Diamond, June 2020.

segregated areas, with little to no opportunities to get ahead. In the South Side of Chicago, steel plants like Acme Steel and factories like the General Mills cereal plant began to close. According to a report by the Great Cities Institute at the University of Illinois at Chicago, there were 11,646 retail jobs in the Back of the Yards neighborhood on Chicago's Near South Side in 1970. By 2015, there were just 1,849 such jobs. Some businesses moved to the suburbs, and others went overseas.

Addressing some of the root causes mentioned above is outside of the direct scope of this project. However, there are other indirect factors which have tremendous impact on the ability of individuals to improve their education, access to healthcare, maintain jobs, and restore the overall health of those in the service area. The proposed strategies also include increased coordination to access physical and behavioral healthcare services. The collaboration between behavioral and physical health providers who are also able to address social determinants of health needs and provide care coordination, aims to narrowing the service gaps and helping communities become stronger and healthier.

According to the National Alliance of Mental Illness (NAMI)[6], one in five adults has a mental health condition. Many adults with a mental illness also have at least one physical health condition. Integrating physical and mental health care and coordination improves outcomes and reduces stigma. People get timely care when most needed. Without integrated care, individuals can experience many challenges navigating two separate health care systems. Without access and coordination between providers, people with multiple conditions present worse health outcomes.

The Collaborative will also provide intensive case management to assist individuals who are housing insecure or homeless connect with housing resources in the community. Homeless individuals will also have access to life skills training, housing assessments, and education related to tenant rights and responsibilities. A detailed description of housing interventions is included in Section 9 of this application, Social Determinants of Health.

The Collaborative will continue to expand its network and develop additional relationships with faith-based groups, non-profits, managed care organizations, school districts, local government, businesses and private funders. These organizations will be key to accomplishing a more comprehensive solution. We are aware that this takes time, and a collective will to find solutions. The Collaborative is willing to continue to grow and build on the assets of South Chicago and the strength and resiliency of its residents.

[3] https://www.illinoispolicy.org/chicagos-unemployment-recovery-near-dead-last-for-big-cities/
[4] "Chicago on the Make". Andrew Diamond, June 2020.
[5] https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Physical-Mental-Health-Integration

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

The Collaborative's proposed project seeks to:

- Meet the increasing needs for inpatient behavioral health services in the community.

[6] https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Physical-Mental-Health-Integration

- Utilize community-based care coordinators and social workers that will be located in the FQHCs to assist patients in the psychiatric unit identify and meet their needs around primary care, behavioral health care after discharge and SDOH.
- Facilitating and tracking the referrals to meet those social needs through a uniform SDOH assessment and referral system.
- Engage the local community in improving community health outcomes.

The interventions and activities of the Collaborative will significantly reduce disparities in accessing physical and behavioral care, and receiving the necessary supports to address social needs. Having access to all interventions in one place, regardless of the "door" patients choose, will reduce the barriers that families in the service area disproportionally encounter.

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

While the Collaborative is not anticipating any unforeseen negative impacts, unanticipated future events may cause a shifting in the proposed activities to meet new demands or reprioritize efforts and resources. Year one will be an opportunity to learn and evaluate the success of the proposed activities, as well as identify unforeseen positive impacts, activities that are not working as planned, areas for improvement, and outcome drivers or deterrents. The groups that will receive the benefits of this initiative include the African American and Hispanic/Latinx community, elderly populations, and those who are underinsured or uninsured. Families of patients and clients will also benefit from the service coordination components of the project, as improving the social conditions that affect physical and behavioral health will benefit the family unit. The strategy for prevention or minimization of adverse impacts will be clearer after engaging in the first six to nine months of the project. Collected data will help identify and address these early. Data will also help identify areas that present new opportunities and drive positive outcomes in a greater way than anticipated. For this reason, continuous stakeholder engagement and feedback will continue to occur. Collective expertise and assets will drive continuous improvement and foster equity on the South Side of Chicago.

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

This proposal has been developed by a diverse group of partners from organizations that are already working with patients and clients who are from diverse racial and ethnic groups. These organizations are already committed to racial equity and inclusion as part of their mission, values, programs and who they are as an organization. However, as the project is implemented the collaborative will continue to learn, take a closer look at disparities, and explore new or different ways to identify, address and reduce them. The acquisition of a common platform to conduct SDOH assessments and refer patients to services will also assist in reducing the identified disparities.

An additional component to improve equity and inclusion is the participation of the SSH Patient Advisory Committee. This group is comprised of individuals who live in the service area and have unique insights of the conditions, opportunities, and challenges in their community. They could serve as advocates for the community and ambassadors for the project by sharing information and feedback two ways: to the community and from the community. During year one, the collaborative

will also start the process of identifying key community members and patients that would be willing and able to participate alongside the patient advisory committee. The Collaborative will identify community leaders and representatives from the faith-based community. The development of this component of community engagement must be thoughtful and thorough and will entail identifying the right individuals and ensuring representation from all key sectors.

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

The Collaborative engaged the services of a specialized consultant to assist in the development of the budget in collaboration with all partners. This budget was jointly and carefully crafted so that it realistically and adequately accounted for all project components, and adjusted yearly to account for foreseeable future needs such as inflation and cost of living. All partners reached consensus and made sure that all entities were assigned the resources needed to successfully implement and evaluate the project. Racial and health equity are also at the center of the budgeting process. Staff should be fairly and equitably compensated, and healthcare facilities in South Chicago must be adequately staffed and equipped. Our aim is that patients receiving healthcare in community hospitals or health centers in the service area will have the same quality of care as those who live in areas with more financial resources.

Collaborative partners are already producing reports and collecting data that will help take a closer look at each organization, their workforce, hiring practices, current impact on disparities, outcomes for each population, and the interventions that are taking place to address SDOH. One key component that the Collaborative is improving care coordination and developing a system to capture data collectively, make referrals to partner agencies, and track the outcomes of the referrals. This information will allow the Collaborative to better understand of the needs, and assess the interventions or group of interventions that prove to be most effective in addressing SDOH and improving health outcomes. Refining the methods for data collection and the quality of the data captured will help the collaborative remain focused, impartial, and accountable for the results throughout and after implementation. The Patient Advisory Committee will allow meaningful involvement of stakeholders and accountability to the community.

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

Exhibit 04.02 displays the benchmarks and success indicators related to racial equity. Based on the results of the first quarterly assessment of patient population diversity data, the findings from the community survey, and the level of meaningful stakeholder engagement achieved during the first quarter, the Collaborative will work with the SSH Patient Advisory Committee to identify where strategies should be adjusted, or whether there is a need to develop new methods to engage community members more effectively and equitably.

Exhibit 04.02

Success Indicator	Indicator	Evaluation/Assessment Method	Frequency of Evaluation
Patient Population Is reflective of racial and ethnic	Racial and Ethnic Composition	Data from Electronic Medical Records	Quarterly

diversity of the community.		systems	
Board of Directors Is reflective of racial and ethnic diversity of the community.	Racial and Ethnic Composition	Survey of incoming board members	Annually
New Employees / Promotions Collaborative partners hire and promote employees who represent the racial and ethnic diversity of the community.	Racial and Ethnic Composition of new hires and staff promoted	Analyze reports from human resources data	1st Qtr - Yr 1 3rd Qtr – Yr 1 Annually - Yrs 2, 3, and 4
Subcontractors/Providers hired by Collaborative partners are reflective of racial and ethnic diversity of the community.	Racial and Ethnic Composition of leadership or providers	Analyze new contracts data	Semi-Annually
Community Input The local community is informed and engaged. Their feedback utilized in decision-making.	Level of local community engagement and participation	Community survey and input from Patient Advisory Board	Quarterly
Patient Advisory Group is actively engaged in the implementation and oversight of the project.	Includes representation and reflection of the community's racial composition	Survey Patient Advisory Board participation	Quarterly

5. Community Input

Service Area of the Proposed Intervention

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

South Shore Community in Chicago

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

(Hold CTRL+click on a PC or command+click on a Mac to select multiple counties).

Select counties:

Cook County

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

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

Community Input

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

Community and stakeholder input, along with the findings from the comprehensive community needs assessments, informed and drove the development of the model for this system of care and the planning process. The following is a detailed description of the service area, the needs assessments, community involvement, methodology and results.

Collaborative Community Service Area. The South Shore Community Behavioral Health System of Care (SSCBHSC) collaborative serves the South Shore community and 16 surrounding areas of throughout 8 zip codes in the City of Chicago with an estimated population of 428,700[6] individuals. The majority of the population within the service area identifies as African American/black (87%). Nine percent (9%) of the population identifies as Hispanic/Latinx, and three percent (3%) as non-Hispanic white. The majority of the patient population resides in the South Shore community. The primary patient population is geriatric with low to moderate income levels. Please refer to Exhibit 05.01.

Exhibit 05.01

SSCBHSC Collaborative Service Area Population by Zip Code	
Zip Code	**Population**
60617	83,553
60619	61,207
60620	67,711
60621	28,018
60628	64,254

SSCBHSC Collaborative Communities in Service Area	
Auburn Gresham	Roseland
Avalon Park	South Chicago
Burnside	South Deering
Calumet Heights	South Region
Chatham	South Shore
East Side	West Englewood

60636	30,024
60637	47,300
60649	46,633
TOTAL	**428,700**

Englewood	West Pullman
Greater Grand Crossing	Woodlawn
Pullman	

Establishing Community Needs and Community Input Strategy. In 2019, the South Shore Hospital (SSH) and members of the Alliance for Health Equity (AHE), a collaborative of 35 non-profit hospitals, two public hospitals, six health departments, and nearly 100 community-based organizations, worked together between March 2018 through March 2019 to conduct a comprehensive Community Health Needs Assessment (CHNA) for Chicago and Suburban Cook County. This comprehensive assessment included focus groups, surveys, and service provider input.

Also, during the months of August and September 2021, the South Shore Community Behavioral Health System of Care Collaborative engaged in a second community needs assessment specific to the proposed project, in order to gage the level of support from stakeholders, elected officials and community members. This needs assessment would also assist the collaborative validate needs from 2019 or identify evolving needs, as the reality of the communities we serve have been significantly altered by the COVID-19 pandemic. The 2021 community engagement strategy included:

- Over 15 meetings with FQHC partners to assess the needs and establish collaborations
- A community kick-off webinar to share information about the Collaborative and seek meaningful community feedback on the proposed approach (27 attendees representing health plans, the State of Illinois, Community Behavioral Health Providers, local clergy, local elected officials and community organizations, and other HFS funded collaboratives)
- A community and patient survey including SSH and partner organizations
- Outreach and engagement with elected officials, including securing letters of support.

[6] https://www.illinois-demographics.com/zip_codes_by_population (Original source: United States Census Bureau. B01001 SEX BY AGE, 2019 American Community Survey 5-Year Estimates. U.S. Census Bureau, American Community Survey Office. http://www.census.gov/)

Input from Elected Officials

1. Did your collaborative consult elected officials as you developed your proposal?

☒Yes
☐No

1A. Select legislators:

Name	Position	Government Entity
Marcus C. Evans	Assistant Majority Leader	State Representative 33rd District
Elgie R. Sims, JR.	State Senator, 17th District	Illinois State Senate
Michelle A. Harris	Alderman, 8th Ward	City of Chicago City Council

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

Prior to finalizing the proposed approach and model, the Collaborative shared information with elected officials to share information and seek their support for this initiative. State, county, and local

elected officials were also invited to the community kick-off. As the project moves forward, the Collaborative will continue to share progress and outcomes, and seek opportunities to further collaborate. Through these relationships, the Collaborative is laying the foundation for opportunities to secure additional funding as part of the sustainability plan.

6. Data Support

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

Data Used in the Design and Planning Phases and Methodology of Collection

- **Primary Data**
  - 2019 CHNA data collected through four methods:
    - Community input surveys – 432 responses
    - Community resident focus groups and learning map sessions - 57 focus groups with priority populations such as veterans, individuals living with mental illness, communities of color, older adults, caregivers, teens and young adults, LGBTQ+ community members, adults and teens experiencing homelessness, families with children, faith communities, adults with disabilities, and children and adults living with chronic conditions such as diabetes and asthma.
    - Health care and social service provider focus groups
    - Two stakeholder assessments led by partner health departments: A Forces of Change Assessment and Health Equity Capacity Assessment
  - 2021 CHNA data collected through 3 methods:
    - Community input surveys in English and Spanish – 90 responses
    - Community and Stakeholder Kick-off Meeting – 27 participants
    - Project partner meetings - 15 meetings
- **Secondary Data**
  - Secondary data for the CHNA was compiled and analyzed in partnership with epidemiologists from Chicago Department of Public Health, Illinois Public Health Institute, and member hospitals.

The 2019 community input survey was a qualitative tool designed to understand the health needs and assets within communities. A total of 432 individuals from the SSH service area responded to the survey, of which 84% were African American, 8% Black, 6% Hispanic/Latinx, and 2% White. Findings from this assessment informed the selection of priority areas and strategies for community health improvement.

The 2021 community survey gathered data related respondents' type of health care coverage and primary provider, healthcare services received, additional services needed in the community, barriers to care, and input on the collaborative's model. Project partners administered the survey to patients and clients, and the survey was available in English and Spanish (Exhibit 06.02). A total of 90 individuals responded, of which 84.4% were African American/Black, 7.8% White, 2.2 Asian, 1.1% Hispanic/Latinx, 2.2 Other and 2.2% Unknown.

Data obtained through the needs assessments and stakeholder meetings was used to frame the proposed model and establish the expected outcomes and activities.

Results of the Analysis. The 2019 community survey asked residents about top health issues, top needs for a healthy community, greatest strengths in the community, and what needs to be improved. Based on the responses, the top five needs identified were diabetes, mental health, violence, substance use, age-related illnesses, and heart disease and stroke. In addition, when asked about the most important factors for a healthy community, the majority of the respondents identified

access to care and mental health as the number one factor. Socioeconomic inequities, including community economic investment and development, employment opportunities, quality affordable housing, education opportunities, community safety, and food access were highlighted. These inequities were exacerbated by the catastrophic impact of the COVID-19 pandemic. According to the Chicago COVID-19 Community Vulnerability Index (CVI)[7] (Exhibit 06.01), seven out of the eight zip codes in the Collaborative's service area are among the top 20 most vulnerable communities in the state, with 60636 ranked as the community with the highest vulnerability in the state (58 Chicago zip codes reported).

A major theme that emerged from the focus groups was chronic stress. Focus group participants linked chronic stress to different health effects. Community members reported that stress impacted their ability to cope with chronic illnesses such as diabetes and could disrupt their ability to engage in behaviors such as healthy eating and exercise. Parents caring for children with asthma reported that the stress of caring for a family member had negative impacts on their mental and physical well-being. Youth living with asthma reported that stress was a trigger for their asthma attacks. Participants from one focus group directly linked chronic stress to the development of substance use disorders. In addition to chronic stress, focus group participants described a number of situations that have led to trauma among community members living on the South Side including:

- Child abuse
- Domestic violence
- Living in high crime neighborhoods
- Continual discrimination against marginalized racial and ethnic groups
- Homelessness.

Exhibit 06.01

Zip Code	CVI	Rank (Out of 58)
60636	62.5	1
60621	53.3	4
60628	48.8	12
60620	48.1	13
60617	47	14
60619	46.5	16
60649	44.6	19
60637	36.4	23

Multiple participants on the South Side of Chicago mentioned barriers that impede their ability to access the healthcare system and community resources including:

- Complexity of obtaining and keeping public benefit coverage
- High cost of some private insurance plans;
- Unequal distribution of healthcare services and facilities; and
- Poor quality healthcare options particularly for LGBTQ+ individuals and people of color.

The 2021 Community Survey Results (Exhibit 06.03)

- Overall demographics: In addition to the racial distribution already provided, 61 of respondents were female while 29 were male.

- The majority of respondents reside in the following zip codes: 60649 (32%), 60617 (14%), 60619 (10%), 60628 (6%), 60653 (3%)
- In terms of age distribution, 7% were under the age of 34, 21% between the ages of 35-54, 49% ranged between 55-74 years old, and 23% were over 75 years old.
- Ten percent (10%) are enrolled in Medicaid and 29% are enrolled in Medicare. A total of 39% reported private insurance, and 2% were uninsured. Other respondents had a combination of the categories already mentioned.
- Sixty-eight percent (68%) of respondents reported having a Primary Care Home (PCH), while 24% did not have a PCH. Eight percent (8%) did not respond.

When asked what types of health care services would be helpful to have more access in the South Shore Community, responses included:

- Behavioral health provider who can provide mental health counseling and therapy – 46%
- Linkage to services in that help keep you and your family healthy – i.e. connections to food pantries, transportation, utility payment assistance and housing resources – 36%
- Care for your chronic conditions such as: diabetes, asthma, and heart disease – 33%
- Care for substance use disorders and addiction – 23%

The following were identified as **barriers to care** in the community:

- Need after hour appointments – 25%
- Doctors or specialists are not available in their area – 22%
- Do not have health insurance - 20%
- Need transportation to services – 18%
- Health insurance is difficult to utilize – 9%
- Doctors are not accepting new patients – 7%
- Don't know how to find a doctor – 7%
- Language barriers – 4%

Exhibit 06.03

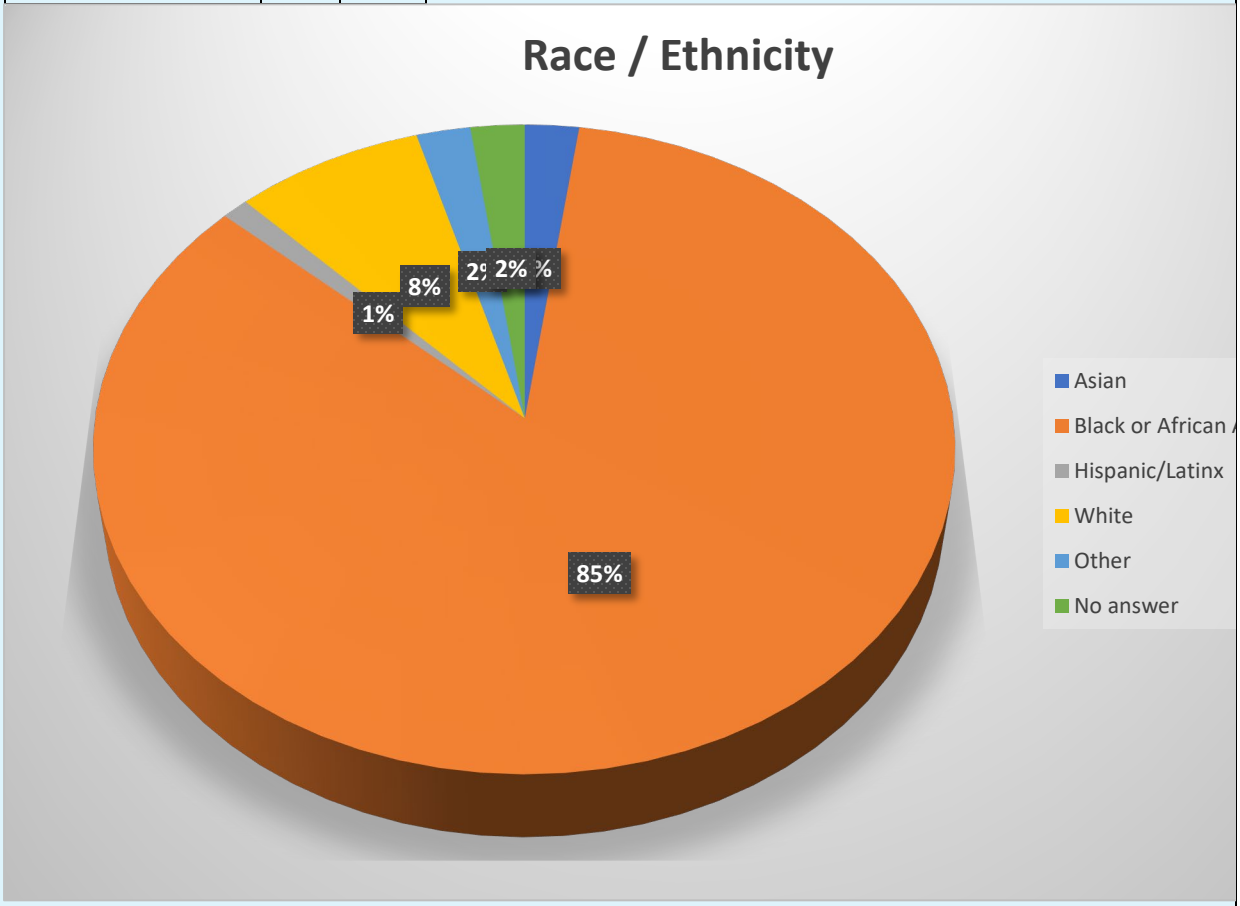
Gender	
Female	61
Male	29

Zip Code	
60649	32%
60617	14%
60619	10%
60628	6%
60653	3%
Unknown	4%
Other Zip Codes*	31%

*-Many other zip codes with 1-2 patients.

Age		
18-24	1	1%

25-34	5	6%
35-44	9	10%
45-54	10	11%
55-64	25	28%
55-65	1	1%
65-74	18	20%
75 years or older	21	23%



Type of Insurance	#
Medicaid	9
Medicare	26
Dual	5
Private	35
Private and Medicare	6
Uninsured	2
Other or blank	7

Have Primary Care Home	
Yes	61

No	22
Unknown	7

What health care services do you think would be helpful to have more access to in the South Shore Community?	
a. Care for your chronic conditions such as: diabetes, asthma and heart disease.	33%
b. Care for substance use disorders and addiction.	23%
c. Linkage to services in that help keep you and your family healthy – i.e. connections to food pantries, transportation, utility payment assistance and housing resources.	36%
d. Behavioral health provider who can provide mental health counseling and therapy.	46%

What prevents you from getting the healthcare you need? (mental health or physical health related care) - Selected Choice" (55 people responded to this question)	
a. You do not have health insurance	20%
b. Your health insurance is difficult to utilize	9%
c. You need after hour appointments	25%
d. You need transportation to services	18%
e. Doctors or specialists are not available in my area	22%
f. Doctors are not accepting new patients	7%
g. Language barriers	4%
h. Don't know how to find a doctor	7%

When looking at the above model – what are the 3 areas of this model that you think are the most important to improve health and wellness in the South Shore Community? 79 Answers		
a. Community Input	26	33%
b. Inpatient Psychiatric Care	22	28%
c. Pre-discharge Care Coordination	11	14%
d. Community Behavioral Health	31	39%
e. Access to Primary Care	27	34%
f. Linkage to Social Needs	33	42%
g. Patient Centered Care	27	34%

Do you support the South Shore Community Behavioral Health System of Care model? Please rank your level of support. (63 Answered the question)		
5- Very Supportive	29	46%
4- Supportive	17	27%
3- Somewhat Supportive	7	11%
2- Unsure	10	16%
1- Do not support	0	0%

[7] https://data.cityofchicago.org/Health-Human-Services/Chicago-COVID-19-Community-Vulnerability-Index-CCV/2ns9-phjk

7. Health Equity and Outcomes

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

The following disparities were identified through the Community Needs Assessment. These are provided as a point of reference and context. Regarding race and ethnicity, it is important to mention that 82% of individuals who participated in the 2019 needs assessment identify as African American and 6% identify as Latinx/Hispanic. These demographics are also a reflection of the patient population for all partners in the collaborative. Please refer to Exhibit 07.01.

Exhibit 07.01

Health Disparities in the Collaborative's Service Area[7]

	FPL< 100%	Children in Poverty	Median Income	% Unemployed Adults 16+	Cost-Burdened Households	No High-School Diploma	Life Expectancy	% Low Birth-weight	Infant Mortality # per 1K	Teen Births
CHICAGO	**19%**	**28%**	**$53,006**	**8%**	**36%**	**16%**	**77**	**10%**	**7**	**25**
Auburn Gresham	29%	42%	$29,285	24%	45%	17%	72	15%	14	40
Avalon Park	21%	18%	$37,208	24%	43%	12%	75	13%	21	32
Burnside	33%	8%	$23,684	18%	50%	19%	70	16%	13	48
Calumet Heights	17%	26%	$46,581	14%	35%	11%	74	15%	20	34
Chatham	29%	37%	$34,612	19%	46%	12%	74	14%	13	41
East Side	20%	34%	$44,079	18%	34%	30%	79	8%	5	35
Englewood	45%	56%	$22,507	35%	56%	25%	71	17%	18	53
Greater Grand Crossing	37%	55%	$28,154	24%	48%	15%	71	15%	14	53
Pullman	25%	32%	$36,777	20%	39%	13%	72	13%	19	32
Roseland	30%	39%	$38,562	26%	43%	15%	72	14%	12	39
South Chicago	31%	45%	$27,692	22%	44%	20%	72	12%	12	42
South Deering	30%	45%	$31,878	25%	37%	20%	75	11%	11	34
South Region										
South Shore	38%	54%	$26,906	21%	53%	12%	72	13%	13	42
West Englewood	36%	49%	$27,911	34%	45%	23%	69	16%	13	61
West Pullman	29%	44%	$37,675	25%	41%	16%	72	13%	12	42
Woodlawn	40%	51%	$25,364	18%	47%	14%	75	14%	11	33

The following health disparities and underlying causes will be addressed through the proposed project.

Medical Professional Shortages[8]**.** Health Professional Shortage Areas (HPSAs) are geographic areas of health care provider shortages in primary care, mental health, or dental health. Primary care and mental health HPSAs are scored on a scale of 0-25 with higher scores indicating greater need. As shown in Exhibit 07.01, the communities of the Collaborative's service area, particularly South Shore

[7] SSH 2019 Community Health Needs Assessment. https://www.southshorehospital.com/wp-content/uploads/2019/12/FINAL-South-Shore-Hospital-Report_13November2019.pdf

Greater Grand Crossing, South Chicago, and East Side are in great need of primary care health providers. In regard to mental health, all communities in the Collaborative's service area have mental health professional shortages.

Mental Health and Substance Use Disorders. Mental Health provider shortages are experienced across the Collaborative's service area. The rate of emergency room usage due to mental health is relatively high in Collaborative's service area and varies greatly between zip codes. The lowest rate is 137 per 10,000 persons in zip code 60617 and the highest is 262 per 10,000 persons in zip code 60621. The rate of emergency room usage due to substance use ranges from 35 per 10,000 persons in zip code 60617 and 88 per 10,000 persons in zip code 60621.

Food Insecurity and Access. Risk of food insecurity disproportionately affects almost all of the communities within in the Collaborative's service area at alarmingly high rates. This lack of access to sufficient and/or healthy food also affects the health and wellbeing of the community and leads to poor health outcomes. With the exception of Chatham and Avalon Park, all of the communities in the Collaborative's service area have a risk higher than the citywide risk of 39%. Englewood has the highest risk of food insecurity at 72%.

Leading Causes of Death and Chronic Disease Risk Factors. Rates of obesity and overweight adults in Chicago are similar to national rates; 39.8% of adults reported being overweight, and 31% of adults reported obesity in Chicago for the time period between 2015 and 2017. With the exception of Pullman, all communities served by the Collaborative have obesity rates higher than the citywide rate. The rate of self-reported diabetes in Chicago is 9% among adults, and the rates are higher in almost all of the communities within the Collaborative's service area. The rate of emergency department visits due to diabetes is high in zip code 60621 at a rate of 83 per 10,000 people.

Emergency Department Visits. Emergency department visits due to asthma are particularly high in the Collaborative's service area. Every zip code in SSH's service area has more than 100 per 10,000 emergency department visits due to asthma, with zip codes 60636 and 60621 having greater than 200 per 10,000 per persons.

After careful consideration and strategic analysis, the Collaborative determined that it is well positioned to collectively address these disparities based on the strengths, capacity, and assets of our partners. These disparities also align with the most pressing needs and barriers identified through the needs assessments.

[1] Health Professional Shortage Areas (HPSAs). (May 2019). Retrieved from: https://bhw.hrsa.gov/shortage-designation/hpsas on October 31, 2019.

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

In order to address these disparities, the Collaborative will:

- Meet the increasing needs for inpatient behavioral health services in the community.

- Utilize community-based care coordinators and social workers that will be located in the FQHCs to assist patients in the psychiatric unit identify and meet their needs around primary care, behavioral health care after discharge and SDOH.
- Engage in partnerships with organizations that will help patients who experience food insecurity, make referrals and track the patients' progress.
- Facilitating and tracking the referrals to meet those social needs through a uniform SDOH assessment and referral system.
- Engage the local community in improving community health outcomes.

Based on the results of the CHNAs, the Collaborative has identified a set of interventions and desired outcomes. The proposed activities include and strategic partnerships are designed to support the achievement of these outcomes, which are aligned with the Healthcare Transformation Collaboratives priorities.

- Reduce the number of psychiatric admission transfers to other facilities by 80% in the first 2 years.
- Reduce the number of psychiatric readmissions at 30, 60, and 90 days post hospitalization by 50%
- Complete closed loop care plans at discharge for 100% of patients.
- 75% of discharged eligible inpatients will receive 7-day and 30- day follow-up visits post hospitalization for mental illness
- 75% of eligible patients discharged from mental illness related Emergency Department visits will receive 7-day and 30-day follow-up visit
- 75% of unique individuals without a Primary Care Physician (PCP) will schedule and attend a PCP visit within 30 days of discharge from hospital or emergency department.
- 100% of patients in the inpatient psychiatric setting and the FQHCs will receive care management services.
- 90% of patients in the inpatient psychiatric setting and the FQHCs will complete a SDOH assessment.
- 90% of patients with identified SDOH needs will receive referrals to community partners.
- 60% of patients referred to social services will attend their schedule appointment.
- 75% of referral outcomes will be tracked and documented. (By year 2)
- 80% of patients with housing needs, who voluntarily request housing services, will receive housing case management.
- 85% of patients with identified food insecurity will receive a referral to the food security partner closest to their home.

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

Collaborative partners have a real understanding of the everyday challenges of these communities. Serving them for many years, and having the trust of their community members and patients is a key component to engage in open and honest conversations around social needs, behavioral health needs and disparities. According to a study from the National Institute of Health[9], from a clinical perspective, patients reported more beneficial health behaviors, less symptoms and higher quality of life and to be more satisfied with treatment when they had higher trust in their health care professional. Patients' trust in their health care professional is central to clinical practice. The General Medical Council states that "patients must be able to trust doctors with their lives and health" and

that maintaining trust is one core guidance for physicians. The Collaborative partners know their patients and, in many cases, have long-term relationships with them. This trust is also essential in order to have meaningful and productive conversations around SDOH, as patients feel very vulnerable as they discuss delicate issues around housing, food, childcare, and many other potential needs. For Latinx patients or those who are immigrants, vulnerability is exacerbated by the fear of deportation or children being removed from the household. Collaborative partners are well positioned to achieve the intended results and continue to improve the lives of individuals and families in South Chicago.

[2] "Trust in the health care professional and health outcome: A meta-analysis" https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5295692/

8. Access to Care

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

Our proposal addresses the following obstacles and barriers:
(1) The lack of comprehensive behavioral health (BH) services in the community that is provided through a continuum of care system.
(2) The inability of individuals to gain timely access to treatment based on their required inpatient or outpatient level of care, leading to unnecessary repeat ED visits.
(3) Limited adult inpatient capacity within the South Shore hospital catchment area requiring patients to transfer from South Shore ED to inpatient facilities in other geographic area. This is compounded by the out of area hospitals lacking a care transition system that would facilitate BH patients returning to their communities to get follow up care.
(4) The need to expand BH capacity available through community providers. There is also a need for this care to be rendered as part of integration with primary care.
(5) The lack of integration of BH into primary care practices that is needed to ensure total health care needs are met. The current system requires the patient to navigate complex processes to obtain primary care which is complicated by the individual's BH status.
(6) The difficulty BH patients encounter obtaining needed social services and assistance. This difficulty impacts BH patients' health engagement and ability to achieve positive outcomes.

Causes of the obstacles and barriers

- Insufficient inpatient beds in the area for adults 19 to 64 years.
- Access to available primary care and SDOH resources is inconsistent and not well coordinated leading to recidivism at the highest acuity level. Patients experience difficulty navigating system required to gain access to needed services.
- The health providers in the catchment area have loose affiliations and lack alignment across the health care continuum. Provider entities' rules and arrangements with insurers require special knowledge to gain timely access that is not easy for patients to get working on their own.
- Overall complex and disconnected systems with unique requirements, are difficult for patients to navigate especially patients confronting behavioral health issues.

Rationale for Collaborative Projects
Major contributing factors impeding access include:

- insufficient capacity not enough BH providers and not enough BH beds in the community
- Difficult for patients to know community-based services exist and how to meet requirements to use these existing services
- lack of culturally appropriate care coordination and management system to assist patients in navigating complex criteria and nonaligned care givers

The Collaboratives' approach and the proposed program address these contributing factors and the underlying causes that are described above.

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

Collaboratives projects that will improve access:

- An acute BH inpatient unit that is directly linked to community health providers through a seamless continuum of care network will be created to address the gap in inpatient BH services. The BH inpatient unit with 18 additional beds will located within South Shore hospital serving an adult 18–64-year-old population.

- BH services will be expanded at CFHC and CCHC to provide additional community-based services supplementing existing services. Additional BH providers will provide counseling and therapeutic services. Additional case managers and community health workers will coordinate services and assist patients with transitions between levels of care and facilitate patient access to social services.

- Improving access to these expanded BH services and connecting patients to existing primary care will be addressed with the alignment of the new inpatient BH service to community-based care through a newly created care management infrastructure. Care managers, social workers and community health workers will navigate the complex systems, rules and arrangements to facilitate and smooth the transition from one level of care to another giving patients access to community based BH services and primary care services. The system will include structured screenings, real time communication and patient data sharing between partners, commitment from partners to timely availability of services and a monitoring and tracking system to keep patients consistently engaged at the appropriate level of care.

- A care coordination system will also be used to connect patients with social service agencies. Existing relationships between FQHCs and CBOs will be leveraged to help patients address issues related to SDOH. The coordination system design is a closed loop system to ensure patients receive needed services and clinical providers receive real time information and updates on patients' status.

Collaboratives programs impact

The collaboratives programs will have the following impact on BH and integrated BH services provided in the South Shore community:

- Reduction in BH patient wait time in ED to be admitted to inpatient service.
- Fewer transfers out of the SS ED to inpatient units in other areas, keeping care within the community.
- BH patients will receive follow up care in the community at the appropriate level.
- Patients will have an assigned PCP to address all health care concerns including non-BH chronic conditions.
- Patients will receive social services that have been a barrier to getting needed clinical care.

Vulnerable patients will receive care at the appropriate level in a system that provides ongoing support including a system that will have continuous monitoring to sustain patients' engagement in health care.

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

- Collaborative partners are well grounded in the community and will be trusted by patients.
- Partners have long history in the community, with staff who know the community and are committed to ensuring improved access.
- The initiatives are evidenced based and strongly supported by providers who have long sought these remedies.

9. Social Determinants of Health

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

Social Determinants of Health. Based on the findings from the community needs assessment, the Collaborative will focus on two main SDOH, food security and housing. In addition, the Collaborative will work with patients to assess their needs and connect them with health insurance and healthcare resources when patients are uninsured or underinsured. Although the Collaborative will focus directly on food security and housing, patients will also be assessed in the following domains: transportation, employment, education, childcare, and financial strain. Social workers and community health workers will conduct follow-up assessments during follow-up visits and other interactions with the patients.

Collaborative members will utilize a modification of the PRAPARE SDOH assessment (Exhibit 09.01). Patients will be assessed in different settings including while in the inpatient unit, while receiving services at the Collaborative partner organizations, and during follow-up visits. During year 1, the Collaborative will work to identify a system or platform to capture SDOH data, make and track referrals, analyze SDOH data to identify effective interventions, and produce reports for funders and stakeholders.

The major themes that emerged from focus groups on the South Side included access to social services, limitations in the food systems, chronic diseases such as asthma and diabetes, access to care and community resources, behavioral health, and community safety and violence. Other underlying causes of the identified SDOH needs include lack of community economic investment and development, employment opportunities, quality affordable housing, education opportunities, community safety, and access to healthy food. These are directly tied to poor management of chronic disease and behavioral health conditions.

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

The Collaborative has identified a set of SDOH domains that will be prioritized and addressed based on findings from the CHNA. Community health workers will assess all patients during their first interaction using the PRAPARE SDOH assessment (Exhibit 09.01). Once social needs are identified and patients determine which services they would like to receive, referrals will be made to community partners. Christian Community Health Center currently provides assessments, connect patients to other medical and dental health services, and is equipped to meet other immediate needs, such as clothing and other personal care items.

Food Security: Participants on the West and South Sides of the city county reported a high proportion of fast food restaurants and limited access to grocery stores selling healthier options. Community members living with chronic diseases such as diabetes explained that living in communities with less access to healthy food options and more access to fast food made it more difficult to manage their conditions.

Exhibit 09.01- PRAPARE SDOH Assessment

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

Yes	No	I choose not to answer this question

2. Which race(s) are you? Check all that apply

Asian	Native Hawaiian
Pacific Islander	Black/African American
White	American Indian/Alaskan Native
Other (please write):	
I choose not to answer this question	

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

Yes	No	I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

Yes	No	I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? ____

I choose not to answer this question

7. What is your housing situation today?

I have housing
I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
I choose not to answer this question

8. Are you worried about losing your housing?

Yes	No	I choose not to answer this question

9. What address do you live at?
Street:_____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

Less than high school degree	High school diploma or GED
More than high school	I choose not to answer this question

11. What is your current work situation?

Unemployed	Part-time or temporary work	Full-time work
Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:		
I choose not to answer this question		

12. What is your main insurance?

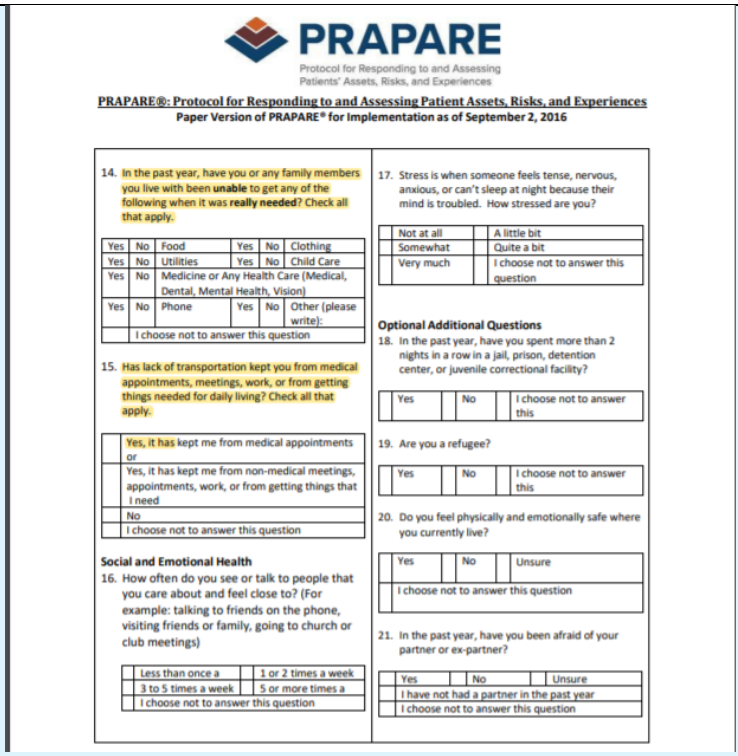
None/uninsured	Medicaid
CHIP Medicaid	Medicare
Other public insurance (not CHIP)	Other Public Insurance (CHIP)
Private Insurance	

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

_____

I choose not to answer this question

OPCA



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14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
		I choose not to answer this question			

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

- Yes, it has kept me from medical appointments or
- Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
- No
- I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

Less than once a	1 or 2 times a week
3 to 5 times a week	5 or more times a
I choose not to answer this question	

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

Not at all	A little bit
Somewhat	Quite a bit
Very much	I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

Yes	No	I choose not to answer this

19. Are you a refugee?

Yes	No	I choose not to answer this

20. Do you feel physically and emotionally safe where you currently live?

Yes	No	Unsure
I choose not to answer this question		

21. In the past year, have you been afraid of your partner or ex-partner?

Yes	No	Unsure
I have not had a partner in the past year		
I choose not to answer this question		

Proposed Intervention:

Community health workers and social workers will conduct SDOH assessments. Patients who disclose food security needs will be connected with the most appropriate food resource based on their location and any other specific needs. During follow-up visits, community health workers will continue to assess social needs and determine if the resources identified are the most appropriate for the patient, or if additional referrals are needed. By year two, the Collaborative will have a system in place to track those referrals and coordinate care with additional partners.

Housing and Homelessness. Homelessness and housing instability are associated with high rates of mortality and morbidity. Housing instability does not have a standard definition and encompasses several issues including difficulty paying rent, overcrowding, frequent moves, living with relatives, and cost-burdened housing. Focus group participants on the South Side of Chicago highlighted that segregation results in poor quality housing being concentrated in communities of color with high rates of violence and poverty. Some of the housing quality issues mentioned included dilapidated and crumbling structures, incomplete units, plumbing problems, and pest infestations. The health problems that were most often associated with these housing quality problems included exposure to mold, asthma, and stress. Children were identified as being at a higher risk for health problems associated with poor quality housing. A further complication is that several residents reported living in buildings where smoking is allowed within units and explained that this can further exacerbate health issues such as asthma.

Adults and youth who are experiencing homelessness and housing instability reported several health problems that were a direct result including hypothermia, frost bite, severe weight fluctuations, gangrene, poor sleeping habits, and severe stress. Behavioral health conditions such as mental illness and substance use disorders were identified as both a cause of homelessness and the direct result of homelessness or housing instability.

Proposed Intervention:
Christian Community Health Center will address the housing needs of patients who disclose facing housing insecurity. Services available through their housing program include:

- Case Managers meet with a client at minimum of once a week
- Provide Intensive Case Management
- Assist clients with completing Housing Assessments
- Assist clients with developing Housing Plans and housing search/resources
- Provide life skills trainings
- Tenant Rights and Responsibilities
- Assist clients with developing an Individual Support Plan (ISP)
- Assist clients with obtaining vital documents
- Assist clients with developing a budget
- Refer clients to employment training programs/agencies
- Assist clients in establishing a savings plan
- Assist clients with credit counseling
- Enroll clients into the Central Referral System (CRS)
- Assist client with stabilization
- Link clients to available wrap around services after discharge.

CCHC works with the local coordinated entry systems and will ensure that patients are evaluated and supported while they are able to secure a safe place to live.

The Collaborative will achieve will work to achieve the following outcomes:

- 90% of patients in the inpatient psychiatric setting and the FQHCs will complete a SDOH assessment.
- 90% of patients with identified SDOH needs will receive referrals to community partners.
- 80% of patients with housing needs, who voluntarily request housing services, will receive housing case management.
- 85% of patients with identified food insecurity will receive a referral to the food security partner closest to their home.

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

Research has overwhelmingly linked food insecurity and homelessness or poor housing conditions to poor health outcomes. Healthy food continues to be particularly limited for low-income communities, communities of color, and rural areas. The research also suggests that access to healthy food corresponds with a good diet and lower risk for obesity and other diet-related chronic diseases[10]. Also, homelessness increases the risk of developing health problems such as diseases of the extremities and skin disorders; it increases the possibility of trauma, especially as a result of physical assault or rape. It can also turn a relatively minor health problem into a serious illness[11]. As the Collaborative has learned based on the results of both needs assessments, food insecurity and

[10] Policy Link and the Food Trust. "Access to Healthy Food and Why it Matters". http://thefoodtrust.org/uploads/media_items/access-to-healthy-food.original.pdf
[11] Institute of Medicine (US) Committee on Health Care for Homeless People. Homelessness, Health, and Human Needs. Washington (DC). Health Problems of Homeless People. https://www.ncbi.nlm.nih.gov/books/NBK218236/https://www.ncbi.nlm.nih.gov/books/NBK218236/

housing are at the top of the needs of South Chicago. The proposed activities are designed to assist patients in addressing both needs. Once the Collaborative is able to track referrals and interventions, additional data will be available to measure the impact of the proposed activities. Additionally, project activities assisting patients access behavioral and physical healthcare services will be part of the continuum of services designed to improve the overall health of these communities disproportionally affected by health disparities.

[1] Policy Link and the Food Trust. "Access to Healthy Food and Why it Matters". http://thefoodtrust.org/uploads/media_items/access-to-healthy-food.original.pdf

[1] Institute of Medicine (US) Committee on Health Care for Homeless People. Homelessness, Health, and Human Needs. Washington (DC). Health Problems of Homeless People. https://www.ncbi.nlm.nih.gov/books/NBK218236/https://www.ncbi.nlm.nih.gov/books/NBK218236/

10. Care Integration and Coordination

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

Our proposal responds to a deficit in BH care coordination services throughout the community. BH services are currently provided on an episodic basis. BH services are provided in both hospital and community settings. The community health centers provide limited BH service and limited integration of BH with primary care occurs sporadically. A very inefficient system exists with the burden for accessing services largely the patient's responsibility. The patient's ability to obtain needed services is dependent on having knowledge of provider systems and requirements. This information is not easily obtained by the public.

The foundation of our Collaborative's programs is care coordination. The new care coordination infrastructure establishes a seamless transition from the hospital to community health and social service programs based on patient needs. The care coordination will provide navigation to guide the patient through different system requirements with the goal of ensuring patients receive appropriate behavioral health, primary care at the appropriate level while simultaneously addressing social needs. The process incorporates a patient centered model, that achieves efficiency by reducing the number of interactions needed to connect patients with needed services. This will achieve positive outcomes and will do so while eliminating multiple entities reaching out frustrating patients that leads to noncompliance.

Care coordination will be anchored within CFHC and CCHC, led by the primary care providers working with the care coordination team. The team includes social workers for hospital-based care coordination and community managers and coordinators working directly in CFHC and CCHC locations providing strong access and linkages to facilitate warm hand offs and a closed loop process. The closed loop process ensures patients received services and is a platform for information exchange among participants responsible for different aspects of care. The care plans developed by care coordinators working with the PCP and other clinical staff provides the roadmap for coordinating services.

Community based staff will coordinate all health care services patients require including, BH, primary care, specialty care. This care coordination system will also be used to connect patients with social service agencies. Existing relationships between FQHCs and CBOs will be leveraged to help patients address issues related to SDOH. The coordination system design is a closed loop system to ensure patients receive needed services and clinical providers receive real time information and updates on patients' status.

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

☒Yes
☐No

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

75 per TOC case manager – assuming entire caseload is at High-Risk and the cost is derived from looking at the salary of the LCSW/RN Case manager and dividing by # of patients managed.

Per NACHC references, the expected caseload numbers for a care manager caring for Rising or High-Risk patients (which are our population), the caseload would be 50-100 individuals. Our population is likely to be stratified mostly as high risk or medically complex, based on the number of medical/behavioral health conditions presented: so they would need to be managed by an LCSW or RN – we are not likely to be referring back and forth those patients that are in the lower risk stratifications due to the nature of the proposal.

Cost can also be offset by hospital for some services being billable for care management to high risk/medically complex patients. Resources found for billing in below links as well.
https://www.nachc.org/wp-content/uploads/2019/03/Risk-Stratification-Action-Guide-Mar-2019.pdf
https://www.nachc.org/wp-content/uploads/2017/09/Action-Guide_Pop-Health_Models-of-Care-Sept-2017.pdf

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

☐Yes
☒No

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

☒Yes
☐No

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

County care managed care members are the majority of enrollees at CFHC and CCHC. The largest number of managed care patients using South Shore hospital also are County Care plan enrollees. In developing the Collaboratives care coordination approach, the model was shared with County Care. County Care enrollees have access to care coordination through an existing program. The intent in sharing information about the project is to leverage and ensure alignment with existing County Care coordination practices. These discussions will be ongoing to be certain resources are used effectively.

Non-County Care patients receive services at South Shore hospital, CFHC and CCHC. Some of these patients are enrolled with other managed care organizations. The Collaborative's philosophy is to provide a consistent level of service and coordination for all patients regardless of their insurance status. The Collaborative will similarly work with all managed care organizations to establish alignment and coordinated outreach to patients.
The Collaborative will work with managed care organizations to enhance patients' access to services that address the social determinants of health using existing or future MCO programs for this area.

11. Minority Participation

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

List entities here:

South Shore Hospital, Chicago Family Health Center, Christian Community Health Center

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

Each entity will have a role during implementation and in the ongoing operation of the delivery system. Refer to Exhibit 11.01 for the Board Makeup of each entity.

+ Partnership with the FQHCs will ensure linkage to primary care.
+ Goal of Integrated Primary Care-Behavioral Health is to take population-based approach to identify BH needs in primary care panel and aid patients in self-management of chronic BH and medical conditions.
+ Population Health data states that at least 60 percent of FQHC medical patients have some underlying or comorbid BH condition that also requires treatment.
+ Overlap between physical and behavioral health services has increased 50% over baseline since the pandemic.
+ Goal is to match patients with the right level of care at the right time and lower cost, improve quality, patient and provider satisfaction.
+ This collaborative will ensure that patients served by South Shore's inpatient psychiatric beds will effectively link to outpatient care upon discharge.
+ FQHCs will identify patients who require inpatient care for mental health or substance use services and use SSH as a resource for stabilization.
+ FQHCs will continue to improve patients' stability post-hospitalization with engagement in the medical home.
+ FQHCs and local BH provider will work to provide linkages to care to BH providers who provide specialty services and more intensive levels of care, if needed.
+ FQHC partners can refer patients to South Shore for acute psychiatric stabilization and treatment.
+ Patients who are admitted to this unit will have a strong linkage and coordination with outpatient care for both primary care and behavioral health needs.
+ FQHCs will refer patients to South Shore for acute substance use needs including medical detox and initiation of medication assisted treatment.
+ FQHCs will provide address social needs of patients through existing partners and programs, the resources available.

12. Jobs

Existing Employees

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

Employment information collected from South Shore Hospital, Christian Community Health Center, and Chicago Family Health Center has been consolidated into one document displaying jobs delineated by category and zip code. Please refer to Exhibit 12.01.

New Employment Opportunities

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

23

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

Jointly, The Collaborative estimates to employ 23 new employees, in which majority reside in the South Shore community service area. The objective of adding these positions is to help support the increase of BH Providers to absorb IP discharge appointments and keep same day access for acute patients. Funding will help maintain these roles and positions for the next 5 years.

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

We expect to have improvements of these jobs' categories with the allotted budget. Grant funds will be used to hire supportive roles and work towards sustainability. New employees will be recruited from the community to serve the community. The Collaborative will be working with Malcolm X College, the City of Colleges of Chicago Center of Excellence for Healthcare Education, to continue community relationship.

South Shore Hospital has served as a quality educational and workforce partner with Malcolm X College over the last decade. South Shore Hospital has supported clinical education curricular components for Malcolm X College's nursing, radiography, and respiratory care programs, offering students a robust and comprehensive environment to learn and professionally grow. Malcolm X College's programs continue to grow, matching the South Shore Hospital's synergy. New employment opportunities would be leveraged with Malcolm X graduate programs to help fulfil and sustain workforce demand.

13. Quality Metrics

Alignment with HFS Quality Pillars

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

The South Shore Community Behavioral Health (SSCBH) System of Care Collaboratives quality and outcomes measures aligns with the following HFS Quality Pillars:
Adult Behavioral Health – Multidisciplinary teams working across the collaborative will coordinate care and facilitate care transitions between hospital and community-based services ensuring patients are receiving the appropriate behavioral health (BH) service reducing unnecessary inpatient admissions and ED visits.
Equity – Providing care using a team-based, person -centered and integrated model of care that will improve access to primary care and connect patients to community and social support services.
Community Placements – Providing care in the appropriate setting, integrating primary care and behavioral health.

This collaborative's programs ensures that individuals in need of behavioral health services have access to both inpatient and outpatient care treatment at the level of care to meet their needs. This access is designed to improve outcomes through an approach that is patient-centered, multi-disciplinary, timely and equity focused. The collaborative constructed a model based on actions identified by the HFS Quality Strategy Vision as those needed to enhance and improve behavioral health services and supports for communities. These actions include and our model addresses the integration of physical and behavioral health, reduction in the inpatient service gap, improving transitions of care from inpatient to community-based services and finally improve care coordination and access to care. The Collaborative further believes monitoring the effectiveness of the actions taken is equally important. The monitoring system will assess that reduction in hospitalization inpatient and ED recidivism is occurring, continuity of care through an effective care transitions system is happening, and durable linkages and connections are being made between outpatient behavioral health care and primary care.

The quality metrics identified (see Exhibit 13.01) for the target population will track the success in meeting the collaboratives' overall goal of improving adult behavioral services on Chicago's southside. As stated above the outcomes align with HFS quality pillars, the specific metrics to be tracked are consistent with HFS pay for performance measures. We will measure 7- and 30-day post hospitalizations and ED follow-up to ensure care coordination is working as designed. ED patient transfers to other inpatient psychiatric facilities and short-term repeat admissions will be tracked to provide evidence that the inpatient service gap has been reduced or eliminated. Patients receiving a care plan that includes closed loop care transitions will be tracked with the goal set at care plans for 100% of discharged patients. Similarly, the goal is for 100% of discharged patients without a PCP having a PCP visit within 30 days and this will be tracked. Compliance with establishing care plans and patients having initial PCP visits will be monitored to ensure timely care transitions between the inpatient service, community based BH and primary care providers. Finally, we will track the number of closed loop referrals to community-based organizations as a measure of the success in addressing social determinants of health.

Quality metrics that will be used to track outcomes for the target population are listed in the chart below. Given the initial patients will be coming from one of the partnering entities, baseline data will be available unless the service is new. The baseline data will be extracted from the most recent reporting period if available. Data will be extracted or obtained from each entity as required to develop reports for each metric listed in the chart. A data analyst position will be created and have responsibilities that include facilitating data collection, analyzing

the data and developing outcome reporting. The data analyst will present reports on a routine basis to each entity and to the collaborative's committees as required.

A Quality and Outcomes Committee (QOC) consisting of representatives from clinical partners and leaders from CBOs will be created. The QOC will ensure targets and milestones are achieved. The committee's objectives will be to track milestones, assess the need to modify the model or processes, and use data to evaluate performance to target. The QOC will identify the specific data to be collected, the timeframe for collection and establish a reporting schedule. The QOC will provide feedback and recommendations to the partners as required to ensure outcomes are achieved within the specified timeline. The QOC will meet regularly and will submit reports to the steering committee.

In Exhibit 13.01 goals are listed indicating outcomes that will be achieved by year 3, post award. In the first year after the award is received up to year 3, milestones will be established for achieving interim improvements to get to the stated goal by the end of year 3. The timing of the interim improvements or targets will depend on the service becoming operational if the goal is associated with a new service.

The interim measurement period will be established by the QOC. Quality reports will be created from information obtained by the QOC and this information will be shared routinely with the Collaborative's steering committee.

Exhibit 13.01

HFS Pillar Alignment	Goal / Metrics	Baseline Data	Goal to be Achieved 3 Years Post Award
• **ADULT BEHAVIORAL HEALTH**	**Goal:** Improving access to Inpatient Services with appropriate follow up		
	Metrics: Track # of psychiatric admission transfers to other facilities	TBD	Reduce by 80% from current level
	Track # of repeat inpatient admissions @ 30, 60, 90 days post hospitalization for the patient	N/A new service	Reduce readmissions by 50% from baseline.
• **ADULT BEHAVIORAL HEALTH** • **COMMUNITY PLACEMENT**	**Goal:** Timely access to community-based care		
	Metrics: • Measure: # of unique individuals with complete closed loop care plans (working with Southside Collaborative's care managers) at discharge.	N/A new service	100 %
	Goal: Care Transition - Receiving required follow-up care		
• **ADULT BEHAVIORAL HEALTH**	**Metrics:** • % of discharged inpatients that received 7-day and 30- day follow-up post hospitalization for mental illness		80% of eligible patients

	• % of discharged ED patients that received 7-day and 30-day follow-up post ED visit for mental illness		80% of eligible patients
• **EQUITY** • **ADULT BEHAVIORAL HEALTH** • **COMMUNITY PLACEMENT**	**Goal:** Integration of behavioral health and primary care		
	Metrics: • # of unique individuals without PCP completing PCP visit within 30 days discharge from hospital or ED.		80% of eligible patients
• **EQUITY** • **ADULT BEHAVIORAL HEALTH** • **COMMUNITY PLACEMENT**	**Goal:** Addressing the social determinants of health		
	Metrics: • # of unique individuals with completed SDOH closed loop referrals or engagement.		Compare to industry benchmark, best practice.

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

2B. Adult Behavioral Health?

☒Yes
☐No

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

Multidisciplinary teams working across the collaborative will coordinate care and facilitate care transitions between hospital and community-based services ensuring patients are receiving the appropriate behavioral health (BH) service reducing unnecessary inpatient admissions and ED visits.

2D. Equity?

☒Yes
☐No

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

Providing care using a team-based, person -centered and integrated model of care that will improve access to primary care and connect patients to community and social support services.

2E. Community-Based Services and Supports?

☒Yes

☐No

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

Providing care in the appropriate setting, integrating primary care and behavioral health.

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

☐Yes
☒No

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.

Please refer to Exhibit 14.01 for a calendar of milestones.

The Collaborative will provide quarterly updates regarding the project to local community organizations, local community leaders, elected officials and to the community advisory committees, providing an opportunity for feedback. Once the project is serving patients, there will be opportunity for patient feedback and input to aid in improving care.

Exhibit 14.01

Year 1: Planning, Infrastructure

	M1	M2	M3	M4
Objective 1: Planning				
Q1 Initial Planning				
Q1 Staffing Development				
Q1 Develop onboarding clinical operating processes				
Objective 2: Implementing				
Q2 Implement staffing				
Q2 Implement process for inpatient sites/beds				
Objective 3: Project Launch				
Q3 Implement Program at Full Operation				
Q3 Implement linkages for patients in the inpatient psych unit				
Objective 3: Quarterly Report of Metrics				
Q4 Community Engagement Meetings				

Year 2

	M5
Objective 3: Quarterly Report of Metrics	
Q4 Community Engagement Meetings	

Year 3	
	M6
Objective 3: Quarterly Report of Metrics	
Q4 Community Engagement Meetings	
Year 4	
	M7
Objective 3: Quarterly Report of Metrics	
Q4 Community Engagement Meetings	
Year 5	
	M8
Objective 3: Quarterly Report of Metrics	
Q4 Community Engagement Meetings	

15. Budget

1. Annual Budgets across the Proposal

2. Number of Individuals Served

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

Year 1 Individuals Served

239

Year 2 Individuals Served

410

Year 3 Individuals Served

624

Year 4 Individuals Served

776

Year 5 Individuals Served

866

Year 6 Individuals Served

N/A

3. Alternative Payment Methodologies

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

The Collaborative partners are already working to implement value-based arrangement with health plans to effectively navigate behavioral health high system utilizers. The Collaborative is planning to build on those existing relationships and arrangements to also aid in developing sustainability of this work.

South Shore will continue to utilize Collective Medical Technologies (CMT) which provides alerts of ED and inpatient admissions, discharges and transfers (ADT). This connectivity will aid in demonstrating the impact of this proposal.

In addition, MHNConnect, the platform CountyCare currently contracts with to provide real-time alerts to the health plan, PCPs and care coordinators. MHNConnect has 29 hospitals live using this important tool for coordination. In the System of Care partners, both Christian Community and Chicago Family, are both part of the MHN ACO, and they highly rely on this tool. South Shore hospital is not yet live on MHNConnect but has started the work to connect. This will also help to build on this technology and relationship to identify.

16. Sustainability

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

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

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

Provide your narrative here:

SSH's sustainability plan takes into consideration that a portion of funding is being utilized for one time infrastructure costs that will not require ongoing funding. Services eligible for reimbursement by health care payers will provide sustainability, such as inpatient and outpatient behavioral health services that are being expanded by the grant. The Collaborative will work closely with our health plan partners to identify savings realized through grant initiatives, such as reduced emergency department use or transportation costs for transfers to other hospitals, and potentially repurpose these funds to support addressing needs specific to social determinants of health.

November 11, 2021

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

Dear Director Eagleson,

I would like to share my enthusiastic support for the Illinois Healthcare Transformation Collaborative (HTC) application led by South Shore Hospital (SSH) in partnership with Chicago Family Health Center and Christian Community Health Center. This application seeks to create **The South Shore Community Behavioral Health System of Care.** This collaborative includes a robust group of partners, including key CountyCare Health Plan providers, who are committed to creating a patient driven approach to behavioral health care and linkage to primary care for those most in need, many of whom are CountyCare members.

This SouthShore Community Behavioral Health System of Care accomplishes the goals of the HTC: it is community informed and once funded, will maintain community input and engagement. Their goals include improved outcomes in primary care, outpatient behavioral health, access to acute psychiatric inpatient care, and improved transitions to outpatient follow-up after psychiatric hospitalization for adults in the South Shore Community who have co-occurring behavioral health conditions. The expansion of psychiatric inpatient care on the southside will hopefully decrease the transfers of acutely ill individuals across the County and increase coordination of both health care and social support care among the South Shore providers who together offer comprehensive services.

South Shore Hospital (SSH) shares with Cook County Health the critical role of a long-standing safety net hospital; SSH is a non-profit organization that has provided quality care to the South Shore community since its founding in 1912. SSH is located in the South Shore community area of Chicago and its service area encompasses 17 community areas in the City of Chicago with an estimated population of 411,148 individuals. Much of the patient population resides in the communities surrounding the hospital. SSH is a critical community asset both as a service provider and an employer.

I recommend that you fund this important application that will address the immediate community needs in the South Shore community and build a stronger healthier future together with the community.

Sincerely,

Aaron Galeener
Interim Chief Executive Officer
CountyCare Health Plan

COUNTY BUILDING
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Fax: (312) 603-2039

4th DISTRICT OFFICE
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COMMISSIONER STANLEY MOORE
COOK COUNTY BOARD OF COMMISSIONERS – 4th DISTRICT

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

November 10, 2021

Dear Director Eagleson,
My name is Stanley Moore, Cook County Commissioner of the 4th District. It gives me great pleasure to write this letter of support for the Illinois Healthcare Transformation Collaborative (HTC) application submission. I am extremely pleased that this initiative being led by South Shore Hospital (SSH) is in collaboration with Chicago Family Health Center and Christian Community Health Center. This collaboration will yield a more efficient and effective use of allocations of dollars.

This application seeks to create **The South Shore Community Behavioral Health System of Care.** This collaborative includes a robust group of partners who are committed to creating a patient driven approach to behavioral health care and linkage to primary care for those most in need, building on existing community resources and assets, and filling the gaps with new partnerships to better serve the South Shore community.

Since its founding in 1912, South Shore Hospital (SSH), a non-profit organization, has provided quality care to the South Shore community. SSH's current services include hospital inpatient med-surge beds and psychiatric inpatient beds and has five primary care outreach facilities. Currently, they employ over 470 individuals, including a medical staff of approximately 104 physicians. SSH is located in the South Shore community area of Chicago and its service area encompasses 17 community areas in the City of Chicago with an estimated population of 411,148 individuals.

This joint initiative will focus its attention on serving the needs of the residents located in many of the wards and communities within my district. This includes but not limited to residents who reside in wards 7, 8 and a small portion of 10 in the City of Chicago.

If funding is granted, HTC is committed to maintain community input and engagement. In addition, project goals to name a few will include improved outcomes for individuals with co-occurring behavioral health conditions in the areas of penetration in both primary care and outpatient behavioral health, access to acute psychiatric inpatient care for adults between 18 and 64 years of age.

It is my request that full consideration is given to this application request for HTC to address the goals outlined in the application submission.

Warm regards,

Stanley Moore

Cook County Commissioner 4th District

CITY COLLEGES of CHICAGO
Malcolm X

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

November 2, 2021

Dear Director Eagleson,

I would like to share my enthusiastic support for the Illinois Healthcare Transformation Collaborative (HTC) application led by South Shore Hospital (SSH) in partnership with Chicago Family Health Center and Christian Community Health Center. For over a decade, South Shore Hospital has been a consistent and quality educational and workforce partner with Malcolm X College, the City of Colleges of Chicago Center of Excellence for Healthcare Education. SSH support for the clinical education curricular component of our nursing, radiography, and respiratory care program students has been invaluable to the growth and development of the next generation of the healthcare workforce. Further, the employment of our graduates in these programs with current plans to expand hiring to community health worker and medical assisting graduates demonstrates their ability to partner with institutions like Malcolm X College to fulfill and sustain workforce demand. SSH is a critical community asset to Malcolm X College both as an educational partner and an employer.

The South Shore Hospital application seeks to create The South Shore Community Behavioral Health System of Care. This collaborative includes a robust group of partners who are committed to creating a patient driven approach to behavioral health care and linkage to primary care for those most in need, building on existing community resources and assets, and filling the gaps with new partnerships to better serve the South Shore community. As you review the application, you will find that this collaborative accomplishes all the goals of the HTC, it is community informed and once funded, will maintain community input and engagement. The Collaborative transformation project goals include improved outcomes for individuals with co-occurring behavioral health conditions in the areas of penetration in both primary care and outpatient behavioral health, access to acute psychiatric inpatient care for adults between 18 and 64 years of age within the South Shore community, and improved transitions and engagement in outpatient follow-up after psychiatric hospitalization. The Collaborative intends to achieve these outcomes through improved linkage and coordination of care between South Shore providers when level of care needs change, and expanded access to both inpatient and outpatient behavioral health and social support services to strengthen social factors impacting a person's health. Malcolm X College will support the proposed model through our Community Health Worker and Nursing programs to meet workforce demands.

I strongly recommend that you fund this important application that will address the immediate community needs in the South Shore community and build a stronger healthier future together with the community.

Sincerely,

David A. Sanders, President Malcolm X College

NAMI CHICAGO
Mental health advocacy, education and support.

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

November 1, 2021

Dear Director Eagleson,

On behalf of NAMI Chicago, I would like to extend my full commitment and support for the establishment of The South Shore Community Behavioral Health System of Care (SSCBHSC) led by South Shore Hospital (SSH) in partnership with Chicago Family Health Center and Christian Community Health Center. Guided by the experiences of those living with mental health conditions and rooted in equity, NAMI Chicago provides mental health support, education and advocacy throughout the City of Chicago and parts of Illinois. We will act as one of the dedicated SSCBHSC partners who are committed to addressing the immediate needs in the South Shore community.

The SSCBHSC will accomplish the outlined goals of a Healthcare Transformation Collaborative such as:

- Maintain a community informed lens with community input and engagement
- Improve outcomes for individuals with co-occurring behavioral health conditions in the areas of both primary care and outpatient behavioral health
- Provide access to acute psychiatric inpatient care for adults between 18 - 64 years of age within the South Shore community
- Improve transitions and engagement in outpatient follow-up after psychiatric hospitalization

This collaborative intends to achieve these outcomes through improved linkage and coordination of care between South Shore providers. It also will achieve this through the expansion of access to both inpatient and outpatient behavioral health and social support services to strengthen social factors impacting a person's health.

NAMI Chicago will support these outcomes by building out support services focused on the family unit, as well as the patient, through our experience and expertise in peer recovery work. We will also be the primary provider of training on mental health awareness, community connection, and stigma reduction for community members, as well as collaborative partners.

NAMI Chicago fully supports and aligns with SSH's commitment to improving mental, behavioral, and physical health outcomes and expanding access to services for adults in SSH's areas of service. We look forward to supporting South Shore Hospital and the other SSCBHSC partners in working to build a stronger healthier future together with the community.

Sincerely,

Jennifer McGowan-Tomke
Chief Operating Officer, NAMI Chicago

ILLINOIS HOUSE OF REPRESENTATIVES

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

CHAIR PERSON:
- Labor & Commerce

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

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

August 17, 2021

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

Dear Director Eagleson,

I would like to share my enthusiastic support for the Illinois Healthcare Transformation Collaborative (HTC) application led by South Shore Hospital (SSH). This application seeks to create **The South Shore Community Behavioral Health System of Care.** This collaborative accomplishes all the goals of the HTC, it is community informed, and once funded will maintain community input and engagement. This initiative also addresses critical health and wellness needs, it creates a patient-centered approach to care and will lead to long-term sustainable health improvements in the community.

Since its founding in 1912, South Shore Hospital (SSH), a non-profit organization, has provided quality care to the South Shore community. The staff are committed to providing appropriate care to each individual patient, regardless of race, color, creed, sexual orientation, and financial status. SSH's current services include hospital inpatient med-surge beds and psychiatric inpatient beds, and has five primary care outreach facilities. Currently, they employ over 470 individuals, including a medical staff of approximately 104 physicians. South Shore Hospital is located in the South Shore community of Chicago and its service area encompasses an estimated population of 411,148 individuals. South Shore Hospital is a critical community asset both as a service provider and an employer.

I strongly recommend that you fund this important application that will address the immediate community needs in the South Shore community and build a stronger healthier future together with the community.

Sincerely,

Marcus C. Evans, Jr.
Assistant Majority Leader
Chairman, Committee on Labor & Commerce
Representative, 33rd District of Illinois

MICHELLE A. HARRIS
ALDERMAN, 8TH WARD

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CITY COUNCIL

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COMMITTEE MEMBERSHIPS

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(CHAIRMAN)

BUDGET AND GOVERNMENT OPERATIONS

ECONOMIC, CAPITAL AND
TECHNOLOGY DEVELOPMENT

EDUCATION AND CHILD DEVELOPMENT

FINANCE

HOUSING AND REAL ESTATE

HUMAN RELATIONS AND HEALTH

TRANSPORTATION AND PUBLIC WAY

August 17, 2021

Ms. Theresa Eaglesson, MSN
Director, Illinois Department of Healthcare and Family Services
201 South Grand Avenue, East
Springfield, IL 62704

Dear Ms. Eaglesson:

I would like to share my enthusiastic support for the Illinois Healthcare Transformation Collaborative (HTC) application led by South Shore Hospital (SSH). This application seeks to create The South Shore Community Behavioral Health System of Care.

As you review the application, you will find that this collaborative accomplishes all the goals of the HTC, it is community informed and once funded, will maintain community input and engagement. This initiative also addresses critical health and wellness needs, it creates a patient-centered approach to care and will lead to long-term sustainable health improvements in the community.

Since its founding in 1912, South Shore Hospital (SSH), a non-profit organization, has provided quality care to the South Shore community. In addition, the staff are committed to providing appropriate care to each individual patient, regardless of race, color, creed, sexual orientation, and financial status.

I strongly recommend that you fund this important application that will address the immediate community needs in the South Shore community and build a stronger healthier future together with the community.

Thank you for your consideration in this matter.

Sincerely,

Michelle A Harris

Michelle A. Harris
Alderman, 8th Ward

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THE OFFICE OF
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COMMITTEE MEMBERSHIPS

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

August 16, 2021

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

Dear Director Eagleson,

I would like to share my enthusiastic support for the Illinois Healthcare Transformation Collaborative (HTC) application led by South Shore Hospital (SSH). This application seeks to create **The South Shore Community Behavioral Health System of Care.** This collaborative includes a robust group of partners who are committed to creating a patient driven approach to behavioral health care and linkage to primary care for those most in need, building on existing community resources and assets, and filling the gaps with new partnerships to better serve the South Shore community.

As you review the application, you will find that this collaborative accomplishes all the goals of the HTC, it is community informed and once funded, will maintain community input and engagement. This initiative also addresses critical health and wellness needs, it creates a patient-centered approach to care and will lead to long-term sustainable health improvements in the community.

Since its founding in 1912, South Shore Hospital (SSH), a non-profit organization, has provided quality care to the South Shore community. In addition, the staff are committed to providing appropriate care to each individual patient, regardless of race, color, creed, sexual orientation, and financial status. SSH's current services include hospital inpatient med-surge beds and psychiatric inpatient beds, and has five primary care outreach facilities. Currently, they employ over 470 individuals, including a medical staff of approximately 104 physicians. The following services are provided on an inpatient and outpatient basis: respiratory care,

physical therapy, surgery, nuclear medicine, radiology, laboratory, vascular, diagnostics, pharmacy, non-invasive cardiology, detox services, chemical dependency, transportation, wound and skin care, emergency medicine, geriatric psychiatry, HIV/AIDS services, and gynecological services. South Shore Hospital is located in the South Shore community area of Chicago and its service area encompasses 17 community areas in the City of Chicago with an estimated population of 411,148 individuals. Much of the patient population resides in the communities surrounding the hospital. South Shore Hospital is a critical community asset both as a service provider and an employer.

I strongly recommend that you fund this important application that will address the immediate community needs in the South Shore community and build a stronger healthier future together with the community.

Warmest regards,

Elgie R. Sims, Jr.

Elgie R. Sims, Jr.
State Senator, 17th District