

Healthcare Transformation Collaboratives Cover Sheet



1. Collaboration Name:

Whole Person Accountable Community of Health

2. Name of Lead Entity:

Lutheran Social Service of Illinois

3. List All Collaboration Members:

Lutheran Social Service of Illinois
Asian Human Services
Aunt Martha's Health and Wellness
Heartland Health Alliance
Illinois Joining Forces
TASC
CareAdvisors
Unite Us
Swedish Hospital
Community First Medical Center
Weiss Memorial Hospital
Methodist Hospital

4. Proposed Coverage Area:

Northside of Chicago - 60618, 60625, 60630, 60631, 60634, 60639, 60641, 60646, 60656, 60659, 60706, 60707

5. Area of Focus:

Behavioral Health

6. Total Budget Requested:

\$27,240,485

1. Participating Entities

Contact Information for Collaborating Entities

1. What is the name of the lead entity of your collaborative? **Lutheran Social Services of Illinois**
2. Please provide primary contact information, secondary contact information, and the Tax ID # of each entity in your collaborative. Please list the lead entity in the top row.

Entity Name	Tax ID # (xx-xxxxxx)	Primary Contact	Position
Lutheran Social Services of Illinois	36-2584799	Ruth Jajko	Vice President, Network Performance and Growth
Asian Human Services	36-3005889	Eric Lindstrom	Director of Programs
Aunt Martha's Health and Wellness	23-7188150	Audrey Anewishki Pennington	Chief Operating Officer
Heartland Alliance Health	36-3775696	Joan Liautaud	Chief Clinical Officer
Illinois Joining Forces	47-2152382	Brenda Osuch	Interim Executive Director
TASC	36-2870923	Malik Nevilles	COO
Care Advisors	47-5186817	Chris Gay	CEO
Unite Us	46-1914165	Brian Chmura	Strategic Sales Director
Swedish Hospital	36-2179813	Marcia Jimenez	Director of Intergovernmental Affairs
Community First Medical Center	47-2313900	Jared Marcucci MD MS	Interim Chief Medical Officer Emergency Department Medical Director
Weiss Memorial Hospital	36-4413031	Dr. Yolanda Coleman	Chief Nursing Officer
Methodist Hospital	36-6000085	Genevieve Presbitero	Chief Nursing Officer

Participating Entities

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

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

**Heartland Alliance Health
Aunt Martha's Health and Wellness**

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

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

**Asian Human Services
Heartland Health Alliance
Illinois Joining Forces
TASC**

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

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

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

3D. Please give the name of your second hospital provider here.

Community First Medical Center

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

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

Weiss Memorial Hospital

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

3J. Please give the name of your fourth hospital provider here.

Methodist Hospital

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

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

**Lutheran Social Services of Illinois
Asian Human Services
Heartland Alliance Health
TASC**

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

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

**Lutheran Social Services of Illinois
Heartland Alliance Health**

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

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

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

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

**Swedish Hospital
Methodist 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**

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.

Care Advisors: BEP

Aunt Martha's: non-profit majorly controlled and managed by minorities

Heartland Alliance Health: non-profit majorly controlled
and managed by minorities

TASC: non-profit majorly controlled and managed by
minorities

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

Lutheran Social Services, Asian Human Services, Aunt Martha's, and Heartland Health are the non profit organizations that can bill Medicaid. All of the hospital collaborators are also Medicaid- eligible billers.

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).

☒ Other

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

Community Based Providers, in collaboration with Safety Net Hospital and other community hospitals, addressing equity, capacity, and sustainability of mental health and social determinants of health.

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

***Please see Addendum A**

2. Project Description

Brief Project Description

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

Whole Person Accountable Community of Health

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

The Whole Person Accountable Community of Health brings together community based nonprofits that provide specialized, primary, and behavioral health care; safety-net and acute care hospitals; and social determinants of health data specialists to create a comprehensive collaborative of providers working to ensure equity-informed resources are in place to meet the mental health and social supports necessary to improve the health and wellness of individuals in the community. The overall goals are to increase equity-informed care coordination, increase access to mental health and psychiatric services, and increase access to social determinants of health for individuals needing support, specifically in the areas of housing and food security.

Detailed Project Description

The Whole Person Accountable Community of Health (ACH) has twelve committed collaborators, including nonprofit organizations, hospitals, and data specialists, with the goal of adding more community-based and specialized organizations to the collaborative. Community-based organizations in the collaborative include the following:

- Lutheran Social Services of Illinois (LSSI), the lead organization, has been a health and human services provider for over 150 years. LSSI specializes in mental health and substance use treatment on Chicago's northside.
- Heartland Alliance Health (Heartland) is a leader in primary care for individuals experiencing homelessness.
- Asian Human Services (AHS) helps people become healthy, educated, and employed, with special expertise in the challenges facing refugees, immigrants, and other underserved communities.
- Illinois Joining Forces (IJF) specializes in helping service members, veterans, and their families find the holistic supports they need. TASC provides services for individuals involved with the criminal justice system, from courts to reentry to family services and more.
- Aunt Martha's Health and Wellness provides a variety of healthcare services, including Federally Qualified Health Centers, and will provide psychiatric services for this collaborative.

Swedish Hospital, Methodist Hospital, Community First Medical Center, and Weiss Memorial Hospital have also committed to being part of the Whole Person Accountable Community of Health. All four hospitals provide emergency department services; Swedish Hospital and Methodist Hospitals are safety net hospitals and Weiss provides inpatient psychiatric services. LSSI has also partnered with two technology companies, CareAdvisors and Unite Us, who are working to enhance the quality of care and reduce barriers by building coordinated networks.

Together, the Whole Person Accountable Community of Health will ensure equity-informed resources are in place to meet the mental health and social supports necessary to improve the health and wellness of individuals in the community. The collaborators will do this by providing care coordination, case management, and access to all areas of health: physical, behavioral, and social determinants. The collaborative will offer care coordinators and behavioral health specialists, employed by the above community organizations, in order to ensure equity-informed and specialized care. Connecting individuals to the right type and level of care will result in a decreased need for more intensive and expensive services. Care Coordination will provide outreach and engagement to work with the community to identify populations that do not have equitable access or culturally appropriate services. When working with specialized populations, such as veterans, they need care coordination by organizations informed about Military and Veteran resources and best practices. Similarly, when individuals are homeless, a homeless provider needs to provide the care coordination to ensure the most appropriate services are being offered to the individual. Individuals who are involved in the criminal justice system are best served by a provider who has mastery of the many complexities of criminal justice. Some clients may have overlapping specialty needs, and the right care coordination will be enacted when the collaboration offers the best practice option for individuals to choose their care coordination provider. The Whole Person Accountable Community of Health brings together collaborators that each have one or more specific populations they specialize in working with, to ensure a variety of options for individuals to choose a care coordinator. In the event an individual is not able to improve functioning in the community, this initiative provides for best practice Transitions of Care and robust discharge planning capacity for inpatient services. The addition of open access psychiatry, 24/7 community support services, and equity-informed care coordination will provide those served with the highest quality services.

On top of care coordination, expanded psychiatry services are needed. Currently, there is a lack of capacity for equity-informed direct mental health services in the ACH service area. This proposal will provide open access psychiatric hours five days per week, allowing psychiatrists to work with clients and community providers to provide critical clinical leadership. This includes time for psychiatrists to ensure equity issues have time to be addressed and that each client has wraparound services needed to improve their functioning. There is also an ongoing need for high intensity community care and support, necessitating the development of three Community Support Teams (CST) in the first year, and adding an additional team in years 2-4.

It is commonly recognized that safety net providers (including hospital and community providers) do not have interoperable data and often cannot afford to solve this considerable challenge on their own. Interoperability will allow the needed data to be in the hands of care coordinators and other members of the clinical team at time of service. Electronic Health Records, Care Management Software, Admission Discharge, Transfer Notifications, and Community Referral Platforms are not currently integrated, which inhibits improved access to resources and does not support integrated data management capability. This proposal will change that by providing integration for these various platforms to identified community providers, which will allow for the continual increase in utilization of platforms. This proposal will provide the option for collaborators to utilize a community referral platform provided by Unite Us for free, and the interoperability capability will ensure that all vendors and providers can connect to the enhanced community providers. The interoperability will allow providers the ability to better understand the whole person needs, with available resources and clinical pathways to provide the needed care. This will transform the way data is shared and implemented to improve health outcomes and care.

The community referral platform provided by Unite Us will increase equitable access to health and social services, addresses the fragmentation of services that makes our health and social systems challenging to navigate, and will confront barriers to health equity such as poverty, lack of access, racism, and discrimination. A diverse range of stakeholders will be included in the community referral program, including community based organizations, health plans, health systems, hospitals, government entities, and public programs. Providers across sectors will be able to send and receive secure electronic referrals, track each individual's total health journey, and report on tangible outcomes across a full range of services in a centralized, cohesive, and collaborative ecosystem. An end-to-end social care solution will take full advantage of changes in the approach to the current gap in accessing behavioral health services. The platform will support secure, bidirectional data-sharing; screening for unmet social needs; track a person's care journey through closed-loop referrals; and ensure a culturally-sensitive community engagement process. It will provide true closed-loop referral functionality to confirm a member received a defined service, and not just information on providers or a few community resources.

These emerging capacities will be organized and supported by the Whole Person Accountable Community of Health. The ACH model was chosen, in part, given its established equity framework that will ensure that the governance and operational standards will be guided by a structured and recognized national model. Additionally, the ACH will support participating providers having free access to Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), a nationally recognized social determinants of health data and screening tool.

Sustainability will begin the first year and will evolve into value-based care contracts supporting care coordination and targeted social determinants of care. The Whole Person ACH initiative provides for the administrative capability to analyze and manage claims data and partner with the Managed Care Organizations to develop contracts that do not duplicate services and resources, but instead partner to ensure the health and safety for all individuals served.

3. Governance Structure

Structure and Processes

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

The governance structure for the Whole Person Accountable Communities of Health will follow ACH administrative best practices, including operationalizing, at minimum, a Steering Committee, Advisory Board, Standing Committees, and Ad Hoc Committees.

Steering Committee: The Steering Committee participants include behavioral health providers, primary care providers, social service providers, diversity and inclusion leaders, community stakeholders and a community consumer advocate. The Steering Committee will make decisions including but not limited to the following:

- Approve budget and allocation of funds
- Assess data to gauge and hone the project's impact on local racial and health disparities Review trends in metrics when needed to ensure course corrections are implemented
- Assure coalition performance and compliance as set forth in terms of the agreement with HFS

Advisory Board: The Advisory Board includes one representative from each partner organization. It is designed to promote collaboration and inclusive decision making and augment the knowledge of the Steering Committee. The Advisory Board will have input for the training, staffing structure, targeted populations, targeted health and service agencies, and community outreach activities.

Standing Committees: The governance structure includes several Standing Committees. Membership will vary based on each committee's focus, but may include representatives from the Steering Committee. The Standing Committees will include:

- **Clinical and Quality Committee:** This committee will ensure that all systems are in place to implement and maintain an effective quality assurance and quality improvement process for the project. This will include (but is not limited to) overseeing and ensuring the quality of care coordination, client safety, quality metrics for core strategies, and quality assurance and improvement.
- **Health Equity Committee:** This committee will assess and support racial equity across its policies, programs, practices, and partnerships.
- **Finance Committee:** These committee members will act as liaisons between the Steering Committee and all Foundational partners regarding finance and compliance related updates. This committee includes one or more Co-Chairs from the Steering Committee.
- **Community Input Committee:** This committee will provide a formal channel for community engagement and input.
- **MCO Collaboration Committee:** This committee will closely interface with a broad group of Medicaid MCOs. It will serve as the liaison between this project and MCOs and will implement a number of strategic initiatives with MCOs including data sharing coordination for engagement of hard-to-reach members, coordinating care management services to avoid duplications of support, and developing a sustainable payment model.

Ad Hoc Committees: Ad Hoc Committees will be formed on an as-needed basis to accomplish specific purposes not addressed by other committees within our governance structure. Ad hoc committees will include one co-chair from the Steering Committee.

Accountability

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

Participating collaborators in the Whole Person ACH will have contractual data sharing agreements to achieve the desired outcomes of the proposal. Data sharing policies and procedures will comply with HFS Medicaid Managed Care requirements, regulatory guidance, contractual agreements, program integrity, compliance risks, and applicable federal and state laws, as well as internal policies and procedures to protect against non-compliance.

The Whole Person ACH collaborators will have free access to the Unite Us platform, which is HIPAA-compliant and allows collaborators to connect clients with community resources. Collaborators are able to track the status and progress of their client referrals and the outcomes of the services provided, creating an accountable system of care that puts the community first. Organizations that join the collaborative and utilize the free Unite Us platform agree to be held accountable to these standards to facilitate good collaboration and communication:

- The maximum length of time partners should take to respond to a referral is 2 business days
- Three attempts over ten business days should be made to contact an unresponsive client before closing a case or referral
- Organizations should review/update their organization and program information at least once a quarter or sooner as needed
- Organizations should update their user information when users leave the organization/should no longer have access within two business days of change in user access The maximum length of time users should take to close client cases once they know the outcome is within two business days of resolution
- The maximum length of time users should take to add the first note to the client's case after the case is created is within seven business days
- The maximum length of time a case should be open without a note being added is no more than three months. Otherwise, the case should be closed with a resolution

New Legal Entity

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

LSSI will take the lead on ensuring payments are made to providers and the data/finance committee will monitor all HFS payments made to participating organizations. Regular reports showing how the payments have been utilized and the results from utilization, such as reports on the number of individuals receiving care, the amount of social determinant of health dollars are going toward each individual, and so forth.

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.)

Within the service area of the Whole Person Accountable Community of Health, there are significant health disparities between racial and ethnic groups, including social determinants, behavioral, and physical health disparities. Minority populations are more likely to be impacted by insufficient care coordination, lack of access to psychiatric services, lack of community support capacity, and a need for rapid rehousing and food security, in order to effectively achieve an equitable system of care. The Whole Person ACH will bring together community stakeholders, nonprofit organizations, hospitals, and data specialists to provide equity-informed, collaborative care.

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

Racial Equity Impact Assessment Questions

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

The data demonstrates the minority populations that are most impacted in this community service area are Latinx and Asian. Among the zip codes being served through this proposal, 40% of the population is Latinx; 13% is Asian; and 4% is African American. Although our project is open to all those needing care in our service area, we will focus on serving Asian and Latinx members who are most often disadvantaged by racial, health, and social inequities.

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

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?

Organizations representing different racial/ethnic groups have been engaged to identify what services and resources are needed. LSSI serves a Hispanic population through our mental health services on the Northside of Chicago, and Asian Human Services, whose clients are 73% Asian, is a partner in this collaboration. LSSI brought this proposal to the State Senate and House representatives in the area, as well as the City of Chicago Aldermen, to gain input and support. What was quickly recognized is that there is insufficient care coordination, lack of access to psychiatric services, lack of community support capacity, and a need for rapid rehousing and food security in order to effectively achieve an equitable system of care. It was noted that there is no structured, sustainable organizing mechanism where data can be reviewed, no efforts to fill gaps in a collaborative manner, and a lack of action plans developed to leverage the capability of multiple organizations. Incorporating these measures in the area would achieve better access and care. Additionally, partners outside of health and human services, such as technology partners, will be necessary to address prioritized challenges with integrated clinical and outcome data. We plan to engage community stakeholders throughout the program.

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

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

Within the service area of the Whole Person ACH, there are significant health disparities between racial and ethnic groups, including social determinants of health and physical healthcare disparities. The Northside of Chicago is populated by a significant Latinx population, approximately 40%. Across the service area, racial and ethnic minority populations experience higher rates of poverty than non-Hispanic whites. They also fare worse on a host of social determinants of health indicators, including educational attainment, insurance access, housing affordability, and food security. Minority populations are also more likely to experience homelessness, with 70% of the homeless population in Chicago identifying as a person of color (Chicago Coalition for the Homeless). People who are homeless experience a number of health challenges. They have a low life expectancy, high Emergency Department utilization, and serious mental health issues often compound their service needs. Research shows that when people who are homeless find shelter, their health index improves on all counts. This proposal will directly serve individuals who are homeless.

These social determinants of health disparities translate into marked health inequities, exacerbated by the COVID-19 pandemic. Minorities in Chicago, who are 30% of the population, accounted for 70 of the first 100 COVID-19 deaths. Latinx populations tended to have the highest infection rates, and African American people have the highest death rates. Health factors, such as chronic disease, particularly diabetes, heart disease, mental health, and trauma combined with social factors worked to create these outcomes. Chronic disease mortality rates also underscore the disparity patterns on the Northside of Chicago, where Hispanic and African Americans have the highest rates of mortality for cardiovascular disease, cancer, diabetes, and stroke compared to other race/ethnic groups in the region.

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

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

This proposal addresses the root causes that are impacting care to minority populations, including lack of access to care and inability to hire staff. By building competitive salaries into the budget for positions, focusing on hiring from the community, and providing available care coordination and open access psychiatry hours, the Whole Person ACH will address this challenge.

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

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

By bringing together a variety of nonprofit partners who all specialize in different areas, including hospitals, and bringing in data partners, this proposal seeks to reduce disparities by providing equity-informed care coordination and access to services. LSSI is partnering with Unite Us, a company that supports the advancement of racial equity through its shared, community-wide infrastructure.

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

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

The goal of the Whole Person Accountable Community of Health is to provide equity informed care to members of this area who have historically been underserved, with an emphasis on minority populations. If not done correctly, this could promote distrust between providers and community members, which is why the collaborating partners include minority controlled nonprofits and BEP vendors. The community-based partners in the collaborative also have a long history of working with members in the community. The ACH will ensure that community stakeholders and members of the community are part of the process in providing care.

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

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

Proper data collection, data sharing, and data privacy can help advance racial equity by getting a full picture of the existing disparities. These techniques can help partners understand the disparities, address them seamlessly, and build trust among previously marginalized communities. This can be achieved in the following ways, which we plan to do in our collaborative by providing access to the Unite Us system to all members of the collaborative:

Collecting sociodemographic data and improved standardized data fields to capture the diversity of the US population. Broad racial categories and poor distinctions between sexual and gender identities, for example, obscure the nuanced experiences of different communities and limit full visibility, inclusion, and understanding of disparities within larger populations. Creating more specific categories can reduce confusion in health surveys, afford individuals a greater sense of respect, better capture critical health and social care information pertaining to 'hard to reach populations' such as sexual and gender minorities, and generate greater buy-in and willingness to participate in data collection efforts. Attached is an example of recommended fields for data collection and reporting that will be discussed and decided upon by the ACH.

Sharing information across stakeholders to improve care coordination and stop individuals from falling through the cracks. The Unite Us system enables data sharing between providers working in health and social care settings. The technology

supports integrations and interoperability, which can reduce the burden of working in multiple systems, mitigate duplicative work and data entry, and allow for secure cross-sector collaboration. Unite Us maintains a single Enterprise Master Person Index (EMPI), which enables identity resolution and synchronization across multiple domains and systems and ensures that the person in question is the same patient, client, or member in different health and social care settings. Such a system creates a single and complete record of care, minimizing the need for a client to retell their story and facilitating more seamless care delivery.

- **Building and Maintaining Trust through Data Privacy and Data Transparency:** Developing and maintaining trust is critical for individuals to use and willingly participate in their care. This is a crucial consideration when working with underserved or marginalized populations that have been historically harmed by new technologies, the misrepresentation of data, and personal and systematic biases that were used to deny service. These individuals may rightfully harbor mistrust. Unite Us has implemented a robust, person-centered, and equity-driven process that requires each individual seeking care to consent to share their information before any referrals can be sent on their behalf via the Unite Us Platform. The Unite Us consent is translated in over 30 languages and outlines in plain language the ways in which client information may be shared across the network in order to connect them to services. If a client does not provide consent, their information will not be shared via Unite Us to receive services.
- **Supporting Community Participation:** Unite Us integrates community participation into collection and standardization of health equity data elements in order to build trust, elevate the importance of collecting this information, and develop an understanding within communities of how this information will be used. Whenever possible, Unite Us recommends identifying avenues and/or developing processes to share data and information back with community members. This includes ensuring that communities have an understanding of how to analyze and leverage local data, providing accessible and community-facing tools that enable meaningful engagement with data insights, establishing mechanisms for sharing data insights back with community members, and prioritizing full transparency as to how data and key findings will be used. Unite Us ensures that partners retain ownership of their data and provides tools such as data exports and the Health Equity Dashboard, which allows for actionable and accessible data insights.

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

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

This proposal is realistic because it builds off of work that is currently being done by the collaborators committing to being part of the ACH and incorporates collaborators from different sectors, including hospitals, nonprofits with different specializations, and technology companies to work with and configure data for the best use possible. The ACH received support from elected officials and community-based organizations, and will put in place a plan to ensure that stakeholder participation continues throughout the project. Additionally, the data/technology partners in the collaboration will help ensure data collection is ongoing and seamless. Without this proposal, the partners in the collaboration will not have access to the technology and data company services, which will help streamline and improve care coordination for minority populations.

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

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

As a collaborative, all success indicators and progress benchmarks will be determined based on community input and stakeholder engagement. We will be able to utilize the Unite Us Health Equity Dashboard to evaluate indicators and progress benchmarks, as it can stratify data on race, ethnicity, age group, and gender. This will help in assessing and setting collaborative success indicators and benchmarks.

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

5. Community Input

Service Area of the Proposed Intervention

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

2. Please select all Illinois counties that are in your service area

Select counties:

Cook

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

60618, 60625, 60630, 60631, 60634, 60639, 60641, 60646, 60656, 60659, 60706, 60707

Community Input

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

Given the lack of data regarding mental health and social determinants of health capacity existing in the community, LSSI discussed the challenges with a local hospital and numerous community partners that serve individuals across multiple cultures and languages. It was consistently recognized that there is a need for a multi-pronged approach to address equitable access to care.

There is a significant need for the ability to integrate data, improve provider knowledge of available resources, identify needed services, as well as evolve this work from fee-for-service to value-based care. In addition to the primary aim of improving equity, care coordination is needed, the core missing component of care, through the lens of subject matter experts in minority populations, Veteran care, homelessness, and individuals involved with the criminal justice system. LSSI reached out to organizations recognized as leaders in each of these areas to discuss the challenges and develop potential solutions. LSSI also recognizes the need to develop a sustainable structure to engage community members and stakeholders that could over time provide a deep understanding of the equity challenges that must be met. This all led to developing an Accountable Community of Health (ACH). The ACH, developed through this collaborative proposal, will be data driven, bringing to the table community stakeholders, peers, Managed Care Organizations, and providers to drive the expansion of behavioral and social determinants of health services to better serve the members of the community.

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

Input from Elected Officials

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

Select legislators:

Andrade Jr., J. - Ill. Representative - 40th State Representative District,
 Feigenholtz, S. - Ill. Senator - 6th State Senate District,
 Guzzardi, W. - Ill. Representative - 39th State Representative District,
 LaPointe, L. - Ill. Representative - 19th State Representative District,
 Martwick, R. - Ill. Senator - 10th State Senate District,
 Pacione-Zayas, C. - Ill. Senator - 20th State Senate District

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

Alderman Ariel Reboyas - 30th Ward,
 City of Chicago Alderman
 Rossana Rodríguez-Sánchez - 33rd Ward,
 City of Chicago Alderman
 Carlos Ramirez-Rosa - 35th Ward, City



of Chicago Alderman
Nicholas Sposato - 38th Ward, City of
Chicago Alderman
Samantha Nugent - 39th Ward, City of
Chicago Alderman
Andre Vasquez, Jr. - 40th Ward, City of
Chicago Alderman
Matt Martin - 47th Ward, City of Chicago

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

Please see Addendum A

6. Data Support

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

LSSI worked with CareAdvisors, one of our data partners, to gather information on the population on the Northside of Chicago. Data from the U.S. Census, Medicaid Coverage, and on dually- eligible beneficiaries was used to estimate the total number of dually-eligible beneficiaries. The largest minorities in each zip code were identified and the social vulnerability index was calculated using data from the CDC. The social determinants of health need and cost per member per month was calculated based on historical experience of local agencies delivering housing and food services in the community. Please see Addendum C for more information.

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 Northside of Chicago faces a nexus of disparities in care delivery and health outcomes for racial and ethnic minorities and other vulnerable populations. Based on findings from community listening sessions, Community Health Needs Assessments, and other sources described within the proposal, the ACH has chosen to focus on the following health disparities to improve health equity and well-being in North Chicago:

Behavioral Health: The community service area includes several regions classified as a mental health shortage area by the Health Resources and Services Administration (HRSA). While most racial/ethnic minority groups have similar rates of behavioral health disorders to Caucasians, they are more likely to suffer from poor health outcomes due to “inaccessibility of high quality mental healthcare services, cultural stigma surrounding mental healthcare, discrimination, and overall lack of awareness about mental health.” The shortage of behavioral health providers on the Northside of Chicago contributes to community members’ limited access to appropriate care. This shortage is in part due to insufficient wages - local mental providers report that there is a 20% gap between current compensation levels and market rates for licensed clinicians. Due to these barriers to care, many individuals go without treatment entirely, which can have devastating effects on the health and stability of their households. The risks of untreated behavioral health issues in these communities include higher incidence rates of unemployment, substance use disorder and overdose, and suicide when compared to white communities. Other individuals may delay care until they hit a crisis point.

Chronic Conditions: Based on the ACH’s review of the population health and individual member-level data, Latinx and African American community members in the service area suffer significantly more complications and severity of chronic conditions than their White counterparts. For example, we found that 1) the congestive heart failure hospital admission rate was nearly triple the national rate for patients 19-64 years old and 20% higher for patients 65 years and older; 2) the age-adjusted hospitalization rate due to heart failure per 10,000 population aged 18 years and older was 72.9 compared to 61.5 for the state of Illinois; and 3) the percentage of Medicare members who were treated for stroke totaled 4.3% compared to 3.8% for both Illinois and nationally. Contributing factors include mistrust of the healthcare system, inability to navigate the healthcare system, and the financial and emotional stress of managing chronic care with limited caregiver support.

Access to Care: Medicaid members face a variety of challenges to achieving timely access to care. In the ACH community services area, significant care coordination gaps exist as member data is fragmented and siloed in disparate Electronic Health Records and case management systems, making it difficult for clinicians and case managers to adequately address member needs. Additional gaps of note include information transfer, systems to monitor patients, tools to support patients’ self-management goals, and tools to link patients and their caregivers with community resources. There are also few tools that provide interoperability with legacy case management software for community resources which are defined as any service.

Social Determinants of Health: nonclinical social care barriers can include lack of childcare, limited time off from work, or language barriers, among others. Patients face numerous barriers to addressing social care needs, including knowing how to navigate complex benefit application requirements, cultural or language differences, and concerns about divulging sensitive information such as immigration status. On a more systemic level, patients may have difficulty finding specialty physicians due to low Medicaid acceptance rates and provider shortages, resulting in longer wait times to get appointments. Medicaid patients may ultimately choose not to pursue seeing a specialist, which can put them at risk for adverse health outcomes. Many individuals on the Northside of Chicago face inequalities across social determinants of health that negatively impact their health outcomes. Connecting these individuals with targeted community-based resources can help address social determinants of health disparities and achieve better health outcomes. The ACH model assesses patients for all social determinants of health and provides appropriate linkages and follow-up to community resources.

We chose to address the causes of these disparities because the members of our targeted services area are disproportionately affected by very poor health outcomes in these conditions, reflecting the scale of change needed across the local healthcare and social service delivery ecosystem. We feel the partners in our collaborative have the knowledge and skills to work together to address these health inequities and improve whole person health outcomes for historically underserved populations.

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?

Behavioral Health: By providing resources to combat the workforce shortage such as increased salaries, a recruiter, and hiring from within the communities that we are serving, this proposal addresses the lack of providers in the area. Our case

workers will be community-based, working to reach everyone in the community, including the hard to reach and engage members. We will be able to measure this by the number of positions hired to directly serve members and the number of members the case managers interact with.

Chronic Conditions: Clients will be connected to a physical healthcare home, making sure they have a place to go to address chronic conditions and maintain and/or prevent them rather than seek emergency care.

Access to Care: This will be addressed by data integration and partners having access to information. By closing the loop on referrals, we can insure that clients are not simply getting a list of resources, but actually seeing other providers to meet all of their needs.

Social Determinants of Health: By building in funding for housing and food security, the ACH is ensuring that there are resources for the immediate social determinants of health, and are also connecting and closing the loop on referrals for additional determinants, such as child care or transportation.

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

By involving stakeholders from a variety of services, specialties, backgrounds, and experiences, this proposal provides an ACH that can address all of these activities in an equity-informed, data-driven way. LSSI and our collaborative partners have proven success in working with the adversely impacted populations in this service area and are confident these activities will lead to better health outcomes.

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.

The Whole Person Accountable Community of Health seeks to address the barriers to healthcare access, which include a lack of resources preventing organizations from being able to expand and provide equity informed services. This includes workforce challenges and a lack of funding to address them. Across the community, workforce challenges have for some time inhibited the expansion of services. Not having the staff to fill positions, having staff who are less qualified, and not being able to afford salary demands have left many organizations in a scarcity mindset. Many organizations are simply trying to maintain operations and often do not have the resources to expand. This proposal will allow equity-informed partners in this Accountable Community of Health to hire workforce at a competitive salary, with an emphasis on providing jobs to individuals who are familiar with the community and populations they will be serving. Many providers don't believe they have sustainable funding for services, let alone to expand access and address equity issues, which will be changed through this Accountable Community of Health, especially with a long-term goal of value-based care contracts. The challenge of starting up new programs, due to workforce challenges, is compounded by a lack of start-up funds to stand up programs that now take longer than ever to launch. Organizations cannot weather the cash drain new services create, which results in organizations who are passionate about addressing equity issues not having an organizational pathway to be successful.

Community-Based Care Coordination is not a funded, stand alone service, for the majority of Medicaid recipients. Lutheran Social Services of Illinois has provided a comprehensive array of mental health services on the northside of Chicago since 1971, when the State first established community-based mental health centers for counseling and psychiatry. Over the years, the Northside has become one of the most populated and culturally diverse planning areas of Chicago and LSSI's programs have grown with the community, providing services in English, Spanish, and Polish. As a consistent provider and leader in this community, LSSI has strong partnerships with community members and organizations and we have chosen to address these important inequities in the community.

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

To address workforce issues, the Accountable Community of Health collaborative budget has targeted salaries at a competitive level, requested support for hiring individuals from the community, included training to ensure competence regarding issues of equity, and implemented a system to provide staff with real time data they need to be more clinically successful with individuals. We have requested support for Community Health Workers and Behavioral Health Specialist Care Coordinators to solve the issue of a lack of critical Care Coordination. For the Community Support Teams, we have requested start-up funds for six months to reflect the challenging hiring environment. These resources will be critical to support organizations as they risk expansion in the challenging workforce environment. The request provides for funding services to successfully begin Fee-For-Service and have a structured plan to move the Care Coordination into value-based contracting. Additionally, having the support of the ACH to provide the resources needed to manage challenging programs will be important to providers.

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

Based on research for Accountable Communities of Health, as well as Integrated Health Homes and recent data from community efforts, the requested resources are critical missing pieces of the comprehensive care necessary to methodically address the equity, access and quality issues.

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.

LSSI has identified housing and food as the two most needed social determinants of health in this service area. Social care management data available through CareAdvisors demonstrates a widespread need for food and housing interventions across Cook County. CareAdvisors received 731 unique patient referrals from six local hospitals over the last 12 months. Of these patients, 72.8% were referred to CareAdvisors for assistance with accessing government benefits (Medicaid, SNAP, TANF, SSI/SSDI, and/or WIC) and 27.2% were referred for assistance with accessing community resources. Of the individuals referred to CareAdvisors to access community resources, 16.9% screened positive for food insecurity. (Data provided by CareAdvisors).

Similarly, homelessness is typically considered across chronic, transitional, and episodic categories, with chronic homelessness being the most common type. Individuals facing housing instability or homelessness are more likely to experience poor health outcomes when compared to individuals who are stably housed. Research finds that the “stability, quality safety, and affordability” of housing can directly impact health outcomes, as can the physical and social characteristics of the communities in which we live.

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?

Every organization in the community will have free access to the Unite Us platform, which provides predictive analytics allowing users to proactively understand the specific social needs of their populations and provide recommendations on how to drive improved outcomes. Some examples of predictive analytics offerings are:

- Community Health Map: interactive mapping tool that allows users to explore and identify communities with a high potential for SDOH impact. These visualizations are built on a set of proprietary community-level risk models.
- Person-level Social Opportunity Indices: A set of indices representing key aspects of social need (food insecurity, housing instability, social isolation, and so forth) that allow Unite Us customers to proactively understand the social needs of their patients/members and identify which may benefit from Unite Us network interventions. These indices are built using both public and proprietary data, and can be applied to clients who are already a part of a Unite Us network as well as new clients who've yet to have a single service episode or screening. This makes the Social Opportunity Indices an excellent choice for customers looking to kick-start a new network by identifying those who may benefit most from Unite Us intervention.

We have also established funds to provide immediate housing, such as rapid rehousing and temporary hotel stays, as well as access to food. These numbers were calculated using actual costs of local providers, as well as data from external sources.

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

Closing the loop on referrals through the Unite Us system and providing access to housing and food will allow members to focus on other aspects of their health, once they have their basic needs met.

10. Care Integration and Coordination

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

This proposal specifically addresses whole person care coordination in the following ways:

Approach: The care coordination intensity and frequency will be adjusted depending on stratified level of care. Ranging from multiple interventions per week to linking individuals to some services, care will be taken to provide the right intensity of coordination. Each level will have a consistent methodology of engagement, alerts, data, analytics, and accountability, regardless of intensity of care needed.

Engagement: Care coordination staff and members of the care team work to empower individuals to fully participate in their care. Assertive community engagement is critical to ensure access to services and resources is achieved with every individual in need of care.

Alerts: Data interoperability will generate alerts in order for care coordinators to close gaps in care, intervene with more complete clinical information, and ensure services occur as early as possible to avoid higher levels of care.

Data consolidation: Critical for 24/7 care, clinical information must be made available to front line staff to ensure coordination with hospitals, primary care providers, and other key partners is achieved.

Analytics: The Accountable Community of Health will collaborate with our technology partners to ensure the metrics are in place to achieve targeted HEDIS metrics, and to also include emerging metrics that will be measured to improve community health.

Accountability: The Accountable Community of Health will ensure that consistent workflows are agreed to and utilized. This will be critical to collaborate most effectively with Managed Care Organizations and other partners so there is no duplication of efforts with each client. Role definition will be critical to ensure consistency of care coordination across organizations. Within this whole person care coordination approach, we are ensuring the ACH includes subject matter experts, equity-informed care coordinators, and current and developing clinical services to achieve outcomes. Outcomes include Immediate Outcomes, which are 7 and 30 Day FUH for Mental Illness and Plan All Cause Readmission. as well as the Long Term Outcomes, which include Client Satisfaction and Decreased Total Cost of Care. The Accountable Community of Health will support the integration of providers, data, clinical, and care coordination services to support achieving both immediate and long-term outcomes.

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

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

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

LSSI worked with CareAdvisors to determine the number of care coordination positions to utilize for this proposal. Based on an estimated 34,671 member panel, Behavioral Health Specialists will have approximately 48 cases per month and Community Health Workers will have about 103. We anticipate needing 9 behavioral health specialists and 14 community health workers.

3. Are there any managed care organizations in your collaborative? ☒ No

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

- ☒ Yes

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

All Medicaid MCOs will be invited to participate in the Accountable Community of Health. From the initiation of the ACH, MCOs will be critical in a number of areas, including:

- Collaborating on 7/30 Day FUH for Mental Illness as well as Plan All Cause Readmission (PAR) workflows and strategies. Appropriate coding, integrating of data, and sharing what is most effective as a group of stakeholders will be essential for improving the quality of equity informed care.
- Insuring MCO Care Management and Community Care Coordination are complementary and not duplicative in their services. Role definition will continue to be reviewed to ensure that each team member knows their role and will be accountable to implement it consistently with all clients.
- Value-based care discussions will be part of the ACH from the beginning. Data sharing and identifying the best clinical and reimbursement strategy that will benefit the clients, community and all stakeholders.

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.**

Within the Whole Person Accountable Community of Health, there are four providers who are identified as part of the Illinois Business Enterprise Program (BEP) or a non-profit majorly controlled and managed by minorities. These four collaboration partners are CareAdvisors, Aunt Martha's Health and Wellness, Heartland Alliance Health, and TASC.

- 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.**

All of the listed entities will be contributing partners in the Whole Person ACH. CareAdvisors will help guide the data integration, social determinants of health, and help access the hardest to reach members. Aunt Martha's will provide psychiatric services. Heartland Health will provide care coordination and primary healthcare, with a focus on individuals who are homeless. TASC will provide care coordination with a specific focus on individuals involved with the criminal justice system. The ACH hopes to add additional BEP vendors and/or not-for-profit entities majorly controlled and managed by minorities to this proposal, especially as a subcontractor for the quarterly equity, diversity, and inclusion trainings we are planning to put out for bid.

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.
 -
 - Between the seven collaborators who will be hiring employees, there are over 500 current employees in Cook County.
 - Resources will be directed to help organizations hire individuals from the communities which the Whole Person Accountable Community of Health will be serving. To best assure culturally competent staff, and given extensive workforce shortages, considerable time and resources will be directed toward ensuring staff are a core part of the equity strategy throughout the ACH. For example, Unite Us is driven and supported by team members who are representative of the communities served, hired locally, skilled in stakeholder engagement and collective impact, and have past experience in public health, non-profit management, and community-based care coordination. Please see attached for more detail on zip codes and positions of current employees.

New Employment Opportunities

2. Please estimate the number of new employees that will be hired over the duration of your proposal. **58**
3. Describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve.

This Accountable Community of Health plans to hire the following positions in Year 1 of the proposal:

14 Community Health Workers

9 Behavioral Health

Specialists 5 Nurse

Team Leads

1 Director

1 Coordinator

1 Data/Grant Manager

1 Recruitment Specialist

Additionally, throughout the proposal, we will hire employees to be part of CST Teams. We plan to start 3 teams in year 1, and add an additional team in years 2-4, for a total of 26 CST employees, which includes 2 Persons with Lived Experience, 18 Case Managers, and 6 Supervisors.

This proposal will allow equity-informed partners in this Accountable Community of Health to hire workforce at a competitive salary, with an emphasis on providing jobs to members of the community and/or persons with lived experience.

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

This proposal incorporates resources to support organizations in hiring, including a 50% dedicated Recruitment Specialist position and funds for job postings and recruitment. Additionally, we will be providing formal equity, diversity, and inclusion training on a quarterly basis to all staff, as well as cross training across staffs on the specialty populations organizations within the collaborative are serving.

13. Quality Metrics

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

The 2021-2024 Quality Strategy twelve Quality Framework Goals, identified under the Better Care, Healthy People/Healthy Communities and Affordable Care served as the framework for this proposal. Specific to the "Vision for Improvement" - we addressed the Program Goals as follows:

Improve Behavioral Health Services and Supports for Adults

1. "Improve integration of physical and behavioral health"
 - The Psychiatric Open Access will operate with an integrated primary care - behavioral health design. The Care Coordinators will be responsible to ensure physical and behavioral health integration.
 - The Community Support Teams will be trained, staffed and structured to address 'Whole Person Care', ensuring that both physical and behavioral health services are integrated. The data integration will connect the medical and behavioral health information which will provide actionable data at the point of service.
2. "Improve transitions of care from inpatient to community-based services"
 - Best Practice Transitions of care workflows will yield positive improvement in 7 & 30 Day FUH measure performance. Leveraging current community staff co-located at hospitals to support timely and effective transitions of care.
 - The improved transitions of care will directly support the improvement in Plan All Cause Readmission rates.
 - For transitions of care to improve in this community, needed direct service, care coordination and social determinants of health need to be in place.

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

2A. Maternal and Child Health? No

2B. Adult Behavioral Health? Yes

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

- 1) FUH 7/30 day for Mental Illness. How we will meet them: We have attached two documents that describe best practice pathways for Whole Person Accountable Community of Health Care Coordinators. The two workflows provide a methodology which has yielded proven success with 7 & 30 Day FUH for Mental Illness. The addition of care coordination and necessary food and housing will create an optimal transitions of care strategy.
- 2) Plan All Cause Readmission. This will be achieved through the expansion of Community Support Teams and Psychiatry. The community lacks sufficient resources to prevent rehospitalization for mental illness. Additionally, if an individual is inpatient, the additional community resources will create a discharge plan that once enacted, will assist in improving Plan All Cause Readmission rates.

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

2C. Child Behavioral Health? No

2D. Equity? Yes

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

Rather than select one equity measurement now, we will instead utilize the attached framework to develop the metric(s) in partnership with the collaborating organizations.

2E. Community-Based Services and Supports? No

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

2022 Year 1:

Month 1

- Initiate establishing the ACH, which will coordinate the roll out of the below timeline
- Reach out to community stakeholders, people with lived experience, public officials, and other community members and invite their participation Initiate discussions to identify Fee-For-Service amounts that can be generated by the care coordinators in years 2 and thereafter

Month 2

- Establish Fee-For-Service billing rules (specifically regarding Targeted Case Management) to identify potential Fee-For-Service amounts that can be generated by the care coordinators in Year 2 and thereafter
- Prioritize the identification of underserved individuals and assign to equity informed care coordinators
- Ensure workflows and procedures reflect best practice outreach and engagement
- strategies to ensure an increase in client activation Identify barriers to improving engagement and ensure resources and solutions are applied to identified challenges Community referral Platform awarded
- Engage MCO's, orient them to process and identify next steps Finalize housing and food security providers
- Hire Director, Coordinator, Data/Grants

Manager, and Recruiter Month 3

- Standing up and providing open access psychiatric services
- Assign care coordinators to organizations; initiate hiring care coordinators
- Confirm sufficient number of housing and food security providers are active participants in Accountable Community of Health Initiate Equity trainings for all entities

Month 4

- Initiate integration of

electronic platforms Month 5

- Stand up first of three Community Support Teams to create community access for individuals who need significant mental health care.

Month 6

- Stand up second Community Support Team to create community access for individuals who need significant mental health care.

Month 9

- Stand up third Community Support Team to create community access for individuals who need significant mental health care.

Years 2 & 3: Provide services, establish fee-for-service billable amount that can reduce HFS payments. Year 4: Finalize Value Based Contracting with MCOs, using data from the first three years.

Year 5: Providers go to Value-Based Contracting, and no money is requested from HFS.

15. Budget**1. Number of Individuals Served**

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

Year 1

Individuals

Served

27232

Year 2

Individuals

Served

27232

Year 3

Individuals

Served

27232

Year 4

Individuals

Served

27232

Year 5

Individuals

Served

27232

Year 6

Individuals

Served

27232

2. Alternative Payment Methodologies

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

The request provides for funding services to successfully begin Fee-For-Service and have a structured plan to move the Care Coordination into Value-Based Contracting in Year 5.

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.

In Year 1 of the proposal budget, we are seeking full funding for Care Coordination in order to start-up services, finalize billing rules, configure Electronic Health Records, and establish consistent workflows and practices across organizations. Given workforce challenges, a primary goal will be to have equity-informed staff fully trained and providing services as efficiently as possible.

Starting in Year 2 and continuing through Year 4, Fee-For-Service billing will lower the needed level of Transformation Funding. This will allow the analysis of multi-year data to support discussions with MCOs regarding moving to Value-Based Care.

Please see Addendum E for the Sustainability Analysis details the impact on Medicaid Beneficiaries and Dual Eligible with inclusion of HEDIS Measure engagement Impact and Redetermination efforts.



ANDERSONVILLE (METHODIST)

5025 NORTH PAULINA
CHICAGO IL 60640

November 19, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

Thorek Andersonville (Methodist) Hospital, located at 5025 North Paulina in Chicago, Illinois is pleased to partner with Lutheran Social Services of Illinois (LSSI) on their Healthcare Transformation Collaboratives Proposal. Methodist Hospital is an acute care hospital that provides, among other things, emergency department and inpatient services to residents of Chicago's Northside.

In order to further the goals of the Transformation Proposal and to improve the care provided to residents of the community, Methodist Hospital will work with LSSI to meet the health care needs of individuals served by the Transformation Proposal, specifically to ensure that the following HFS Quality Measures are met:

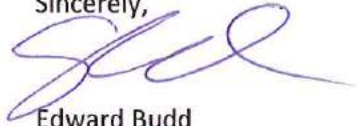
- Follow-Up After Hospitalization for Mental Illness – 7 and 30 Day (FUH)
- Plan All-Cause Readmission (PCR-HH)

LSSI will work with Methodist Hospital Emergency Department and Discharge Planning staff to coordinate and manage the overall health care needs of patients in the Transformation Project. LSSI will provide patient care coordination and management and work with Methodist Hospital by communicating about patient needs and collaborating on patient discharge plans that include a pathway to above mentioned HFS Quality Measures.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

We look forward to partnering with LSSI on this proposal.

Sincerely,



Edward Budd
President and CEO
Methodist Hospital

Swedish Hospital

Part of **NorthShore**

November 17, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

Swedish Hospital, located at 5140 N. California in Chicago, Illinois is pleased to support Lutheran Social Services of Illinois (LSSI) in their Healthcare Transformation Collaboratives Proposal. Swedish Hospital is an acute care hospital that provides, among other things, emergency department and inpatient services to residents of the Northside of Chicago.

In order to further the goals of LSSI's Transformation Proposal and to improve the care provided to residents of the community, Swedish Hospital will make efforts to support, as practical and appropriate, LSSI in their efforts to meet the health care needs of individuals served by the Transformation Proposal, specifically LSSI's efforts related to the following HFS Quality Measures:

- Follow-Up After Hospitalization for Mental Illness – 7 and 30 Day (FUH)
- Plan All-Cause Readmission (PCR-HH)

LSSI has indicated that they will work with Swedish Hospital Emergency Department and Discharge Planning staff to coordinate and manage the overall health care needs of patients in the Transformation Project. LSSI has also indicated that they will provide patient care coordination and management and work with Swedish Hospital by communicating about patient needs and collaborating on patient discharge plans that include a pathway to above mentioned HFS Quality Measures.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. From the information we've received, this project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

We look forward to supporting LSSI on this proposal.

Sincerely,



Bruce McNulty
Chief Medical Officer
Swedish Hospital



WEISS MEMORIAL HOSPITAL
4646 North Marine Drive
Chicago, Illinois 60640

facebook.com/weisshospital
twitter.com/weisshospital
WWW.WEISSHOSPITAL.COM

November 18, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

Weiss Memorial Hospital, located at 4646 N. Marine Drive in Chicago, Illinois is pleased to partner with Lutheran Social Services of Illinois (LSSI) on their Healthcare Transformation Collaboratives Proposal. Weiss Hospital provides emergency department and inpatient psychiatric services to residents of the Northside of Chicago.

In order to further the goals of the Transformation Proposal and to improve the care provided to residents of the community, Weiss Hospital will work with LSSI to meet the health care needs of individuals served by the Transformation Proposal, specifically to ensure that the following HFS Quality Measures are met:

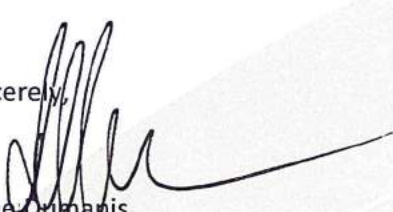
- Follow-Up After Hospitalization for Mental Illness – 7 and 30 Day (FUH)
- Plan All-Cause Readmission (PCR-HH)

LSSI will work with Weiss Hospital Emergency Department and Inpatient Psychiatric Discharge Planning staff to coordinate and manage the overall health care needs of patients in the Transformation Project. LSSI will provide patient care coordination and management and work with Weiss Hospital by communicating about patient needs and collaborating on patient discharge plans that include a pathway to above mentioned HFS Quality Measures.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

We look forward to partnering with LSSI on this proposal.

Sincerely,



Irene Dumanis
Chief Executive Officer



Community First
Medical Center

November 17, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

Community First Medical Center, located at 5645 W. Addison in Chicago, Illinois 60634 is pleased to partner with Lutheran Social Services of Illinois (LSSI) on their Healthcare Transformation Collaboratives Proposal. Community First Medical Center is a non-profit corporation that provides, among other things, emergency department services to residents of the Northside of Chicago.

In order to further the goals of the Transformation Proposal and to improve the care provided to residents of the community, Community First will work with LSSI to meet the health care needs of individuals served by the Transformation Proposal, specifically to ensure that the following HFS Quality Measures are met:

- Follow-Up After Hospitalization for Mental Illness – 7 and 30 Day (FUH)
- Plan All-Cause Readmission (PCR-HH)

LSSI will work with Community First Medical Center Emergency Department staff to coordinate and manage the overall health care needs of patients in the Transformation Project. LSSI will provide patient care coordination and management and work with Community First by communicating about patient needs and collaborating on patient discharge plans that include a pathway to above mentioned HFS Quality Measures.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

We look forward to partnering with LSSI on this proposal.

Sincerely,

Jared Marcucci MD MS

Interim Chief Medical Officer
Emergency Department Medical Director
Community First Medical Center
[e] jmarcucci@cfmedicalcenter.com
[c] 630-715-6933



M106 STATE CAPITOL
SPRINGFIELD, ILLINOIS 62706
217-557-0523

SENATOR SARA FEIGENHOLTZ
STATE OF ILLINOIS

3223 N. SHEFFIELD AVE. SUITE. A
CHICAGO, ILLINOIS 60657
773-296-4141

November 15, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

I am pleased to provide this letter of support for Lutheran Social Services of Illinois (LSSI)'s Healthcare Transformation Collaboratives Proposal. I believe that their proposal will work toward the Healthcare Transformation Collaboratives' goal of improving healthcare outcomes and reducing health disparities on the Northside of Chicago.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

LSSI's history of providing healthcare services on the Northside of Chicago and their strong partnerships with hospitals, community organizations, managed care organizations, city entities, and other providers makes them an ideal organization to lead this project.

I look forward to hearing about this project and the progress once the program is initiated. Thank you for your continued partnership in caring for our community and my constituents.

Sincerely,

A handwritten signature in black ink that reads 'Sara Feigenholtz'. The signature is written in a cursive, flowing style.

State Senator, 6th District

District Office:
4349 N. Milwaukee Ave., Suite 1
Chicago, IL 60641
(773) 286-1115
(773) 545-7106 Fax



Robert Martwick
State Senator • 10th District

Springfield Office:
Capitol Building, Room 119A
Springfield, IL 62706
(217) 782-1035

11/5/2021

Illinois Department of Healthcare and Family Services

Attn: Theresa Eagleson, Director

36 South Wabash Avenue

Chicago, IL 60603

Dear Ms. Eagleson,

I am pleased to provide this letter of support for Lutheran Social Services of Illinois (LSSI)'s Healthcare Transformation Collaboratives Proposal. I believe that their proposal will work toward the Healthcare Transformation Collaboratives' goal of improving healthcare outcomes and reducing health disparities on the Northside of Chicago.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

LSSI's history of providing healthcare services on the Northside of Chicago and their strong partnerships with hospitals, community organizations, managed care organizations, city entities, and other providers makes them an ideal organization to lead this project.

I look forward to hearing about this project and the progress once the program is initiated. Thank you for your continued partnership in caring for our community and my constituents.

Sincerely,

A handwritten signature in cursive script, reading "Robert F. Martwick".

Robert F. Martwick

Senator 10th Senate District



CRISTINA H. PACIONE-ZAYAS, PHD
STATE SENATOR – 20TH DISTRICT

November 10, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

I am pleased to provide this letter of support for Lutheran Social Services of Illinois (LSSI)'s Healthcare Transformation Collaboratives Proposal. I believe that their proposal will work toward the Healthcare Transformation Collaboratives' goal of improving healthcare outcomes and reducing health disparities on the Northside of Chicago.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

LSSI's history of providing healthcare services on the Northside of Chicago and their strong partnerships with hospitals, community organizations, managed care organizations, city entities, and other providers makes them an ideal organization to lead this project.

I look forward to hearing about this project and the progress once the program is initiated. Thank you for your continued partnership in caring for our community and my constituents.

Sincerely,

A handwritten signature in black ink, appearing to read "C. Pacione-Zayas".

Cristina Pacione-Zayas, IL State Senator
20th Legislative District

District Office:
4349 N Milwaukee Ave
Chicago, IL 60641



Springfield Office:
280-S Stratton Office
Building
Springfield, IL 62706

Lindsey LaPointe
STATE REPRESENTATIVE • 19th DISTRICT

November 12, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

I am pleased to provide this letter of support for Lutheran Social Services of Illinois (LSSI)'s Healthcare Transformation Collaboratives Proposal. Their proposal will work toward the Healthcare Transformation Collaboratives' goal of improving healthcare outcomes and reducing health disparities on the Northside of Chicago.

LSSI's proposal has the goal of improving racial equity and access to mental health and social support for families on the Northside of Chicago. As a former social worker, I share this goal and recognize that this work needs to be performed at the highest level in order to effectively serve our community in the 19th District. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

LSSI has demonstrated a history of successfully delivering services here on the Northwest side. Those services include a [Mobile Crisis Response Team](#), which helps people of all ages and meets them where they are. This history of providing healthcare services and their strong partnerships with hospitals, community organizations, managed care organizations, city entities, and other providers makes them an ideal organization to lead this project. Their services have always been and continue to be crucial as families navigate healthcare systems in a pandemic-era.

I look forward to hearing about this project and the progress once the program is initiated. Thank you for your continued partnership in caring for our community and my constituents.

Sincerely,

A handwritten signature in black ink, appearing to read "L. LaPointe", with a stylized flourish at the end.

Lindsey LaPointe
207-712-7472
State Representative
Illinois' 19th House District

ILLINOIS HOUSE OF REPRESENTATIVES

SPRINGFIELD OFFICE:

200-3S Stratton Building
Springfield, Illinois 62706
(217) 558-1032 (Office)



DISTRICT OFFICE:

3458 N. Cicero Ave.
Chicago, Illinois 60641
(773) 853-2570 (Office)

Will Guzzardi
STATE REPRESENTATIVE
39th DISTRICT

November 8, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

I am pleased to provide this letter of support for Lutheran Social Services of Illinois (LSSI)'s Healthcare Transformation Collaboratives Proposal. I believe that their proposal will work toward the Healthcare Transformation Collaboratives' goal of improving healthcare outcomes and reducing health disparities on the Northside of Chicago.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

LSSI's history of providing healthcare services on the Northside of Chicago and their strong partnerships with hospitals, community organizations, managed care organizations, city entities, and other providers makes them an ideal organization to lead this project.

I look forward to hearing about this project and the progress once the program is initiated. Thank you for your continued partnership in caring for our community and my constituents.

Sincerely,

A handwritten signature in black ink that reads "Will Guzzardi".

Will Guzzardi
State Representative
11th House District

DISTRICT OFFICE:
3007 W. IRVING PARK RD.
CHICAGO, IL 60618
773-267-2880



SPRINGFIELD OFFICE:
109 Capitol BUILDING
SPRINGFIELD, IL 62706
217-782-8117
EMAIL: info@staterep40.com

JAIME M. ANDRADE, JR.

STATE REPRESENTATIVE
40TH DISTRICT
ASSISTANT MAJORITY LEADER

November 8, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

I am pleased to provide this letter of support for Lutheran Social Services of Illinois (LSSI)'s Healthcare Transformation Collaboratives Proposal. I believe that their proposal will work toward the Healthcare Transformation Collaboratives' goal of improving healthcare outcomes and reducing health disparities on the Northside of Chicago.

LSSI's proposal has the goal of improving racial equity and access to mental health and social support for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

LSSI's history of providing healthcare services on the Northside of Chicago and their strong partnerships with hospitals, community organizations, managed care organizations, city entities, and other providers makes them an ideal organization to lead this project.

I look forward to hearing about this project and the progress once the program is initiated. Thank you for your continued partnership in caring for our community and my constituents.

Sincerely,

A handwritten signature in blue ink that reads "Jaime M. Andrade Jr.".

Jaime M. Andrade Jr.
IL State Representative
40th District



ARIEL E. REBOYRAS
Alderman, 30th Ward
Service Office
3559 N. Milwaukee Ave
Chicago, IL 60641
(773) 794-3095
(773) 794-8576 (Fax)

City of Chicago
City Council
City Hall, Room 200
121 N. LaSalle Street
Chicago, IL 60602
(312) 744-3304/3305

COMMITTEE
MEMBERSHIPS

Immigrant and Refugee Rights
Chairman

Aviation
Budget and Government
Operations
Committees and Rules
Contract Oversight and Equity
Economic, Capital & Technology
Development
Finance
Public Safety
Transportation and Public Way
Zoning, Landmarks and
Building Standards

November 8, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

I am pleased to provide this letter of support for Lutheran Social Services of Illinois (LSSI)'s Healthcare Transformation Collaboratives Proposal. I believe that their proposal will work toward the Healthcare Transformation Collaboratives' goal of improving healthcare outcomes and reducing health disparities on the Northside of Chicago.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

LSSI's history of providing healthcare services on the Northside of Chicago and their strong partnerships with hospitals, community organizations, managed care organizations, city entities, and other providers makes them an ideal organization to lead this project.

I look forward to hearing about this project and the progress once the program is initiated. Thank you for your continued partnership in caring for our community and my constituents.

Sincerely,

Ariel E. Reboyas
Alderman, 30th Ward

5425 WEST LAWRENCE AVENUE
CHICAGO, ILLINOIS 60630
PHONE: 773-853-0799
E-MAIL: WARD45@CITYOFCHICAGO.ORG



CITY OF CHICAGO
CITY COUNCIL

★
JAMES M. GARDINER
ALDERMAN, 45TH WARD

COMMITTEE MEMBERSHIPS
AVIATION
COMMITTEES AND RULES
LICENSE AND CONSUMER PROTECTION
PUBLIC SAFETY
SPECIAL EVENT, CULTURAL AFFAIRS
AND RECREATION

November 5, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

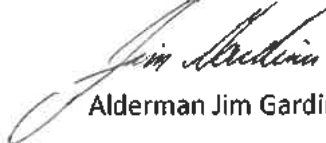
I am pleased to provide this letter of support for Lutheran Social Services of Illinois (LSSI)'s Healthcare Transformation Collaboratives Proposal. I believe that their proposal will work toward the Healthcare Transformation Collaboratives' goal of improving healthcare outcomes and reducing health disparities on the Northside of Chicago.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

LSSI's history of providing healthcare services on the Northside of Chicago and their strong partnerships with hospitals, community organizations, managed care organizations, city entities, and other providers makes them an ideal organization to lead this project.

I look forward to hearing about this project and the progress once the program is initiated. Thank you for your continued partnership in caring for our community and my constituents.

Sincerely,



Alderman Jim Gardiner

NICHOLAS SPOSATO
ALDERMAN, 38TH WARD

3821 NORTH HARLEM AVENUE
CHICAGO, ILLINOIS 60634
PHONE: 773-283-3838
FAX: 773-283-3235

E-MAIL: WARD38@CITYOFCHICAGO.ORG



**CITY OF CHICAGO
CITY COUNCIL**

★
COUNCIL CHAMBER
CITY HALL ROOM 200
121 NORTH LASALLE STREET
CHICAGO, ILLINOIS 60602
PHONE: 312-744-1836

COMMITTEE MEMBERSHIPS

SPECIAL EVENTS, CULTURAL AFFAIRS,
AND RECREATION
(CHAIRMAN)
AVIATION
BUDGET AND GOVERNMENT OPERATIONS
COMMITTEES AND RULES
ECONOMIC, CAPITAL, AND
TECHNOLOGY DEVELOPMENT
EDUCATION AND CHILD DEVELOPMENT
FINANCE
LICENSE AND CONSUMER PROTECTION
PUBLIC SAFETY
WORKFORCE DEVELOPMENT

November 5, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

I am pleased to provide this letter of support for Lutheran Social Services of Illinois (LSSI)'s Healthcare Transformation Collaboratives Proposal. I believe that their proposal will work toward the Healthcare Transformation Collaboratives' goal of improving healthcare outcomes and reducing health disparities on the Northside of Chicago.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

LSSI's history of providing healthcare services on the Northside of Chicago and their strong partnerships with hospitals, community organizations, managed care organizations, city entities, and other providers makes them an ideal organization to lead this project.

I look forward to hearing about this project and the progress once the program is initiated. Thank you for your continued partnership in caring for our community and my constituents.

Sincerely,

Nicholas Sposato
Alderman, 38th Ward



PUBLIC SERVICE OFFICE
4200 WEST LAWRENCE AVENUE 60630
TELEPHONE: 773.736.5594
FAX: 773.736.2333
E-MAIL: WARD39@CITYOFCHICAGO.ORG

SAMANTHA NUGENT

ALDERMAN, 39TH WARD

CITY HALL - ROOM 300
121 NORTH LA SALLE STREET
CHICAGO, ILLINOIS 60602
TELEPHONE: 312.744.7242
FAX: 312.744.0717

CITY COUNCIL COMMITTEE MEMBERSHIPS

ENVIRONMENT PROTECTION
AND ENERGY
(VICE CHAIRMAN)

AVIATION

RULES

ETHICS AND GOVERNMENT OVERSIGHT

PUBLIC SAFETY

SPECIAL EVENTS, CULTURAL AFFAIRS
AND RECREATION

November 5, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

I am pleased to provide this letter of no objection for Lutheran Social Services of Illinois (LSSI)'s Healthcare Transformation Collaboratives Proposal.

The proposal will work toward the Healthcare Transformation Collaboratives' goal of improving healthcare outcomes and reducing health disparities on the Northside of Chicago, particularly the 39th Ward.

Improving racial equity and access to mental health and social supports for families are the keystone of this proposal. There need for these resources for families on the northwest side is evident. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

LSSI's history of providing healthcare services on the Northside of Chicago and their strong partnerships with hospitals, community organizations, managed care organizations, city entities, and other providers makes them an ideal organization to lead this project.

I look forward to hearing about this project and the progress once the program is initiated. Thank you for your continued partnership in caring for our community and my constituents.

Sincerely,

Samantha Nugent
39th Ward Alderman

ANDRE VASQUEZ
ALDERMAN, 40TH WARD
5620 NORTH WESTERN AVENUE
CHICAGO, ILLINOIS 60659
PHONE: 773-654-1867
EMAIL: WARD40@CITYOFCHICAGO.ORG
WEBSITE: WWW.40THWARD.ORG



**CITY OF CHICAGO
CITY COUNCIL**

★
COUNCIL CHAMBER
CITY HALL, ROOM 34
121 NORTH LASALLE STREET
CHICAGO, ILLINOIS 60602
PHONE: 312-744-6858

COMMITTEE MEMBERSHIPS

SPECIAL EVENTS, CULTURAL AFFAIRS
AND RECREATION
(VICE-CHAIRMAN)
CONTRACT OVERSIGHT AND EQUITY
ECONOMIC, CAPITAL, AND TECHNOLOGY
DEVELOPMENT
HEALTH AND HUMAN RELATIONS
PEDESTRIAN AND TRAFFIC SAFETY
TRANSPORTATION AND THE PUBLIC WAY
ETHICS AND GOOD GOVERNANCE
COMMITTEES AND RULES

9 November 2021

**Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603**

Dear Ms. Eagleson,

I am pleased to provide this letter of support for Lutheran Social Services of Illinois (LSSI)'s Healthcare Transformation Collaboratives Proposal. I believe that their proposal will work toward the Healthcare Transformation Collaboratives' goal of improving healthcare outcomes and reducing health disparities on the Northside of Chicago.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

LSSI's history of providing healthcare services on the Northside of Chicago and their strong partnerships with hospitals, community organizations, managed care organizations, city entities, and other providers makes them an ideal organization to lead this project.

I look forward to hearing about this project and the progress once the program is initiated. Thank you for your continued partnership in caring for our community and my constituents.

Sincerely,

Andre Vasquez
Alderman – 40th Ward

MATT MARTIN
ALDERMAN, 47TH WARD
4243 NORTH LINCOLN AVENUE
CHICAGO, ILLINOIS 60618
PHONE: 773-868-4747
EMAIL: WARD47@CITYOFCHICAGO.ORG



**CITY OF CHICAGO
CITY COUNCIL**

COUNCIL CHAMBER
CITY HALL, ROOM 200
121 NORTH LASALLE STREET
CHICAGO, ILLINOIS 60602

COMMITTEE MEMBERSHIPS

RULES AND ETHICS
ETHICS AND GOVERNMENT OVERSIGHT
ENVIRONMENTAL PROTECTION AND ENERGY
HOUSING AND REAL ESTATE
HUMAN RELATIONS AND HEALTH
LICENSE AND CONSUMER PROTECTION COMMITTEE
PUBLIC SAFETY
SPECIAL EVENTS, CULTURAL AFFAIRS AND RECREATION

November 5, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

I am pleased to provide this letter of support for Lutheran Social Services of Illinois (LSSI)'s Healthcare Transformation Collaboratives Proposal. I believe that their proposal will work toward the Healthcare Transformation Collaboratives' goal of improving healthcare outcomes and reducing health disparities on the Northside of Chicago.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

LSSI's history of providing healthcare services on the Northside of Chicago and their strong partnerships with hospitals, community organizations, managed care organizations, city entities, and other providers makes them an ideal organization to lead this project.

I look forward to hearing about this project and the progress once the program is initiated. Thank you for your continued partnership in caring for our community and my constituents.

Sincerely,

Matt Martin
Alderman, 47th Ward



Rossana Rodríguez-Sánchez

Alderman, 33rd Ward

COUNCIL CHAMBER

City Hall Room 20
121 North LaSalle Street
Chicago, Illinois 60602
(312)744-6835

Office of the 33rd Ward

3001 W. Irving Park Rd.
Chicago IL, 60618
773-840-7880
info@33rdward.org

COMMITTEE MEMBERSHIPS

Ethics
Education and Child Development
Environmental Protection and Energy
Health and Human Relations
Pedestrian and Traffic Safety Rules
Immigrant and Refugee Rights

November 17, 2021

Illinois Department of Healthcare and Family Services
Attn: Theresa Eagleson, Director
36 South Wabash Avenue
Chicago, IL 60603

Dear Ms. Eagleson,

I am pleased to provide this letter of support for Lutheran Social Services of Illinois (LSSI)'s Healthcare Transformation Collaboratives Proposal. I believe that their proposal will work toward the Healthcare Transformation Collaboratives' goal of improving healthcare outcomes and reducing health disparities on the Northside of Chicago.

LSSI's proposal has the goal of improving racial equity and access to mental health and social supports for families on the Northside of Chicago. Their project has a clear vision of being equity informed, building capacity for social determinants of health and mental health access, and using data-driven approaches to create sustainability.

LSSI's history of providing healthcare services on the Northside of Chicago and their strong partnerships with hospitals, community organizations, managed care organizations, city entities, and other providers makes them an ideal organization to lead this project.

I look forward to hearing about this project and the progress once the program is initiated. Thank you for your continued partnership in caring for our community and my constituents.

Sincerely,

Rossana Rodriguez-Sanchez
Alderwoman of the 33rd Ward

Addendum B

Northside: Supplemental Data

Zip Code	Total Population	Percent Poverty Line		Hispanic		Asian		African American		Social Vulnerability Index
		Amount	Percent age	Amount	Percent age	Amount	Percent age	Amount	Percent age	
60631	38,303	2,949	7.7%	5,749	15.1%	1,618	4.2%	297	0.8%	0.3034
60646	19,596	2,293	11.7%	2,935	15.1%	2,076	10.7%	231	1.2%	0.3265
60659	77,122	10,874	14.1%	14,835	18.9%	18,650	23.8%	9,086	11.6%	0.8360
60656	13,418	1,100	8.2%	1,381	10.6%	1,582	12.1%	256	2.0%	0.6749
60706	14,703	679	4.6%	1,161	7.9%	768	5.2%	86	0.6%	0.7511
60630	26,216	2,255	8.6%	6,806	24.7%	2,625	9.5%	293	1.1%	0.3819
60625	48,396	5,662	11.7%	22,399	45.0%	7,391	14.8%	2,461	4.9%	0.8760
60634	43,147	3,711	8.6%	12,855	29.6%	2,509	5.8%	722	1.7%	0.7281
60641	51,940	6,077	11.7%	22,426	41.9%	4,529	8.5%	1,750	3.3%	0.7314
60618	36,257	5,112	14.1%	21,471	56.3%	1,591	4.2%	795	2.1%	0.5497
60707	14,401	3,111	21.6%	8,581	59.9%	460	3.2%	388	2.7%	0.8124
60639	78,116	16,873	21.6%	63,777	81.2%	1,453	1.8%	1,865	2.4%	0.8612
	461,615	60,696	13.1%	184,376	39.9%	45,252	9.8%	18,230	3.9%	

Notes

1) Population Data: US Census

2) Social Vulnerability Index from the Centers for Disease Control

Addendum C

Northside: Member Population Estimates

Zip Code	Town	Total Population (1)	Medicaid Estimate	Medicaid Coverage (2)
60631	Norwood Park	38,303	4,382	11.4%
60646	Forest Glen	19,596	4,031	20.6%
60659	West Ridge	77,122	17,561	22.8%
60656	O'Hare	13,418	1,535	11.4%
60706	Norridge	14,703	2,507	17.1%
60630	Jefferson Park	26,216	4,672	17.8%
60625	Albany Park	48,396	9,955	20.6%
60634	Dunning	43,147	7,689	17.8%
60641	Irving Park	51,940	10,684	20.6%
60618	Avondale	36,257	7,338	20.2%
60707	Montclare	14,401	5,243	36.4%
60639	Belmont Cragin	78,116	28,442	36.4%
		461,615	104,039	22.5%

Percentage of Dually-Eligible Beneficiaries (3.24%

Total Number of Dually-Eligible Beneficia 14,956

Notes

1) Population Data: US Census

2) Medicaid Coverage: Uniform Data System (UDS) Mapper includes Medicaid beneficiaries and Medicaid eligible, not enrolled

3) Estimate of Dually-Eligible deneficiaries as a percentage of Medicare beneficiaries from Kaiser Family Foundation

<https://www.kff.org/medicaid/state-indicator/duals-as-a-of-medicare-beneficiaries>

Northside: Supplemental Data

Largest Minority Demographic

Zip Code	Town	Percent Poverty Line	Ethnicity/Race	Percentage	Social Vulnerability Index
60631	Norwood Park	7.7%	Hispanic	15.5%	0.3034
60646	Forest Glen	11.7%	Hispanic	15.1%	0.3265
60659	West Ridge	14.1%	Asian	23.8%	0.836
60656	O'Hare	8.2%	Asian	12.1%	0.6749
60706	Norridge	4.6%	Hispanic	6.4%	0.7511
60630	Jefferson Park	8.6%	Hispanic	24.7%	0.3819
60625	Albany Park	11.7%	Hispanic	45.0%	0.8760
60634	Dunning	8.6%	Hispanic	29.6%	0.7281
60641	Irving Park	11.7%	Hispanic	41.9%	0.7314
60618	Avondale	14.1%	Hispanic	56.3%	0.5497
60707	Montclare	21.6%	Hispanic	59.9%	0.8124
60639	Belmont Cragin	21.6%	Hispanic	81.2%	0.8612

Notes

1) Population Data: US Census

2) Social Vulnerability Index from the Centers for Disease Control

Housing & Food Security Detail

Total Members w/ Behavioral Health Diagnosis	28,090
Total Dually-Eligible Members w/ Behavioral Health Diagnosis	6,581
Total high-risk members	4,981
Estimated percentage of households in-crisis for housing	5.0%
Estimated number of households in-crisis for housing	260.00
Estimated annual households in need of rental assistance	110
Rental assistance per household	3,000
Total rental assistance	\$ 330,000
Estimated annual households in need of rapid re-housing assistance	40
Rapid re-housing assistance for 6 months	10,500
Total rapid re-housing assistance	\$ 420,000
Estimated annual households in need of diversion assistance	110
Diverasion assistance cost per household	2,000
Total diversion and outreach assistance	\$ 220,000
Total housing assistance	\$ 970,000
Estimated percentage of high-risk patients in need of food assistance (2)	13.0%
Food assistance for up to four months	700
Number of high-risk patients in need of food assistance	650
Total food assistance	\$ 455,000
Total Housing and Food Assistance	\$ 1,425,000

1) Housing and food assistance need and cost estimates based on historical experience of local agencies delivering services in the community.

Northside Enhanced Social Care Management

Total Medicaid beneficiaries w/ behavioral health diagnosis	28,090
Total dually-eligible beneficiaries w/ behavioral health diagnosis	<u>6,581</u>
Total members w/ behavioral health diagnosis	34,671

Total high-risk social needs members (1)	3,467
Housing and food security costs per member / per month	\$ 34.25
Total annual costs for food security and housing for high-risk members	<u>\$ 1,424,989</u>

Estimated percentage of hard-to-reach Medicaid beneficiaries	5%
Estimated number of hard-to-reach Medicaid beneficiaries	1,405
Estimated percentage of hard-to-reach dually eligible beneficiaries	50%
Estimated number of hard-to-reach dually eligible beneficiaries	3,290
Total hard-to-reach members (2)	4,695
Hard-to-reach care management per member / per month cost	\$ 20.00
Total annual cost hard-to-reach members care management	<u>\$ 1,126,780</u>

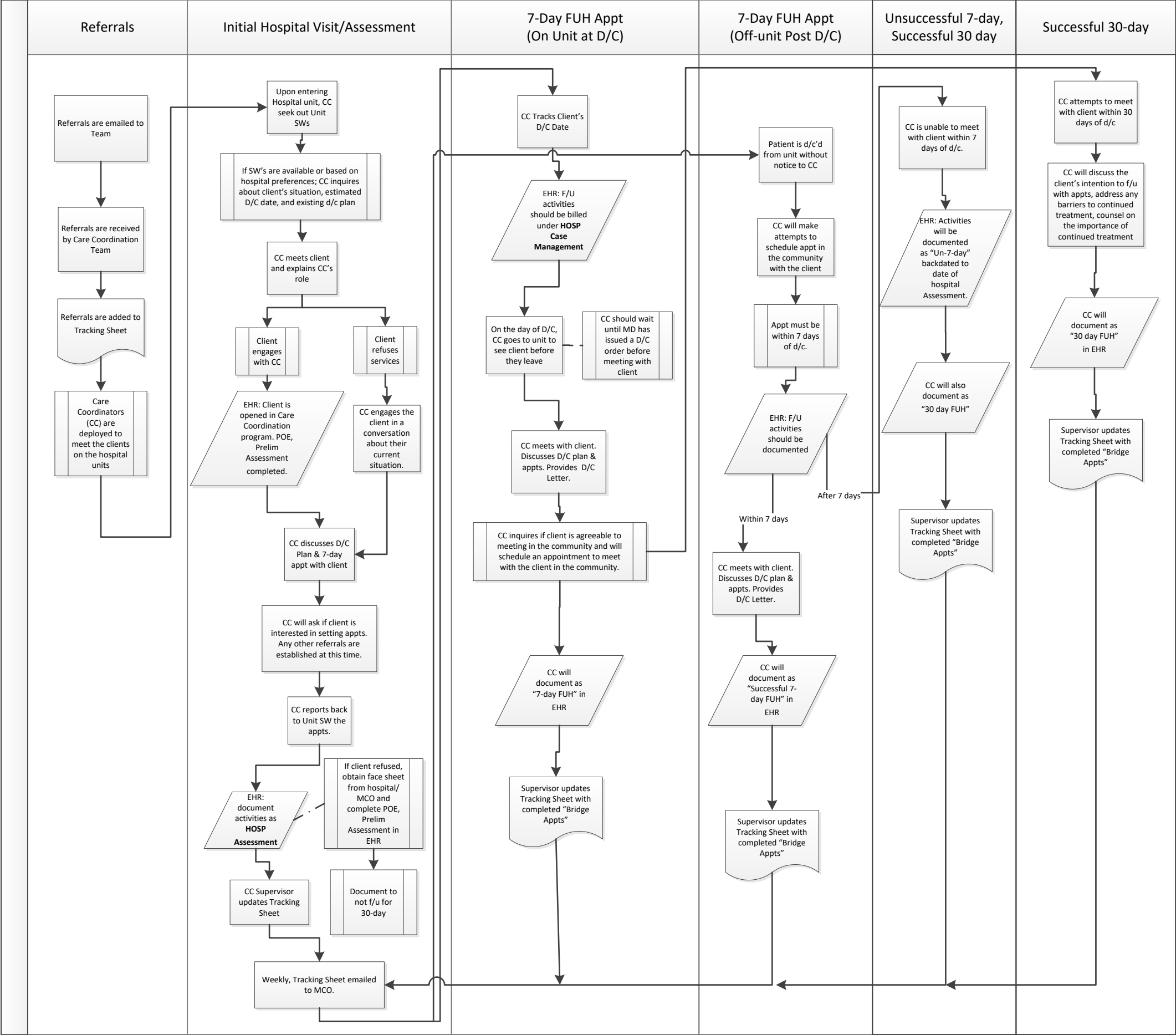
Notes

1) 10% of total members estimated as high-risk for social needs.

2) 50% of dually-eligible and 5.0% of medicaid beneficiaries estimated as hard-to-reach

FUH Process

Addendum D



Care Coordination Client Initial Meeting Guide



Northside Sustainability Analysis

Shared Cost Savings: Medicaid Beneficiaries

Total Cost of Care Per Patient Per Year (1)	\$7,075
Target Cost Savings Percentage from Benchmark (2)	5.0%
Target Cost Savings (Annual Dollars per Member)	\$354
Total Members	104,039
Percentage of Members w/ Behavioral Health Diagnosis (3)	27%
Total Members w/ Behavioral Health Diagnosis	28,090
Total Cost Savings	\$9,937,004
Northside Percentage of Shared Cost Savings	50%
WCC Shared Cost Savings Funding	\$4,968,502

Shared Cost Savings: Dual-Eligibles

Total Cost of Care Per Patient Per Year	\$12,000
Target Cost Savings Percentage from Benchmark	5.0%
Target Cost Savings (Annual Dollars per Member)	\$600
Total Members	14,956
Total Dually-Eligible Members w/ Behavioral Health Diagnosis (4)	44%
Total Dually-Eligible Members w/ Behavioral Health Diagnosis	6,581
Total Cost Savings	\$3,948,470
Northside Percentage of Shared Cost Savings	50%
WCC Shared Cost Savings Funding	\$1,974,235

Engagement Impact (HEDIS Measures)

Per Member Fee (5)	\$36
Total Members	34,671
Total Engagement Incentive (HEDIS Measures)	\$1,248,165

Engagement Impact (ReDe Improvement)

Total Members	34,671
Percentage of Members for ReDetermination Engagement (5)	15%
No. of Members Engaged for ReDe	5,201
Per Member Fee (5)	\$85
Total Engagement incentive (ReDe Improvement)	\$442,058

Total Value-Based Payment Revenue	\$8,632,961
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Annual Cost Adjustment (6)	2.0%
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Five-Year Cost Adjustment	\$9,344,594
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Notes

- 1) Source: Illinois Healthcare Family Services cost data on behavioral health Medicaid beneficiaries 0-64 for FY2015
https://www2.illinois.gov/hfs/SiteCollectionDocuments/20160902_1115_Waiver_for_Public_Comment_vF.pdf
- 2) Cost of savings target based on 24% reduction in hospitalization cost for highest decile Medicaid members.
- 3) Source: Illinois Healthcare Family Services cost data on behavioral health Medicaid beneficiaries 0-64 for FY2015
https://www2.illinois.gov/hfs/SiteCollectionDocuments/20160902_1115_Waiver_for_Public_Comment_vF.pdf
- 4) Source: Kaiser Family Foundation research on "Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending"
<https://www.kff.org/health-reform/report/chronic-disease-and-co-morbidity-among-dual/>
- 5) Based on historical value-based pricing experience
- 6) Annual cost adjustment of 2.0% based on historical trend analysis