Medicaid Innovation Collaborative Proposal Submission

04/09/2021

Executive Contacts

Michelle Conger, Chief Strategy Officer OSF HealthCare
Chief Executive Officer OSF OnCall Digital Health
Michelle.Conger@osfhealthcare.org
309-370-7981

Jennifer Junis, Senior Vice President OSF OnCall Digital Health
Jennifer.Junis@osfhealthcare.org
309-853-7507

Contents

Participating Entities

Primary Contact for Collaboration

Name: OSF HealthCare – Michelle Conger

Position: Chief Strategy Officer and CEO OSF OnCall Digital Health

Email: Michelle.D.Conger@osfhealthcare.org

Office Phone: (309) 683-7448

Mobile Phone: (309) 370-7981

Address: 800 NE Glen Oak Avenue, Peoria IL 61603

Primary Contact of Participating Entities

Name: OSF HealthCare – Michelle Conger

Position: Chief Strategy Officer and CEO OSF OnCall Digital Health

Email: Michelle.D.Conger@osfhealthcare.org

Office Phone: (309) 683-7448; Mobile Phone: (309) 370-7981

Address: 800 NE Glen Oak Avenue, Peoria IL 61603

Name: Aunt Martha's Health Center - Kenny Martín-Ocasio

Position: Senior Vice President Community Integration- Health Services

Email: kmocasio@auntmarthas.org

Office Phone: (708) 747-7441; Mobile Phone: (630) 886-8886

Address: 19990 Governors Hwy., Olympia Fields, IL 60461

Name: Chestnut Family Health Center – Joan Hartman

Position: Vice President of Strategy and Public Policy Chestnut Health Systems

Email: jahartman@chestnut.org

Office Phone: (309) 530-2322

Address: 1003 Martin Luther King Drive, Bloomington, IL 61701

Name: Heartland Health Service – Sharon Adams

Position: Chief Executive Officer

Email: S.Adams@hhsil.com

Office Phone: (309) 680-7657

Address: 2214 N University, Peoria, IL 61604

Name: Eagle View Community Health System – Kelci Foss

Position: Director of Population Health

Email: KFoss@eagleviewhealth.org

Office Phone: (309) 867-2202 ext. 241; Mobile Phone: (815) 213-1498

Address: PO Box 198, Oquawka, IL 61469

Name: Mile Square Health Center – Dr. Karriem S. Watson

Position: Assoc. Exec. Director

Email: kswatson@uic.edu

Office Phone: (312) 413-8908;Mobile Phone: (312) 933-4825

Address: 1220 S Wood St, Chicago, IL 60608

List of Entities participating Community Based Organizations

Entity Name: Chestnut Health Systems

Primary Contact: Matt Mollenhauer

Position: Chief Clinical Officer

Email: mmollenhauer@chestnut.org

Office Phone: (309) 820-3620; Mobile phone: (309) 825-7419

Address: 1003 Martin Luther King Drive, Bloomington, IL 61701

Entity Name: Home Sweet Home Ministries

Primary Contact: Matt Burgess

Position: CEO

Office phone: (309) 828.7356

Address: 303 E. Oakland Ave, Bloomington, IL 61701

Entity Name: The BabyFold

Primary Contact: Dianne Schultz

Position: CEO

Office phone: (309) 452-1170

Address: 108 E. Willow St., Normal, IL 61761

Entity Name: MarcFirst

Primary Contact: Brian Wipperman

Position: CEO

Office phone: (309) 451-8888 ext. 225

Address: 1606 Hunt Drive, Normal, IL 61761

Entity Name: The Boys and Girls Club

Primary Contact: Tony Morstatter

Position: CEO

Office phone: (309) 829-3034; Mobile phone: (309) 838-8522

Address: 1615 Illinois St., Bloomington, IL 61701

Entity Name: The Jamieson Center

Primary Contact: Nancy Mowen

Position: Executive Director

Office Phone: (309) 734-4251

Address: 1025 S. 2nd Street, Monmouth, IL 61462

Entity Name: Greater Auburn-Gresham Development Corporation

Primary Contact: Carlos Nelson

Position: Chief Executive Officer

Email: Cnelson@gagdc.org

Office Phone: (773) 483-3696

Address: 1159 West 79th St., Chicago, IL 60620

Entity Name: Dream Center Peoria

Primary Contact: Andy King

Position: Executive Director

Email: andy.king@dreamcenterpeoria.org

Office Phone: (309) 676-3000

Address: 714 Hamilton Blvd., Peoria, IL 61603

Entity Name: Salvation Army

Primary Contact: Brandi Wright

Position: Social Ministries Manager

Email: brandi_wright@usc.salvationarmy.org

Office Phone: (309) 346-3010

Address: 234 Derby St., Pekin, IL 61554

Entity Name: Salvation Army

Primary Contact: Paul Cousin

Position: Men's Safety Net Coordinator

Email: paul_cousin@usc.salvationarmy.org

Office Phone: (309) 682-8866

Address: 2903 W. Nebraska Ave, Peoria, IL 61604

Entity Name: Neighborhood House

Primary Contact: Brent Oest

Position: Development Director

Email: brento@nhpeoria.org

Office Phone: (309) 674-1131 ext. 244

Address: 1020 S. Matthew, Peoria, IL 61605

Entity Name: Peoria Rescue Ministries

Primary Contact: Jonathan Rocke

Position: Executive Director

Email: jrocke@peoriarescue.org

Office Phone: (309) 676-6416 ext. 1003

Address: 601 SW Adams, Peoria, IL 61602

Entity Name: Peoria Rescue Ministries

Primary Contact: Julie Philyaw

Position: Women's & Family Ministries Senior Director

Email: jphilyaw@peoriarescue.org

Office Phone: (309) 688-0202 ext. 1204

Address: 6847 N. Allen Rd, Peoria, IL 61614

Entity Name: Carver Community Center

Primary Contact: Jacobie Proctor

Position: Executive Director

Email: jacobie.proctor@thecarvercenter.com

Office Phone: (309) 839-0722

Address: 710 W. Percy Baker Jr Ave, Peoria, IL 61605

Entity Name: East Bluff Community Center

Primary Contact: Kari Jones

Position: 710 W. Percy Baker Jr Ave

Email: kari.jones@eastbluffcommunitycenter.org

Office Phone: (309) 839-0781

Address: 512 E. Kansas St, Peoria, IL 61603

Entity Name: Illinois Central College

Primary Contact: Julie Howar

Position: Dean, Corporate and Community Education

Email: Julie.howar@icc.edu

Office Phone: (309) 690-6909

Address: 5407 N. University St., Hickory 115, Peoria, IL 61635-0001

List of BEP Vendors

Entity Name: Clarity Partners LLC

Primary Contact: Scott Hilkert

Position: Partner

Office phone: (312) 920-0550; Mobile phone: (847) 533-7179

Address: 20 N Clark St. #3600, Chicago, IL 60602

Entity Name: CSE Software Inc.

Primary Contact: Renee Gorrell

Position: President and CEO

Office phone: (309) 670-7595; Mobile phone: (309) 360-0068

Address: 316 SW Washington St #300, Peoria, IL 61602

Entity Name: Nerevu Group LLC

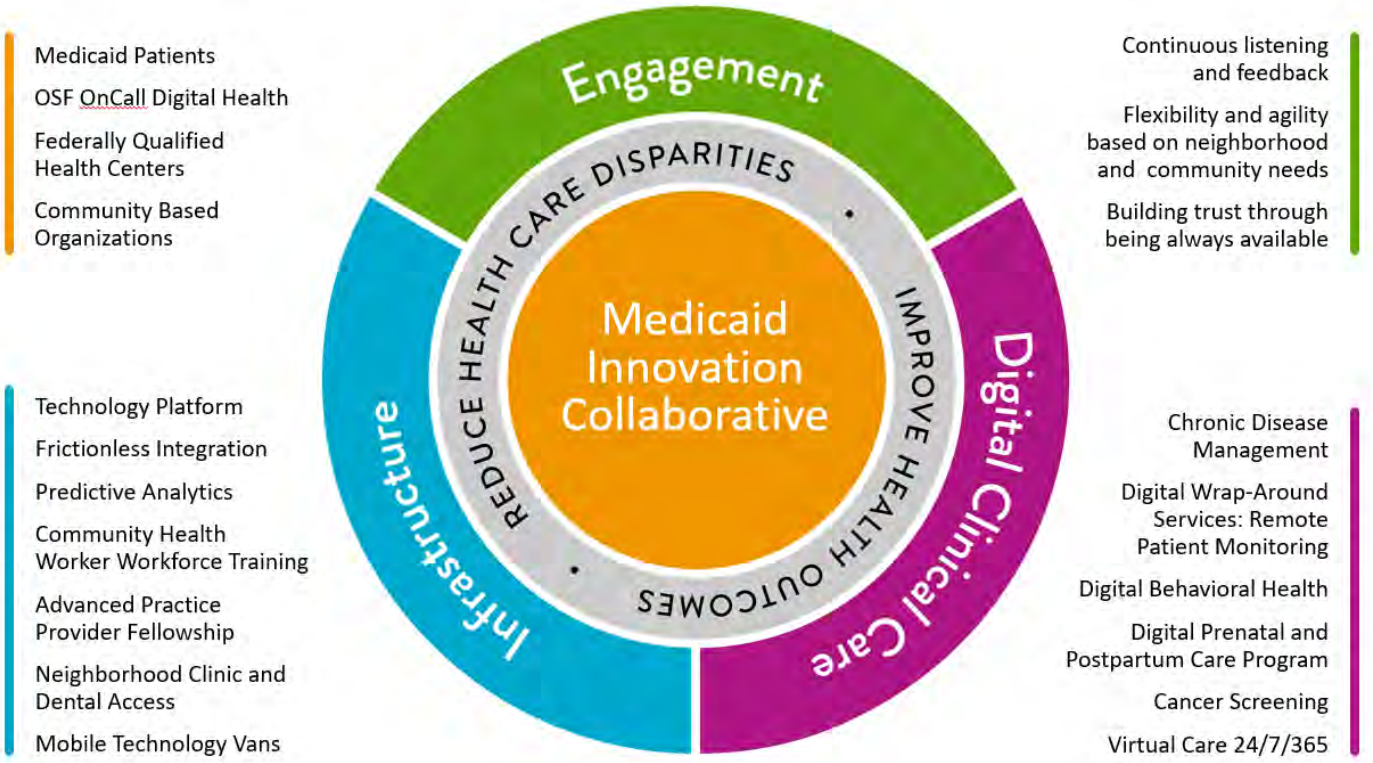
Primary Contact: Reuben Cummings

Position: President

Office phone: (234) 738-2266; Mobile phone: (309) 361-7702

Address: 820 SW Adams St, Suite C Peoria, IL 61602

Executive Summary



The visual displayed above depicts the vision for the Medicaid Innovation Collaborative

In response to calls to transform Medicaid delivery in the State of Illinois, OSF HealthCare has formed a new Medicaid Innovation Collaborative with like-minded partners whose shared goal is to radically transform the way Medicaid is delivered in Illinois. Covering a large geographic area of Illinois we serve rural and urban areas with a wide variances in payer mix, age, socioeconomic status, race, and ethnicity. While the communities served may vary, our communities are united in the struggles they often face when seeking access to quality care. Moreover, this has been compounded by the Covid-19's impact on communities and the citizens that reside within them, especially those most vulnerable and impacted by inequities. We are confident that we can improve quality, increase access, and address long-standing health disparities of marginalized communities. The care delivery model is designed to put the patient/population at the center of

the care creating care "with them" instead of "for them" recognizing the importance of the voice of the communities served. These aims can be met through increased access, informatics, and infrastructure supporting the new collaborative to serve marginalized populations. In addition, our efforts will contribute to greater long-term stability of the Medicaid program as we address unnecessary hospitals stays and reduce emergency room utilization by focusing on the social determinants of health. Our collaborators for this work include the following federally qualified health centers (FQHC): UI Health Mile Square Center (Chicago, IL), Heartland Community Health Center (Peoria, IL), Chestnut Health Systems, Inc. (Bloomington, IL), Eagle View Community Health System, Inc. (Oquawka, IL), and Aunt Martha's Health Center (Danville, IL).

Specifically, we are seeking $137.4 million over five years to support the efforts of our Medicaid Innovation Collaborative. These funds will support the building of a layered approach to care that allows scarce resources to be maximized. By using a centralized team of caregivers, including physicians, advanced practice providers, nurses, pharmacists, and wellness coaches with decentralized local resources, we can provide specific episodes of care to support over one million Medicaid patient interactions over the five years of this collaboration. These innovative programs in ambulatory care will focus on adult behavioral health, maternal and child health, hypertension and diabetes, and other chronic medical conditions based on the prevalence in the community. Deploying telehealth from OSF OnCall, we can support our FQHC partners and expand their capacity to serve the Medicaid population. Using these funds, we will focus on Medicaid populations that experience barriers to access to healthcare and quality for a variety of reasons, which we document in the body of this proposal. Using innovative technologies and knowledge gained from our work as the developer of a Statewide Pandemic Health Worker (PHW) program as well as the knowledge from our local partners, our collaborators will deploy new intervention strategies interwoven into community programs designed to increase access to telehealth solutions and local Federally Qualified Health Centers (FQHC).

In addition to creating greater access to care with OSF OnCall, this Medicaid Innovation Collaborative will take immediate steps to address localized issues that impact access to care. Specifically, the collaborative will significantly expand dental services for Medicaid patients in the Bloomington/Normal area as well as in Warren and Henderson Counties. Both of these areas lack

adequate dental services for Medicaid patients. As a result, there are high volumes of emergency department visits by these same patients suffering from dental issues that can be addressed in a more appropriate setting. In the Auburn Gresham neighborhood of Chicago, transformation dollars will be used to expand a soon to be opened Health Clinic to provide 7-day a week primary and urgent care services with extended hours to reduce unnecessary emergency department utilization that should be provided in a lower acuity setting. In the city of Peoria, the collaborative will, in partnership with homeless shelters and other providers of homeless services, stand up small sites where community health workers (CHWs) will be able to conduct outreach to Medicaid patients, provide digital health services, and establish a medical home to address their health needs and provide supportive services to address their social determinants of health. In rural Illinois, transportation is one of the most significant barriers to access. The Medicaid Innovation Collaborative will provide transportation services for Medicaid patients in need. While one collaborative partner will provide an actual van to facilitate transportation for Medicaid patients in need, all collaborative partners serving our rural communities will deploy digitally enabled CHWs that will be able to serve as a mobile/digital link to the FQHC and OSF HealthCare. Lastly, in the Bloomington/Normal area, a food pharmacy in the local FQHC will be managed by a local community based organization to address the issue of food insecurity for Medicaid patients.

While each of the communities served will vary on specific health needs that have been identified by its members, we will attain the following collaborative goals for health care delivery:

1. Establish a single point of contact for a patient to schedule services or receive information to achieve their health goals

2. Provide access 24/7/365 to services using in-person and digital capabilities

3. Provide consumer friendly options including self-service that are culturally appropriate

4. Provide transparency so patients can be partners in their health care and decision-making

5. Proactively identify social determinant and health equity needs that impact health outcomes

6. Equip and empower health care providers to be culturally competent, addressing unintentional bias and stereotyping

7. Deliver seamless navigation of care of the health care services needed through OSF services and in collaboration with FQHC community partners

8. Create a meaningful entry point for persons of color into health care occupations by supporting educational and workforce development goals

We expect to demonstrate the effectiveness of our efforts in three of the Illinois Department of Health and Family Services (HFS) identified pillars, Adult Behavioral Health, Maternal and Child Health, and Equity and Access. In each section of this document, you will find specific metrics for each intervention and for each of the HFS pillars our collaboration will address. As we prepare to take on this challenge, we are very much aware that the communities we will be focusing on are some of the most vulnerable and marginalized in the state. We understand that these communities deserve to have their voices heard and that any effort to address health disparities, improve access, or increase quality must come from the communities themselves. Our collaboration will produce high quality access and address equity. Special attention will be on equity and inclusion when engaging vendors or employing persons involved in this multi-region effort, an emphasis will be placed on utilizing companies or persons that are reflective of the communities we are serving. Most importantly, we are confident we can make measurable improvements in the quality of care provided to Medicaid patients.

As the leader of the collaborative, we are fully capable of coordinating complex, novel strategies that incorporate innovation, analytics, and new digital technologies to improve quality and access to care. OSF HealthCare and OSF OnCall will provide scalable training, clinical services, and remarkable support through human connection, advanced software, and data science. Our partnering entities will often be the face of our collaborative partnership within the community. It is these same partners, working with the Medicaid patients they serve, who have helped to identify the unmet health needs specific to their community. Together, we bring valuable skills, knowledge, and experience to this endeavor. While each FQHC's approach will be unique to their specific community needs, all activities will focus on improving quality, access to care, and addressing ever present health disparities. It is expected that these efforts will result in healthier communities, through the reduction of health disparities plaguing communities we serve, greater access to high quality care, a demonstrated reduction in the need for unnecessary emergency room visits, as well as improvement in specific health metrics, which are articulated later in this document.

The following table depicts Pillars, Programs and Clinical Services that will be the focus of collaboration between OSF HealthCare and the FQHC partners. Each program has an aspect of centralized telehealth providers and "boots on the ground" connectors to Medicaid patients.

Pillar	Programs/Services	Volumes
Adult Behavioral Health	OSF OnCall Wellbeing: A digital application for stress, anxiety, and depression. Access to therapist(s) within the app and escalation to behavioral health navigator(s) and virtual clinical services, if needed.	38,679 patients
Maternal and Child Health	OSF OnCall Connect: Prenatal/postpartum care service delivery redesign: Increase the total number of visits with a reduction of required in-person visits, utilization of digital applications and virtual visits, remote patient monitoring. Digital health worker deployment to distribute tablets/internet connection if needed and assistance with learning to use digital monitoring tools.	2,210 patients
Equity and Access	OSF OnCall Connect Chronic Disease Management and Digital Wrap Around Services: Digital connection to education, remote patient monitoring, access to a 24/7 virtual clinical team. Data driven assessments, predictive analytics, and personalized plans based on individual need.	75,425 patients
	OSF OnCall Virtual Care: A seamless virtual care experience that includes asynchronous and synchronous connections to care. The service is 24/7/365 and is staffed by OSF employed clinicians to ensure that our high-quality standards and expectations are upheld. Through technology, we are able to provide this care in multiple languages.	30,526 patients

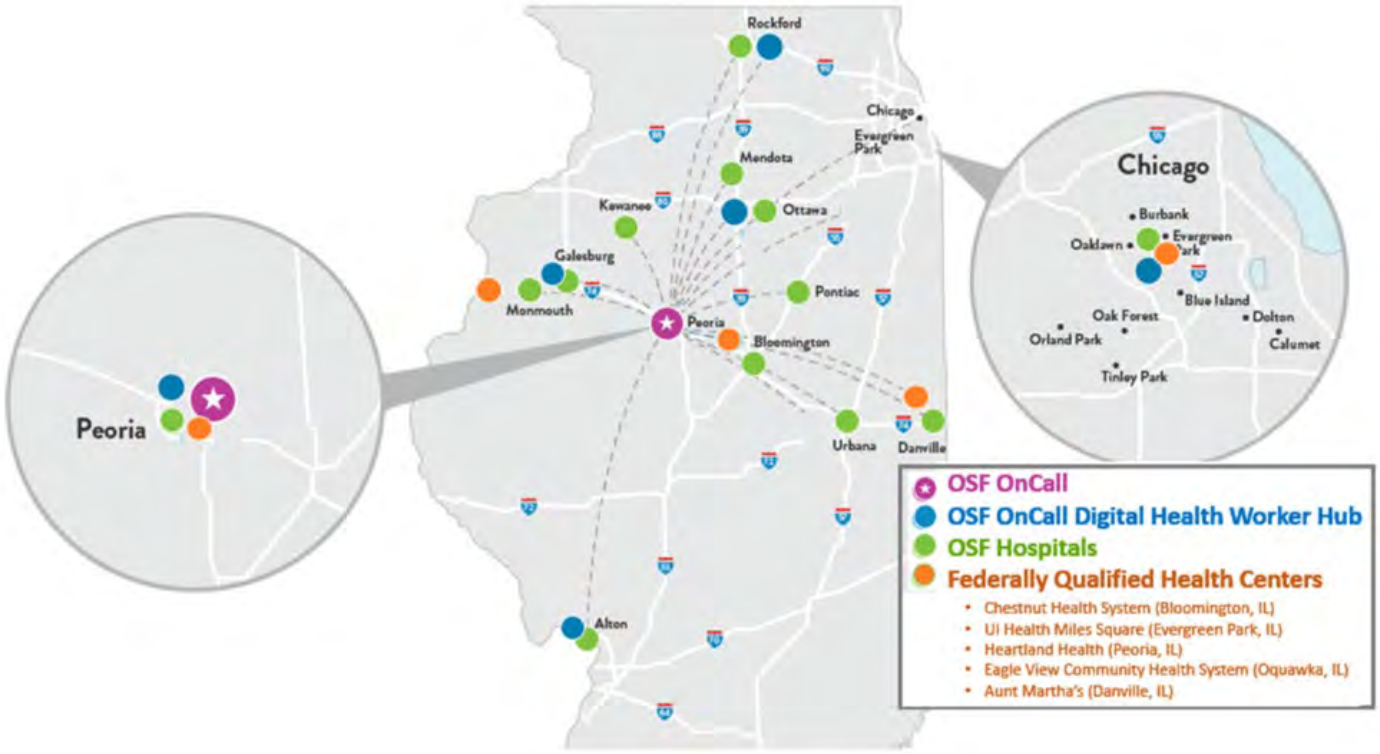
	Physical spaces to connect: In collaboration with community partners, we can provide a small physical footprint to allow individuals to find applications to connect and also reach us for clinical services. If needed, patients can be provided an electronic tablet device with internet connection.	10 physical spaces
	OSF OnCall Automated Personalized Text Outreach for Cancer Screenings: Reaching the communities through mobile technologies (texting) and/or providing transportation services to the appropriate screening locations.	63,000 patients
	Advanced Practice Provider Training and Education to Serve FQHC & Underserved: Partner with FQHCs to provide the additional education and transition to practice support for new APPs that would like to serve as clinicians for the Medicaid programs.	125 APPs
Equity and Access	Community Health Worker (CHW) Workforce Training: Provide an evidence-based didactic, interactive learning experience for onboarding and ongoing education and training for local CHW workforce.	75 CHWs
Federally Qualified Health Center Partners		
UI Health Mile Square Center	• Expanding a soon to be open clinic (Auburn Gresham) to provide primary and urgent care with extended hours • Deploy a navigator in OSF Little Company of Mary Medical Center Emergency Department • Access to OSF OnCall services	

Eagle View Community Health System	• Expanded dental services • Integration and build out of Electronic Medical Record (EMR) • Training and deployment of community health workers • Technology enabled vans to serve in community • Vans for transportation within community • Access to OSF OnCall services
Chestnut Health Systems, Inc.	• Expanded dental services • Integration and build out of EMR • Training and deployment of community health workers • Technology enabled vans to serve in community • Food pharmacy • Access to OSF OnCall services
Heartland Community Health Clinic	• Training and deployment of community health workers • In partnership with homeless shelters, stand up small sites for CHW visits • Access to OSF OnCall services
Aunt Martha's Health Center	• Training and deployment of community health workers • Technology enabled vans to serve in community • APP fellowship program enrollment • Access to OSF OnCall services

The map (Exhibit 1) below depicts the expansive service coverage area we will serve. OSF OnCall represents the centralized telehealth clinical teams that can provide care across a wide geography. The OSF Hospitals, FQHC partners, and the OSF OnCall digital health worker (DHW) hubs serve as the decentralized boots on the ground workforce. We are focusing our efforts on areas identified by the state of Illinois as being the primary focus of the Medicaid Transformation Program. Geographically, the counties include Cook, Peoria, Madison, Winnebago, and counties

adjacent to the Metro East area of St. Louis. We are focusing on areas served by Critical Access Hospitals in Warren, Henderson, Henry and LaSalle Counties, which are also served by our Safety Net hospital in Ottawa. Finally, we focus on rural communities where Medicaid patients face demonstrated health disparities. In McLean County, which, geographically, is the largest county in Illinois, and Vermillion County, located along the Illinois/Indiana border, are also a focus within this proposal. While our efforts are initially focused on nine regions, the interventions we are deploying, as our statewide PHW program demonstrated, are easily scalable and adaptable to any Medicaid population demonstrating such a need for services.

Exhibit 1: Service Coverage by OSF HealthCare & Participating FQHC Locations



In the pages that follow, this application request will describe in detail the strategies, care delivery redesign, and the targeted disparities encompassed within our vision for Medicaid transformation.

Collaborators

OSF HealthCare

OSF HealthCare (OSF) is an integrated, not-for-profit health system headquartered in Peoria, Illinois (IL). OSF employs more than 23,000 employees in over 350 locations including 14 hospitals, 30 urgent care locations, 11 centers for health, an extensive home health network, and 2 colleges of nursing. The OSF HealthCare physician network employs more than 2,400 primary care, specialty physicians and advanced practice providers.

Exhibit 2: OSF HealthCare regions

The Sisters of the Third Order was founded in 1877. The Mission of OSF HealthCare is "In the spirit of Christ and the example of Francis of Assisi, the Mission of OSF HealthCare is to serve persons with the greatest care and love in a community that celebrates the Gift of Life." Throughout the rich history of OSF HealthCare as a faith based organization, the Sisters' exceptional commitment to the health of our communities has never changed. Serving all people regardless of race, ethnicity, sex, or ability to pay is at the core of the beliefs of our Sisters' and engrained within our employees. Seven of our 14 hospitals are designated as critical access hospitals and/or small rural hospitals (IHA, 2015). Approximately, 63% of our care is provided to underserved, rural populations. OSF HealthCare is organized into regions (Exhibit 2) and serves

many distressed and underserved areas of the state of Illinois. The regional organization allows OSF to increase coordination of care, to gain efficiencies in care delivery, and to deliver health care across the communities we serve.

OSF HealthCare has been recognized as one of the Most Wired in the country in 2017, according to the results from the 19th Annual HealthCare's Most Wired® survey, released by the American Hospital Association's Health Forum. In 2018 and 2019, OSF HealthCare retained it status when the survey was acquired by the College of Healthcare Information Management Executives. This marked the eighth consecutive year for this achievement by OSF HealthCare. As a Most Wired health system, OSF HealthCare is using technology to create more ways to reach our patients in order to provide access to care. We are transforming care delivery, investing in new delivery models in order to improve quality, providing access in rural areas, and controlling costs. The Sisters' consider human caring as the most powerful medicine of all. They integrate that belief with an eagerness to provide caregivers with the best in technology and tools for superior patient care. The early Sisters were pioneers in health care and so are the Sisters of today.

Certified Level 8 CHiME Digital Health most wired Survey

OSF OnCall – Digital Health

In 2019, OSF HealthCare made a bold commitment to utilize digital health to better serve our communities alongside the traditional human components of care. The digital experience is focused on the "digital front door" and personalized customer experience. The aim is to provide clinical guidance to make the overall health care journey easier, more convenient, and seamless. *OSF OnCall* was developed with a dedicated leadership and clinical structure to ensure growth, sustainability, and outreach to deliver population-based care in communities we serve across our widely dispersed geographic area within Illinois. *OSF OnCall* is comprised of centralized teams of nurses, providers, and support staff that can care for a large number of patients by using telehealth. There are three

operational areas, which include digital experience, digital care, and on-demand services. Examples of digital care programs include *OSF OnCall* Intensive Care, *OSF Telehospitalist* program, and *OSF OnCall Connect*. *On Demand* includes tools, methods, processes, and services to make a self-navigated health care experience possible, convenient and seamless. *OSF OnCall Urgent Care* is an on-demand service that provides in person and virtual urgent care platforms.

The OSF OnCall Digital Health building (Exhibit 3) opened in January 2021. This state of the art facility, located in downtown Peoria houses all of OSF HealthCare's digital and telehealth services. The building allows for multidisciplinary teams to care for patients across the state using innovation, technology, and clinical expertise. Based on the lessons learned from the pandemic including how to scale programs to serve larger populations, OSF firmly believes we can be transformative with the Medicaid population and address the equity opportunities related to race and ethnicity in partnership with high performing FQHC partners. Coordinated services will have a direct impact on our Medicaid patients by increasing access to specialty care, improving quality, and providing cost savings for the Medicaid program. Expansion of telehealth services will address many of the typical challenges and barriers in provider recruitment, transportation, and other access concerns within marginalized populations. The ability to grow and advance telehealth services requires the build out of the fourth floor to scale and spread specialty services in both rural and urban areas. This projected expansion allows for 20,000 square feet of additional space with over 100 seats to expand services across the state to serve our vulnerable populations through Medicaid transformation.

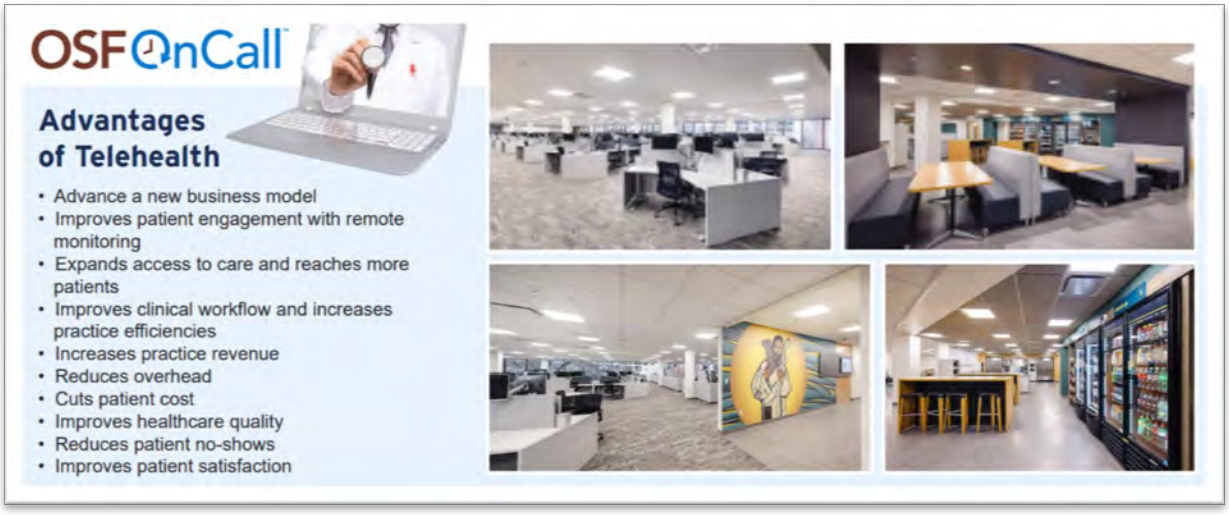


Exhibit 3: OSF OnCall Digital Health Building

OSF HealthCare's Jump Trading Simulation & Education Center

As one of the largest simulation centers in the nation, Jump Trading Simulation & Education Center (Jump), located in Peoria, IL, will be engaged in this endeavor as an internal partner. Jump has over 168,000 square feet of space dedicated to education, performance improvement, and innovation. With a vision to incorporate translational research in all of its work, this partnership serves OSF Healthcare System and the University of Illinois College of Medicine, Peoria (UICOMP). Jump is a state-of-the-art virtual medical training center as well as a testing ground for research and development of new innovations, procedures, and medical devices. This well-established collaboration between OSF HealthCare and UICOMP provides outstanding education to health care professionals and has been in existence for eight years. The talented Jump education leadership team was deeply engaged in the conceptual framework and planning phases for the digital pandemic response within OSF HealthCare.

The Innovation Discovery Labs within the Jump Canter support exploratory efforts for the benefits of our patients through strategic support of a small number of funded programs of activity. The Discovery Labs are far from basic or "bench" scientific research laboratories. Projects within laboratories bring value quickly to our patients, collaborations with academic institutions enhance their impact, and are supported by shared infrastructure. Apart from their applied research efforts, the labs are supported through philanthropist funding and advance the development knowledge within OSF Innovation. These applied laboratories are staffed and led with the purpose to provide value to patients in the shared Mission-set of OSF and its partners.

The Innovation Discovery Labs goals are as follows:

- Leverage creativity, analysis, design, process management, and collaboration to develop useful tools and technologies
- Encourage technology development and the development of know-how

- Foster innovation in the formation of Innovation Fellows, Innovation Research Fellows, students and others.
- Partner with other areas of OSF Innovation
- Support external collaboration and partnerships

Of particular note and relevance to the proposed collaboration are the developments of novel software solutions such as OSF Constant Connect (OCC), developed within the Discovery Lab as a middle-layer electronic community health record. The pandemic health worker program revealed a significant need to develop this software to connect clients to clinical services, digital or in person, to collect information on social determinants and to close the loop with community-based organizations, and to ensure the fulfillment of deliveries of goods and services. Advanced analytics and machine learning informed the most efficient routes for pandemic health workers, and layered intelligence to understand which patients were at risk to decline during the monitoring period. This invaluable software will now be committed to all members of the collaborative as OSF OCC now meets its new purpose in population health.

FQHC Partners for Medicaid Innovation Collaborative

Below is a brief summary of our FQHC partners and the unique, community driven, additional approaches they will be taking to address health disparities, and improve access and quality for the communities they are serving.

UI Health Mile Square Center

UI Health Mile Square Health Center (UI Mile Square) has provided quality health care services to vulnerable Chicagoland residents for over 50 years and is one of the oldest Federally Qualified Health Centers (FQHC) in the nation. UI Mile Square is part of the University of Illinois at

Chicago (UIC), which includes the broader University of Illinois Hospital & Health Sciences System (UI Health). As such, UI Mile Square is the only public sector academic FQHC in Chicago and one of only a few in the nation. UI Mile Square provides an array of medical services, including family medicine, pediatrics, women's health, behavioral health, and substance use disorder services (SUDS). Other services include medication assisted therapy (MAT), optometry, urgent care, podiatry; dental, HIV/AIDS care, and social/enabling services. In addition, as part of UI Health, UI Mile Square provides its patients with access to an advanced health care system and a vast array of services and resources that UI Mile Square leverages to reduce health disparities among its target patient population.

UI Mile Square has developed a South Side regional health model that supports Englewood, South Shore, Back of the Yards, and Auburn Gresham (opening Spring 2022). The Mile Square South Side Regional Health Model provides the following services: a) integrated primary care; b) adult and youth behavioral health rooted in trauma informed care and support for substance use disorders (SUDS); c) maternal and child health; d) patient navigation and care coordination to address the social determinants of health (SDoH) and health equity; and e) community outreach and engagement in collaboration with CHWs and community stakeholders to advance community inclusion and access to care.

Using Medicaid Transformation dollars Mile Square will, in addition to using OSF OnCall services, partner with OSF HealthCare and OSF Little Company of Mary Medical Center for these services: a) support the primary care needs of OSF patients who are in the Mile Square South Side Regional catchment area who are identified as "high utilizers" of the OSF Little Company of Mary Medical Center Emergency Department (ED) and currently not affiliated with a primary care provider; b) collaborate with the OSF OnCall team to conduct uniform SDoH assessment of identified patients to be navigated to Mile Square to include an assessment of capacity for telehealth telephonic visits through a brief digital capacity assessment; and c) provide comprehensive behavioral health support. In addition, Mile Square, with

the support of OSF HealthCare will expand the operating capacity of its Auburn Gresham community clinic, which will address an identified need for greater access to high quality care for the residents of the Auburn Gresham community.

Eagle View Community Health System, Inc.

Eagle View Community Health System, Inc. is a not-for-profit provider of community health care services (medical, dental, and behavioral health) with the primary location and administrative offices in Oquawka, IL. Eagle View has operated a clinic in Oquawka since 1979, and a clinic in Stronghurst, IL, since 2000. Both clinic locations offer both dental and medical care for everyone. Behavioral health services are offered only at the Oquawka clinic. Eagle View Community Health System serves the Henderson, Warren, McDonough, and Mercer areas primarily. Besides the primary service area, Eagle View cares for many patients from all over Western Illinois and Eastern Iowa. In 2019, Eagle View served 4,273 patients between both dental and medical clinics with 1,500 of these patients identified as children aged from 0 to 18 years. The area served by Eagle View Community Health System is categorized as a medically underserved area by the Department of Health and Human Services. More specifically, Henderson, McDonough, Mercer and Warren Counties are categorized as a health professional shortage area in terms of dental care.

Using Medicaid Transformation dollars Eagle View will, in addition to using OSF OnCall services to support their clinical activities, partner with OSF HealthCare to deploy CHWs and technology equipped mobile vans throughout their service area to address the unmet health needs of the communities they are serving. The CHWs, along with technologically equipped vans, will allow Eagle View to address digital connectivity issues and the lack of transportation that are often times the most significant barriers to accessing preventive medical care in this part of rural Illinois. Eagle View will also be expanding dental services as well to reduce emergency department utilization for common dental issues. Finally, Eagle View will also use Medicaid Transformation dollars to change and upgrade their electronic medical health record, which will provide better connectivity to local hospitals, including OSF Holy Family Medical Center, and OSF St. Mary Medical Center. OSF Holy Family Medical Center serves as the regions critical access hospital while OSF St. Mary Medical Center in Galesburg has become one of the only hospitals in the region with an

active birthing center. The improved connectivity will improve care coordination and health outcomes for the regions Medicaid patients.

Eagle View is also one of two mental health and substance use providers in the area. Adding more mental health providers, specifically a licensed clinical social worker and substance abuse counselor, will allow for expanded access and reduce emergency room visits. The substance use counselor can offer services to those who are on Medicaid by billing the SUPR funding sponsored by the state of Illinois. Eagle View is also currently working on expanding services to schools as well for behavioral health, substance abuse, and dental services.

Chestnut Health System

Chestnut Health Systems, Inc. (Chestnut), headquartered in Bloomington, IL, was incorporated in 1973 as an IL not-for-profit corporation. Chestnut offers a diverse range of health care and behavioral health care services from multiple locations throughout the state of IL. In June 2012, Chestnut received its first HRSA funding as a 330e New Access Point for one of its Bloomington, Illinois' locations and opened their first health center under the DBA name Chestnut Family Health Center (CFHC). In 2020, CFHC provided medical care to 2,514 patients from newborn to geriatrics. For this project, Chestnut's identified service area encompasses all of McLean County. Along with the federally qualified health center, Chestnut also operates a community-based organization licensed as a community mental health center which provides mental health counseling, 24-hour residential crisis services, and a full continuum of services for the treatment of substance use disorders. Chestnut's community based organization (CBO) also has licensed counselors embedded within several schools in McLean County providing behavioral health assessment and counseling services.

Chestnut plans, in addition to using OSF OnCall services, to support their clinical activities, purchase equipment, and pay for staffing that will allow for the operation of four additional dental operatories at the Bloomington clinic location. Fifty percent of the county's Medicaid recipients never see a dentist, which can lead to poor oral health, poor health and health outcomes. Once the additional dental operatories are functional, it is expected that a significant reduction in the number of hospital emergency department visits related to untreated dental conditions will occur. While a reduction in the need for emergency department care related to untreated dental issues will benefit all area hospitals, OSF St. Joseph Medical Center alone saw hundreds of visits in 2019 related to underlying dental issues that could have been addressed in a more appropriate and cost effective setting. In addition to helping with emergency dental needs, expanding services will allow for more routine dental care to improve overall health. Funding will also be used to stand up a "food pharmacy" in partnership with a local food co-op. This pharmacy will be located at the Bloomington clinic location and address an identified need around food insecurity influencing many of the Medicaid patients serviced by Chestnut. Chestnut will also deploy CHWs and technology equipped mobile vans along with Community Health Workers (CHW) throughout their service area to address the unmet health needs of the communities they serve. These CHWs and the technology-equipped vans will allow Chestnut, like Eagle View, to address digital connectivity issues and the lack of transportation that are significant barriers for access to preventative medical care. Given that McLean County is the largest county, by size in the state, many Medicaid patients find transportation and digital connectivity to be a barrier to accessing care. Finally, Chestnut will also use Medicaid Transformation funding to change and upgrade their electronic medical health record which will provide better connectivity to local hospitals which will improve care coordination for Medicaid patients.

Heartland Community Health Clinic

Heartland Community Health Clinic started as a "free" clinic in 1991 on N.E. Monroe Street in Peoria. In February 2004, it became a Federally Qualified Health Center. Heartland Health Services (HHS) was designated as a federally qualified health center (FQHC) on February 1, 2004. Its targeted population includes

the largest concentration of low-income adults and children and the greatest percentage of minorities, uninsured, underinsured, medically indigent and homeless within the city of Peoria and the larger Tri-county region. Heartland receives support of the local health care systems, the medical schools, community partners, and the local businesses.

Heartland employs approximately 195 employees to provide primary medical care to nearly

22,403 unduplicated patients annually. The community health center's main site is located at 1701 W. Garden, in the south end of Peoria. Peoria's downtown bisects its high poverty and high minority populations, which are concentrated in the north and south valleys and in the East Bluff Peoria area with the same population pools. A second primary site was established in May 2006, at 711 W. John Gwynn Jr. Ave., with an additional community center that opened in 2007 located at 2321 N. Wisconsin Avenue to serve the East Bluff.

Heartland plans to use OSF OnCall services to support and enhance their existing clinical activities while also focusing on improving outreach to the homeless population and other groups of Medicaid patients that currently do not have a health home. This outreach effort will be accomplished by using funding to support new CHWs that will conduct traditional outreach and operate kiosk type locations in high traffic areas like homeless shelters, food banks, and churches.

The focus of these CHWs will be to address the SDoH and enroll patients in a medical home for primary care services.

Aunt Martha's Health Center

Aunt Martha's Health Center was founded in 1977 as a drop-in center for youth, and thereafter expanded to provide community based services such as youth development services, work force, SUDS, parent support, head start, juvenile justice, crisis response and intervention.

Aunt Martha's opened its first health center in 1999 and was soon established as a federally qualified health center. The development of an Integrated Care model began in 2003, and was expanded to include behavioral health through tele-psychiatry in 2007. There are currently 25 health centers, which aim to move forward health equity within the communities they serve. Aunt Martha's serves over 115,000 patients per year in over 600 communities in nine counties throughout the state of Illinois. With the current 25 health centers serving a 67% Medicaid population, health equity is a core aim within the communities served.

For Aunt Martha's, where the quality of life indicators and health outcomes rank in the bottom five of the state every year for the last several years, the role of the CHW is also about developing relationships within the community with individuals, community agencies, and patients

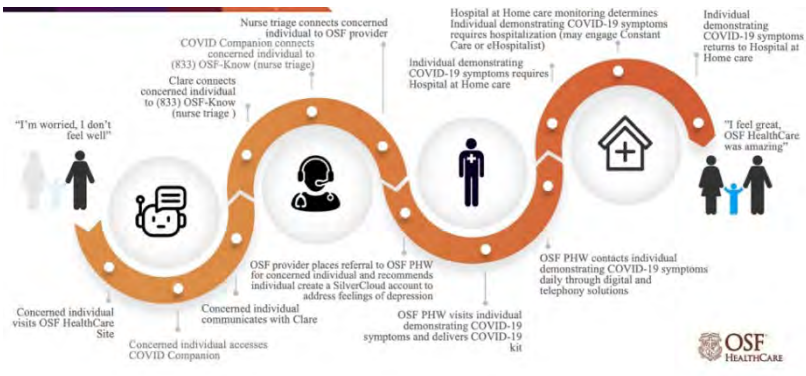
to engage them in health and wellness activities. Aunt Martha's plans to utilize CHW's and mobile vans to reach the most vulnerable communities.

The scalability of programs is critical to success in delivering health care. The following two narratives describe programmatic case studies from OSF HealthCare related to scalability and digital care delivery during the pandemic.

OSF Programmatic Case Study: The PHW Program

In March 2020, OSF HealthCare (OSF) partnered with the State of Illinois to create a pandemic health worker (PHW) program that would serve 110 counties in Illinois. The OSF PHW program was designed as an end-to-end digital health care response to achieve rapid scale, while maintaining the patient centered focus of trust building, anxiety reduction, patient engagement, and optimized clinical outcomes. This program was able to prevent overloading of emergency departments, urgent cares, and hospitals in response to Covid-19. We are aware of thousands of cases where patients successfully managed Covid-19 without hospitalization through our remote patient monitoring supported by our software, machine learning, and data science enhancements to clinical services. During the response, over 200,000 patients were served with 17% identifying as Black/African American or Latino.

Pandemic health workers (PHWs) are typically non-licensed individuals, from the community, who help patients navigate the health system. These positions are available to high school or GED graduates. PHWs assist clients with program enrollment including how to download and use app-based digital programs (e.g., GetWell Loop). PHWs connected with clients twice daily over 14 days as a way to monitor to client's health and engagement. Any health concerns are escalated to PHW RN Clinical Supervisors. The PHW RN Clinical Supervisor either directs the patient to continue with basic at home care for COVID-like symptoms or suggests various options based on presenting symptoms. These options may be a provider telephone or video visit, a visit at an urgent care center, emergency department visit, or instructions to call 911. At that point, the client transitioned to a patient status within a health care system and



traditional health system intake, billing, and coding applied. This same type of program can be adapted for routine preventive care models and for managing social determinants of health. The link between social and clinical care can create better access, address health disparities, and improve health outcomes related to care.

OSF Programmatic Case Study: Acute COVID at HOME

The Acute COVID@home remote patient monitoring program provided care for those who were deemed higher clinical risk for hospitalization due to comorbidities and constituted a higher level of monitoring. During the Covid-19 pandemic, approximately 3,194 Acute COVID@home patients received a remote monitoring toolkit for recording vital signs and oxygen saturation twice daily, along with nurse check-in visits. This program is managed by RNs with the ability to escalate concerns to an advanced practice provider 24/7. This innovative model of care allowed patient care to be delivered within the safety of the home with only 6% of these individuals requiring hospital admission.

As a result of the Covid-19 pandemic, we have refined strategies to meet our community's needs in new ways, including digital services in conjunction with digital health workers within the communities. It is well understood that the human connection within the community is critical to build trust and relationships and can be augmented with digital solutions even in those most marginalized. Our approach to work with collaborative partners, including federally qualified health centers, and other community partners across a wide geography will allow us to be an effective resource and support for their existing services. Among the myriad of barriers to well-being, diminished access to health care services functions as a key driver of inequity and hardship. Utilization of digital health services, including digital health workers embedded in the communities, allows us to infiltrate the community and provide resources where they are needed

most. Therefore, the utilization of human resources, a digital ecosystem, and partnerships with the FQHCs will support all of the access and clinical quality outcomes identified within our proposal.

We understand that our communities and our state officials are seeking a new kind of partner in providing health and wellness services to increase access, engagement, and to gain the trust of Medicaid enrollees in urban and rural communities. Meeting them where they are in their health and wellness journey is critical to success. With our clinical expertise, industry leading innovation, and high performing FQHC partners, we are able to offer a variety of care options that can elevate and support them where it matters most to patients and communities.

Community Input

Realizing Medicaid transformation was on the horizon, since 2019, OSF has been engaged in information gathering with our Medicaid patients and the communities we serve to better understand their needs. This information gathering, which took many forms, including in-person interviews, focus group sessions and online surveys, helped to identify barriers to health, which have led to health disparities within our communities. These patient interactions and information gathering sessions provided the roadmap for how OSF HealthCare, its hospitals, and its partners should move forward. We determined that the best way for us to address health disparities and inequities in our communities was to create a care model that not only focused on the immediate medical need of our patient, but also addressed their SDoH as well. We believe strongly that by addressing both the immediate medical need and the root causes of their medical issues we have the opportunity to have a lasting and meaningful impact on the lives of the Medicaid patients served. We believe that we have created a care model that creates greater access to care, improves the quality of care our patients will receive, addresses long existing health disparities, and is responsive to what our communities have told us they want.

As mentioned, OSF HealthCare employs a variety of methods for engaging the community in meaningful dialogue around existing services, developing new services, understanding unmet needs and inequities, and related topics. Our academic partnerships with UIC, UICOMP, nonprofit research groups, and others also serve as avenues for gathering community perceptions and needs. The most prolific branch of these efforts to date is OSF Innovation's Health Equities Action Laboratory (HEAL). HEAL began its work to reveal and address health disparities in early 2017.

The mission of the HEAL lab is to innovate solutions to achieve scalable tools, technologies, and interventions that promote measurable gains in health equity for our communities. HEAL exclusively targets the hardest-to-reach communities within our health system to innovate new solutions focused on health equity so that we may strengthen individuals, families, and communities to achieve their fullest potential through a focus on health equity. Within this academic partnership model, our process was to lead teams under the guidance of UI and OSF faculty to employ a human-centered design methodology to frame shared problems and better understand the needs of the communities we serve.

This work incorporates interviews of community members and community-based organization leaders, focus groups, collection and analysis of public data, community surveys, and in situ observations. The subject areas that primarily drive this work are grounded in social, racial, and institutional factors that directly impact both equitable access to care and health outcomes, that is, the social determinants of health. The subjects of concern, often defined as "How might we..." statements, are developed through analysis of internal data, community input, and subject matter experts.

Exhibits 4 and 5 are video illustrations of community voice gathered in a personalized manner. An active link that is provided will allow for viewing of the video clips.

Exhibit 4: Recorded interview of community member; clip from a complication video; focus: quality of life, needs, and impact of OSF services.

Monmouth_20180905.mov - Google Drive Click here to see video

Exhibit 5: Recorded interview of community member; clip from a complication video; focus: quality of life, needs, and impact of OSF services.

Peoria_20180905.mov - Google Drive Click here to see video

Another active method OSF employs for soliciting community input is through a partnership with a nonprofit and "urban solutions accelerator" organization, City Tech Collaborative.

City Tech defines themselves as an organization "...that tackles problems too big for any single sector or organization to solve alone...to accelerate technology-enabled solutions to make cities happier, healthier, and more productive" and ensure "successful public-facing technologies rely upon direct resident engagement and community-focused design."

City Tech creates cross-sector teams that develop solutions to global urban challenges. Current initiatives include mobility, health, infrastructure, and emerging growth opportunities. Their member-driven consortium, with OSF HealthCare as a member, combines the best tools and thinking from leading corporations, local governments, startups, civic and academic institutions, and community organizations. The partners' broad and deep expertise enables us to understand complex industry trends, create world-class collaboration, and drive scalable market impact.

CityTech Collaborative

Two core elements of City Tech's work directly enable us to more effectively meet the defined needs of our community. Their work, City Solutions, includes leveraging wellness-related data and advanced analytics to strengthen cities' capacities to meet resident needs. In addition, Resident Engagement, a toolset and understanding that successful public-facing technologies rely upon, enjoin direct resident engagement and community-focused design. City Tech offers guidance, convenes residents, and conducts specialized user testing to support the development and roll-out of digital tools, websites, technology plans, and civic products.

The partners who work with City Tech are able to incorporate community input and rely heavily on their many years of experience and established tools that facilitate direct and meaningful engagements with surrounding community. We are leveraging the City Tech Civic User Testing group (CUTgroup), a 1,600+ member civic engagement program that invites Chicago residents to contribute to emerging technology and needs assessments while providing public, private, and social sector partners with feedback to improve product design and deployment.

This CUTgroup program is used to gather both population and community data as well as unique community member experiences.

City Tech over the past two months has been conducting surveys in the Chicago area, specifically in the primary and secondary service areas of OSF Little Company of Mary. It was designed to collect targeted resident feedback to better understand the health and wellness needs and challenges of residents of Auburn Gresham and surrounding communities, as well as their utilization of and feedback around OSF HealthCare Little Company of Mary Medical Center and its services. In addition to these efforts employed by City Tech, OSF HealthCare has deployed technologies that have facilitated the completion of 40,000 surveys over the past several months concerning questions related to social determinants of health for patients in our care. An overview of City Tech can found in the attachments.

Likewise, the FQHC collaborators have also gathered input and feedback from their communities. Day to day, the FQHCs are interacting with vulnerable populations providing care, and hearing their voice in regards to concerns and barriers to achieving optimal care and health. These collaborations bring us to the heart of the populations that we might otherwise not be as familiar with in regards to their needs. More specifically, the FQHCs are required to have Patient Advisory Committees or have patients on the FQHC Board of Directors to ensure that patients have input around services that meet the needs of the community served. Moreover, our local elected officials are supportive of the collaboration and understand the importance of working together with community based organizations. Letters of support can be found in the attachments.

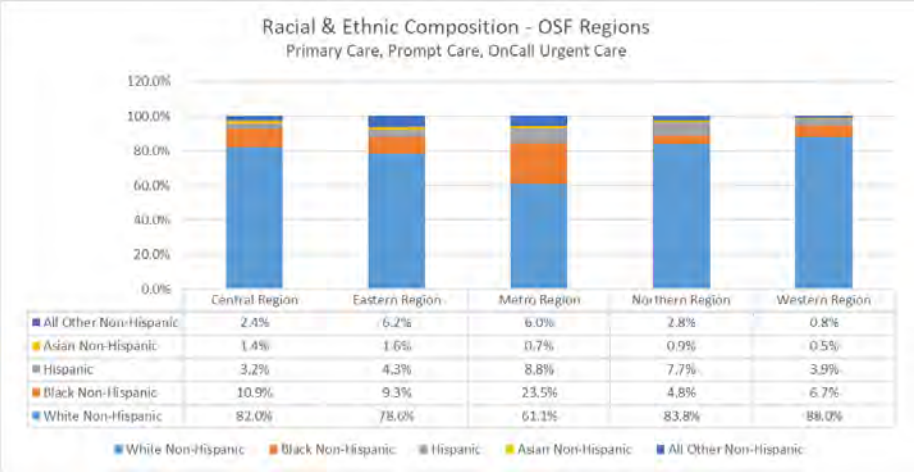
Through our many primary sources of data collection in conjunction with our FQHC partners, we have been able to obtain direct community input allowing us to have clear line of sight into the unique needs for each community we plan to serve in the Medicaid Innovation Collaborative Proposal.

Data

The data within this section were gathered from the FQHC collaborators and from internal OSF data sources that are housed within the health care system's Data Enterprise Warehouse, which is a centralized repository of integrated health data, managed by the data analytics division. With the development and adoption of meaningful use technology, auto extraction of data and standardized quality measures enable our leaders to better examine care coordination processes. The combined data illustrate the need for focus on the marginalized populations that OSF serves along with our community collaborators. A team of researchers from OSF HealthCare recently published their research findings related to access to health care following the Medicaid expansion in Illinois, particularly in relation to rural/urban counties served by OSF HealthCare in 2019. Dalstrom et al. (2021) noted "that although the expansion has increased access to care overall, those who are the most vulnerable are still not benefitting equally from the expansion. Therefore, strategies to assist high-risk adults in enrolling and using their Medicaid coverage need to be developed and implemented." The primary focus of this collaborative is directed towards meeting the health care needs of this population. Similar work done in Maryland utilizing CHWs, education within the community, and behavioral health services led to a savings of almost 19,000 hospital admissions which far outweighed the initial cost of implementation (Okeke et al., 2019). These savings were associated with more traditional type services that were not augmented by the digital and education services we are proposing, thus with our enhancement of existing services there is great promise for an even more direct contribution.

OSF continues to be a leader in serving the Medicaid Population in the State of Illinois as the largest downstate health care system with the greatest number of Medicaid patients. In 2018, which is the latest year available for comparison data, OSF HealthCare served approximately 7% of the State's Medicaid population, which represented over 290,000 interactions. With over 668,000 Medicaid patients in our service areas, there remains opportunity to provide more support to the underserved in new and innovative ways. Exhibit 6 is a graph that illustrates the diversity of clients served across five regions of OSF HealthCare.

Exhibit 6: OSF HealthCare Regional Diversity Percentages



UI Health Mile Square Center, FQHC

Racial and ethnic composition varies throughout the UI Mile Square service area (Exhibit 7). Overall, 35% of the population identifies as Black/African American. Although the overall service population is fairly evenly distributed between the major racial and ethnic groups, the service area is very segregated at the regional level, consistent with Chicago's segregation at the neighborhood and community level. The West/Northwest region is the most diverse, with 42% percent of the population identifying as Hispanic, 32% as Black Non-Hispanic, 21% as White Non-Hispanic, and 4% Asian Non-Hispanic. The highest concentrations of Black Non-Hispanic populations reside in the Near South/South (72%) region, while the highest concentrations of Hispanic populations reside in the Berwyn/Cicero (77%) and Near Southwest (71%) regions. In all Chicago area regions, racial and

ethnic minority populations comprise the majority, with no more than 21% White Non-Hispanic in any of the regions. In contrast, the White Non-Hispanic population makes up a plurality of both the city of Chicago (33%) and of Cook County (42%). The ethnicity data are particularly beneficial for defining and targeting our strategies for outreach efforts and serves as baseline data for further data collection over the next five years not only for the use of services, but also quality outcome metrics.

All Chicago area regions of their service area still have greater rates of poverty and low-income populations than the city or county as a whole (Exhibit 8). Nearly a quarter of the population (23%) is living in poverty, defined as individuals living at or below 100% of the Federal Poverty Level (FPL). Another near quarter of the population (24%) is living between 101% and 200% of the FPL, which is considered low-income. In total, 47% of the service area population is considered low-income or in poverty – much higher than in Chicago (40%) or Cook County (33%) respectively.

Exhibit 7: Racial and ethnic composition for Mile Square service area and Chicago

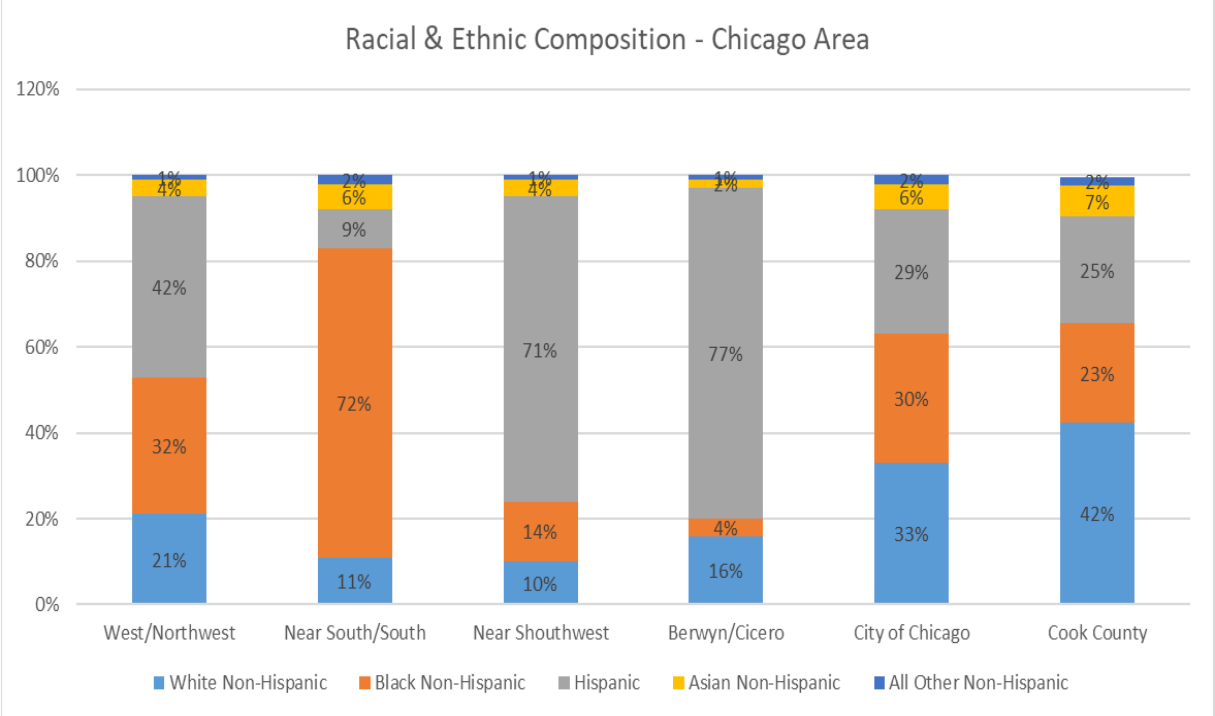
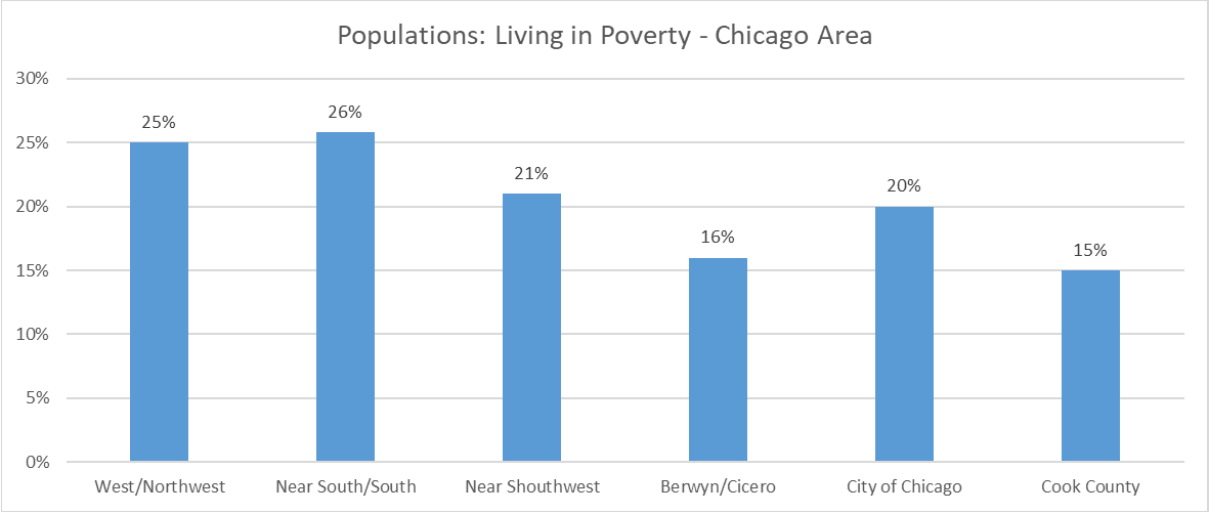


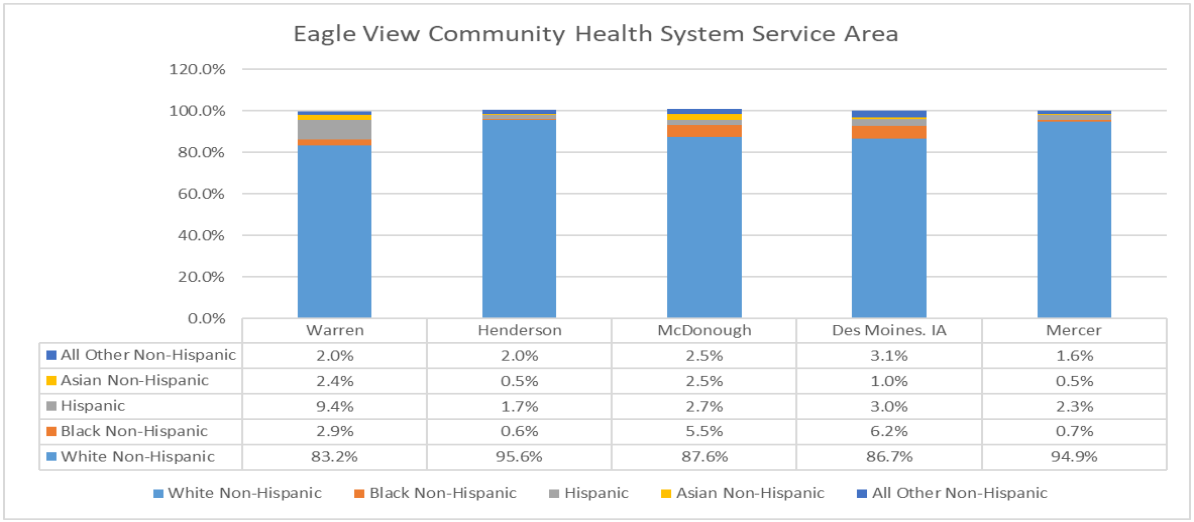
Exhibit 8: Poverty Distribution across the Chicago Area Population



Eagle View Community Health System, Inc., FQHC

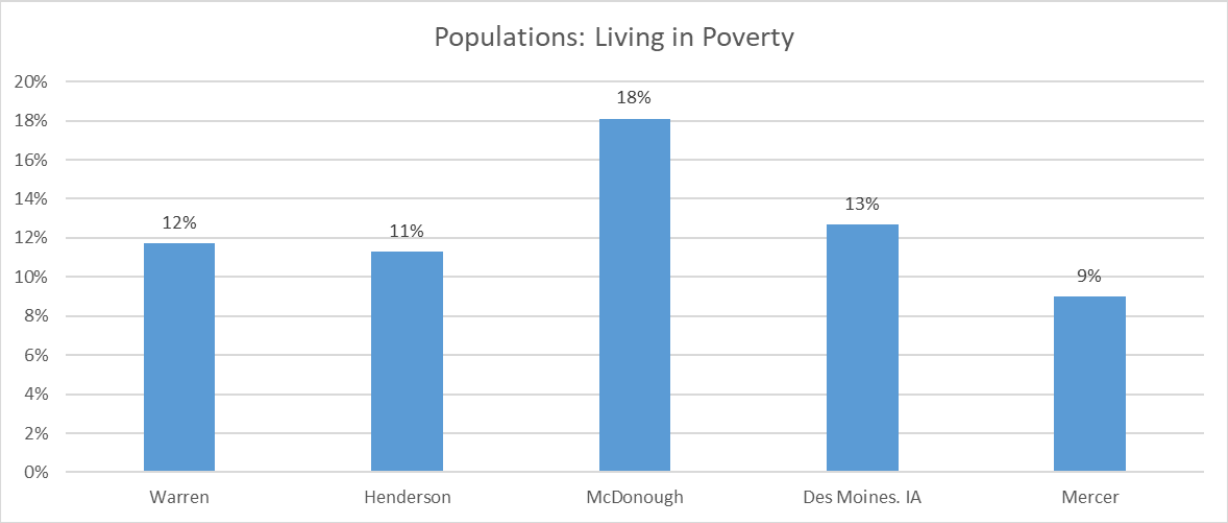
Within the service area of Eagle View Health System, there is a higher proportion of Latin/Hispanic ethnicity attributed in part to the expansion of a meat packing plant in the Monmouth, IL area that employs predominately Latin/Hispanic workers in Warren County (Exhibit 9). The communities served still face significant challenges as it relates to health disparities and poverty, though ethnic diversity is predominantly white. McDonough County represents the largest area for Eagle View with significant poverty (Exhibit 10).

Exhibit 9: Eagle View Community Health FQHC Illinois Service Area



	Warren	Henderson	McDonough	Des Moines. IA	Mercer
All Other Non-Hispanic	2.0%	2.0%	2.5%	3.1%	1.6%
Asian Non-Hispanic	2.4%	0.5%	2.5%	1.0%	0.5%
Hispanic	9.4%	1.7%	2.7%	3.0%	2.3%
Black Non-Hispanic	2.9%	0.6%	5.5%	6.2%	0.7%
White Non-Hispanic	83.2%	95.6%	87.6%	86.7%	94.9%

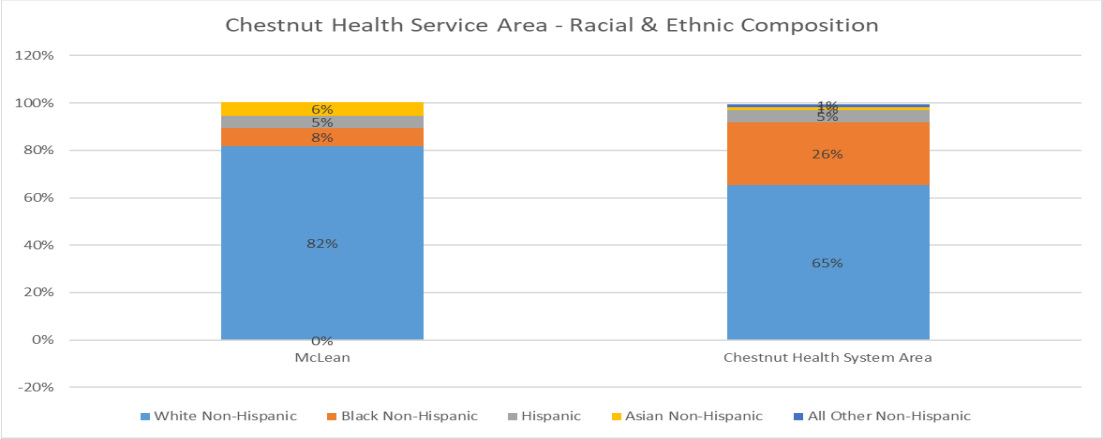
Exhibit 10: Poverty Distribution for Counties Serviced by Eagle View, FQHC



Chestnut Health System, FQHC

Within the Chestnut Health System area, 26% of the population identifies as Black/African American, and another 5% identify as Hispanic (Exhibit 11). White Non-Hispanics account for 65% of the overall service area population, followed by Asian Non-Hispanic and All Other races (non-Hispanic) at 1%. Ninety percent of the population is below the 100% FPL within the Chestnut Health System area. McLean County has approximately 40,000 Medicaid eligible patients. Interestingly, of the 2,800 patients seen in the St. Joseph Medical Center emergency room or OSF OnCall Urgent Care, about 1,200 of these patients do not have a medical home. Engaging these patients in a new way is critical to successfully transform the care provided.

Exhibit 11: Chestnut Health System FQHC – Diversity Distribution of the Population



In consideration of county distribution of ethnicity, McLean County's highest population by race is white at 81.6%. This is 12.2% higher than the state of Illinois. Although the McLean County's percentage of the Asian, Native Hawaiian and 2+ races is consistent with the state population, 7.73% of the McLean county population is African American compared to 14.28% of the Illinois population. In addition to the median household income being lower in Bloomington – 61701 than McLean County, the percent of people living below the poverty level is also higher. In McLean County, the percent of people living below the federal poverty line is 14.5%. This rate is in the worst 50th – 75th percentile range compared to other counties in Illinois. In the Bloomington zip code 61701, 22.2% of people live below the poverty level. This is in the worst 25th percentile range compared to other zip codes in Illinois (Conduent Healthy Communities Institute, American Community Survey, 2013 - 2017). The data reveals poverty to be the greater concern for this area of the state.

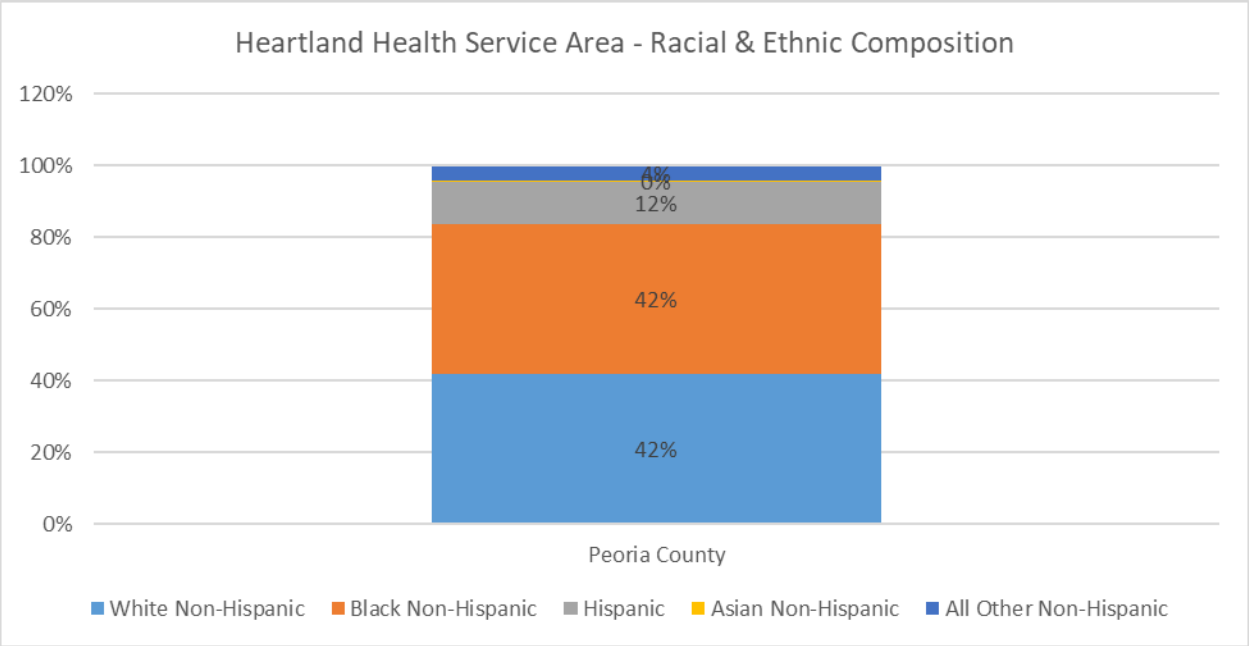
Heartland Health of Peoria, IL, FQHC

Specific to Illinois and to the Peoria area, according to 2019 Community Health Needs Assessment data, the 2017 poverty rates for Peoria County were higher than that of the state of Illinois for both individuals and families. Two targeted zip codes in Peoria County, 61603 and 61605, are also designated as Health Professional Shortage Areas for Primary Care. Income level has an inverse relationship to health literacy, with those living below the poverty level with the lowest health literacy (NAAL, 2003). These two zip codes house over 34% of families living below the poverty level. The majority of the population in both zip codes are non-white minorities, though Peoria County as a whole is comprised of over 70% white.

Within these zip codes are two of the largest Peoria Housing Authority (PHA) public housing projects, Taft and Harrison Homes. Taft and Harrison Homes provide low-income housing to over 400 residents. The challenges of these urban areas are substantial. These two neighborhoods have a significantly higher rate of poverty with the average household monthly income for residents at Harrison Homes at $664.85. The percentage of children living in poverty in the neighborhood surrounding Taft Homes (zip code 61603) and Harrison Homes (zip code 61605) are over 88% and 63%, respectively (Neighborhood Scout, 2020). These urban areas have unique challenges in terms of food insecurity. An internal survey of 165 residents conducted in these zip codes revealed that

80% had experienced food insecurity in the past year, compared with an overall rate of 14.3% in Peoria County.

Exhibit 12: Heartland Health FQHC Ethnic and Racial Composition in Peoria County



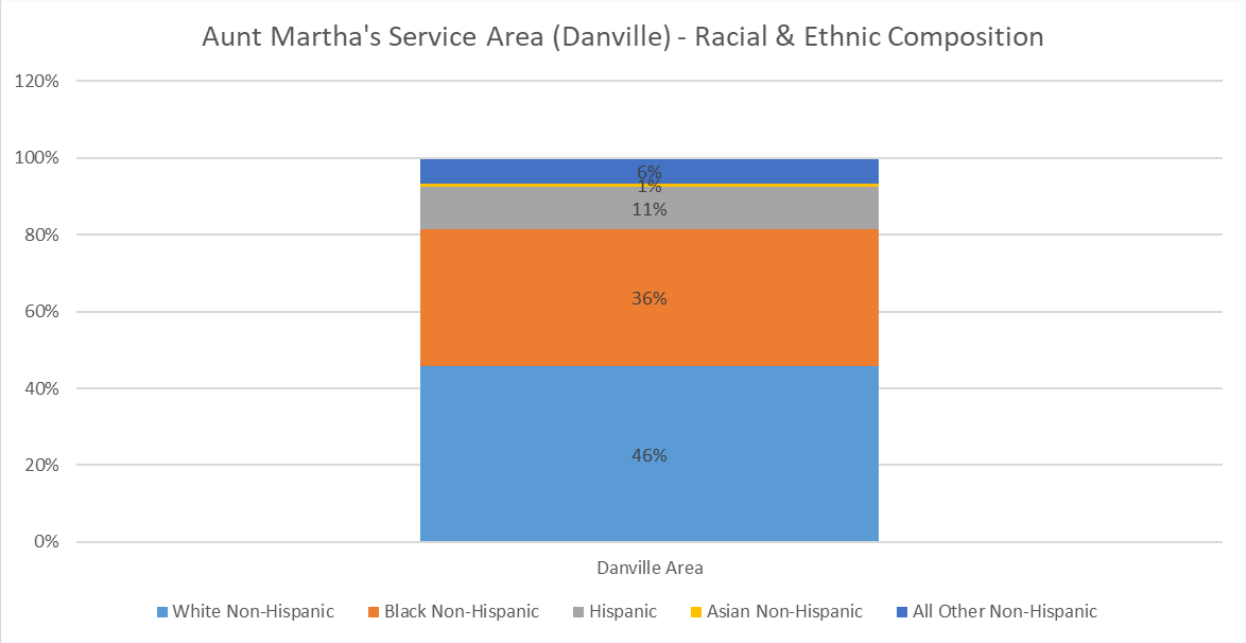
The data for those serviced by FQHCs in McLean County and Peoria demonstrate that poverty is the main concern. In 2018, residents in McLean County rated themselves as having average health (60%) and 13% rated themselves as having poor physical health. Access to care is impacted by residents reporting not being able to afford their co-pay (41%) or not having insurance (29%) (McLean County, CHNA, 2019). Income level has an inverse relationship to health literacy, with those living below the poverty level with the lowest health literacy (NAAL, 2003). Given these findings, the team of collaborators will focus their efforts on ways best to support these residents.

Aunt Martha's Health Center, Danville, IL, FQHC

Aunt Martha's Healthcare Center in Danville, IL, respresents a equitable diverse population of white and black non-Hispanic with a smaller percentage in other races/ethnicities (Exhibit 13). In reports of secondary data for Danville, IL, socioeconmoic needs are noted as the strongest, particularly for Black, Non-Hispanic residents (Vermillion County Health Community Health Plan

{VCHCHP} 2021-2023). Access to healthcare also proves challenging in this community as it is reported to have the highest percentage of households lacking personal vehicles for transportation (VCHCHP, 2021-2023). County rankings as reported by the Robert Wood Foundation Program (RWFP) ranks Vermillion County as 101 out of the 102 counties in Illinois (VCHCHP, 2021-2023).

Exhibit 13: Racial and ethnicity distribution for Danville area serviced by Aunt Martha's FQHC



Decreasing food security, improving use and knowledge of assistance programs, and promoting post-graduate pathways for high school graduates are noted as health priorities for the cycle of 2021-2023 Community Health Improvement Plan for Vermillion County. Addressing the higher rates of obesity (for adults and children), heart disease, and lower respiratory diseases can also be accomplished within our Medicaid Innovation Collaborative by training more advanced practice providers to provide access and education. Our goals align with these stated health priorities for Vermillion County.

Health & Racial Equity Outcomes

Nationally, ethnic and racial disparities have been noted for years within health care. The Institute of Medicine's (IOM) landmark (2003) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* "found continued variation by race in prevalence and burden of a range of illnesses, as well as differences in health care services." Even when controlling for socioeconomic differences and access to care, the differences remained. Review of clinical health encounter data provided evidence of provider stereotyping, bias, and uncertainty that led to health care disparities. Recommendations stressed the importance of providing awareness of disparities, promoting evidenced-based care to provide more equity in care, and a need to train a diverse workforce.

Since this landmark report from the IOM, the *Healthy People 2020* initiatives also posit the need to address "particular types of health differences that are closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health" based on characteristics such as race and ethnicity, gender, disability, and geographical residence, among others. For decades, disparities in health have been well documented in the United States and regrettably, remain prevalent despite evidence and appeals for their elimination. Compared to the majority, racial and ethnic minorities continue to have poorer health status and health outcomes for most chronic conditions including diabetes, cardiovascular disease, cancer, and end-stage renal disease.

Specific disparities and outcomes in care delivery models, which the collaborators will address, include control of chronic diseases such as hypertension, hyperlipidemia, and diabetes. Below are excerpts from literature that demonstrate the inequity.

Hypertension and Stroke Risk

Poor control of hypertension is a significant problem. An expert analysis published by Saeed et al. just a year ago (April 6, 2020), noted the following:

> *"There are significant differences in blood pressure prevalence and control rates based on race/ethnicity.[3] National surveys such as the US National Health and Nutrition Examination Survey (NHANES) have highlighted these differences.* ***Non-Hispanic blacks (NHB) have significantly higher rates of hypertension compared to non-Hispanic whites*** *(NHW), while Hispanics and non-Hispanic Asians (NHA) have lower rates than both groups.[2] In an NHANES survey,[3] hypertension control rates among non-Hispanic white adults (55.7%) was significantly higher than NHB (48.5%), NHA (43.5%), and Hispanic (47.4%) adults.*
>
> *While the prevalence of hypertension is known to be higher in select ethnic/racial groups (e.g., NHBs), there are also significant disparities in hypertension control and hypertension-related morbidity and mortality. Data from a Centers for Disease Control and Prevention (CDC) report found that* ***hypertension control rates were*** *highest among NHWs (55.7%) and* ***lowest among Non-Hispanic Blacks (NHBs) (48.5%), Hispanics (47.4%),*** *and* ***non-Hispanic Asians*** *(NHAs) (43.5%). These differences are significant since the attributable risk for hypertension and 30-year all-cause mortality is nearly double for NHBs when compared to NHWs.[6]"*

Hypertension also increases the risk of stroke and within the literature; stroke identification and management are also dramatically different when considering ethnic/racial groups. Two excerpts from the literature (Cruz-Flores et al.) indicate how necessary it is to consider racial and ethnic differences that need to be considered in treating minority populations.

> *"**Blacks or African Americans tend to be more likely to report stroke symptoms,[66] to experience transient ischemic attacks,[68] and to be hospitalized for stroke,**[69] and they have approximately twice the number of incident strokes*

as whites.[67] ***The disparity in stroke incidence is particularly prominent among younger adults.***"[67]

Howard et al. (2006) recounted this brief analysis of their work:

"findings suggest that ***additional efforts focused on improving hypertension control, especially among blacks, may have a role in reducing excess stroke mortality****."*

Sources:

Cruz-Flores, S., Rabinstein, A., Biller, J., Elkind, M. S., Griffith, P., Gorelick, P. B., ... & *Valderrama, A. L. (2011). Racial-ethnic disparities in stroke care: the American experience: a statement for healthcare professionals from the American Heart Association/American Stroke Association. Stroke, 42(7), 2091-2116.*

Howard, G., Prineas, R., Moy, C., Cushman, M., Kellum, M., Temple, E., ... & Howard, V. (2006). Racial and geographic differences in awareness, treatment, and control of hypertension: the REasons for Geographic And Racial Differences in Stroke study. *Stroke*, *37*(5), 1171-1178.

Saeed, A., Dixon, D., Yang, E. (2020, April 6). Racial Disparities in Hypertension Prevalence and Management: A Crisis Control? *American College of Cardiology*, Expert Analysis. Accessed 4/06/2021.

Type 2 Diabetes Mellitus

Racial Disparities for the occurrence of diabetes and its related complications over time for poor management are noted in multiple research studies. The following excerpt describes these in detail.

"Racial/ethnic minorities also have significantly higher rates of diabetes-related complications. For example, ***African Americans have 2-4 times the rate of renal disease, blindness, amputations, and amputation-related mortality of non-Hispanic whites*** *(Carter, Pugh, and Monterrosa 1996; Lanting et al. 2005; Lustman et al. 2000). Similarly,* ***Latinos have higher rates of renal disease and retinopathy*** *(Carter, Pugh, and Monterrosa 1996; Emanuele et al. 2005; M. A. Harris et al. 1998; Lanting et al. 2005). Diabetes age-adjusted mortality rates (per 100,000) in California in 1998 were 60 for Latinos and 98 for African Americans compared to 38 for non-Hispanic whites (California Medi-Cal Type 2 Diabetes Study Group 2004). Diabetes-related mortality is 2.7 times higher in NA/ANs than*

whites, and when adjusted for underreporting, the rate is estimated to be 4.3 times that of non-Hispanic whites (American Public Health Association 1999).

These ***higher rates of complications may be the product of disproportionately poor control of diabetes as well as associated cardiovascular risk factors such as blood pressure and cholesterol*** *(Gaede et al. 2003). One national data set reported average glycosylated hemoglobin (HbA1c) levels of 7.6% among non-Hispanic white women compared to 7.9% among Mexican American women and 8.3% among African American women (M. I. Harris et al. 1999). In addition, racial/ethnic minorities have higher rates, and worse control, of dyslipidemia and hypertension (Centers for Disease Control and Prevention 2005; Sundquist, Winkleby, and Pudaric 2001)."*

Source:
Peek, M. E., Cargill, A., & Huang, E. S. (2007). Diabetes health disparities. *Medical Care Research and Review*, *64*(5_suppl), 101S-156S.

Hyperlipidemia

Hyperlipidemia represents yet another possible risk for coronary heart disease that may be associated with other secondary factors such as obesity, low activity levels, and high calorie intake. Specific variations in races need to be considered as part of prevention and disease management.

"There are significant variations in cardiovascular disease prevalence and outcomes, as well as in risk factors, including lipid profiles, among different races worldwide and in the United States.[1] ***Racial and ethnic minority groups account for 36% of the US population and are projected to increase to 53% by 2050****: the 2 most rapidly growing of these are Hispanic and Asian-American populations, whose population is projected to increase to 110 and 30 million, respectively.* ***Cardiovascular disease (CVD) burden among different races is heterogeneous: South Asian, Filipino, and Black individuals have more atherosclerotic CVD compared with non-Hispanic White individuals.***[2, 3] *Despite dyslipidemia being more prevalent* ***in certain ethnic minorities, they are***

prescribed lipid-lowering therapy less frequently than White individuals and are less likely to achieve optimal lipid targets *(e.g., women are less likely to be prescribed statin therapy in both primary and secondary prevention, especially Black women).[4, 5] The same is true for younger Black men.[6] Furthermore, Hispanic adults have a higher prevalence of elevated low-density lipoprotein cholesterol (LDL-C), and both South Asian and Hispanic individuals have higher triglyceride and lower high-density lipoprotein cholesterol levels, and a higher prevalence of visceral adiposity, diabetes mellitus, and metabolic syndrome.[7] Black people have a higher prevalence of hypertension, stroke, heart failure, and cardiovascular mortality but are less likely to receive optimal preventive cardiovascular care.[8]"*

Source: Kalra, D. K. (2021). Bridging the Racial Disparity Gap in Lipid-Lowering Therapy. *Journal of the American Heart Association.* Advance online publication. https://doi.org/10.1161/JAHA.120.019533

Targeted Interventions

Interventions that can influence care and outcomes for these chronic diseases are important for reductions in morbidity in mortality. These include:

- Adults age 40 and over with diagnosed diabetes who received at least two hemoglobin A1c measurements in the calendar year
- Adults age 40 and over with diagnosed diabetes who received a dilated eye examination in the calendar year
- Adults age 40 and over with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year
- Adults age 40 and over with diagnosed diabetes who received a flu vaccination in the calendar year
- Adults ages 18-64 at high risk (e.g., COPD) who received an influenza vaccination in the last flu season
- Adults age 65 and over who received an influenza vaccination in the last flu season

- Adults ages 18-64 at high risk (e.g., COPD) who ever received pneumococcal vaccination
- Adults age 65 and over who ever received pneumococcal vaccination
- Control of hyperlipidemia

Many factors, such as affordability, access, and diversity in the health care system, influence care and outcomes, and also create challenges that make the task of eliminating health disparities and achieving health equity daunting and elusive. Novel strategies are needed to bring about much needed change in the complex and evolving United States health care system. Although not exhaustive, our novel approach in the collaboration has great opportunities such as 1) developing standardized race measurements across health systems, 2) implementing effective interventions, 3) improving workforce diversity, 4) utilizing technological advances to continuously monitor efficiency, fulfillment and equity, and 5) adopting personalized medicine practices serve as appropriate starting points for moving towards health equity.

Over the past several decades, diversity in the U.S. population has increased significantly and is expected to increase exponentially in the near future. As the population becomes more diverse, it is important to recognize the possibilities of new and emerging disparities. It is imperative that steps are taken to eliminate the current gaps in care and prevent new disparities from developing. Therefore, we acknowledge present challenges and offer recommendations for facilitating the process of eliminating health disparities and achieving health equity across diverse populations.

In addition to the national efforts, there remains a chasm of opportunity for those living in Illinois. Recently published research on the Medicaid expansion in Illinois has shown that becoming insured represents the initial step for those who do not have a relationship with a primary care physician nor a history of seeking access to preventive medicine (Dalstrom et al., 2021; Klein et al., 2021). In keeping with the Mission of OSF HealthCare, OSF has placed a strategic priority to address health equity and impact the social determinants of health. The focus is to assure that the right of each individual to basic health is respected and to promote good health within communities. The OSF senior leaders act as the integrator of the work from around the system.

The community health assessment, innovation efforts focused on social determinants of health, large regional efforts to impact underserved communities, and the OSF HealthCare System Diversity and Inclusion Strategic Plan are all within the scope of the Medicaid Innovation Collaborative.

Though great work has been done, it is time to take a nontraditional and innovative approach to delivering care to vulnerable populations. Bringing health care to the patient and the community will be key to breaking down transportation, access, and disparity concerns. Community involvement and engagement from federally qualified health centers, critical access networks, and community partners are critical to success as we build programs. OSF has created a Medicaid Transformation team to help support the proposed work and to collaborate with community partners. The OSF OnCall guiding principles were adapted to meet the needs of the specific target population. In addition, our rich history of innovation allows us to approach this work with clinical quality and data science.

In regards to data science, evidence-based medicine (EBM) has been a popular trend in medical care. EBM focuses on large, prospective, double-blinded, controlled clinical trials as the gold standard for determining how care should be provided. If clinicians treat based on these gold standard studies, the belief is that patients will do better. Unfortunately, the real-world results of EBM have been disappointing because: 1) EBM studies often underrepresent many patient populations, 2) the study conditions are often very different than those of the real world, and 3) the studies focus on average results across a population which can miss important effects in certain groups. For example, consider a medication that provides no benefit to 97% of lung cancer patients, but leads to a complete cure in the 3% of patients who are African-American, non-smoking women who live in rural areas. A study of all patients would find no statistically significant benefit because the improvement of the few would be diluted by the medication's failure in all the rest. However, a study focused entirely on the susceptible population would find a huge benefit. For this reason, more personalized approaches — determining what works for "patients like me" — are gaining prominence in the medical community.
Please see Racial Equity Impact Assessment Guide by RACE FORWARD for additional information.

Artificial Intelligence

A team from Stanford, IBM Research, and Atrius Health developed advanced algorithms that personalize therapeutic recommendations. Then they studied these algorithms to see if the "patients like me" approach could improve control of three diseases (diabetes mellitus, hypertension, and high cholesterol). (Exhibit 14). Diabetes and hypertension are considered Ambulatory Care Sensitive Conditions (ASCs), which are diseases for which good outpatient care can prevent hospitalizations or severe complications.

Exhibit 14: Population of Patient Journeys for Hypertension, Hyperlipidemia & Diabetes (T2D)

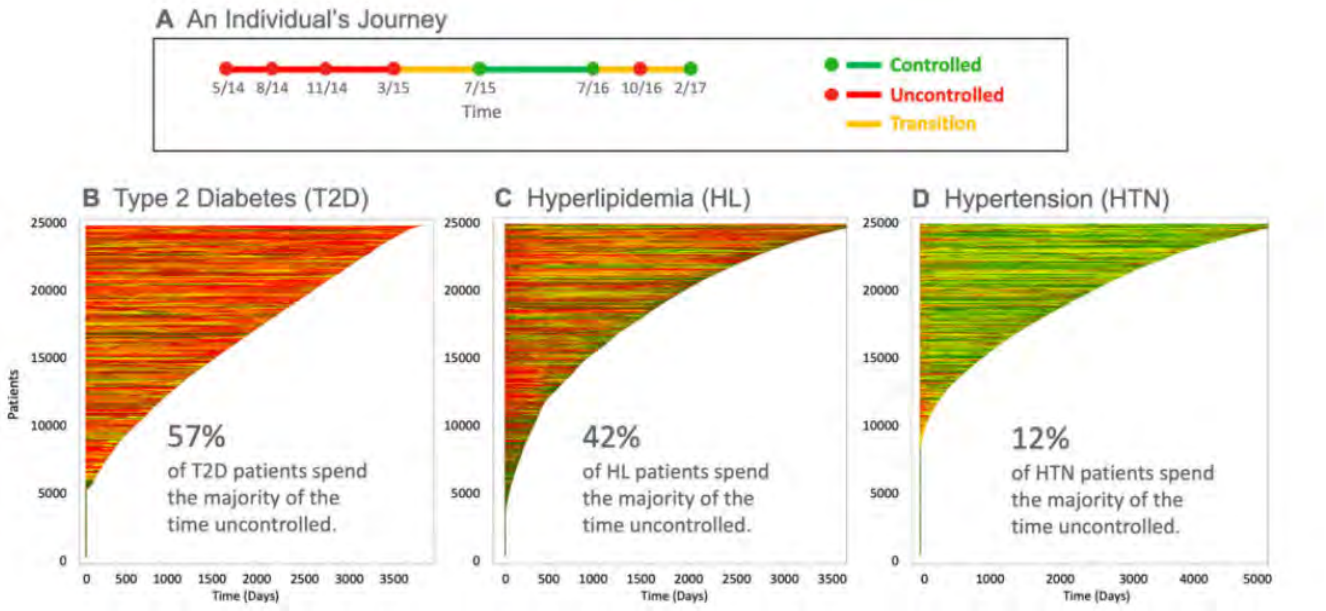


Figure 3. Population of patient journeys for 3 chronic conditions. A) An individual patient's journey. Green dots represent encounters at which the disease parameter (eg, HbA1c) is controlled. Red dots represent encounters at which the disease parameter is not controlled. Red lines connect 2 consecutive encounters with uncontrolled outcomes. Green lines connect 2 consecutive encounters with controlled outcomes. Yellow lines connect consecutive encounters with different outcomes (1 controlled and 1 uncontrolled). B, C, D) Journeys for 25 000 randomly selected type 2 diabetes, hyperlipidemia, and hypertension patients, respectively. The individual patient journeys are stacked vertically and sorted in descending order by the duration of the patient's longitudinal observations (days).

Source: Tang, P. C., Miller, S., Stavropoulos, H., Kartoun, U., Zambrano, J., & Ng, K. (2021). Precision population analytics: population management at the point-of-care. *Journal of the American Medical Informatics Association*, *28*(3), 588-595.

1. They developed an algorithm that can take information about one patient and then find other patients in the database who are similar ("patients like me").

2. Any time a physician had an opportunity to consider changing the medication (like during a patient visit, or a patient phone call), the system would find a set of similar patients on the same therapy.
3. For this group of similar patients, the system would determine which medication plan historically led to the best outcome. For example, for the hypertension patient in front of me now who is already on one particular blood pressure medication, is the best plan to add another blood pressure medication, to change to a different medication, keep the medication the same but increase the dose, or make no change at all?
4. They developed a simple prototype for displaying the recommendations to doctors. It took 50 iterative feedback sessions with doctors to develop the optimal user experience.
5. Finally, they compared how much better the patients would have done (hypothetically) if the best option according to the algorithm had been selected instead of the one that was actually chosen.

The results of the work: a 36% - 138% predicted improvement in control of disease if the algorithm's best option had been chosen every time. These results suggest there is real potential to improve control of chronic disease by using artificial intelligence to personalize therapy for "patients like me." Best of all, publications like this one provide the "recipe" for others, such as OSF HealthCare, to translate this research into clinical practice and bring those benefits to our own patient populations.

Exhibit 15: Overall Workflow for Precision Population Analytics

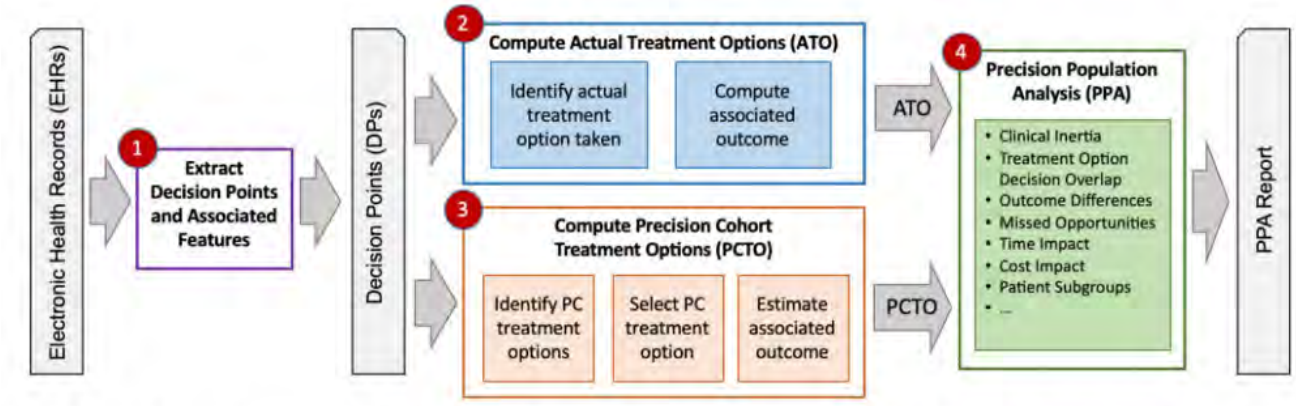


Figure 4. Overall precision population analytics (PPA) workflow consisting of 4 steps: 1) extracting decision points (DPs) and associated features from the EHR data; 2) computing the actual treatment options (ATOs) from the DPs, 3) computing the precision cohort treatment options (PCTO) from the DPs, and 4) analyzing the DPs, comparing the actual versus precision cohort treatment options and associated outcomes, and generating the PPA reports.

Source: Tang, P. C., Miller, S., Stavropoulos, H., Kartoun, U., Zambrano, J., & Ng, K. (2021). Precision population analytics: population management at the point-of-care. *Journal of the American Medical Informatics Association*, *28*(3), 588-595

It is notable that OSF's OCC software is an additional source of data regarding patient reported SDoH and an additional series of facets, which may improve outcomes through this data-science-driven path. OSF's HealthCare data science and machine learning team are prepared to execute this approach for all of the patients within the collaborative.

Other Reviewed Sources:

Peek, M. E., Cargill, A., & Huang, E. S. (2007). Diabetes health disparities: A systematic review of health care interventions. *Medical Care Research and Review*, *64*(5_suppl), 101S-156S.

Mays, V. M., Cochran, S. D., & Barnes, N. W. (2007). Race, race-based discrimination, and health outcomes among African Americans. *Annu. Rev. Psychol.*, *58*, 201-225.

Pillars and Quality Metrics: Proposed Clinical Programming

The Medicaid Innovation Collaborative strategy includes a focus on six areas of concern under three of the five pillars of improvement in the Illinois Department of Healthcare & Family Services (HFS) P4P 2020 program. The focus areas were guided by the primary and secondary data analysis, as well as concerns and issues identified by the collaborating partners and communities we serve. It is understood that one size does not meet the needs of all communities. In order for the transformation work to be successful, this effort must be driven by the needs identified by the marginalized communities and partners. Our methods for addressing these health care needs and associated quality metrics are described.

1. Pillar: Adult Behavioral Health

Quality Metrics:

- 75% of patients receive a seven and 30-day follow up call after hospitalization for mental illness
- 75% of patients receive a seven and 30-day follow up calls for alcohol and/or drug abuse

- 90% of patients who are reached receive a social determinants of health assessment with connection to community partners
- 75% of patients engage with a digital tool
- Patient experience achievement of at least 75%

OSF OnCall Emotional Well-being: Over seven million African Americans have experienced mental illness in the last year. With 13.4% of the population who identify as Black or African American, 16% of them reported mental illness. To place that in perspective, that is a population greater than Houston, Chicago, and Philadelphia combined. While the rate of mental health disease is equivalent to the white ethnicity counterpart, there is increased violence and trauma associated in the African American population that can affect their mental health disease. Mistrust of health care can lead to lack of engagement with traditional health care.

Faith-based outreach has been a successful methodology in various communities. Attitudes, treatment issues, and access to care are all significant issues for the African American population. General concerns for stigma and stereotyping from the individual suffering from mental health illness present as well. Many times, there are not the same treatment options offered to African American individuals that fit their needs. In regards to access, many individuals do not know where to seek treatment, do not trust the health care system to seek care, or have difficulty getting needed care, tests, or treatment. In 2018, approximately 58% of black young adults aged 18-25 and 50% of those between 26-49 years did not receive treatment for severe mental illness (Mental Health America, 2021).

Rural and underserved populations also face barriers to accessing primary care and behavioral health services due to the increased poverty rate, aging community, and higher than average rates of teen pregnancy. Poverty and lack of insurance affects the rural population's health as often times these patients do not access preventive health services. Commonly, patients lack transportation to travel to the primary care office, let alone traveling to see a specialty provider in

an urban area such as Peoria. When patients do seek health care services, they often defer diagnostic testing or filling prescription medications due to cost. Transportation is an issue in the urban underserved communities as well, where only 33% of residents own a vehicle. This creates health care challenges as residents of these communities rely on walking or public transportation only to access health care. Not only does this create a barrier to receiving services, but also without walking access to a medical group office, many of these community members do not have a designated primary care provider and rely on the emergency department for non-emergent health care.

A digital application for stress, anxiety and depression will be used as a method of engagement that ensures privacy protections for individuals who access this service. Additionally, therapists are available through the app if so desired by the individual and is provided based on the individual's needs assessment at time of enrollment and during the eight-week course. If needed, the patient can be escalated to a mental health navigator for additional care and services. There are also many opportunities for collaboration with the FQHCs who may employ behavioral health experts or refer to community based organizations. Those experts can be utilized to provide care for patients to augment their care.

There are adult behavioral health modules as well as substance abuse. Thus far, we have delivered this service to over 3500 patients in the past year, substantiating research findings by our internal team of researchers that demonstrated an interest in telehealth for rural populations across our service areas (Weinzimmer et al., in-press). An additional service would be added to include virtual follow-up in seven and 30 days for those individuals hospitalized for mental health illnesses. This service would also include those who visited an emergency department for alcohol or drug dependence. The virtual visits are escalated to a provider if needed to assist in de-escalation and appropriate level of care. At initial enrollment, the participants are screened for social determinants of health to identify any needs that could be supported by community resources. The combination of digital self-service with the virtual human connection is a good methodology to provide access. This will help to overcome

some transportation barriers within our urban and rural-based populations. Currently, the OSF behavioral health navigators are familiar with IL Department of Human Services behavioral health providers that serve mostly Medicaid populations. Between the navigators and the CHWs, the patients can be linked and monitored by community based behavioral health services that have wrap around capabilities.

2. Pillar: Maternal and Child Health

Quality Metrics:

- 60% of pregnant women will receive timely prenatal, starting within the 1st trimester, augmented with digital remote monitoring
- 60% of women will receive postpartum care for evaluation of postpartum depression
- 60% of women will receive well child visits for their newborn within the first 2 weeks with continued follow up during the first year

Pregnancy is a significant time of change in a woman's life. There are physical changes, emotional changes, and changes that occur within the home and with relationships. Many times, there is a great deal of focus on the physical components of care but there is lack of attention to deficits related to access to care, mental illness, or other socioeconomic factors. Nearly 1 in 4 women nationally do not get the needed care can reduce the risk to the pregnant mother and baby. In the Chicago areas, 26-32% of women have late entry into prenatal care after the first trimester, which can greatly influence prenatal, perinatal, and postpartum outcomes. Redesigning how care is delivered is critical to lowering the number of preterm births, higher birth weights, increasing rates of breastfeeding.

Prenatal/postpartum care service delivery redesign can provide a promising change to the Medicaid population. There are different approaches that may be beneficial depending on a

specific region or community. These include combination of digital and in-person support, mobile services in specific communities, and/or group care. The first goal is to increase the total number of visits and reduce the number of in- person visits by utilizing digital services and virtual visits with clinicians. The number of in-person visits could be reduced to four in comparison to the traditional fourteen to increase engagement and decrease transportation issues. Mobile support into a specific community will be needed to optimize the care being provided. Utilizing digital health workers who are familiar with the community and have trust in the community can be positive partners for this work as well. Group care has been found to improve learning and skills development, attitude changes and motivation, enhanced insight through sharing of common experiences, and social support. In turn, groups facilitate development of new community norms for health enhancing behaviors. Group care is designed to move from a framework of fear and avoidance to embracing good health habits for women and their families.

Digital applications can be a connection point to pregnant mothers and can provide education and support throughout the pregnancy and in the postpartum phase. Extending psychological support and understanding social determinants that may influence her or the baby's outcomes can be achieved by community connections to resources. In addition, remote patient monitoring will allow us to monitor mothers for weight, fetal heart rate, and blood sugar levels for gestational diabetes. If needed, escalation of care can be achieved to provide the right care in the right location. Lastly, in collaboration with FQHC's and community based organizations, the mother and baby can be followed into the postpartum period. Postpartum depression is a critical area for evaluation and treatment to ensure the continued health of the mother and support of the infant. Remote telehealth services can support the mother during this phase and provide an opportunity for assessment/reassessment of postpartum depression. In regards to the newborn, OSF OnCall can collaborate with community partners to ensure the baby receives newborn care and the appropriate vaccines during its developmentally forming first year.

3. Pillar: Equity

a. *Adult Access to Preventive/Ambulatory Health Services –*

Chronic Disease Management and Digital wrap around services

Quality Metrics:

- 70% of patients will achieve hypertension control of a blood pressure less than 140/90
- 75% of patients with diabetes will achieve a Hemoglobin AIC less than 9
- 80% of patients with asthma will have a documented asthma action plan
- 90% of patients will have a pharmacy review of medications
- 100% of applicable patients will have remote patient monitoring with 24/7/365 accessibility to clinicians

Chronic diseases are prevalent in the United States today. A chronic disease impacts one out of two Americans and it accounts for 90% of health care expenditures. While some patients have a relationship with a primary care provider, many individuals do not want this type of relationship or struggle to find the right access. In reality, the patient spends approximately two hours of a year in consultation with a health care provider with the remainder of their time requiring self-management of their chronic disease. For illustration purposes, within the Chestnut Health System FQHC service areas, there are disparities in emergency room rates due to hypertension occur in individuals ages 85 years and older (112.9 emergency room visits per 10,000 population 18+) and Blacks or African-Americans (89.2 emergency room visits per 10,000 population). This rate is 254% higher (more than 3.5 times) than the county rate. The age-adjusted hospitalization rate for hypertension in McLean County is 3.3 hospitalizations per 10,000 population for ages 18 years and older (Conduent Healthy Communities Institute, Illinois Hospital Association, 2015 - 2017). This is in the worst 50th - 75th percentile range compared to other counties in Illinois. Likewise, the highest

hospitalization rates due to hypertension occur in individuals 85 years and older (23 hospitalizations per 10,000 population 18+) and Blacks or African-Americans (15.2 hospitalizations per 10,000 population 18+). This rate is 360% higher (more than 4 ½ times) than the county rate. Diabetes related risk factors were also at least two times higher than the general population in African Americans, which closely aligns to UI Mile Square FQHC statistics for age and adjusted diabetes prevalence in all five regions, at 12.3% to 14.4%, which are above the state of IL and national averages.

Reducing the burden of chronic disease requires coordination of care including surveillance of trends, policy, and environmental approaches to support healthy behaviors, interventions to improve the efficiency of health care, links to high value clinical services, and links to community programs. With many of our proposed programs, we believe that we can achieve improved health outcomes by wrapping around other traditional services. Achieving clinical metrics will require more than a physician or advanced practice provider clinical input within a short office visit. Digitally connecting to these patients with education and remote patient monitoring can allow for agile clinical decision-making to ensure diseases are being treated more effectively with earlier intervention. As an example, providing remote patient monitoring for a hypertensive patient allows for trending analyses to occur over a shorter period for medication adjustment, thus ensuring compliance and reduction of risk of stroke. In addition to these types of services, each individual would receive wellness coaching, dietary guidance, social work connection for social determinant needs, and a pharmacist to ensure that the most appropriate medications are being prescribed.

OSF HealthCare has already successfully implemented a program that has served 147 identified high-risk patients who are part of the OSF Humana Medicare-C population health group. The program has been successful in reducing hospital readmissions and reducing the cost of care for this high-risk population. The program offers a multi-disciplinary team of care manager, pharmacist, dietician, nurse, and physician 24/7 through remote patient monitoring. The goal is to decrease activity across the continuum of health care and is broken down into several categories (e.g., Emergency Department, Inpatient, and Post-Acute) of care, and it includes the clinical outcomes of readmissions and length of stay. OSF HealthCare proposes to expand the program to Medicaid high-risk patients. We believe strongly that expanding this digitally based program to specific Medicaid patients will improve health outcomes as well as have a significant impact on cost of care for the patients enrolled.

3. Pillar: Equity

b. Adult Access to Preventive/Ambulatory Health Services –

Extended Hour Access

- 100% of patients will have access to extended hour contacts within OSF OnCall
- 60% achievement of antimicrobial stewardship metrics for pharyngitis, bronchitis, and UTI

OSF OnCall has a seamless extended hour program that includes asynchronous and synchronous connections to care. The service is 24/7/365 and is staffed by OSF employed clinicians to ensure that our high-quality standards and expectations are upheld. Through technology, care is provided in multiple languages. Patients can use this service instead of being forced to choose higher cost options for lower acuity symptoms or injuries. In addition, mobile vans outfitted with the electronic medical record and Wi-Fi connection can be taken into the communities to provide care within the community where patients feel safe. The vans reduce the transportation barrier that exist within our marginalized populations and provide services close to home at a lower cost.

OSF has demonstrated success with a similar type program for faith community nurses in the Peoria market. The faith community nurse understands that health is a dynamic process that embodies the spiritual, psychological, physical, and social dimensions of the person. The faith community nurse works with pastoral staff and congregants to foster new and creative responses to health and wellness concerns. The OSF faith community nurses specifically help to identify needs within the congregations and communities. They assist in navigation of the health care system and promote health and wellness. One of their functions in the Peoria area is to assist with the Care-a-Van. The Care-a-Van is used in areas where access to care is limited and where individuals residing in an underserved community struggle to trust the health care system. In collaboration with residency programs and the advanced practice fellowship program, providers are physically present on the van to see patients for health-related concerns and to provide education to patients. By implementing this program there has been an estimated 1500 emergency room visits avoided from this market.

3. Pillar: Equity

c. Adult Access to Preventive/Ambulatory Health Services –

OSF Connect Bars

- Increase the number of enrollees into digital programs
- Achieve three community partners each year

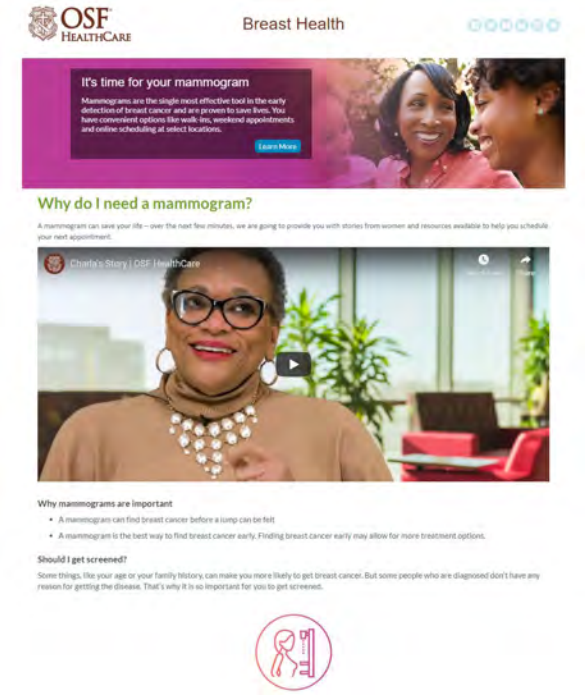
One of the most critical pieces of the Medicaid transformation work is engaging within the communities where individuals live and have a sense of safety. By centralizing clinical resources (nursing and physicians/advanced practice providers), we are able to provide decentralized digitally enabled digital health workers to deploy tools, resources, education and support for those in need. In collaboration with community partners such as NAACP offices, churches, community center, or federally qualified health centers, we can provide connect bars to allow individuals to find applications to connect and also reach us for clinical services. If needed, patients can be provided

an electronic tablet device to make connection to the health care system seamless. This reduces the access to care barriers as well as builds trust with the health care providers who can assist in decreasing disparities. Heartland Health Center plans to add locations like this within homeless shelters.

3. Pillar: Equity

d. Cancer Screenings

- 65% of women over the age of 40 will receive breast cancer screening
- 40% of women of childbearing age will receive cervical cancer screening according to guidelines
- 50% of individuals over the age of 50 will achieve colon cancer screening



Cancer is the second leading cause of death in the United States. While all races and ethnicities are impacted by cancer, there is disparity. Cancer disparities occur from the interplay among a variety of factors including social determinants of health, behavior, biology, and genetics. All of these factors can have profound effects on health outcomes, including morbidity and mortality. Access to care is a major factor that affects a person's ability to obtain appropriate screenings. Reaching the communities through mobile technologies and/or providing transportation services to the appropriate screening represent important components of providing this care. This past year, OSF has been part of a grant-funded outreach program for breast cancer. Through this program, we diagnosed multiple women with breast cancer by utilizing the digital health workers to build trust along with digital outreach. The experience we provide to these individuals sets the stage for trust within the community where these women live.

4. Pillar: Equity and Access

e. Advanced Practice Provider Training & Eduction to Serve FQHC and Underserved

The purpose of the OSF HealthCare APP Fellowship Program is to transition newly graduated advanced practice providers (advanced practice registered nurses or physician assistants) into the complicated practice arena that exists today. Changes in health care reform have contributed to a void of primary care providers and projected needs indicate that the demand is greater than supply. Since the publication of the Institute of Medicine's (IOM) Future of Nursing report in 2010, strides have been made in the number of graduates from nurse practitioner and physician assistant programs, yet the predicted demands will outstrip the enhanced supply (HRSA, 2016). Coupled with the inability to meet the demand are concerns with the lack of standardization across nurse practitioner educational programs (Brown, Poppe, Kaminetzky, Wipf & Woods, 2015; Nicely & Fairmen, 2015), and their ability to fully transition into practice. Higher reported levels of work-related stress for new practitioners in the transition period who are working with high proportions of economically or socially disadvantaged patients have been reported in the nursing literature (Morgan et al., 2020). The resulting effects have been dissatisfaction, role uncertainty, and generalized feelings of lack of support that are reported and acted on by new practitioners. At worst, knowledgeable novice APPs consider various alternatives including leaving the employing organization (Poghosyan et al., 2017).

These effects were evident at OSF HealthCare with an APP attrition rate of 14% in 2015 as the newly developed Center for Advanced Practice was still in its infancy. The high costs associated with recruitment, onboarding, and turnover for APPs indicated a need for enhanced support for new graduate advanced practice providers, which was addressed in 2016 with the development of a centralized primary care APP Fellowship program. OSF has successfully implemented a fellowship program to support primary care, general neurology, and pediatric critical care. In 2018, the program achieved national accreditation through American Nurses Credentialing Center and was the first in the nation to be system wide. With the operational efficiencies we achieved thus far,

OSF could be a partner with FQHCs to provide the additional education and transition to practice support for new advanced practice providers that would like to serve as clinicians for the Medicaid programs through digital health and within the FQHC. This proposed collaborative provides the framework to support the training and education needed to build additional cultural competencies and understanding social determinants of health. The patient then receives the best care for them, which can positively influence health outcomes.

4. Pillar: Equity and Access

e. Community Health Worker Training and Development: Level One Training

The role of the CHW is about being close to the ground engagement, cultivating relationships with community stakeholders (i.e. schools, churches, food pantries, human service providers, community medical providers, etc.), conducting community education on health topics and issues, participating in health fairs (conduct screenings, provide education), facilitate access to health services by scheduling appointments. The CHW is often times the first link to health and wellness that our families make, and often times, the most trustworthy. They require mobility and accessibility to individuals and families that hesitate in accessing health and wellness on their own, thus, falling behind in keeping up with appointments, getting prescription refilled, seeking medical help when needed, or understanding the nuances and complexities of the health care system, and ensuring they get or maintain their insurance enrollment. The role of the CHW is one where proper

mobility and up to date technology is essential in being able to respond and help meet the needs of those we serve, often marginalized and or "falling through the cracks", because of racial and social inequity, leading to health and wellness inequity.

The CHW program to be developed with Illinois Central Community College (ICC) will provide basic training in 10 to 12 core competencies to be defined through a cross-walk of other states' CHW certification exam blueprints, key textbooks in the field, and core competencies form Massachusetts and Washington, two states known to be leaders in CHW education. Completion of Level One training will prepare the learner for placement in underserved areas of rural and urban Illinois, as well as for the CHW Certification Examination once the state of IL is prepared to go forward with testing. Level One will cover support of clients with the specific disease processes elucidated in this application, as well as support of at-risk communities. Completion of this entry-level program will also prepare learners to undertake additional facilitated and self-guided learning focused on support of clients with specific disease processes as described in the section describing Level Three training.

What Sets ICC-OSF Level One CHW Training Apart?

This training will include content that sets the ICC-OSF program apart from others while achieving nationally-recognized CHW competencies. Key differences include instruction related to the concept of psychological safety and how to establish it and how to maintain it through genuine curiosity, empathy, and compassion. Learners will have the opportunity to practice skills around psychological safety with standardized participants (SPs) who reproducibly embody roles and situations and provide feedback to learners concerning perceived psychological safety.

Other distinguishing features of Level One training include content on how to use a conversational structure called Advocacy-Inquiry. It was developed to improve psychological safety of participants engaging in challenging conversations. We have previously trained Digital Health Workers (DHWs) to utilize this technique when discussing Social Determinants of Health (SDOH) with clients. Digital Health Workers report greater comfort in approaching SDOH conversations and feel that clients are receptive to sharing sensitive information when they begin conversations with an advocacy-inquiry. In addition, Level One training will include specific training on implicit bias,

recognizing it in oneself and others, acknowledging it with compassion and taking positive steps to mitigate it.

The same training that sets ICC-OSF CHWs apart will assist them in becoming fully integrated members of the FQHCs that serve their clients. It is known that CHWs have faced a long struggle to be seen as fully integrated members of the health care team. Possessing the skills and confidence to take a leadership role in establishing and maintaining a psychologically safe conversational environment and to meet bias with compassion and the know-how to mitigate bias will help them become a valued and valuable member of the FQHC team.

e. Community Health Worker Training and Development: Level Two Training

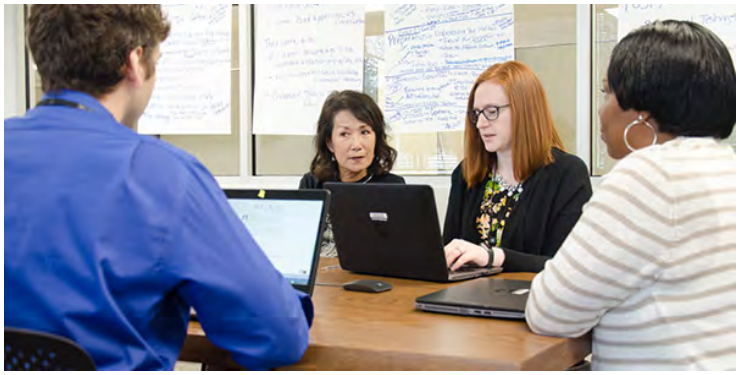
Level Two training, developed by OSF, will contain concise modules concerning how to navigate through OSF Continuing Care, CHW digital workflows, and interacting with clients via digital platforms while supporting human connection between the client and individuals in their support system, the CHW, and clinicians at FQHCs rendering care.

Learners will have the opportunity to practice digital workflows and interactions with standardized patients (SPs) portraying clients in varied circumstances and with varying levels of comfort with technology. The focus of these interactions will include establishing and maintaining psychological safety with the client, connecting them with services they need and supporting human connection mediated through technology. An additional focus of Level Two training will be initiating and receiving warm client hand-offs between the CHW, the client, and other service providers.

e. Community Health Worker Training and Development: Level Three Training

Level Three training, also developed by OSF, represents an opportunity for existing CHWs with a demonstrated drive to serve, to be life-long learners, and to support clients in innovative ways by facilitating telehealth and telemedicine visits in the home while also supporting human connection.

Barriers to routine, high-quality medical care are numerous for individuals served by Federally Qualified Health Centers. These include transportation, the digital divide, complex appointment scheduling processes, low health literacy, and more. CHWs who have completed Level Three training will be equipped to address each of these. Level Three CHWs will learn how to



operate and trouble-shoot digital communications packages installed in vehicles that will provide high-speed connectivity at the client's residence. They will also bring with them a computer from which to host a telehealth visit by a primary care provider or specialist domiciled at a FQHC, along with digitally connected tools such as thermometers, pulse oximeters, blood pressure cuffs, stethoscopes, otoscopes and ophthalmoscopes that can transmit video, audio and other signals back to the provider. Level Three CHWs will be trained to place these instruments on a patient under a clinician's direction to obtain key elements of a physical exam, to diagnose and resolve connectivity issues, and to support the human interaction between the client, individuals in their support system, the CHW and clinicians rendering care. These CHWs will also play a key role in scheduling and facilitating client appointments inside and outside of the home, as well as facilitating connection to other services the client may need.

In addition, the Level Three program will be responsible for developing continuing education programming for CHWs. It will focus on the support of individuals and communities with specific disease processes such as diabetes, congestive heart failure and depression. More specific details of the program can be found in Appendix 1.

Data gathered during this work are critical for understanding what programs are successful or where we need to pivot to better meet the needs of the community. The newly formed steering

team will be the responsible party to review metrics, understand barriers to achievement, and celebrate successes. Together, we will review metrics and hold one another accountable to achieving the aims and goals that were set forth from the beginning

Care Integration and Coordination

Improving the integration, effectivity, and coordination of care across various care sites and among levels of care is core to successful transformation. Lack of continuity and coordination is well documented in literature as a factor leading to suboptimal outcomes and risk for harm due to communication gaps. This risk is escalated further in patients with chronic diseases and social determinants of health that impact their adherence to treatment regimens. As an integrated health care system, OSF has the ability to use the power of the electronic medical record and centralized digital health center to provide a platform to coordinate the care among multiple clinicians inside and outside of our health care system. In addition, OSF provides a vast array of specialist, primary care, home health, and digital programs that can be connected to provide coordinated care to the patient. Other considerations include care management, behavioral health navigation, and management of social determinants of health. With the integration of the electronic medical record (EPIC) within Chestnut and Eagle View FQHCs, this allows for even better collaboration, data sharing, and coordination of care among providers that otherwise is fractured.

Success within transformation resides with collaboration as well. As OSF developed our clinical programming to align to the HFS Pillars, we worked with our FQHC partners to determine the programs that would best fill a void, augment their existing services, or offer expanded access to their patients through digital connections. Together we are seeking to impact the morbidity and mortality within the community. Historically, health care has been designed around health care providers, institutions, and diseases. To make a true change in health care, the focus must be the design of services around patients, with the patient. The vision and design of this collaboration has been completed from the ground up including the voice of patients from marginalized communities, feedback from FQHC partners who work within the communities, and community partners.

Each participating entity can bring strengths and resources together that can affect the coordination of care.

Access to Care

OSF continues to be a leader in serving the Medicaid Population in the State of Illinois. Understanding that access to care is a core component of the health of an individual and the community, OSF has made strong, dedicated efforts to build upon traditional access points. Having adequate access can come in many forms including FQHCs, physical locations of care whether mobile or local bricks and mortar, and virtual care. Bringing together people, processes, and technology to better serve these communities is a key attribute of this partnership. In addition, utilizing the scarce provider resources across a wider geography is another benefit of digital solutions that can be implemented. Within this proposal, there is preventative care, primary care, and specialty care that can enhanced and driven back to the medical home of the FQHC or primary care practice. For example, UI Mile Square FQHC will be enhancing access to care with a physical footprint within the Auburn Gresham area. Eagle View and Chestnut Health FQHCs will be utilizing mobile services to reach further into their communities. Chestnut and Eagle View plan to expand dental services will greatly impact access to care for dental services which are often a significant barrier for the Medicaid population. Lastly, Heartland Health FQHC is focusing on providing greater access to care for the homeless population to ensure they belong to a medical home. Again, the utilization of a shared electronic medical record can have a great impact on access and coordination.

Social Determinants of Health

OSF HealthCare has been engaging in collection and connection of social determinants of health (SDOH) information to connect the clinical expertise with the community expertise. During the pandemic response when an individual was enrolled in the PHW program they were asked if they would like to receive a well-being questionnaire to connect with additional support resources for no additional cost. If consent was given, they could receive the questionnaire in their

appropriate language by text, email, or via a phone call according to their preference. The questionnaire covered the following social determinants categories:

Social integration

Safety/Domestic violence

Education

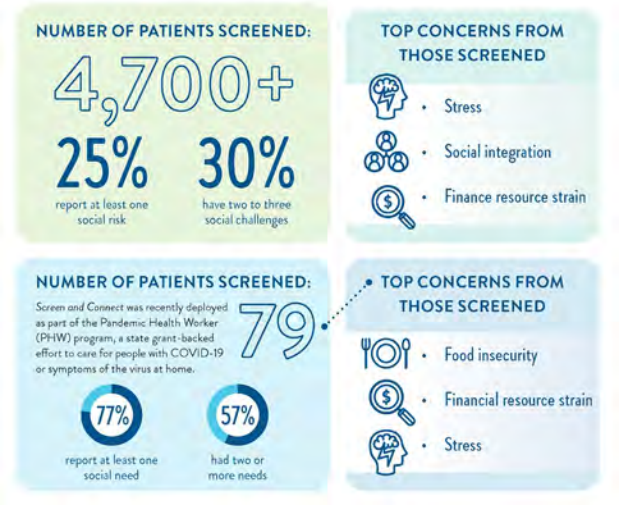
Financial Resource Strain

Food Insecurity

Transportation Needs

Housing Needs

Stress



Following questionnaire completion, the submitted answers were then processed by the Pieces/Connect software platform that generates recommended community based organizational (CBO) resources based on the client's location and needs. Digital health workers then reached out to the patient after they had completed the survey to provide them with the CBO(s) information based on their needs. CBOs were also notified via email that a patient has been identified that may need their support. Ongoing work with Pieces/Connect software and the CBOs is being completed to streamline the process and "close the loop" on the referral process to better facilitate the connection between the patient and the CBO for future interactions.

Case Study: OSF SDoH Screen and Connect

Similar work has been undertaken with OSF Screen and Connect. The Screen & Connect program was initiated in 2019 to screen OSF patients (Those We Serve) to identify SDoH needs as the 5th vital sign to allow our OSF employees to provide individualized, whole-person care. Because the staffing composition of physician practices across OSF varies, work was done with the

frontline employees to develop different workflows to allow each practice to select which workflow would be best for their particular compliment of employees and to ensure the process was most effectively supported. Through this initiative, patients age 18+ are screened by answering a series of 12 questions. Questions are based on the evidence-based PRAPARE Model for FQHCs and include topics such as social integration, safety and domestic violence, financial resource strain, food insecurity, transportation needs, housing needs and stress. Recognizing the extremely sensitive nature of these questions, prior to implementation of the Screen & Connect process, employees participate in soft skills training which includes simulation of various scenarios they may encounter.

Based upon patient responses, a cascade of up to 26 questions may be asked to provide additional patient-specific insights at the individual level to allow more targeted intervention. In addition to the SDoH questions, a specific question is asked to attempt to gain understanding and mitigate concerns when patients decline assistance/resources.

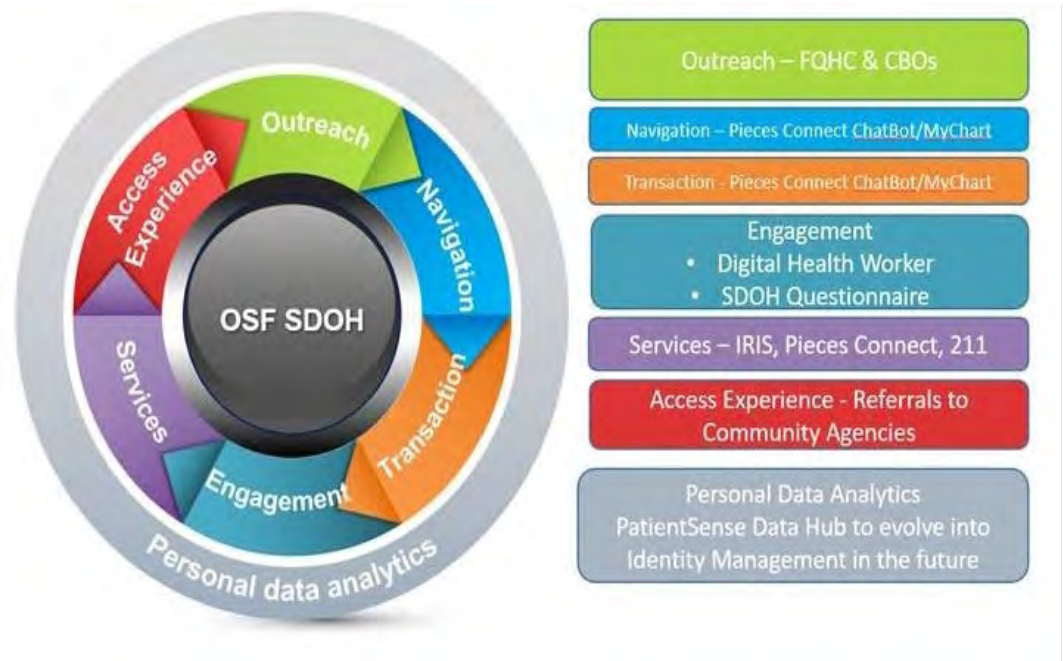
Once the screening is completed and SDoH domains of need are understood, the Connect process allows employees to connect patients to internal (OSF services, care management and/or behavioral health) and external (community based organizations) resources. When providing resources, employees can narrow the search for CBOs to a selected area within a 5-mile radius so these services are most geographically accessible. The information about these resources is provided to the patients on their printed after visit summary and, if the patient agrees, OSF care managers also assist with making the needed referrals to the CBOs. If a referral to care management is declined but resources are accepted, if the patient is agreeable, the nurse at the practice completes a follow up call to check on the patient's status and set goals.

A visual wheel displaying red (needs identified) or green (no needs identified) based upon the SDoH risk domain result is populated into the patient record and available for quick, easy reference at future visits. The Screen & Connect program is currently

being used in the majority of ambulatory Family Practice/Internal Medicine OSF Multispecialty Services practices and two Community Resource Centers with plans to continue spread to other sites across the care continuum. To date, over 40,000 OSF patients have been screened. This is activie demonstration of personal outreach and solution building to our diverse populations across more than 500 zip codes in Illinois.

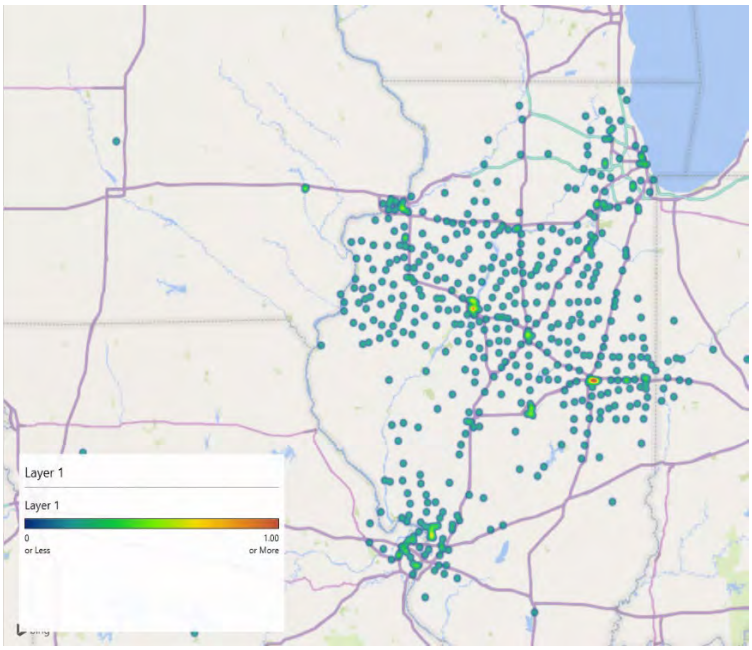
The OSF SDoH EcoSystem allows engagement through CHWs or through questionnaires to allow for understanding of needs. Navigation and outreach is accomplished with the use of technology, analytics, and collaboration with the FQHCs and community based organizations (Exhibit 16).

Exhibit 16: The OSF SDoH EcoSystem model, subcomponents to be managed with personal data analytics



The following heat map (Exhibit 17) illustrates the depth and breadth of SDoH data gathered through Screen and Connect to date and illustrates 40,000 surveys completed by unique patients over the past year.

Exhibit 17: Heat map from Screen and Connect across OSF HealthCare service regions



Our aim with the strategies outlined in this proposal mitigate the negative impact of social determinants of health. Racial and ethnic compositions are geographically sensitive. Rural environments have relatively fewer African-American, Latino and Asian populations. Food security and transportation issues are common despite locations, however, solutions in rural environments will not solve for urban constraints and vice versa. The common thread to mitigate the unintended adverse impact is leveraging data at the zip code and census track level to reveal best fit for solutions of interest. OSF HealthCare has (outside of this proposal) invested in SocialScape, a solution with patient-level data for our managed Medicaid enrollment to better determine social needs in a targeted manner. An overview of Socially Determined can be found in Appendix 2.

Depicted in this example pictorial (Exhibit 18) is patient level information. Social vulnerability is depicted by income and by zip code, revealing high rates of vulnerability in our 61605 and 61604 zip codes generally.

Exhibit 18: Social Vulnerability Example

Exhibit 19 shows the same sample of patient level data with a focus on housing instability within these same neighborhoods, revealing the other related key social determinants among these zip codes. This powerful patient-level tool will allow the collaborative to custom tailor outreach programs of service to these zip codes. Of note, the households in 61605 and 61604 zip codes are primarily 85% percent African American and 15% White.

Exhibit 19: Housing Instability Example

In summary, these tools will allow our team of collaborators to tailor their interventions with precision guidance, to hire and deploy culturally, racially and ethnically sensitive and representative health workers and have the outputs of this work avoid the pitfalls of "one size/one solution fits all" approach. The uniqueness of the model using technology and hands on care achieving size, scale, and geographic diversity can be extremely transformational.

Budget

The Medicaid Innovation Collaborative is requesting a total of $137.4 million over five years in order to implement and maintain the proposed programs discussed. Members of the collaborative will maintain responsibility for their financial resources and reporting. See attachments for budget detail.

Milestones

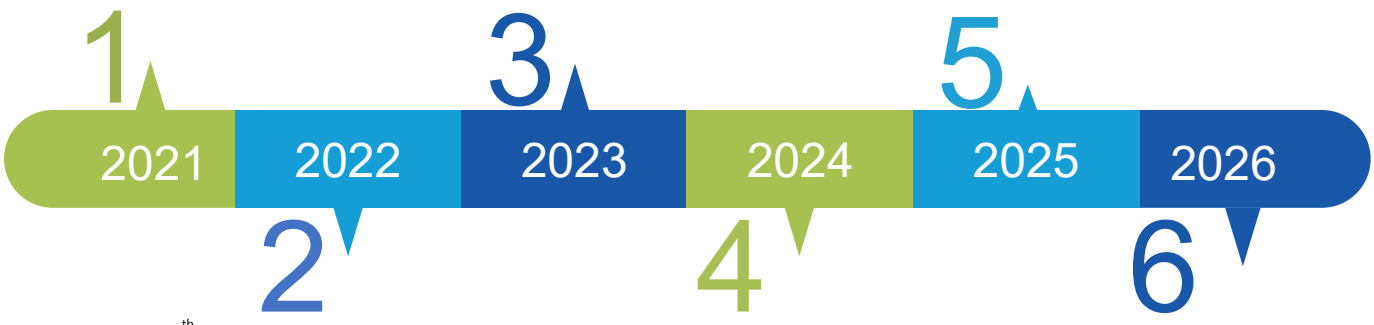
This section provides an outline of the calendar of milestones by fiscal year to show progress from the time of funding awarded through fiscal year five. Bulleted items include initiation of construction projects, IT planning, IT purchase, IT implementation strategies, and operationalization of new programs, data collection, and evaluation strategies from the start of the collaborative through the five years of funding.

Medicaid Innovation Collaborative Proposed Milestones

- Create steering committee
- Collaborate with FQHC partners to develop detailed operational and technology workflows for digital programs
- Communication and orientation to program including measurable goals
- Begin patient enrollment in established OnCall programs
- Begin build of mobile technology vans
- EPIC design (Chestnut and Eagle View FQs)
- Community outreach concerning CHW opportunities (Chestnut, Eagle View, Aunt Martha's, Heartland FQs)
- Bring together research team to begin data collection process and procedure

- Stand up Food Pharmacy (Chestnut FQ)
- Deploy digitally enabled Community Health Workers to site-specific locations
- Grow FQ Visits by 5%
- Reduce dental ED visits for Medicaid patients by 5% (Chestnut and Eagle View)
- Increase enrollment for OnCall programs with proven outcomes (OSF HealthCare, Chestnut, Eagle View, Heartland, and Miles Square FQs) by 10%
- Enhance programs based on patient and community partner feedback
- Expand CHW training and APP Fellow Cohorts
- Launch digital outreach for colonoscopy

- Increase CHW interactions with Medicaid patients over 2024 numbers by 5%
- Grow FQ visits by 5%
- Evaluate future needs for SDoH resources
- Enhance programs based on patient and community partner feedback
- Increase enrollment for OnCall programs with proven outcomes (OSF HealthCare, Chestnut, Eagleview, Heartland, and Miles Square FQs) by 10%
- Increase digital outreach for cervical cancer screening
- Utilize predictive modeling for targeted populations
- Expand CHW training and APP Fellow Cohorts



- Begin build out of 4th floor OSF OnCall building
- Begin Construction of Auburn Gresham Clinic (Miles Square FQ)
- Recruit, hire and train staff for Auburn Gresham clinic expansion (Miles Square FQ)
- Recruit, hire, train and deploy Emergency Department Navigator (Miles Square FQ)
- Recruit and hire first cohort of CHWs
- Recruit clinical team for OSF HealthCare OnCall services
- Purchase and install dental equipment for 4 Operatories (Chestnut FQ)
- Purchase and install dental equipment for Eagle View
- Bring online mobile technology vans for CHWs (Eagle View, Aunt Martha's and Chestnut FQs)
- Deploy digitally enabled Community Health Workers to site-specific locations (Heartland, Aunt Martha's, Eagle View, and Chestnut FQs)
- Train 1st Cohort of CHWs
- Expand technology platform
- Interview and Admit 1st Cohort of APP Medicaid Transformation Fellows
- Launch digital outreach for mammography screening
- EPIC purchase and build out (Chestnut and Eagle View FQ)

- Increase CHW interactions with Medicaid patients over 2023 numbers by 5%
- Grow FQ visits by 5%
- Evaluate future needs for SDoH resources
- Increase enrollment for OnCall programs with proven outcomes (OSF HealthCare, Chestnut, Eagle View, Heartland, and Miles Square FQs) by 10%
- Launch digital outreach for cervical cancer screening
- Utilize predictive modeling for targeted populations
- Enhance programs based on patient and community partner feedback
- Continue CHW training and APP Fellow Cohorts

- Increase CHW interactions with Medicaid patients over 2025 numbers by 5%
- Grow FQ visits by 5%
- Evaluate future needs for SDoH resources
- Enhance programs based on patient and community partner feedback
- Increase enrollment for OnCall programs with proven outcomes (OSF HealthCare, Chestnut, Eagle View, Heartland, and Miles Square FQs) by 10%
- Increase digital outreach for cancer screening
- Utilize predictive modeling for targeted populations
- Expand CHW training and APP Fellow Cohorts
- Enact sustainability plan
- Publish research findings

Minority Participation

In 2020, as part of the second phase of the PHW contract with the Illinois Department of Healthcare and Family Services (HFS), OSF HealthCare System pursued and successfully deployed subcontracts with three Business Enterprise Program (BEP) businesses. The subcontractors successfully completed enhancements to the PHW program as of March 31, 2021.

These businesses within the Peoria service area and Chicago Metro Regions are within the state's Business Enterprise Program. These three businesses advanced our various agendas for population health management, and in particular advanced the development of the OSF Community Connect (OCC) software. Our data scientist, Roopa Foulger led the organization of the three vendors to successfully deploy the platform. This software is currently in use for the fulfillment of services by and for the PHW program and is now extended to support ongoing work with Digital Heath Workers (DHWs).

Our vision for next steps is to build out this important tool today with line of sight to the future deployment of the integrated system of FQHC-based CHWs working with OSF HealthCare's DHWs across many diagnoses and conditions outlined in the proposal. This is a strategic investment for future digital health deployment and for population health.

Three major, future-facing initiatives are to be funded within this Medicaid Innovation Collaborative proposal. All three BEP vendors will work as they have in the past with interconnected skillsets. Building upon the existing framework for simple screening and fulfillment, our team will extend the work to integrate FQHC workflows and systems into the OCC platform so that all members of our collaborative have access to timely and accurate data about quality efficiency and completion of duties related to Medicaid patients.

Initiative 1: Integrate FQHC workflows and data collection to and from CHWs and DHWs as they work with patients within their respective catchments. In particular, the opening and closure of needs identified within social and structural determinants of health and fulfillment by CHWs and CBOs. This work will include feedback from collaborators and patients served across the specified regions.

Initiative 2: Incorporate additional machine learning and predictive analytics tools into operational workflows to guide collaboration members to the efficient service of patients. The technology will include predictive tools to identify patients falling off the curve for the conditions listed within the pillars of service in this proposal.

Initiative 3: Near Real-time Racial and Equity Impact Assessments will appear as a dashboard, leveraging multi-modal feedback from our patients in regards to the services provided within the collaborative. Included in this initiative are not only traditional survey data methods, but also we are leveraging expanded scale through texting-based and automated opinion and data gathering initiatives. These data will create remarkable efficiency in addressing the ongoing HFS Racial and Equity Impact Assessments.

A strong partner in developing culturally diverse training is Illinois Central College (ICC). ICC has a long history of supporting workforce development in the state. The college began a Workforce Equity Initiative to support Central Illinois's workforce by providing the opportunity to earn a credential and a living wage. It addresses high demand careers and targets low-income individuals, those living in high crime and high poverty areas, unemployed individuals and minorities.

As an example of ICC's leadership in workforce development, the college was selected in 2019 to lead an $18.7 million workforce initiative for the state. ICC received $1.8 million and partnered with 14 other community colleges across Illinois, while ensuring that at least sixty percent

of the population served by that award is African American. That same year, the college built a state-of-the-art workforce development center through federal grants and state and local matching funds. The organization will maintain this leadership position as it works with OSF to develop the first Community Health Worker (CHW) training program in the region.

Successful CHWs should be trusted members of the community or have an unusually deep understanding of the area they serve. Learners in Community Health Worker training programs are often recruited from the same underrepresented and underserved areas they will return to as working CHWs, thus serving as trusted agents as well as known examples of successful integration into the workforce. The ICC-OSF collaboration in developing a CHW program will help this vision come full circle.

As the third-largest community college system in the country and the leading public workforce development trainer in the state, Illinois Community College serves over 600,000 residents each year in credit, noncredit and continuing education courses. Together, the collaborative and ICC will make an important new contribution to workforce development.

Jobs

Creating a future workforce to serve the underserved areas within our communities is important for sustainability. Through this Medicaid Innovation Collaborative, 170 new jobs can be created. The training and development plan creates a pathway for entry-level individuals to continue to grow in their knowledge and skill. The training provides the confidence and competence for them to achieve long-term careers within health care or other service areas to support their communities. In addition, clinical jobs will be created to serve the clinical services functions across a wider geography. Working with local schools, colleges, and community resources will be critical to engage the young Black and Latino students into cooperative programs, internships, and interest in longer term training opportunities to secure their future. We

understand the importance of creating a culture of equity and diversity to support the communities we serve and will make dedicated efforts to increase diversity within our workforces in partnership with the FQHCs. Through the pandemic work, 40% of the pandemic health workers hired by OSF HealthCare were from a diverse background.

Sustainability

The FQHCs have the ability to provide access to care and decrease ED utilization rates with a strong clinical partner to support more robust scalable digital solutions. This can lead to increased revenue for the FQHC and optimization of the ED services within OSF leading to patients being seen at the right venue of care. For example, 29% of patients from the Mile square area utilize the emergency department at Little Company of Mary, which could be deferred to an appropriate level of care. In addition, this can greatly impact the quality of care delivered. The State of Illinois also benefits by having a healthier Medicaid population, increased number of jobs, innovative ways to provide care, and healthier pregnant women and newborn babies.

OSF HealthCare is dedicated to serving our communities long term which includes building sustainable models of care. As we develop new physical and digital spaces to serve a larger portion of the population in a more efficient and scalable manner, we will optimize the health care models and deliver higher quality care. As we stretch the programs over a larger population and influence care and outcomes, we will reduce emergency room visits by being more proactive and responsive to needed care driving the patient to their medical home. From the standpoint of training, the education and training costs are a self-fulfilling economic benefit to our communities by training wage earning and taxable employment models. In addition, this type of training can be a framework for more workers to enter into healthcare occupations including but not limited to nursing, medicine, pharmacy, and therapy services. Lastly, we have a

proven record of accomplishment for judicious use of state funding. Our dedicated plan and strategy for use of Medicaid Transformation funding as described in this proposal can make a difference for underserved and those experiencing poverty in Illinois.

Over the next five years, there will be continual dialogue and evaluation of how the programs are meeting the metrics designed as well as providing the support to underserved individuals and communities. There will be adequate time to pivot if needed, and further evaluation to ensure sustainability for over the long term and future.

FQHCs are compensated for each visit and service that they provide. Our collaborative serves to extend their and OSF's high quality services to increase access to patients and to do so on a platform leveraging innovative tools for efficiency and service monitoring. From the perspective of the collaboration as a whole, the increase throughput of service by FQHCs for Medicaid populations serves to reduce the long term costs attributable to chronic disease management and behavioral health by reducing proportionally the utilization of high cost services such as emergency room visits or inpatient hospitalizations. Also, as the availability of specialist remains at a premium cost, the use of telehealth to provide high quality access at scale makes the provision of specialty care more affordable for the entire collaborative.

Governance Structure

In the spirit of collaboration among the OSF HealthCare and FQHC teams, a newly formed steering committee will be created as the responsible group to monitor and enforce to the policies, ensure timelines are met, collaboration is being achieved, and high quality patient care is being delivered in a fiscally responsible manner. This group will be core to the quality improvement structure to ensure outcome metrics are being met or action plans will be put in place for improvements. The participants of the committee will include members of the associated organizations as well as other participants.

Members include:

Michelle Conger, OSF Chief Strategy Officer/CEO OSF OnCall Digital Health,

Dr. Mike Cruz, OSF Chief Operating Officer, OSF HealthCare

Dr. Karriem S. Watson, UI Mile Health Square Center, FQHC

Edward Murphy, Eagle View Community Health System, FQHC

Matt Mollenhauer, Chestnut Health System, FQHC

Sharon Adams, Heartland Community Health Clinic, FQHC

Kenny Martin-Ocasio, Aunt Martha's Health Center, FQHC

Community Member, (open slot) to be filled by a member of the community that is actively enrolled in Medicaid.

Regular meetings will be held to ensure that the work of each collaborator is coordinated to conduct operational and reporting responsibilities associated with the collaborative. At OSF HealthCare, Michelle Conger will serve as the executive leader, overseeing all the facets of the program and ensuring that the proposed aims are met and completed within the proposed timeline. Each site will have an assigned lead coordinator to ensure meetings occur, stakeholders are notified, and the appropriate parties are given input into decision-making.

Conclusion

We are asking for 137.4M to build out a centralized telehealth clinical team of resources with decentralized boots on the ground locations and workforce to care for the Medicaid population. If funded, the Medicaid Innovation Collaborative will improve access, improve quality, and address the unmet health needs of Medicaid residents throughout OSF HealthCare's primary and secondary service areas as well as the communities of the FQHCs. Our efforts will focus on addressing health disparities among marginalized populations, utilizing the knowledge gained as the creator of the State's Pandemic Health Worker program. We will deploy innovative strategies proven during the COVID-19 pandemic as well new concepts and partnerships that will allow us to better reach, communicate, and serve our Medicaid population. We will also place a significant emphasis on creating employment opportunities for communities of color to assure a workforce that is reflective of the population we are serving. This collaborative represents our commitment to

engagement and our desire to serve those most vulnerable in our communities in new equitable, innovative, and sustainable ways.

Brown, K., Poppe, A., Kaminetzky, C., Wipf, J., & Woods, N. (2015). Recommendations for nurse practitioner residency programs. *Nurse Educator, 40*(3) 148-151. https://doi.org/10.1097/NNE.0000000000000117

Conduent Healthy Communities Institute, Illinois Hospital Association. (2019). Website unavailable to the public. Illinois Hospital Association. 2015 - 2017. http://www.team-iha.org/.

Institute of Medicine of the National Academies (IOM). (2003). *Unequal treatment: Confronting racial and ethnic Disparities in health care.* Washington, D.C.: The National Academies Press. Available at https://cdn.ymaws.com/www.aptrweb.org/resource/collection/0B76BF46-69A2-4560-BF7C-98682BBA60C1/Unequal%20Treatment_IOM%20Report.pdf

Dalstrom, M., Weinzimmer, L. G., Foulger, R., & Klein, C. J. (2021). Medicaid expansion and accessibility to healthcare: The Illinois experience. *Public Health Nursing*. Advance online publication. https://doi.org/10.1111/phn.12899. PMID: 33778982

Klein, C. J., Dalstrom, M. D., Foulger, R., & Weinzimmer, L. G. (2021). Auto-assignment of providers in Medicaid Managed Care and factors influencing seasonal flu vaccine uptake: a retrospective analysis. *Journal of Pharmaceutical Health Services Research*. https://doi.org/10.1093/jphsr/rmab012

McLean County Community Health Council. (2019). McLean County Community Health Needs Assessment. Available at: https://health.mcleancountyil.gov/112/Community-Health-Needs-Assessment-Health

Mental Health America. (2021). *The state of mental health in America*. Available at: https://www.mhanational.org/research-reports/2021-state-mental-health-america

Morgan, P., Sanchez, M., Anglin, L., Rana, R., Butterfield, R., & Everett, C. M. (2020). Emerging practices in onboarding programs for PAs and NPs. *Journal of the American Academy of Physician Assistants*, *33*(3), 40-46. https://doi.org/10.1097/ 01.JAA.0000654016.94204.2e

National Center for Education Statistics. (2003). *The health literacy of America's adults: Results from the 2003, national assessment of adult literacy.* Available at: https://nces.ed.gov/pubs2006/2006483.pdf

Nicely, K. & Fairman, J. (2015). Postgraduate nurse practitioner residency programs: Supporting transition to practice. *Academic Medicine, 90*(6), 707-709. https://doi.org/10.1097/ACM.0000000000000567

Okeke, N., Schmidt, C., Alborn, S., & Kumian, E. (2021). Implementing value-based primary care delivery in federally qualified health centers. *Population Health Management*, *24*(1), 78-85. https://doi.org/10.1089/pop.2019.0221

Poghosyan, L., Liu, J., Shang, J., & D'Aunno, T. (2017). Practice environments and job satisfaction and turnover intentions of nurse practitioners: Implications for primary care workforce capacity. *Health Care Management Review, 42*(2), 162-171. https://doi.org/10.1097/HMR.0000000000000094

PRAPARE. (2019). Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences. Available at: https://www.nachc.org/research-and-data/prapare/

Weinzimmer, L.J., Dalstrom, M., Klein, C. J., Foulger, R., & Stewart de Ramirez, S. (In press). The relationship between access to mental health counseling and interest in rural telehealth. *Journal of Rural Mental Health*.

Appendix 1:

Community Health Worker (CHW) Programs Summary Table

	Level One Program	Level Two Program	Level Three Program
Educational Goals	Demonstrate 10 to 12 core competencies defined for CHWs by certifying bodies. Competencies are TBD through a cross-walk of other states' CHW certification exam blueprints, key textbooks, and core competencies lists from MA and WA. Level 1 completion will be prepared to undertake self-guided learning. Specific areas include support of clients with specific conditions such as diabetes, depression, and obesity.	Demonstrate competency in the use of sophisticated software platforms in use at FQHCs to provide precision-guided care in a digital environment while actively supporting human connection and connecting clients with services they need.	Demonstrate competency in use of sophisticated digital tools such as blue-tooth enabled stethoscopes and other digital tools that allow clinicians to perform key portions of a physical exam during a telemedicine visit. Effectively facilitate interactions between the client, their support system, the CHW and clinical staff and providers conducting visits. CHW 3's will demonstrate continued competence in executing duties of Level 1 and 2 health workers.
Program Length and Learning Modalities	Twelve weeks includes didactic content, discussion groups, service learning, and simulations with trained standardized participants.	Five days to include didactic content, simulations, discussions, and service learning. See Content Delivery for details.	Eight weeks to include didactic content, simulations, discussions, and service learning. See Content Delivery for details.

Cohort Size and Progression	Total of 100. The first 10 begin the program X weeks after award. The next 40 begin three weeks after first. The final 50 begin the program 12 weeks after the first. Each cohort will be further divided into groups of 5 for discussion and simulations.	Total of 100. First 10 begin Level 2 training after 4 weeks in the field. The next 40 begin one week after the first Level 2 cohort. Final 50 begin Level 2 training 1 week after the first cohort of 40 is completed. Each cohort will be further divided into groups of 5 for discussion and simulations.	Total of 50. 50 CHWs. To begin four weeks after conclusion of Level Two training. 8 weeks with first 10 beginning; first 20 to begin two weeks later and final 20 begin 2 weeks after first 20 launches. Each cohort will be further divided into groups of 5 for discussion and simulations.

Appendix 2:

Socially Determined Overview: SDOH Risk Analytics & Subject Matter Expertise

Socially Determined developed the health care industry's first purpose-built analytic platform to assess and address the impact of Social Determinants of Health (SDOH) – at scale. Our Platform, SocialScape® enables our clients to understand the impact that SDOH and social risk factors have on their business and community and empowers our partners to leverage these insights to develop and implement effective strategies to mitigate them. In addition to our platform and tools, we have built a multi-disciplinary team of subject matter experts who collaborate closely with our clients, translating our risk insights into actionable strategies that enhance business performance and drive meaningful community impact.

SocialScape manages massive data fusion and analytics of social risk factors and correlates social risk to key performance measures and outcome patterns for individuals, groups, and communities. We have built the deepest and most complete data pipeline of social risk-related data.

Socially Determined believes that a true understanding of SDOH requires us to look at both the individual as well as the context of the community where they live, work, pray, and play. Therefore, we have developed our approach focusing on both individual risk metrics and community risk metrics. We believe that by understanding both together, we can help our customers see a more complete picture of social risk.

The SocialScape platform includes an industry-leading national repository of community-level SDOH risk exposure data, aggregated into multi-factor risk indices across six domains. A custom SocialScape instance has been provisioned for OSF users, enabling their internal teams to access on-demand geospatial visualizations of community SDOH risk exposure across Illinois. This includes dynamic visualizations of risk rendered at an extremely precise level (200- to 400-meters) for the following domains:

- **Economic Climate –** A community's financial resources and resiliency
- **Food Landscape –** A community's ability to access sufficient nutritious food
- **Housing Environment –** Stability and nature of home environments in a community
- **Transportation Network –** A community's access to affordable, reliable transportation
- **Health Literacy –** Community members' ability to navigate the health care system
- **COVID-19 Social Susceptibility –** Community exposure rates and risk of complications

The SocialScape platform also features dynamic access to data visualization tools ("widgets") that provide additional population-level contextual data (e.g., demographic breakdowns), as well as point data overlays for key community assets and resources (e.g., healthy and unhealthy food sources, schools, and pharmacies).

In addition to these standard features, all OSF Medicaid patients will be geocoded and plotted on a custom map layer within the platform to customized geospatial analyses of the distribution of community risk and resources, specifically in the context of OSF's patients and their communities.

Patient Risk Baseline: Individual-Level Social Needs

Using only a roster of Medicaid beneficiaries that contains key identifiers, Socially Determined has generated individual-level social risk factor scores for each OSF Medicaid beneficiary for the following domains:

- **Financial Strain –** An individual's financial resources and resiliency
- **Food Insecurity –** An individual's ability to procure and prepare sufficient healthy food
- **Housing Instability –** The stability and nature of an individual's home environment
- **Transportation Barriers –** An individual's access to affordable, reliable transportation
- **Health Literacy Challenges –** An individual's ability to navigate the health care system

The above social risk factor scores, as well as other relevant features and contextual data will be utilized by the OSF team to support detailed population and member analysis. This data can be provided at the member level or aggregated to the geography (e.g. zip code, county, region), depending on the degree of detail desired by the OSF team.

All Medicaid patients will also be geocoded and plotted on a custom map layer within SocialScape to facilitate robust geospatial analyses of the distribution of patients relative to community risk, resources, and OSF facility locations.

About the Socially Determined and OSF Partnership

OSF recognizes that Social Determinants of Health (SDOH) and social risk factors have a direct impact on our patients' utilization, cost, outcomes and experience. Assessing and addressing those risks has been – and will continue to be – a key strategic priority. We are working with our partner, Socially Determined, to systematically assess and strategically mitigate those risks that result in structural and practical barriers to care and equitable outcomes, across the communities and patients we serve.

Working with our partner, Socially Determined, OSF looks at our patients and the social risk exposure based upon the resources, assets and attributes of every community where they live, work, and play to facilitate our comprehensive understanding of the impact of social determinants of health (SDOH) and individual patients' social risk on structural and practical barriers to care and equitable health outcomes.

This work is informed by Socially Determined's granular community-level risk indices and individual member-level risk scores that are generated across multiple domains, including the economics, food, housing, transportation, and health literacy. We have also added COVID-19 vulnerability and recovery to the metrics to account for immediate impacts related to the pandemic (community exposure rates, risk of complications) and the factors associated with patients' ability to recover from the health and economic impacts of COVID-19.

Socially Determined's models fuse relevant SDOH and social risk data gathered from a variety of public sources (federal, state, and local government open sources; other open sources; and commercial data) to generate analytic insights to inform OSF's strategy and decisions regarding addressing the socio-clinical needs of our patients and communities. Model inputs include:

- Demographic data including age, race and gender

- Community infrastructure and resources, such as options for healthy food and public transportation options
- Community-level social determinants of health such as education and income levels and average rent or mortgage costs
- Individual risk factors such as car ownership, family finances, and a history of liens, evictions, or bankruptcies

Population Health/SDOH/Health Equity:

Socially Determined's data-informed approach to assessing social risk at the community level enables OSF to understand the distribution, concentration, and impact of risk faced by our patients. Community-level SDOH risk exposure data is presented through an on-demand platform accessed by OSF to assess need and inform interventions by providing:

- geospatial visualizations of economic climate, food landscape, housing environment, transportation network, and community health literacy
- overlays for community assets (healthy and unhealthy foods, schools, pharmacies)
- OSF patients– stratified by individual risk - plotted on a map layer

Appendix 3:

City Tech Overview

CONTENTS


PROJECT
BACKGROUND AND
TESTING OVERVIEW
CityTech
CONFIDENTIAL | NOT FOR DISTRIBUTION
3

PROJECT BACKGROUND

Discovery Survey and Focused Conversations

Context

OSF is interested in better understanding the healthcare and wellness needs and challenges of the communities surrounding and users of OSF Healthcare Little Company of Mary Medical Center and its Services.

City Tech will recruit for, design, and execute one survey to get quick targeted resident feedback to better understand the health and wellness needs and challenges of these communities. To gain additional qualitative insights, City Tech will conduct focused surveys with select respondents.

Goals and Outcomes

Unmoderated online surveys coupled with focused conversations will help better understand community healthcare and wellness needs.

TEST PLAN

Recruitment and Eligibility

- Testers were recruited from the pool of CUTgroup members, with the option of sharing call with others
- Residents of 8 prioritized communities surrounding OSF Healthcare Little Company of Mary Medical Center (Ashburn, Auburn Gresham, Chicago Lawn, Englewood, Morgan Park, Washington Heights, West Englewood, West Lawn) OR those who have utilized its services at least once in the last 12 months.
- No digital skills requirement, but had to be able to complete an online survey and, if selected to have a focused discussion, participate on an audio call

Testing

- ***Survey - Profile Questions:*** Collect profile information
- ***Survey - General Healthcare Utilization:*** Understand tester's general healthcare usage, needs, and challenges
- ***Survey - OSF LCMMC Utilization:*** Understand tester's healthcare usage, needs, and challenge as related to OSF LCMMC
- ***Focused Conversations:*** Longer conversations with select testers to better understand responses and get additional qualitative data


EXECUTIVE SUMMARY
CityTech
CONFIDENTIAL | NOT FOR DISTRIBUTION
5

EXECUTIVE SUMMARY

Respondents were most satisfied with physician care and customer service, and wished for better appointment hours and easier hospital access

Profiles

- Eligible **respondents covered a variety of demographics**, though demographic segments often did not drive specific responses
- Due to eligibility requirements, **86% of qualified responses were from the prioritized LCMMC communities**. Those who were from other communities utilized LCMMC.

Healthcare Usage

- Overall, **respondents generally utilized healthcare most for their annual checkups, specialist visits, and prescriptions**. While respondents utilized LCMMC for those purposes, they also noted frequently using the services for emergencies.
- **People like a mix of in-person and virtual visits**, but most often preferred to in-person services. Many were open to virtual methods supplementing some of the in-person interactions.
- **COVID has affected people's healthcare utilization in all ways**: some reported using less healthcare while others reported using more. An important consideration for healthcare institutions is that **perceived inadequate COVID precautions may keep users from pursuing healthcare** at an institution.

LCMMC Utilization

- Most respondents were aware of LCMMC's services; **40% of respondents estimated that they utilized the hospital system for over 50% of their total care.**
- The most common reason for not utilizing LCMMC services was having an **established provider that was not affiliated with the hospital system**. Lack of insurance coverage was also often cited.

Strengths, Pain Points, Barriers

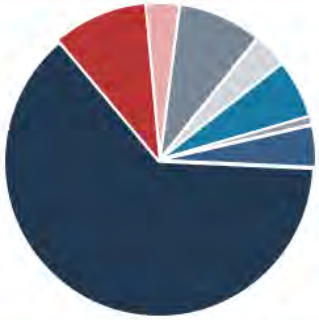
- For those using the system, respondents were **most satisfied with the physician care and customer service** they received at LCMMC.
- Paint points and barriers included **appointment scheduling, wait times, and insurance coverage**. People also mentioned that they **did not understand LCMMC's offerings, which kept them from utilizing the system**, and wished there was more outreach.
- The primary wishlist items that respondents wanted from any hospital system were **expanded appointment times outside of regular working hours to better accommodate their schedules** and **easier locations/adequate transportation options for better access**.

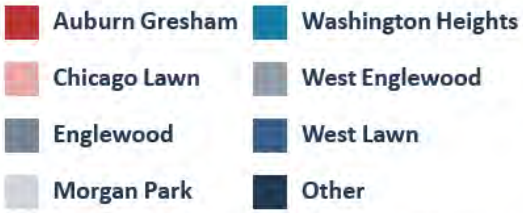

DISCOVERY SURVEY
DETAIL
CityTech
CONFIDENTIAL | NOT FOR DISTRIBUTION
7

RESPONDENT LOCATION

Many people living outside of the prioritized neighborhoods responded to the survey, but only 5 were eligible to continue

Full Data

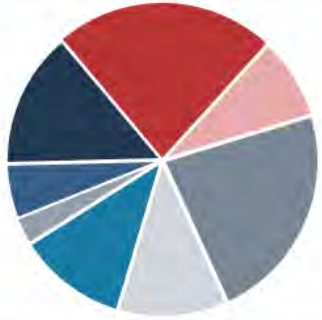




Ashburn was also a prioritized neighborhood, but we did not have any respondents from there

Neighborhood	Respondents
Auburn Gresham	11
Chicago Lawn	4
Englewood	10
Morgan Park	4
Washington Heights	7
West Englewood	1
West Lawn	5
Other	72
TOTAL	**114**

Qualified Responses Only



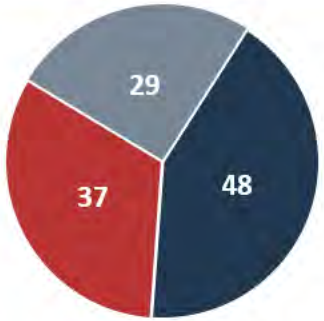
Neighborhood	Respondents
Auburn Gresham	8
Chicago Lawn	3
Englewood	8
Morgan Park	4
Washington Heights	4
West Englewood	1
West Lawn	2
Other	5
TOTAL	**35**

Full Data Respondent Pool: 114 responses from all who answered. Not all qualified to move forward as per the eligibility rules
Qualified Respondent Pool: 35 responses from those who were qualified to move forward as per the eligibility rules

OSF HEALTHCARE LITTLE COMPANY OF MARY MEDICAL CENTER UTILIZATION

LCMMC is being utilized outside of the surrounding neighborhoods and many who don't use it still have awareness of the center

Full Data



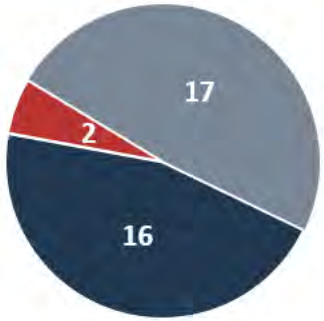
Yes

No, but aware of OSF LCMMC

No, and not aware of OSF LCMMC

	LCMMC Neighborhoods	Other Neighborhoods
Yes	19	10
No, but aware of OSF LCMMC	21	27
No, and not aware of OSF LCMMC	2	35
	42	**72**

Qualified Responses Only



	LCMMC Neighborhoods	Other Neighborhoods
Yes	12	5
No, but aware of OSF LCMMC	16	0
No, and not aware of OSF LCMMC	2	0
	30	**5**

Full Data Respondent Pool: 114 responses from all who answered. Not all qualified to move forward as per the eligibility rules
Qualified Respondent Pool: 35 responses from those who were qualified to move forward as per the eligibility rules
LCMMC Neighborhoods include the 8 prioritized neighborhoods surrounding Little Company of Mary Medical Center

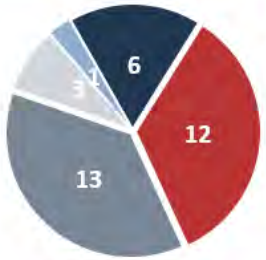
RESPONDENT DEMOGRAPHICS

Qualified respondents spanned a variety of demographics

Race

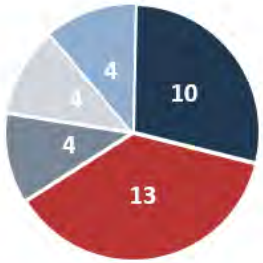
- Black or African American
- Hispanic, Latino, or Spanish Origin
- White
- Prefer Not To Disclose

Insurance Coverage



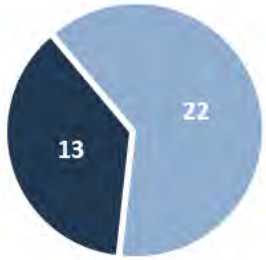
- Uninsured
- Self Paid
- Qualified for Federal Program
- Private Insurance
- Prefer Not To Disclose

Age



- 18-24
- 25-34
- 35-44
- 45-54
- 55-64

Sex at Birth

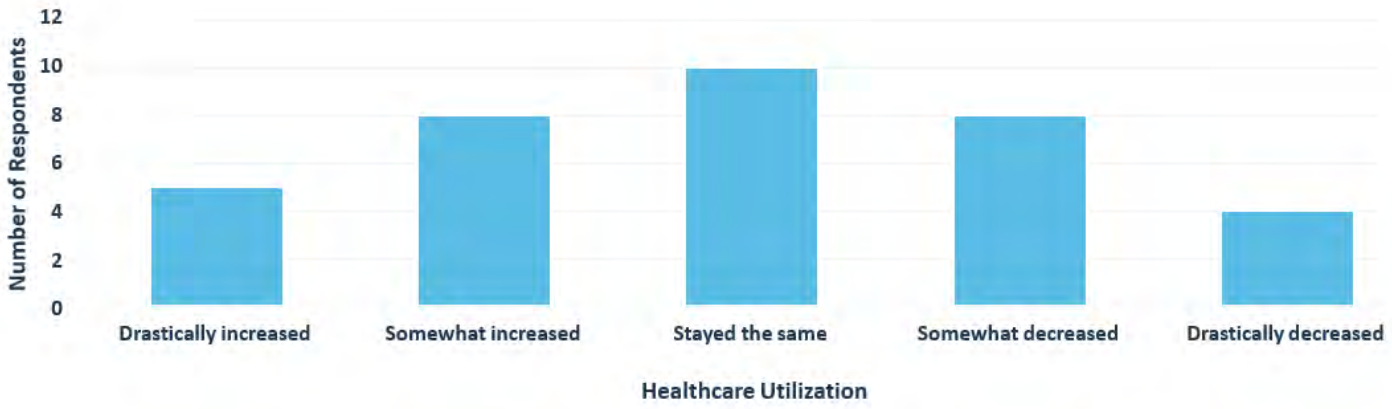


- Female
- Male

Respondent Pool: 35 responses from those who were qualified to move forward as per the eligibility rules

COVID-RELATED HEALTHCARE USAGE

Healthcare usage varied relative to pre-COVID usage



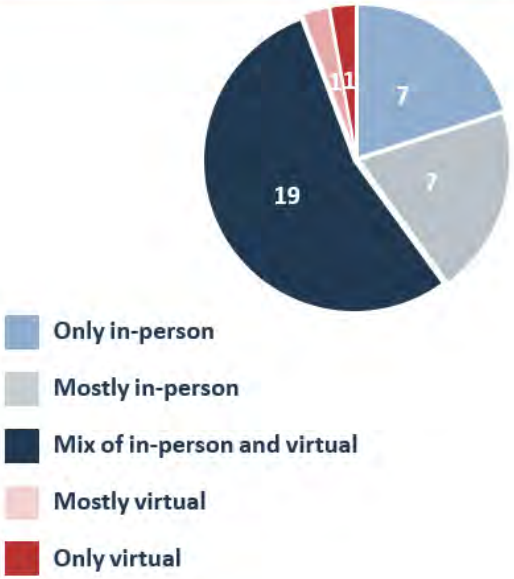
Many respondents noted that they were wary of attending locations that they perceived did not have adequate COVID precautions, either due to location's safety protocols or poor enforcement of others in the space

Respondent Pool: 35 respondents who were qualified to move forward as per the eligibility rules

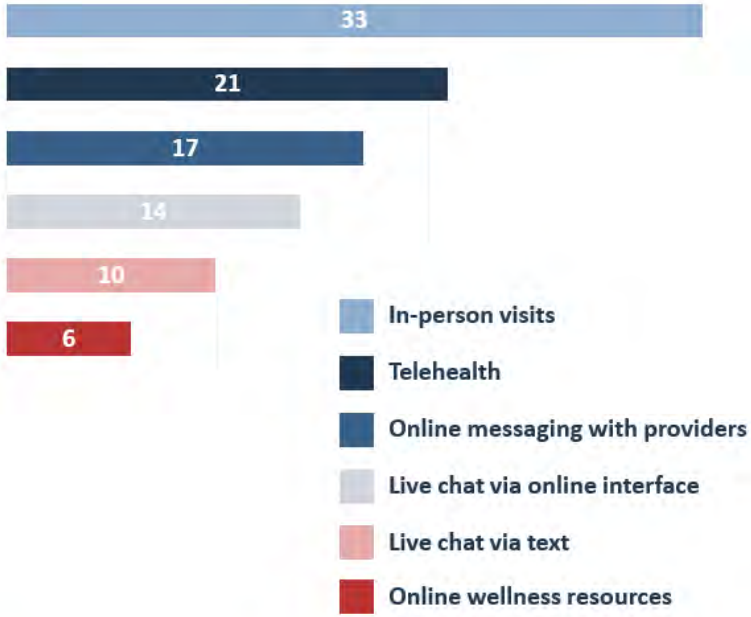
HEALTHCARE INTERACTION PREFERENCES

Most respondents wanted a mix of in-person and virtual resources

Would you prefer your healthcare and wellness interactions to be in person or online?



How would you best like to interact with your healthcare and wellness resources

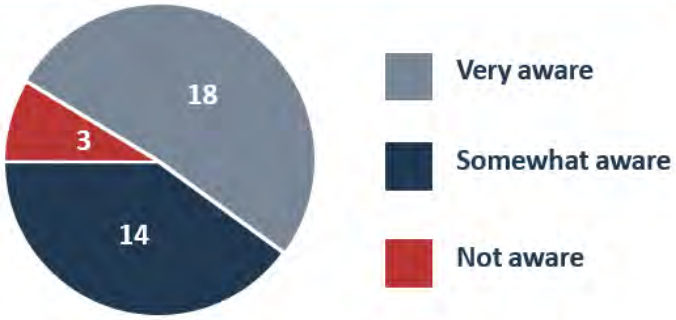


Respondent Pool: 35 responses from those who were qualified to move forward as per the eligibility rules

LITTLE COMPANY OF MARY MEDICAL CENTER AWARENESS AND UTILIZATION

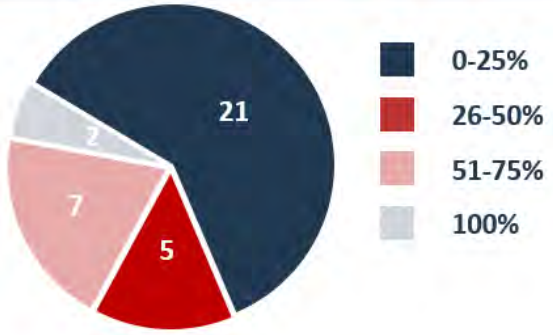
LCMMC is both known and being utilized outside of the immediately surrounding neighborhoods

LCMMC Awareness



	LCMMC Neighborhoods	Other Neighborhoods
Very aware	17	1
Somewhat aware	10	4
Not aware	3	0
	30	**5**

LCMMC Utilization as % of Total Healthcare



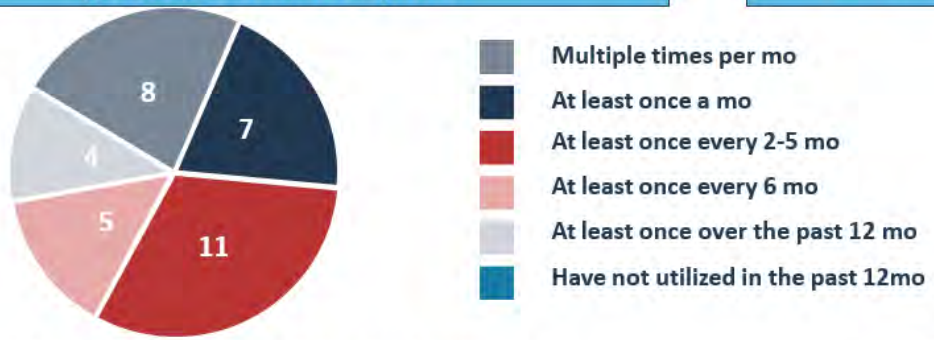
	LCMMC Neighborhoods	Other Neighborhoods
0-25%	21	0
26-50%	2	3
51-75%	6	1
100%	1	1
	30	**5**

Respondent Pool: 35 responses from those who were qualified to move forward as per the eligibility rules
LCMMC Neighborhoods include the 8 prioritized neighborhoods surrounding Little Company of Mary Medical Center

HEALTHCARE UTILIZATION: FREQUENCY

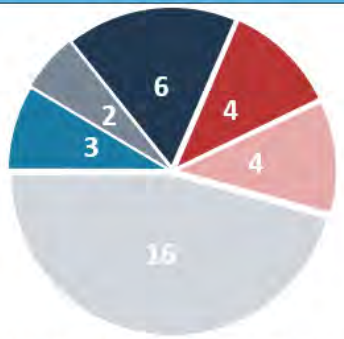
Most respondents have utilized LCMMC for a portion of their healthcare needs over the past 12 months

In the past 12 mo, how often have you used a healthcare system?



	LCMMC Neighborhoods	Other Neighborhoods
Multiple times per mo	6	2
At least once a mo	6	1
At least once every 2-5 mo	10	1
At least once every 6 mo	5	0
At least once over the past 12 mo	3	1
	30	**5**

In the past 12 months, how often have you utilized LCMMC and their related facilities for your healthcare needs?

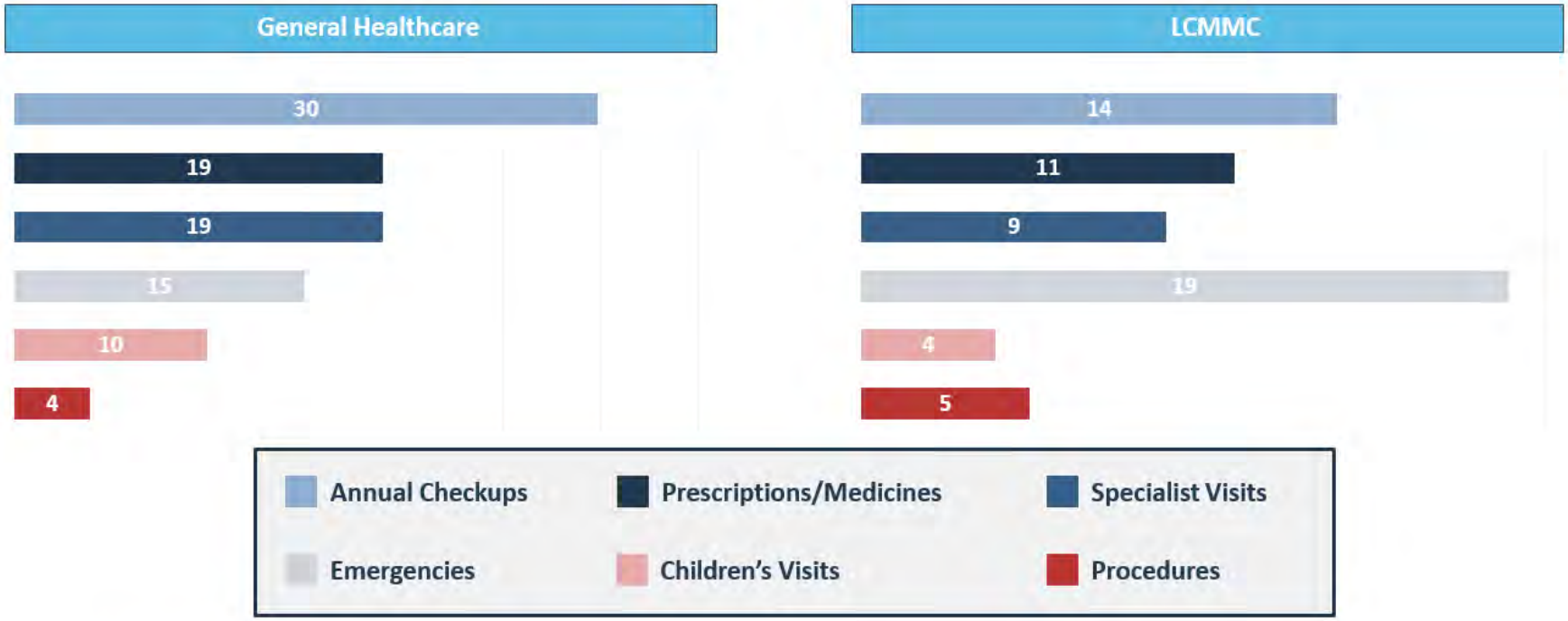


	LCMMC Neighborhoods	Other Neighborhoods
	1	1
	4	2
	4	0
	3	1
	15	1
	3	0
	30	**5**

Respondent Pool: 35 responses from those who were qualified to move forward as per the eligibility rules
LCMMC Neighborhoods include the 8 prioritized neighborhoods surrounding Little Company of Mary Medical Center

HEALTHCARE UTILIZATION: TOP THREE USES

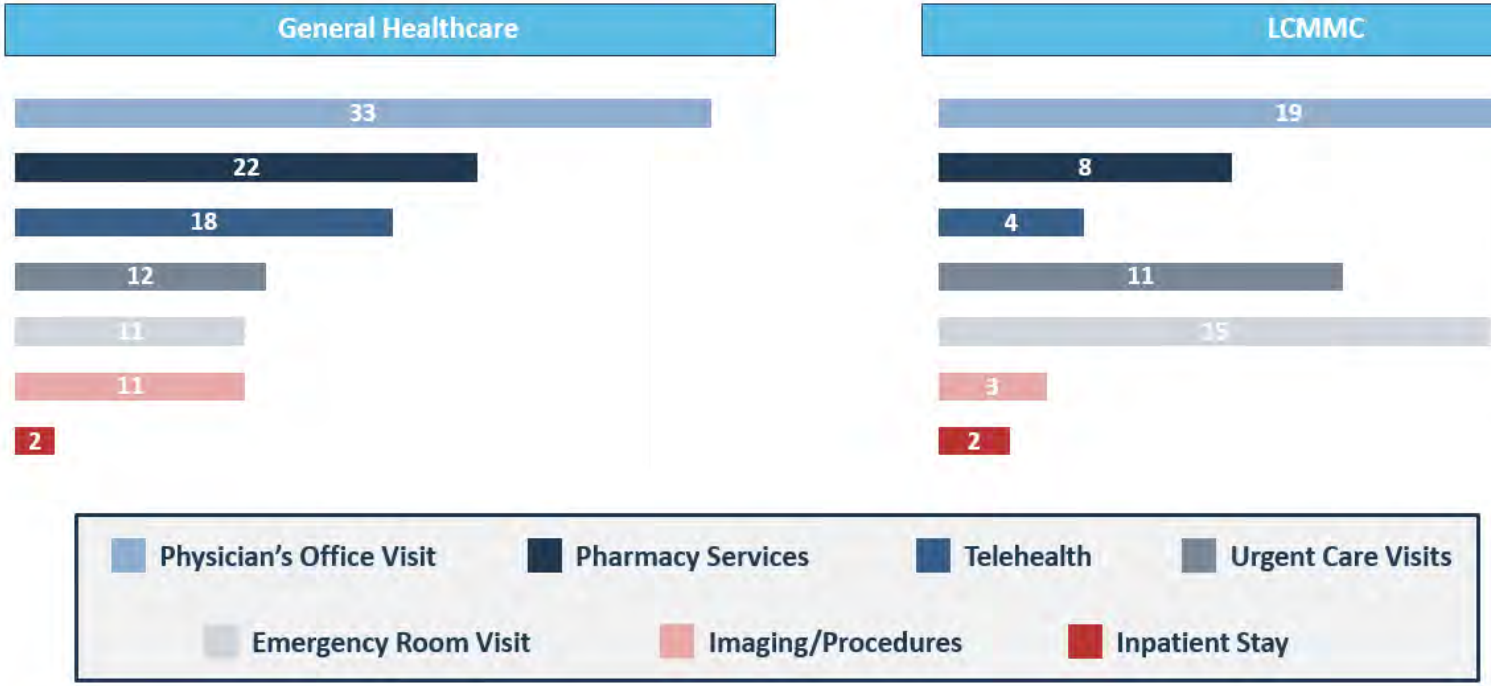
General healthcare visits were reported as mostly annual checkups but LCMMC were more likely to be for emergencies



Respondent Pool: 35 responses from those who were qualified to move forward as per the eligibility rules
Respondents were able to select up to three choices

HEALTHCARE UTILIZATION: CARE DESCRIPTIONS

LCMMC care is primarily physician's office and Emergency Room visits; Emergency Room visits are less prevalent in general healthcare



Respondent Pool: 35 responses from those who were qualified to move forward as per the eligibility rules
Respondents were able to select an unlimited number of choices

HEALTHCARE UTILIZATION: WHAT WOULD YOU LIKE TO SEE?

Respondents were interested in better appointment availability and shorter wait times across all of their healthcare

General Healthcare

LCMMC

- Many respondents were pleased with the current healthcare offerings, and were unsure of what else they would need
- This was especially true when asked specifically about LCMMC, where many respondents said there was nothing else they would like to see.
- Easier scheduling and better appointment availability were commonly named as items respondents wanted to see in their healthcare
- While many were very happy with their physicians and care, there was a desire for more continuity of care and for physicians to take patient's concerns more seriously
- A couple of the respondents mentioned that they were looking for more diversity and representation in the staff
- Respondents were also looking for better communication in a variety of ways: respondents both wanted to better understand available offerings but also want to be able to give feedback.

Respondent Pool: 35 responses from those who were qualified to move forward as per the eligibility rules
Respondents were able to answer via free response

STRENGTHS, PAIN POINTS, AND BARRIERS

	General Healthcare Experience	OSF LCMMC Experience
Strengths	▪ Respondents were most commonly satisfied with the **customer service, supportive physicians, and the urgent care offerings**. ▪ Others mentioned **receiving information on their health** and **location/accessibility** as important.	▪ Respondents noted the **friendly staff, quick care, and knowledgeable, concerned, and supportive physicians** as their top points of satisfaction. ▪ They were also **pleased with the hospital conditions.**
Pain Points	▪ The most common pain points identified include the **lack of appointment availability, waiting time to see physicians.** ▪ Some respondents felt **physicians weren't taking their concerns and symptoms seriously** and wanted better trust. ▪ Respondents were also concerned about pricing and billing, as well as scheduling and response times.	▪ Almost half of the respondents did not feel like they had any paint points. ▪ Of those who did, **scheduling , insurance, and wait times were top pain points.** ▪ There were also some concerns about location, access, lack of appointment availability, and lack of staff diversity.
Barriers to access	▪ **Respondents noted a variety of barriers** including specialist access, appointment availability, and appointment timing.	▪ Echoing the paint points, **appointment availability, scheduling , and insurance coverage were top barriers.** ▪ However, over half the respondents did not note any specific barriers to access to LCMMC. ▪ Respondents also were not always sure what LCMMC offered and wished there was more outreach to help them understand and utilize the available services.

Respondent Pool: 35 responses from those who were qualified to move forward as per the eligibility rules
Respondents were able to answer via free response


FOCUSED
CONVERSATION
FINDINGS
City Tech
CONFIDENTIAL | NOT FOR DISTRIBUTION
19

FOCUSED CONVERSATIONS

City Tech conducted additional 1:1 interviews with 5 survey respondents

Survey respondents were asked about their interest in participating in a focused conversation. 17 of 35 expressed interest and 5 were able to join for 1:1 focused conversation

RedChips

- White Male
- 35-44yo
- Qualified for Federal Program
  Very aware of LCMMC, using for 100% of healthcare needs (travels 20mi to use)

Always Fishing

- Black or African American Male
- 45-54yo
- Uninsured
- Very Aware of LCMMC, not using

Sequoia

- Black or African American Female
- 25-34yo
- Qualified for Federal Program
- Somewhat aware of LCMMC, uses for 51-75% of healthcare needs

FrogGreen

- Black or African American Female
- 55-64yo
- Private Insurance
- Very Aware of LCMMC but not aware of the services, not using

ZacharyS

- Black or African American Male
- 35-44yo
- Qualified for Federal Program
- Very Aware of LCMMC, used to use for 100% of healthcare, no longer using

MOST COMMON CONCERNS

All but the LCMMC specific category applied both to general healthcare and LCMMC experience for those who used LCMMC

Difficulty Scheduling Appointments	Interviewees commented that it was difficult to schedule appointments quickly to see a doctor. This became especially frustrating when getting a referral for a follow-up or for a specialist, as they would have to go through the process a second time.
Long Wait Times	It was common for patients to have to wait long hours in office for a physician, even if they had a scheduled appointment. While interviewees understood that the physicians were trying to give the best care, they felt that it was disrespectful to patient time and often disrupted their days.
Lack of Expanded Hours	The availability of hours outside of general work hours was a pain point for many. When coupled with the long wait times, it was difficult for patients to fit in time to utilize healthcare services, especially for those with little flexibility in their jobs.
Lack of Continuity of Care	Many respondents cited high turnover, leaving them feeling like they were having many introductory visits and their care was not progressing. Many noted that this was especially frustrating given how long it took them to get the appointment.
Rushed Visits and Ignored Concerns	Physician visits felt rushed to a number of the interviewees. In addition, some interviewees noted that they didn't feel like their physician was taking their symptoms or condition seriously.
Unclear on LCMMC Offerings	While many chose their primary healthcare location based on insurance and needs, they stated that they would be open to utilizing LCMMC if they better knew what they offered. This communication could come through an email/flyer or via a health fair or something more interactive.

Interviewees noted that many of these concerns were shared by friends/family or people they had met in healthcare waiting rooms

MOST COMMON CONCERNS

All but the LCMMC specific category applied both to general healthcare and LCMMC experience for those who used LCMMC

Quotes From Focused Conversations

Difficulty Scheduling Appointments

- "Scheduling a doctor's appointment during COVID is bad. Even getting a referral is a pain. If you miss a scheduling call, you might miss an appointment opportunity" – *RedChips*
- "If it's hard to get appointments scheduled in a timely fashion, it's very hard to get things looked at urgently." - *ZacharyS*

Long Wait Times

- "You wait on a doctor for 2hrs for an appointment that was scheduled, and a doctor is only in for 5 minutes. Why are you scheduling all of these patients if you don't have time to see us and don't talk to us?" - *Sequoia*

Lack of Expanded Hours

- "Some people work M-F so they can't go in when they get off at 5:30. If they can make it for working-type people... maybe make a [small] window on weekends" – *Fishing Anywhere*

Lack of Continuity of Care

- "Every appointment I have, it's been a different doctor. And then you have to explain to them again what is going on." –*Sequoia*
- "There is so much turnover of healthcare professionals. You get accustomed to a style and then they are gone." - *FrogGreen*

Rushed Visits and Ignored Concerns

- "Us as patients know our bodies. A lot of doctors don't listen to us." – *Sequoia*
- "The nurses and techs are more likely to listen than doctors, but I am not sure my concerns are heard." –*FrogGreen*
- "Sometimes you go places and you feel like you are just a customer and they are just rushing you. I don't like that type of treatment" – *Fishing Anywhere*

Unclear on LCMMC Offerings

- "They haven't shown me any reason to go there. The have a lack of advertising. I would love to be able to go there if they have what I need but I don't know what they have." - *FrogGreen*

ADDITIONAL FEEDBACK

Hospital System Choice:

- **80% of the interviewees chose their hospital based on proximity, location of preferred provider, or insurance compatibility.**
- One had researched many hospitals and stated that **OSF and LCMMC were most aligned with their values and needs**, and was willing to drive farther for this preference.
- There was some hesitancy to change, as they did not want to give up the known care for a new unknown, but **they could be convinced to switch if they understood and needed the available services in a location OR had a friend recommend it**.

Access To a Variety of Physicians:

- **Within the communities surrounding LCMMC, there is little choice of physician**s and a patient is often stuck with the one person in that specialty in the area.
- **There was a real desire to have a choice when selecting providers**, without having to travel very far.

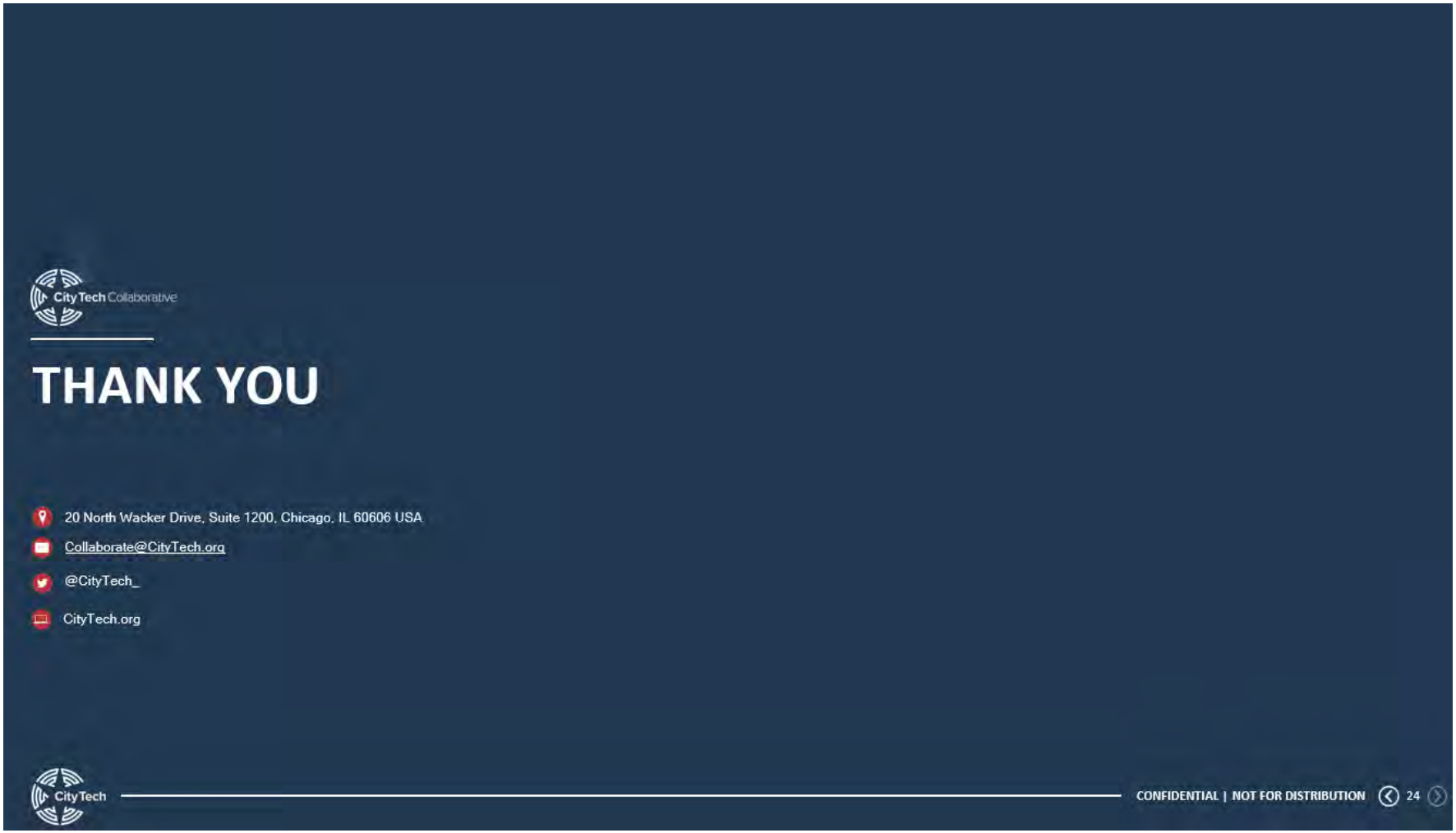
Transportation Concerns:

- Many noted **long transportation journeys to and from appointments**.
- Some interviewees mentioned concerns for the elderly and more vulnerable as they waited, and wished that **a subsidy or organized ride share** were available to help with those situations.

Visit Medium:

- The interviewees all noted that they **felt more comfortable with in-person visits**, but thought that **virtual options could be useful for quick consultations or prescriptions**.
- However, it was important for healthcare providers to note that any **messages should be acknowledged with a response turnaround time** so patients trust the process.

> I would love to look for other specialties or fancier facilities, but there is not a lot of choice or access in the area.
> - *FrogGreen*
>
> I don't even know what a Zoom is!
> - *GoneFishing*
>
> I have no problems with a virtual appointment, but I feel more connected to a doctor if I see them in person. A lot of times, what they say virtually, I don't understand.
> - *RedChips*


City Tech Collaborative
THANK YOU
20 North Wacker Drive, Suite 1200, Chicago, IL 60606 USA
Collaborate@CityTech.org
@CityTech_
CityTech.org
City Tech
CONFIDENTIAL | NOT FOR DISTRIBUTION
24

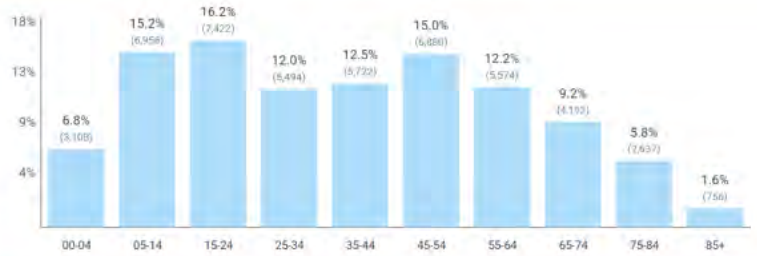

APPENDIX
CityTech
CONFIDENTIAL | NOT FOR DISTRIBUTION
25

PRIORITIZED NEIGHBORHOOD DETAIL: AUBURN GRESHAM

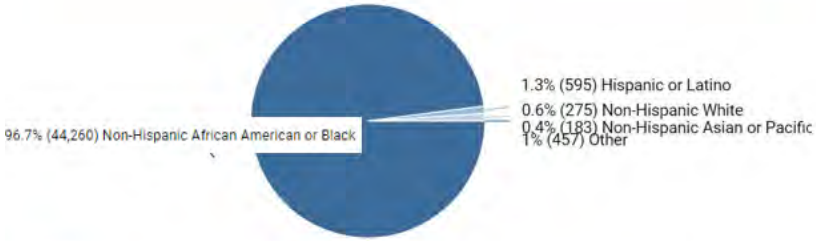
Respondent Breakdown

Neighborhood	Respondents
Auburn Gresham	8
Chicago Lawn	3
Englewood	8
Morgan Park	4
Washington Heights	4
West Englewood	1
West Lawn	2
Other	5
TOTAL	**35**

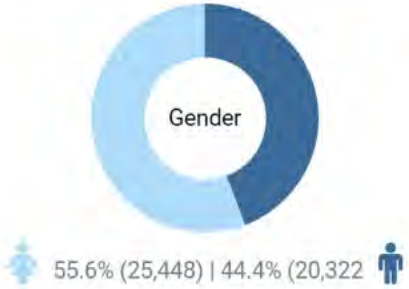
Age



Race



Gender



Source: https://chicagohealthatlas.org/community-areas/auburn-gresham

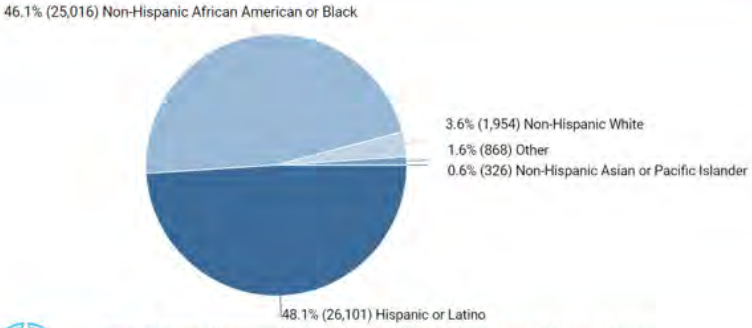
PRIORITIZED NEIGHBORHOOD DETAIL: CHICAGO LAWN

Respondent Breakdown

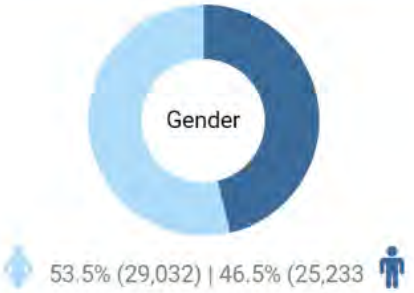
Neighborhood	Respondents
Auburn Gresham	8
Chicago Lawn	3
Englewood	8
Morgan Park	4
Washington Heights	4
West Englewood	1
West Lawn	2
Other	5
TOTAL	**35**

Age

Race



Gender



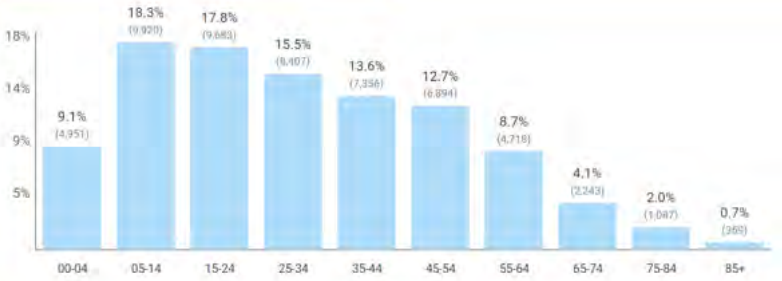
Source: https://chicagohealthatlas.org/community-areas/chicago-lawn

PRIORITIZED NEIGHBORHOOD DETAIL: ENGLEWOOD

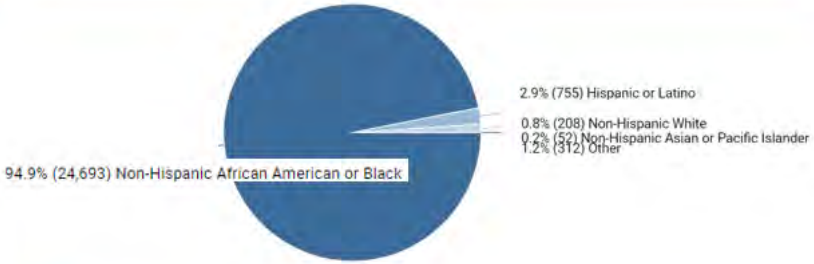
Respondent Breakdown

Neighborhood	Respondents
Auburn Gresham	8
Chicago Lawn	3
Englewood	8
Morgan Park	4
Washington Heights	4
West Englewood	1
West Lawn	2
Other	5
TOTAL	**35**

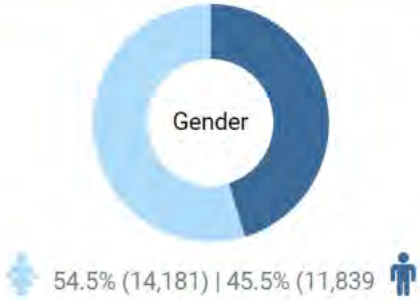
Age



Race



Gender



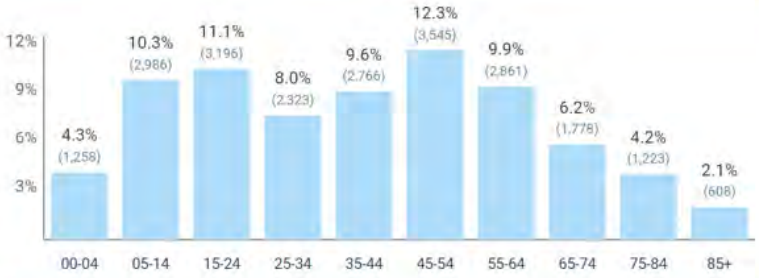
Source: https://chicagohealthatlas.org/community-areas/englewood

PRIORITIZED NEIGHBORHOOD DETAIL: MORGAN PARK

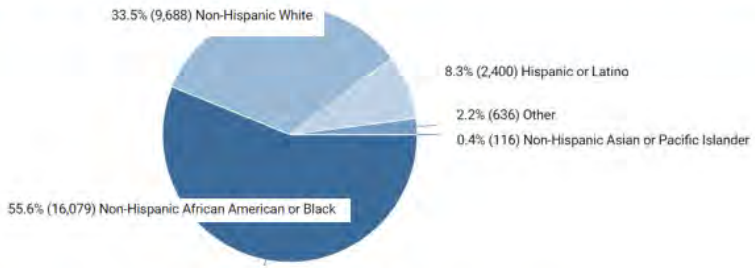
Respondent Breakdown

Neighborhood	Respondents
Auburn Gresham	8
Chicago Lawn	3
Englewood	8
Morgan Park	4
Washington Heights	4
West Englewood	1
West Lawn	2
Other	5
TOTAL	**35**

Age



Race



Gender

54.2% (15,674) | 45.8% (13,245

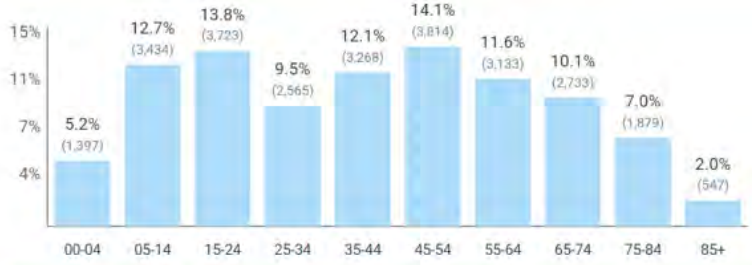
Source: https://chicagohealthatlas.org/community-areas/morgan-park

PRIORITIZED NEIGHBORHOOD DETAIL: WASHINGTON HEIGHTS

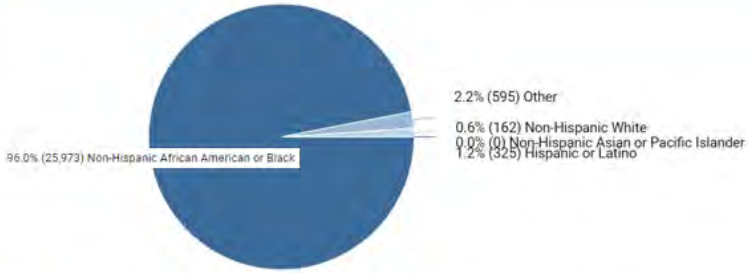
Respondent Breakdown

Neighborhood	Respondents
Auburn Gresham	8
Chicago Lawn	3
Englewood	8
Morgan Park	4
Washington Heights	4
West Englewood	1
West Lawn	2
Other	5
TOTAL	**35**

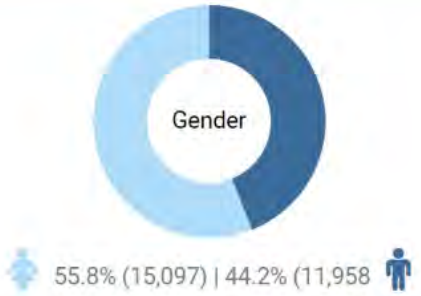
Age



Race



Gender



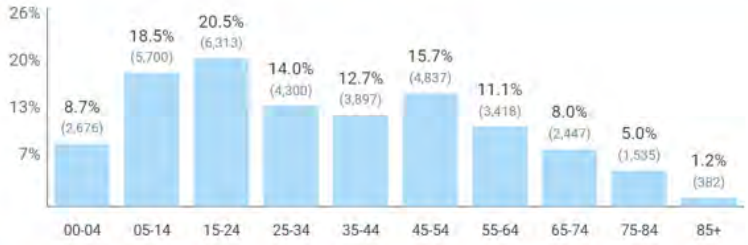
Source: https://chicagohealthatlas.org/community-areas/washington-heights

PRIORITIZED NEIGHBORHOOD DETAIL: WEST ENGLEWOOD

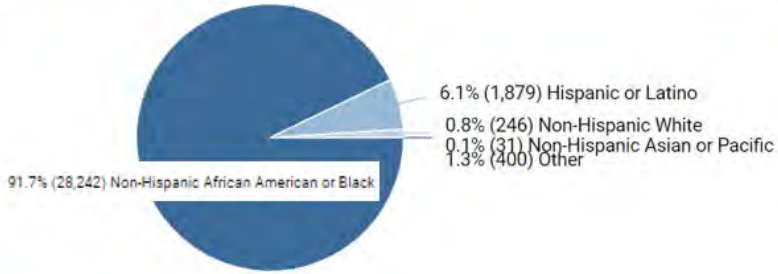
Respondent Breakdown

Neighborhood	Respondents
Auburn Gresham	8
Chicago Lawn	3
Englewood	8
Morgan Park	4
Washington Heights	4
West Englewood	1
West Lawn	2
Other	5
TOTAL	**35**

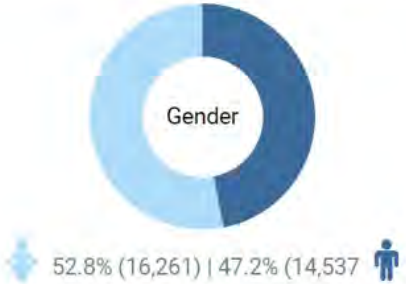
Age



Race



Gender



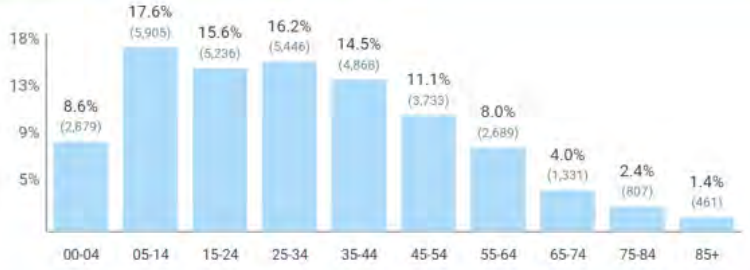
Source: https://chicagohealthatlas.org/community-areas/west-englewood

PRIORITIZED NEIGHBORHOOD DETAIL: WEST LAWN

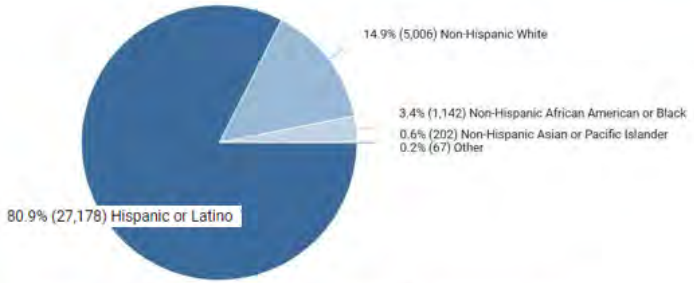
Respondent Breakdown

Neighborhood	Respondents
Auburn Gresham	8
Chicago Lawn	3
Englewood	8
Morgan Park	4
Washington Heights	4
West Englewood	1
West Lawn	2
Other	5
TOTAL	**35**

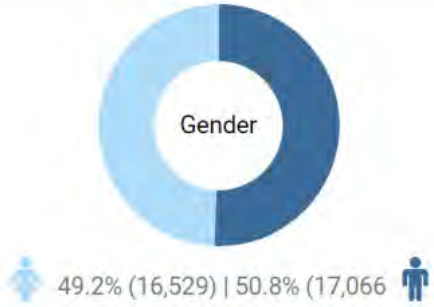
Age



Race

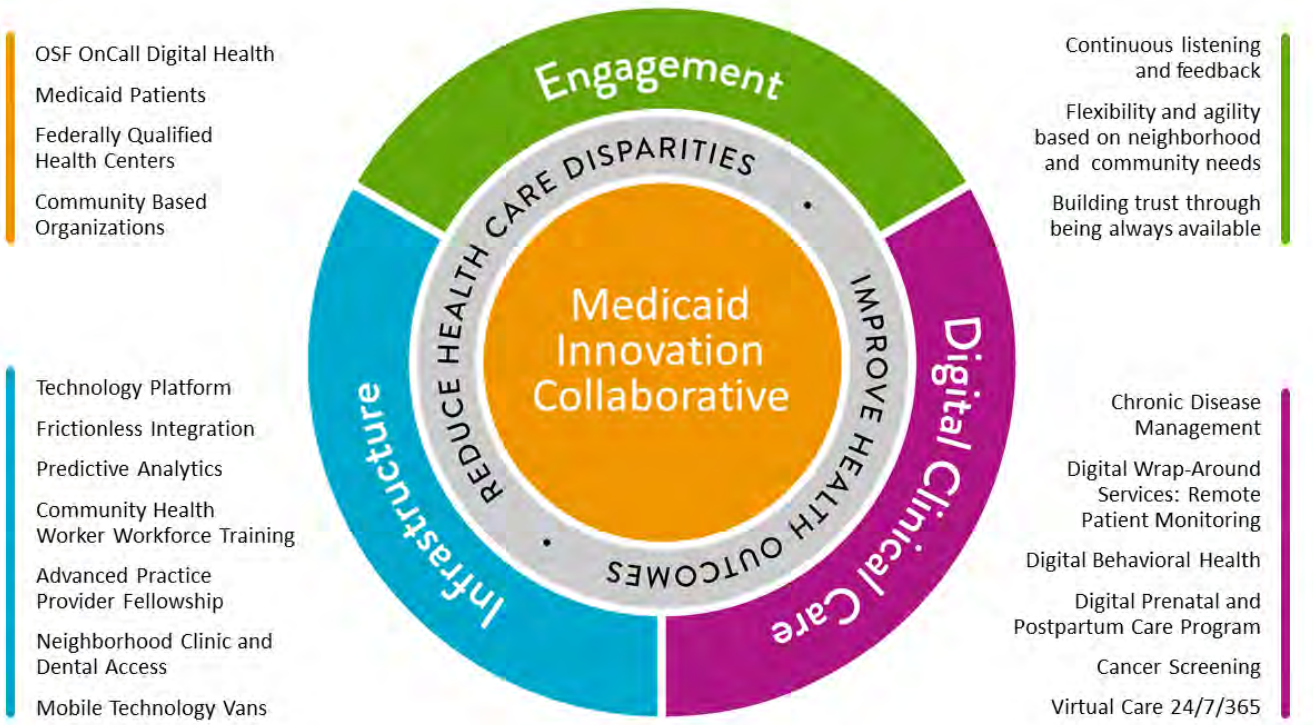


Gender



Source: https://chicagohealthatlas.org/community-areas/west-lawn

ILLINOIS DEPARTMENT OF Healthcare and Family Services



Racial Equity Impact Assessment Guide
by RACE FORWARD

1. IDENTIFYING STAKEHOLDERS

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

Racial and ethnic composition varies throughout the areas served by the collaborators in the proposal, yet the goal remains consistent: ensuring a reduction in health care disparities and improvement of health outcomes for those underserved and disproportionately represented. Several areas of focus for the proposal are communities in which racial and ethnic minorities are the populations that experience highest socioeconomic hardship, high negative health outcomes, and have reduced access. The two groups most affected by and concerned with the tools, services, and related initiatives outlined within the proposal are Black or African

American (Non-Hispanic) and Hispanic populations. For example, within the Chicago portion of the service area, communities of the Near Southwest and Near South/South areas of Chicago, several have been identified by CDPH as experiencing high economic hardship and severe health disparities in numerous health indicators. Chicago's highest concentration of Black Non-Hispanic populations reside in the Near South/South (72%) region, while the highest concentrations of Hispanic populations reside in the Near Southwest (71%) region – both directly supported by this proposal. In all Chicago area regions included, racial and ethnic minority populations comprise the majority; with no more than 21%, White Non-Hispanic in any of the regions listed Chicago area regions. Looking more broadly across the other service areas included in the proposal, the patient community majority groups differ yet disparities among racial and ethnic groups persist. For example, as seen in the tables below, the majority of the patients served in the central region are White, yet there are disproportionate uses of services and positive health outcomes. For examples, in the central region, 14.9% of patients are Black/African American but to date only 4% have been screened for SDOH. Hypertension control rates and complications from diabetes are more prevalent in Black/African American communities. The scope of work defined within the collaborative proposal is informed by and directed toward the service of distressed communities. Regional and localized variations will be employed in the services to reflect the needs of the diverse stakeholders to be most affected by the work.

OSF Region	White	Black/African American
Greater Peoria Area	262,380	39,162
Central Secondary	12,573	721
Central Region	274,953	39,883

Table 1. For the many zip codes within the Peoria service area, there are significant populations of African Americans; however, even in the relatively less rural Peoria markets; there is a significant (15 percent AA vs. 5 percent AA) change in racial composition.

				Community Economic Climate			Ethnicity				
Zip Co	Neighborhood	County	Sta	Risk Sco	% ER	# ER	% Latino or Hispan	% Not Latino or Hispani	% White	% Black or African Americ	% Asian
61602	Peoria	Peoria	Illinois	4.9	100%	828	6%	94%	69%	19%	7%
61605	Peoria	Peoria	Illinois	4.5	90%	13,676	8%	92%	35%	58%	0%
61603	Peoria	Peoria	Illinois	4.0	74%	12,354	11%	89%	46%	41%	0%
61625	Peoria	Peoria	Illinois	4.0	100%	378	6%	94%	82%	9%	9%
61606	Peoria	Peoria	Illinois	3.9	63%	4,989	4%	96%	69%	22%	3%
61604	Peoria	Peoria	Illinois	3.2	32%	9,474	5%	95%	66%	27%	2%
61562	Rome	Peoria	Illinois	3.0	0%	-	24%	76%	100%	0%	0%
61539	Kingston Mines	Peoria	Illinois	2.9	0%	-	2%	98%	99%	0%	0%
61607	Peoria	Peoria	Illinois	2.7	15%	1,615	1%	99%	96%	2%	0%
61616	Peoria Heights	Peoria	Illinois	2.7	0%	-	2%	98%	90%	4%	1%
61523	Chillicothe	Peoria	Illinois	2.6	24%	2,653	3%	97%	94%	0%	2%
61529	Elmwood	Peoria	Illinois	2.6	0%	-	1%	99%	97%	0%	2%
61533	Glasford	Peoria	Illinois	2.3	0%	-	0%	100%	100%	0%	0%
61614	Peoria	Peoria	Illinois	2.3	10%	2,821	2%	98%	77%	11%	7%
61559	Princeville	Peoria	Illinois	2.2	1%	32	9%	91%	94%	1%	2%
61615	Peoria	Peoria	Illinois	2.2	13%	3,018	6%	94%	72%	12%	10%
61451	Laura	Peoria	Illinois	2.0	0%	-	0%	100%	100%	0%	0%
61569	Trivoli	Peoria	Illinois	2.0	0%	-	1%	99%	96%	0%	0%
61528	Edwards	Peoria	Illinois	1.8	0%	-	8%	92%	89%	0%	10%
61517	Brimfield	Peoria	Illinois	1.7	0%	-	1%	99%	97%	2%	0%
61536	Hanna City	Peoria	Illinois	1.7	0%	-	3%	97%	97%	2%	0%
61526	Edelstein	Peoria	Illinois	1.6	1%	7	2%	98%	100%	0%	0%
61547	Mapleton	Peoria	Illinois	1.4	0%	-	2%	98%	99%	0%	0%
61525	Dunlap	Peoria	Illinois	1.2	4%	356	3%	97%	73%	2%	20%
61552	Mossville	Peoria	Illinois	1.0	0%	-	9%	91%	100%	0%	0%

Table 2. With OSF's data science team, we are able to identify areas of structural and social disparities and depict here the racial composition by zip code. Peoria county zip codes with significant racial diversity often are under the most significant economic strain. High-risk scores relate to poor conditions and presence of strain due to SDOH; five is worst score possible.

Listed above are the zip codes in the Peoria region provided as an example, with the racial and ethnicities represented as percentages of the total population. This list is ordered in highest risk (least favorable conditions) and it is clear that these most economically disadvantages zip codes are among the most diverse. Please note that these zip code-level data are available for all zip codes within the collaboration.

Zip Co	Neighborhood	County	St	Community Economic Climate	Community Food Landsca	Community Housing Environmen	Community Transportation Network	Community Health Litera	Community COVID-19 Susceptibili	Populati	% Male	% Female	% Latino or Hispanic	% Not Latino or Hispani	% White	% Black or African American
61350	Ottawa	La Salle	Illinois	2.9	2.6	2.9	1.9	2.9	3.9	24,025	48%	52%	9%	91%	91%	4%

Table 3. Example of data from same source focused on a single zip code in Ottawa, IL.

2. ENGAGING STAKEHOLDERS

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

Yes, leading entities of the collaborative, particularly the FQHCs and those CBOs guiding the identification of success measures, guiding the allocation of funds, delivering new service

models, etc., have representation from the two listed adversely affected groups in both executive leadership positions as well as positions on of the board of directors for their organizations. In addition to leadership roles as collaborators, members of these groups have been pivotal to the identification of needs, testing and refining proposed services and technologies, and establishing culturally conscious practices through involvement in focus groups, one-on-one interviews, survey responses, and other modalities employed for collecting community input. The representation can be noted in both those soliciting input as well as those providing the insights. Please see the governance section of our proposal for further detail on the leadership of our collaborative.

The efforts of collaborators to consistently engage a diverse group of stakeholders often goes beyond the direct health and wellness services. This can be seen in formalized commitments to equitable representation in governance and/or leadership positions, through extensive involvement and investment in with CBOs, and through a variety of other means. One example of a policy commitment can be seen at Heartland Health Services. Heartland's volunteer Board of Directors, who has the responsibility to provide leadership and guidance to ensure the organization provides primary health care to residents residing in areas that have been designated as medically underserved, "serves Heartland Health Services as a voice of the communities. Fifty one percent (51%) of the board's members are individuals who are served at the sites and who, as a group, represent the patients who are being served in terms of demographic factors, i.e., race, ethnicity, sex, income." UI Health demonstrates an example of community involvement. As a member of the Chicago Hispanic Health Coalition, a non-profit organization in Chicago that coordinates health awareness and outreach through a weekly electronic newsletter to 600 plus members, direct services to community residents, and an annual "*Vive Tu Vida,* Get up! Get Moving!" an annual health fair is designed to promote physical activity for better health. UI Health is a fiscal sponsor and brings health education to the event.

Further engagement is still needed, as there is not yet sufficient representation of these groups within the teams charged with deployment and or operationalizing the initiatives proposed within the collaborative. Analysis of opportunities within hiring and recruiting practices for roles within the operations of the new services is underway.

Below are artifacts from ongoing engagements that reflect the diversity of stakeholders involved in the development, deployment, and refinement processes associated with this proposal. First set, sample insights from a recent survey conducted to solicit input from a community that will be directly impacted by the services in the proposal. These survey results

serve as both initial baseline to inform strategy as well as ongoing support for evaluation of service efficacy. Second, excerpts from an active analysis of how a community hospital can move from traditional hospital outreach, e.g. health fairs and newspaper advertisements, to more authentic engagement with the communities it serves, e.g. culturally-reflective programming and services, community need based care, investments in mitigation of barriers to care, etc. It is based on a historical analysis of the community framed by race, inequities, and works to create flexible framework for continuous engagement; the artifacts depicts the various dimension of engagement where the hospital meets the community. These are used to frame future services and offer a holistic perspective of the context.

Figure 1 Excerpt from community survey.

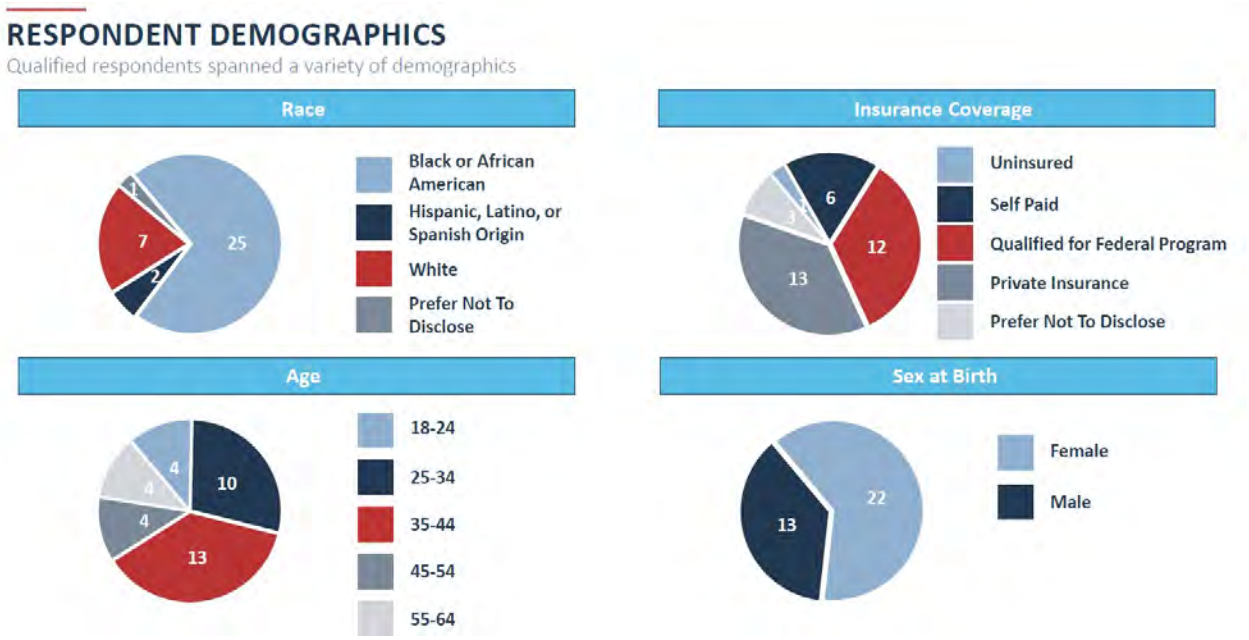


Figure 2 Excerpt from community survey.

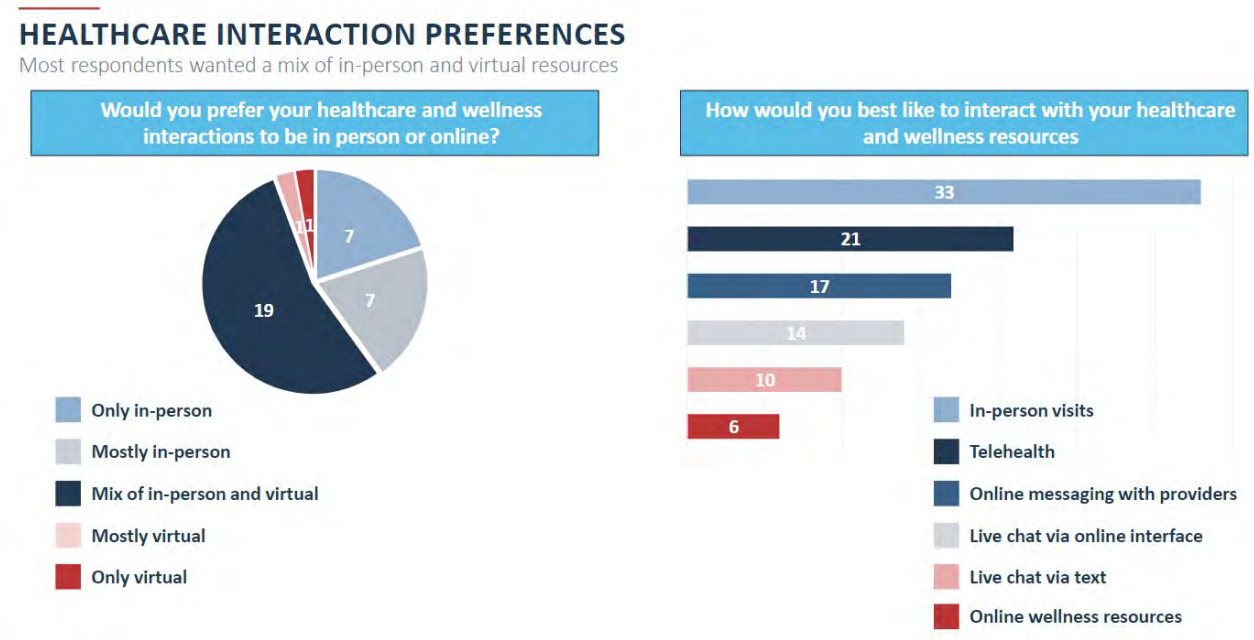


Figure 3 Excerpt from "Authentic Community Engagement Analysis"

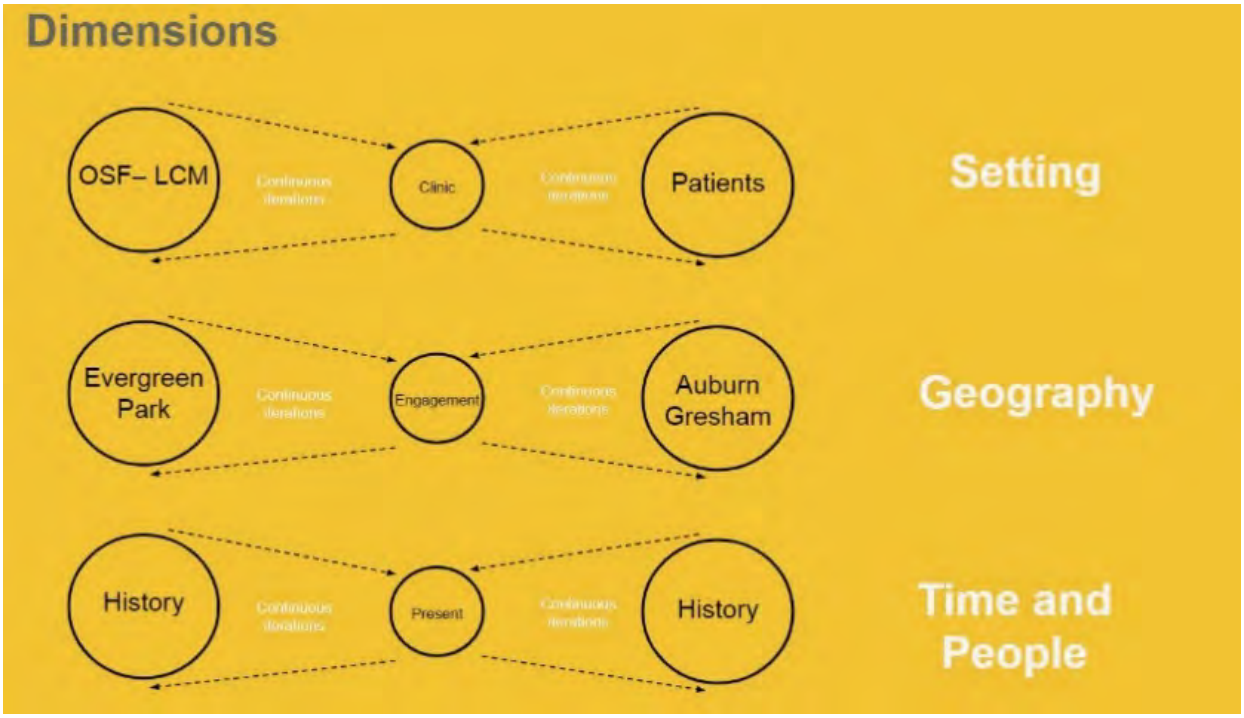


Figure 4 Excerpt from "Authentic Community Engagement Analysis"

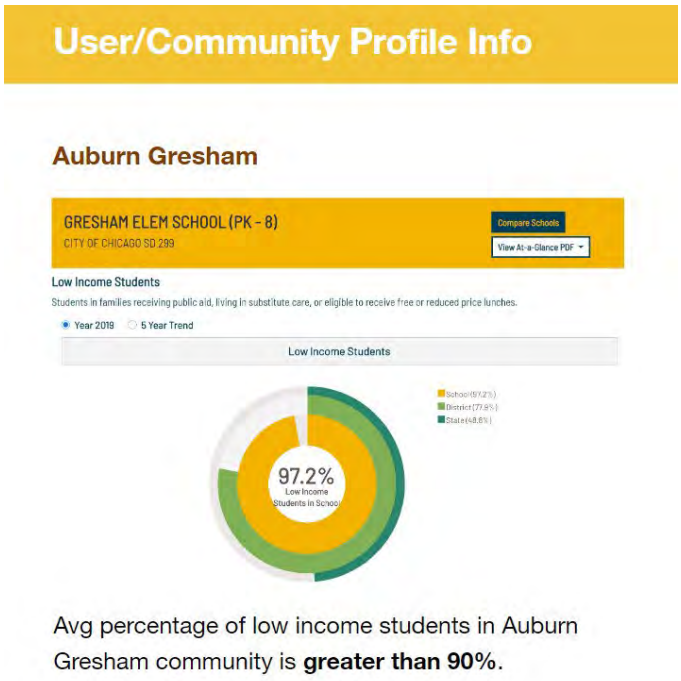
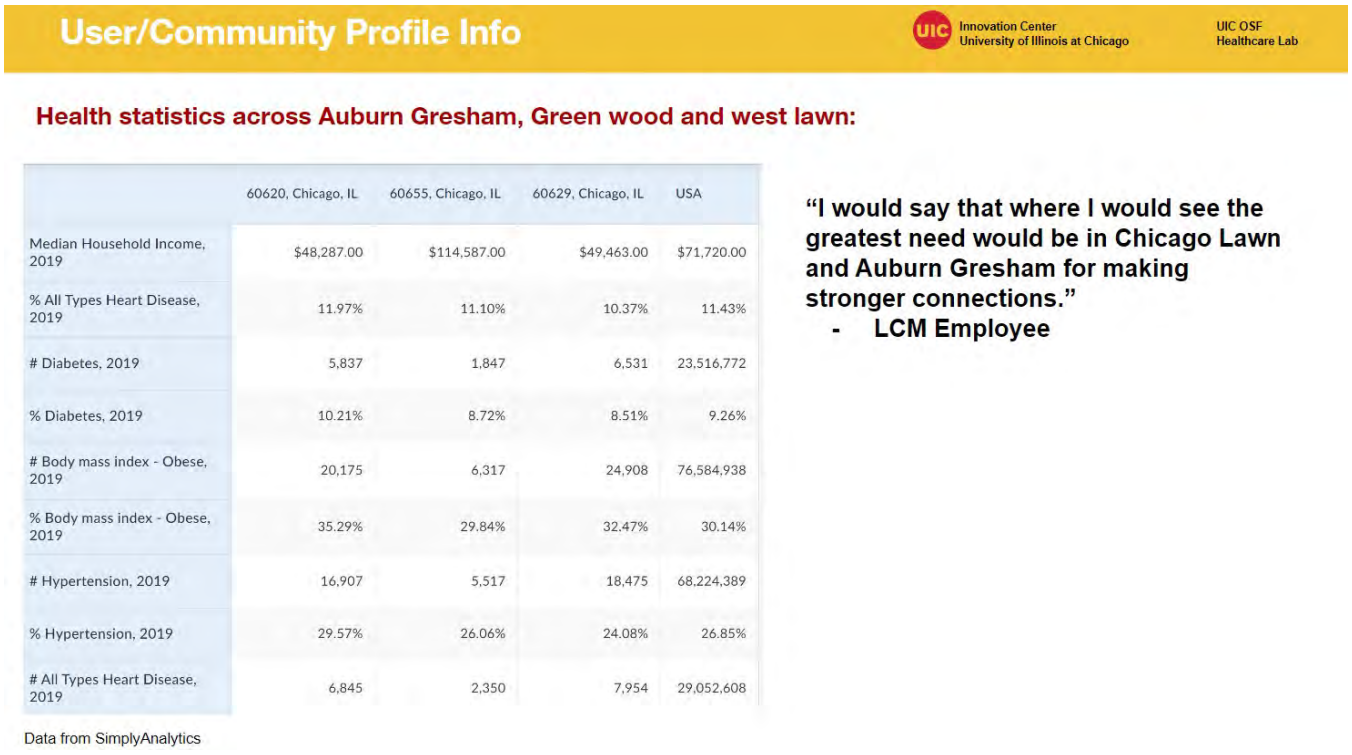


Figure 5 Excerpt from "Authentic Community Engagement Analysis"



	60620, Chicago, IL	60655, Chicago, IL	60629, Chicago, IL	USA
Median Household Income, 2019	$48,287.00	$114,587.00	$49,463.00	$71,720.00
% All Types Heart Disease, 2019	11.97%	11.10%	10.37%	11.43%
# Diabetes, 2019	5,837	1,847	6,531	23,516,772
% Diabetes, 2019	10.21%	8.72%	8.51%	9.26%
# Body mass index - Obese, 2019	20,175	6,317	24,908	76,584,938
% Body mass index - Obese, 2019	35.29%	29.84%	32.47%	30.14%
# Hypertension, 2019	16,907	5,517	18,475	68,224,389
% Hypertension, 2019	29.57%	26.06%	24.08%	26.85%
# All Types Heart Disease, 2019	6,845	2,350	7,954	29,052,608

The collaborators within the proposal, if funded, will compose healthcare transformation advocacy groups for additional input on ongoing processes and measures. In addition, a near-real-time dashboard for similar feedback has been proposed.

3. IDENTIFYING AND DOCUMENTING RACIAL INEQUITIES

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?

Racial inequities in healthcare are evident in an array of findings at both the state level and in specific regional data. This proposal seeks to reduce barriers that impact access to care, e.g., technological, physical/geographic, etc. that have a disproportionately negative affect on racial and ethnic minority groups. The groups disproportionately represented are primarily Black or African American (Non-Hispanic) and Hispanic populations. The inequities, often driven by a lack of access, take a variety of forms from rates of diagnoses, utilization rates, and health outcomes. Key drivers of these inequities can be found in accessibility and quality of care. This collaborative proposal seeks to reduce inequities through fostering strong community partnerships and engagements and leveraging technology initiatives.

How each group is affected differently is demonstrated in the following examples of race-based inequities. According to a 2019 study by the United Health Foundation, Black/African American and Hispanic/Latino adults 65 and older have both higher rates of preventable hospitalizations and have higher costs per preventable hospitalization. Overall, in Chicago, older adults 65 and older account for close to 30 % of all inpatient hospitalizations and 11% of all emergency department (ED) visits. Similar disparities can be identified at a regional level as well. In Peoria, an internal study found that ED utilization rates by individuals identifying as Black/African American were significantly higher than those recorded from other races and ethnicities. In addition, disparities were identified when surveying patients including those who responded with “No PCP”. Nineteen percent were Black/African American compared to 10% of the white population who had no PCP. The readmission rate analysis illustrated that Black/African American populations were 12.27% more likely to be readmitted compared to white populations at 10%.

In line with utilization rates, the disparaging trends of racial inequity can also be tracked in mortality rates. In the case of breast cancer, the data reveal similar case rates of breast cancer amongst Black/African American and White women; however, the data reveal much higher death rates exist amongst Black/African American women. For example, in Peoria, Black/African American female breast cancer case rates are higher than white (167 vs 138) and death rates are much higher (27.8 versus 18 per 100,000, respectively). In another region of the service area, the South Chicago area, disproportionate heart disease mortality rates affect Black/ African American populations. In certain communities, it is particularly severe where the rate is 244.28 deaths per 100,000– more than 40 excess deaths per 100,000 compared to the state average of 202.3 or national average of 198.1 per 100,000.

EXAMINING THE CAUSES

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

The racial inequities present in the communities served by the collaborative proposal originate from a multitude of sources including institutional and structural elements of housing, economic development, education, and transportation. The impacts and nature of the listed factors that both produce and perpetuate the inequities vary within the areas served by this proposal. The proposal incorporates community types that range from small, homogenous, rural towns to densely populated, racial and ethnically diverse urban neighborhoods.

One site-specific analysis of causes revealed historical factors related to population growth and changes to federal law as drivers of inequities and a culture of mistrust between the neighborhood and the healthcare system, leading to decreased investments and use which in turn perpetuated the downward cycle of inequities. The Little Company of Mary Medical Center, located in the northern region of the areas within the proposal, once served the predominantly white, Catholic community of Evergreen Park, IL. It was a small community hospital. Following the removal of racial covenants in the 1940s, population boom in the 1950s and 1960, and ensuing “white flight”, the population served shifted from white, Catholic, middle class to lower income, racial and ethnic minorities, i.e., populations identifying as Black/ African American and Hispanic. Once known as the “baby hospital”

serving only Evergreen Park, it now primarily services South and Southwest communities that heavily depend on the emergency department as a source of primary care. These community shifts and community needs have not yet sufficiently been reflected in the hospital, including staffing, services offered, culturally responsive/appropriate communication, etc. Although the shifts in population have slowed, the hospital does not yet holistically reflect the communities served and the negative impacts on the community caused by the change persist.

The services and deployment strategies outlined in this proposal will directly respond to the impacts of these social and structural caused inequities. By improving locations, increasing service hours of facilities, and deploying culturally and community reflective services, patients living far from the hospital can feel supported and have greater access to needed services. This is achieved by empowering existing community health workers, through digital enablement, para medical service training, and increased connectivity to support infrastructure. Community members can engage with a trusted community member to meet their health and wellness needs. Through authentic community engagements and partnerships, such as those with FQHCs, the hospital can start to build a relationship of trust with the communities served.

5. CLARIFYING THE PURPOSE

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

The proposal seeks to address identified health disparities in marginalized communities through improved access to care, increased quality, opportunities for meaningful employment for community members, and a reduction in inequitable distribution of care. The access and quality of care to be made available through this collaborative will provide traditionally disadvantaged communities with access to a full spectrum of specialty care and the latest advancements in health innovations.

The innovation within our collaboration is the blended personal approach that is culturally, racially, and ethnically sensitive and representative of health workers who are trained in and deployed using the latest data-science driven tools. Our approach is to leverage data and clinical informatics to design interventions, deploy these representative health workers efficiently, and promote the use of mobility solutions to inform both CHW and patients to ensure shared decision-making.

6. CONSIDERING ADVERSE IMPACTS

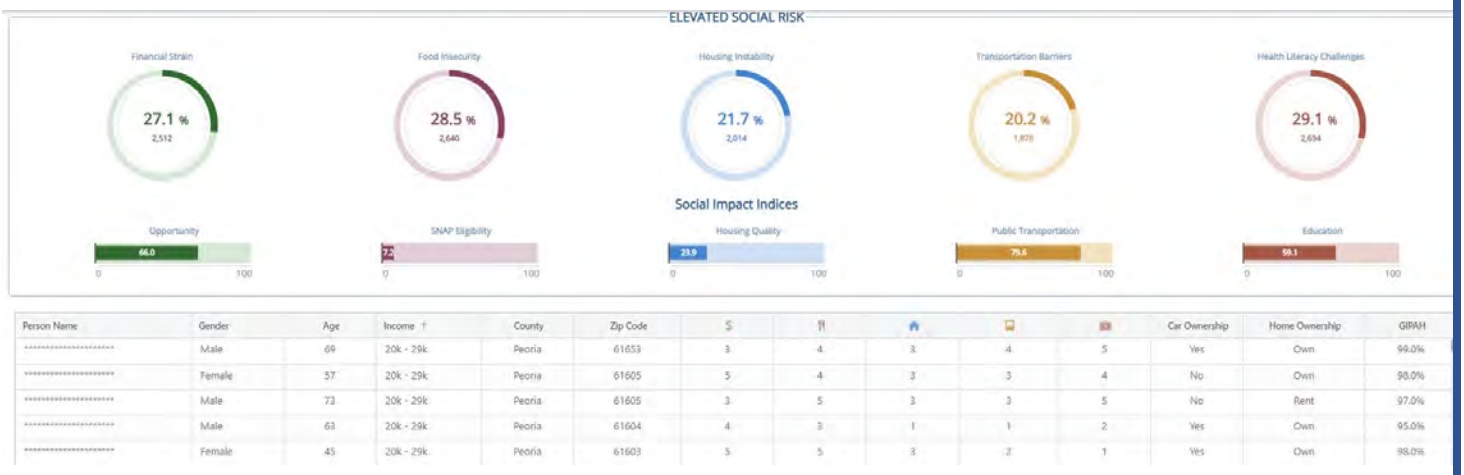
What adverse impacts or unintended consequences could result from this policy?

A main thrust for the activity of the collaboration is to maximize the efficiency of CHWs and through digital and other means increase the utilization of quality services offered in the FQHC clinical sites. There is a small risk that as we create these efficiencies and increase demand for available appointments, that we overshoot or outstrip the FQHCs capacity.

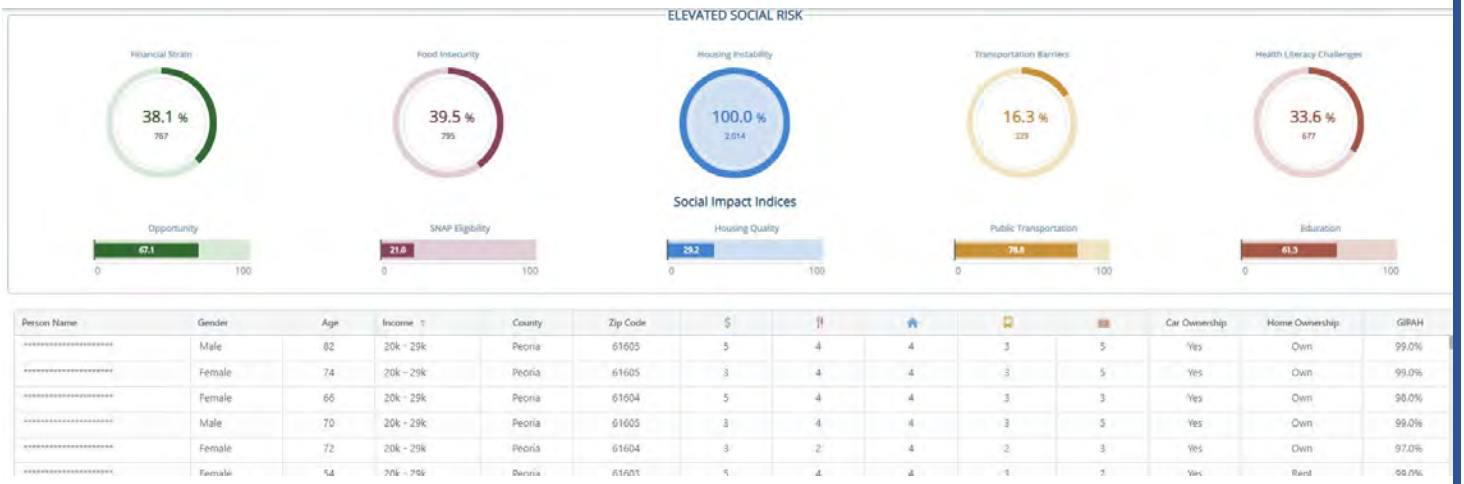
Which racial/ethnic groups could be negatively affected?
Vulnerable populations will remain the most likely to suffer the negative effects of poor implementation.

How could adverse impacts be prevented or minimized?
Our aim with the strategies illustrated in the document mitigate the negative impact of social determinants of health. Racial and ethnic compositions are geographically sensitive. Rural environments have relatively fewer African-American, Latinx and Asian populations. Food security and transportation issues are common despite locations, however, solutions in rural environments will not solve for urban constraints and vice versa.

The common thread to mitigate the unintended adverse impact is leveraging data at the zip code and census track level to reveal best fit for solutions of interest. OSF HealthCare has (outside of this proposal) invested in SocialScape, a solution with patient-level data for our managed Medicaid enrollment.



Depicted here at the patient level, social vulnerability is depicted by income and by zip code, revealing high rates of vulnerability in our 61605 and 61604 zip codes generally.



Person Name	Gender	Age	Income	County	Zip Code	$					Car Ownership	Home Ownership	GIPAH
**********	Male	82	20k - 29k	Peoria	61605	5	4	4	3	5	Yes	Own	99.0%
**********	Female	74	20k - 29k	Peoria	61605	3	4	4	3	5	Yes	Own	99.0%
**********	Female	66	20k - 29k	Peoria	61604	5	4	4	3	3	Yes	Own	98.0%
**********	Male	70	20k - 29k	Peoria	61605	3	4	4	3	5	Yes	Own	99.0%
**********	Female	72	20k - 29k	Peoria	61604	3	2	4	2	3	Yes	Own	97.0%
**********	Female	54	20k - 29k	Peoria	61603	5	4	4	3	5	Yes	Rent	99.0%

Here now are the same patient level data with a focus on housing instability within these same neighborhoods, revealing the other related key social determinants among these zip codes. This powerful patient-level tool will allow the collaborative to custom tailor outreach programs of service to these zip codes. Of note, the households in 61605 and 61604 zip codes 85% percent African American and 15% White.

In summary, these tools will allow collaborators to tailor their interventions, to hire and deploy culturally, racially, and ethnically sensitive representative health workers and have the outputs of this work avoid the pitfalls of "one size/one solution fits all" approaches.

7. ADVANCING EQUITABLE IMPACTS

What positive impacts on equity and inclusion, if any, could result from this proposal?

The direct effects of the clinical services provided in this proposal are detailed and enumerated as health outcomes known to be subject to racial and ethnic disparities. For example, our outcomes from the primary care domain include improved regulation of blood pressure in hypertension, improved glucose regulation and screening in diabetes, and monitoring of and control of hyperlipidemia. Our team has made excellent progress in breast cancer screening initiatives as well, reported as a case study in our proposal.

The other positive impacts of diversity and inclusion relate to the employment, training, and education of authentic members of communities in our areas of impact. We will be

hiring a more racially/ethnically diverse workforce with job creation by and with FQHC partners for the following roles: peri-medical (CHW) in three tiers of training and technical expertise, digital health workers, APP providers trained within our fellowships, and when needed and possible physicians. We have listened to the voice of our community, which calls for more diverse and representative members by race and ethnicity.

The services offered to community members through community based organizations and through BEP vendors will have the effect of addressing the equity gap identified through our community based partnerships. BEP vendors will be involved in the creation of a race and ethnicity impact dashboard and may be engaged for cultural sensitivity training engagements.

Which racial/ethnic groups could benefit?

Due to the population distributions and the data available through SocialScape and other solutions, we believe that the African American and Latinx communities are most likely to receive the positive impacts of our collaboration.

				Community Food Landscape			Community Housing Environment			Community Transportation Network			Community Health Literacy			Community COVID-19 Susceptibility		
Zip Cod	Neighborhood	County	Sta	Risk Sco	% ER	# ER	Risk Sco	% ER	# ER	Risk Sco	% ER	# ER	Risk Sco	% ER	# ER	Risk Sco	% ER	# ER
61602	Peoria	Peoria	Illinois	4.4	75%	621	5.0	100%	828	1.3	0%	-	4.6	100%	828	4.0	91%	753
61605	Peoria	Peoria	Illinois	3.5	48%	7,294	4.9	99%	15,043	1.7	5%	760	4.7	91%	13,827	4.3	84%	12,764
61603	Peoria	Peoria	Illinois	3.6	42%	7,012	4.6	89%	14,859	1.2	1%	167	4.1	84%	14,024	3.9	71%	11,853
61625	Peoria	Peoria	Illinois	5.0	100%	378	5.0	100%	378	1.0	0%	-	1.5	0%	-	4.7	100%	378
61606	Peoria	Peoria	Illinois	3.9	73%	5,781	4.6	86%	6,810	1.0	0%	-	2.2	30%	2,376	4.2	76%	6,018
61604	Peoria	Peoria	Illinois	2.9	26%	7,698	4.0	68%	20,132	1.9	15%	4,441	3.4	48%	14,211	4.0	69%	20,428
61562	Rome	Peoria	Illinois	1.0	0%	-	3.0	0%	-	4.0	100%	45	3.0	0%	-	3.0	0%	-
61539	Kingston Mines	Peoria	Illinois	2.0	0%	-	3.0	0%	-	3.9	91%	157	2.0	0%	-	2.9	0%	-
61607	Peoria	Peoria	Illinois	3.0	34%	3,660	3.1	29%	3,122	2.5	24%	2,584	2.4	3%	323	3.1	29%	3,122
61616	Peoria Heights	Peoria	Illinois	3.0	12%	703	3.9	63%	3,692	1.3	0%	-	2.2	0%	-	3.0	17%	996
61523	Chillicothe	Peoria	Illinois	2.5	27%	2,985	3.0	33%	3,648	2.7	35%	3,869	1.9	0%	-	3.3	32%	3,538
61529	Elmwood	Peoria	Illinois	2.1	0%	-	2.9	0%	-	3.1	44%	1,236	2.1	0%	-	2.9	11%	309
61533	Glasford	Peoria	Illinois	2.6	20%	472	2.6	0%	-	3.5	53%	1,251	2.1	0%	-	3.2	23%	543
61614	Peoria	Peoria	Illinois	3.0	27%	7,616	2.5	5%	1,410	1.1	0%	-	2.5	0%	-	3.5	40%	11,283
61559	Princeville	Peoria	Illinois	2.4	8%	258	2.6	0%	-	2.9	1%	32	2.0	0%	-	3.0	43%	1,386
61615	Peoria	Peoria	Illinois	2.2	8%	1,858	1.9	5%	1,161	1.6	7%	1,625	2.3	21%	4,876	3.5	49%	11,377
61451	Laura	Peoria	Illinois	2.1	3%	10	3.0	0%	-	3.0	0%	-	2.0	0%	-	2.1	3%	10
61569	Trivoli	Peoria	Illinois	2.8	3%	37	2.7	0%	-	3.8	83%	1,017	2.6	0%	-	3.2	24%	294
61528	Edwards	Peoria	Illinois	1.6	0%	-	1.2	0%	-	2.3	4%	119	2.1	0%	-	4.0	64%	1,912
61517	Brimfield	Peoria	Illinois	2.1	0%	-	2.1	0%	-	2.8	20%	688	2.0	0%	-	2.7	2%	69
61536	Hanna City	Peoria	Illinois	2.4	4%	115	2.2	0%	-	3.3	39%	1,118	2.4	0%	-	3.5	51%	1,462
61526	Edelstein	Peoria	Illinois	2.0	0%	-	2.3	0%	-	3.3	34%	253	1.7	0%	-	2.8	25%	186
61547	Mapleton	Peoria	Illinois	1.9	0%	-	1.7	0%	-	3.1	6%	243	1.5	0%	-	2.2	0%	-
61525	Dunlap	Peoria	Illinois	1.4	3%	267	1.3	0%	-	2.2	7%	624	1.0	0%	-	2.0	9%	802
61552	Mossville	Peoria	Illinois	1.0	0%	-	1.2	0%	-	4.0	100%	191	1.2	0%	-	4.0	100%	191

For those populations seen in the related figure in section 1 of this questionnaire, here again we demonstrate the relative risk scores across our most diversely composed zip codes. Extension of services in rural and predominantly white populations will address primarily social determinants specific to those populations. Where there is little diversity, there is still opportunity.

Are there further ways to maximize equitable opportunities and impacts?

We will continue throughout the five-year period to explore through our data and community engagement, new strategies that can improve our impact.

8. EXAMINING ALTERNATIVES OR IMPROVEMENTS

Are there better ways to reduce racial disparities and advance racial equity?

Yes, building systems and collaborations such as this to ensure there is equitable access to healthcare services can offer a degree of mitigation. The broad spectrum of health and wellness disparities that impact racial and ethnic minority groups are caused by factors beyond the scope of traditional healthcare providers, e.g. quality of schooling, access of nutritious foods, affordable housing, air quality, etc. Coalitions formed between institutions, organizations, and governmental bodies that directly impact an array of social and institutional determinants of health, committed to a shared mission, shared data, and shared governance could offer a more holistic, sustainable solution to advance racial equity.

What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

In this collaborative proposal, several provisions have been incorporated to support positive impacts in terms of racial equity and inclusion. For example, we have modified our approach from a strictly 'provider oriented viewpoint' to 'shared community decision-making', i.e. information gathered from and about the community via surveys, focus groups, public health data, etc., become as central in strategic decision making as the health providers themselves. Another provision included is the expansion of our academic partnerships. In previous generations, the partnership between the hospital and the university was only through the College of Medicine focusing on clinical topics. Over the last four years, through collaboration with the UIC Innovation Center, OSF has engaged the state's highest academic expertise in social justice, public health, business, design, computer science, engineering, and others to address some of the most complex issues in health equity. The partnership has afforded the hospital to engage with diverse groups of students and faculty from throughout the city of Chicago, across the state, and around the world. Teams of faculty and students have interviewed hundreds of patients and community members from rural and urban environments. This diversity in cultures and life guides the research and community engagement, is infused in the findings, and thus frames the policies and practices that the

collaborative deploys. The provisions in the collaborative move the academic partnerships and research from periphery explorations to a necessary precursor to decision making. Another element of establishing community voice in the decision making process is the inclusion of City Tech, the lead designer in the now UIC Public Health solution and their work with the "City Atlas". They have been engaged to go deeper into solution development through active surveys in their Civic User Test Group and Community Engagement surveying.

A provision that could be incorporated to expand the positive impact on racial equity and inclusions is the explicit coordination or alignment with indirectly related community projects, both from operational and data perspectives. For example, if a new mixed-income and affordable housing project was in development in a community incorporated in the proposal and the developer as a collaborator, it could be ensured that health services would be extended to residents with inclusions of community expansion data projections from the development into the health data, etc. A provision that, at minimum, recognized intersections of the collaborative's mission with related projects could further support the assurance of positive impacts on racial equity and inclusion.

ENSURING VIABILITY AND SUSTAINABILITY

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

Yes, at its core, the proposal is an expansion and refinement of currently established and or piloted initiatives. The included tools, services, platforms, etc. have existing operational processes and procedures, vetted roles and responsibilities, known budgetary requirements, methods for collection and tracking outcomes, and the other necessary operational mechanisms to ensure viability and sustainability. For example, the proposal will expand the breadth, depth, and the incorporation of digital tools within the CHW training program. The viability of this CHW training component comes from two primary sources. One, a long history of expertise in the development of training and educational experience from Jump Simulation and two, the recent successes related to the rapid deployment of the training to support Pandemic Health Worker program. Jump Simulation and Education, the simulation training and education branch of OSF Healthcare, is internationally recognized as a leader in simulation education, and served as the lead on developing the curriculum content and instructional tools for the CHW/PHW program. The program was designed as an amalgam of existing competencies from various credentialing bodies, best practices in communication, and interpersonal engagements developed by Jump. Training on novel

technologies leveraged to guide CHW efforts, e.g. the OCC. The foundations of this training program were successfully deployed to rapidly train and prepare hundreds of Pandemic Health Workers as part of the response to the pandemic.

Through this proposal, this CHW Training program will grow into a collaboration with a community college to expand the offering to a more diverse group of learners, larger cohort sizes, and enhanced online training materials. The program will also expand to include advanced training opportunities, preparation for certification, incorporation of career pathways, and training offerings for CHWs at collaborating institutions to both improve and expand localized workforces. The training includes quality assurance methods that will collect outcomes regarding the CHW learners' experience, educational efficacy, and equip CHWs in the field with digital tools to further support and track positive practice changes.

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

Yes, the collaborators are very strong in the data and infrastructure categories, and in particular will have access to novel software, novel analytics, and machine learning layered on our electronic community health record, OCC. Our intention is to create transparency through data and reporting and to incorporate broad stakeholder participation and feedback.

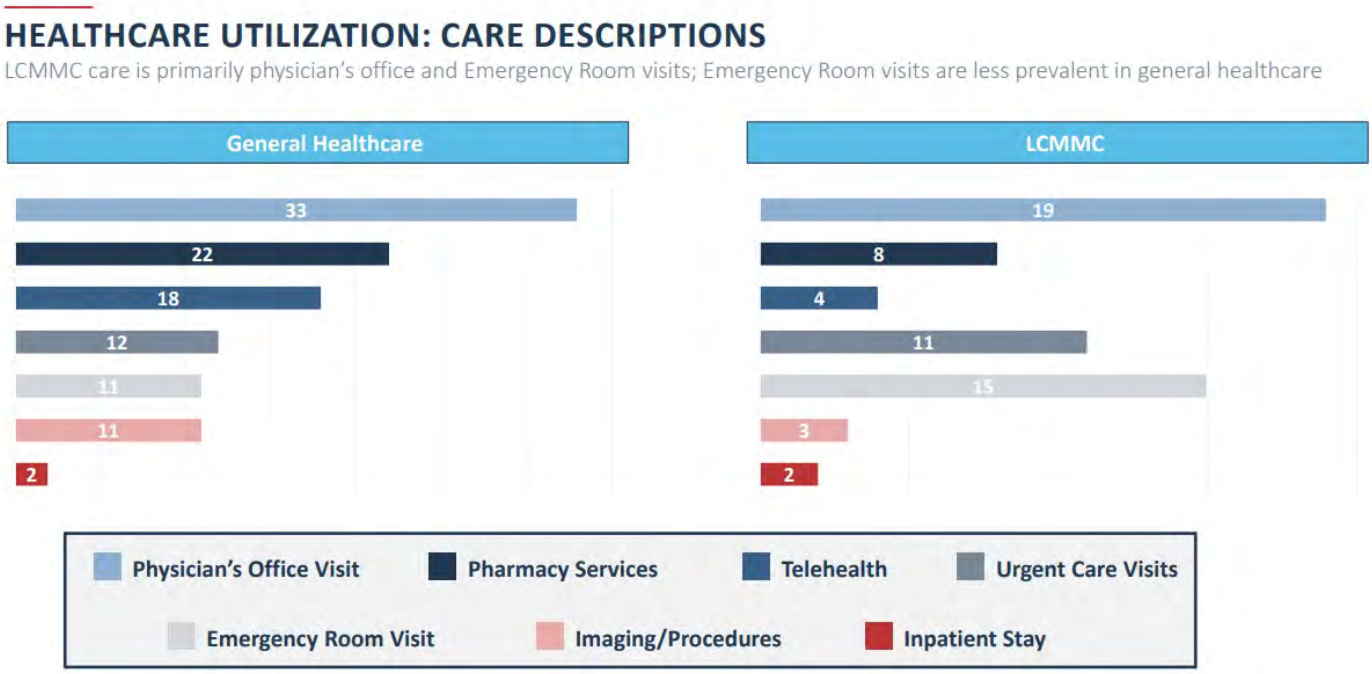
IDENTIFYING SUCCESS INDICATORS

What are the success indicators and progress benchmarks?

The Collaborative will use a multitude of metrics to measure the impact of the work in terms of quality, accessibility, and a reduction in race and ethnicity-related disparities. Successful implementation of the panel of services related to the collaboration include:

- Patient racial and ethnic composition consistent with general population data when normalized by zip code for primary care and other services rendered.
- Hiring practices within the collaborators consisting of representative members by race and ethnicity for patient care services, especially in healthcare related jobs/professions.

- Satisfaction measures in the “highly satisfied” category



How will impacts be documented and evaluated?

Elsewhere in this proposal, we have innumerated and detailed clinical service measures. Other measures include job creation and training within the collaborative. Some additional broad measures include:

-Clinical service to clients served by the collaborative organized by race and ethnicity and by social determinants

-Service to clients related to SDOH organized by race and ethnicity

-Clinical outcomes (listed elsewhere)

-“Closure of loop” metrics for community based organizations addressing SDOH

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

OSF will engage with Nerevu (a BEP minority owned business) to establish a near-real time dashboard, incorporating SMS, email and survey data with more traditional survey data from client encounters. The purpose of this dashboard is to provide documentation and feedback through various mechanisms on the racial and ethnic composition of services rendered and the quality and satisfaction of patients on these services. More traditional focus groups will leverage more qualitative techniques to provide narrative commentary on services rendered. These will be organized into regions of coverage in line with the service areas of the FQHCs

LAST REVISED: DECEMBER 10, 2020

Collaboration name	**OSF Healthcare**	**Project Period:**	**2021-2026**
Primary Contact	**Jennifer Junis**		
Preparer Name/Title:	**Thomas Razo/Senior Financial Analyst**		
Phone:	**309-417-2000**	**Email:**	Thomas.M.Razo@osfhealthcare.org

Temporary Staff related to implementation or initial cost of permanent employees

Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Total	
	Behavioral Health Navigator	$58,240	$17,472	340%		$ 257,421	Wellbeing
	Advanced Practice Provider	$124,800	$24,960	360%		$ 539,136	Virtual UC
	SIM Program Developmt Spec	$83,200	$24,960	100%		$ 108,160	CHW Training
	Educator	$125,000	$25,000	100%		$ 150,000	APP Fellowship
	Fellows	$100,000	$20,000	500%		$ 600,000	APP Fellowship
	Registered Nurse	$87,360	$26,208	960%		$ 1,090,253	Connect
	Advanced Practice Provider	$124,800	$24,960	960%		$ 1,437,696	Connect
	Digital Health Worker	$39,520	$11,856	2000%		$ 1,027,520	Connect
	Medical Office Assitant	$52,000	$15,600	960%		$ 648,960	Connect
	Registered Nurse	$87,360	$26,208	1638%		$ 1,860,244	Connect
			Total Salary and Benefits			$ 7,719,389	

B. Other Direct Costs

Item	Description/Justification		Total	
Silver Cloud Annual Licenses fee	Behavioral Health Software to help treat patients with mental health conditions		$ 99,500	Wellbeing
Modern OB Supplies/Outreach	Supplies for program including scales, BP cuffs, Fetal Heartrate monitors, software,		$ 519,764	Connect
Chronic Disease Managmenet Mediur	Costs include supplies, software, and current OSF staff oversight based on historica		$ 2,734,335	Connect
Chronic Disease Managmenet High C	Costs include supplies, software, and current OSF staff oversight based on historica		$ 2,367,160	Connect
Chronic Disease Management Low To	BP Cuffs and Software as well as patient outreach		$ 1,195,350	Connect
OSF OnCall Building Buildout	4th Floor Buildout to support added remote patient monitoring services		$ 4,185,000	Connect
Zipnosis Urgent Care Platform	Virtual Platform to host OnCall Urgent Care visits		$ 456,000	Virtual UC
Technology Bar Setup Costs	Costs nedded to build 10 Technology Bars into service areas		$ 100,000	TechBars
Pieces Connect	Software to communicate with the patients in communities		$ 250,000	SMS Outreach
OCC Platform Development	Costs needed to develop OSF software support system for Health Workers		$ 2,600,000	CHW
Patient Related Cost	CHW Monitoring costs which include utilizing BEP vendors		$ 115,000	CHW
Patient Data Cost	Costs needed to monitor patient data		$ 105,000	CHW
Standing Up Ed Platform for CHW I &	CHW Monitoring costs which include utilizing BEP vendors		$ 500,000	CHW
Comms Enabled Trucks	Vans needed to provide transportation for CHW's to provide support to communities		$ 480,000	CHW
APP Fellowship Program Costs	Supplies and Education Costs		$ 283,763	APP Fellowship
Administration and OnCall Building	Administration oversight and new building occupancy costs such as depreciation, re		$ 1,562,526	
OSF Support/Unexpectant Costs	HR, IT, Accounting, etc support from corporate plus unexpectant costs		$ 2,278,643	
		Total Other Direct Costs	$ 19,832,042	

C. Consultants

Name	Organization	Activity	Fees/Travel Expenses		Total
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)

Organization	Contact Person	Activity		Total
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST $ 27,551,431

F. Revenue

Source	Activity Funded	Amount
Transformation Funds	Operations of programs	$ 22,786,431
Collaborators' Funds		
State Capital Funds	Building, Tech Bar, and Vans	$ 4,765,000
Philanthropy		
Other	CHW subscription and van leas	500,500
Total Revenue		$ 28,051,930.98

Item from Tab 1	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Behavioral Health Navigator	21,451.73	21,451.73	21,451.73	21,451.73	21,451.73	21,451.73	21,451.73	21,451.73	21,451.73	21,451.73	21,451.73	21,451.73
Advanced Practice Provider	44,928.00	44,928.00	44,928.00	44,928.00	44,928.00	44,928.00	44,928.00	44,928.00	44,928.00	44,928.00	44,928.00	44,928.00
SIM Program Developmt Spec	9,013.33	9,013.33	9,013.33	9,013.33	9,013.33	9,013.33	9,013.33	9,013.33	9,013.33	9,013.33	9,013.33	9,013.33
Educator	12,500.00	12,500.00	12,500.00	12,500.00	12,500.00	12,500.00	12,500.00	12,500.00	12,500.00	12,500.00	12,500.00	12,500.00
Fellows	50,000.00	50,000.00	50,000.00	50,000.00	50,000.00	50,000.00	50,000.00	50,000.00	50,000.00	50,000.00	50,000.00	50,000.00
Registered Nurse	90,854.40	90,854.40	90,854.40	90,854.40	90,854.40	90,854.40	90,854.40	90,854.40	90,854.40	90,854.40	90,854.40	90,854.40
Advanced Practice Provider	119,808.00	119,808.00	119,808.00	119,808.00	119,808.00	119,808.00	119,808.00	119,808.00	119,808.00	119,808.00	119,808.00	119,808.00
Digital Health Worker	85,626.67	85,626.67	85,626.67	85,626.67	85,626.67	85,626.67	85,626.67	85,626.67	85,626.67	85,626.67	85,626.67	85,626.67
Medical Office Assitant	54,080.00	54,080.00	54,080.00	54,080.00	54,080.00	54,080.00	54,080.00	54,080.00	54,080.00	54,080.00	54,080.00	54,080.00
Registered Nurse	155,020.32	155,020.32	155,020.32	155,020.32	155,020.32	155,020.32	155,020.32	155,020.32	155,020.32	155,020.32	155,020.32	155,020.32
Silver Cloud Annual Licenses fee	8,291.67	8,291.67	8,291.67	8,291.67	8,291.67	8,291.67	8,291.67	8,291.67	8,291.67	8,291.67	8,291.67	8,291.67
Modern OB Supplies/Outreach	43,313.67	43,313.67	43,313.67	43,313.67	43,313.67	43,313.67	43,313.67	43,313.67	43,313.67	43,313.67	43,313.67	43,313.67
Chronic Disease Managmenet Medium Costs	227,861.25	227,861.25	227,861.25	227,861.25	227,861.25	227,861.25	227,861.25	227,861.25	227,861.25	227,861.25	227,861.25	227,861.25
Chronic Disease Managmenet High Costs	197,263.35	197,263.35	197,263.35	197,263.35	197,263.35	197,263.35	197,263.35	197,263.35	197,263.35	197,263.35	197,263.35	197,263.35
Chronic Disease Management Low Touch	99,612.50	99,612.50	99,612.50	99,612.50	99,612.50	99,612.50	99,612.50	99,612.50	99,612.50	99,612.50	99,612.50	99,612.50
OSF OnCall Building Buildout	348,750.00	348,750.00	348,750.00	348,750.00	348,750.00	348,750.00	348,750.00	348,750.00	348,750.00	348,750.00	348,750.00	348,750.00
Zipnosis Urgent Care Platform	38,000.00	38,000.00	38,000.00	38,000.00	38,000.00	38,000.00	38,000.00	38,000.00	38,000.00	38,000.00	38,000.00	38,000.00
Technology Bar Setup Costs	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33
Pieces Connect	20,833.33	20,833.33	20,833.33	20,833.33	20,833.33	20,833.33	20,833.33	20,833.33	20,833.33	20,833.33	20,833.33	20,833.33
OCC Platform Development	216,666.67	216,666.67	216,666.67	216,666.67	216,666.67	216,666.67	216,666.67	216,666.67	216,666.67	216,666.67	216,666.67	216,666.67
Patient Related Cost	9,583.33	9,583.33	9,583.33	9,583.33	9,583.33	9,583.33	9,583.33	9,583.33	9,583.33	9,583.33	9,583.33	9,583.33
Patient Data Cost	8,750.00	8,750.00	8,750.00	8,750.00	8,750.00	8,750.00	8,750.00	8,750.00	8,750.00	8,750.00	8,750.00	8,750.00
Standing Up Ed Platform for CHW I & II	41,666.67	41,666.67	41,666.67	41,666.67	41,666.67	41,666.67	41,666.67	41,666.67	41,666.67	41,666.67	41,666.67	41,666.67
Comms Enabled Trucks	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00
APP Fellowship Program Costs	23,646.92	23,646.92	23,646.92	23,646.92	23,646.92	23,646.92	23,646.92	23,646.92	23,646.92	23,646.92	23,646.92	23,646.92
Administration and OnCall Building	130,210.51	130,210.51	130,210.51	130,210.51	130,210.51	130,210.51	130,210.51	130,210.51	130,210.51	130,210.51	130,210.51	130,210.51
OSF Support/Unexpectant Costs	189,886.93	189,886.93	189,886.93	189,886.93	189,886.93	189,886.93	189,886.93	189,886.93	189,886.93	189,886.93	189,886.93	189,886.93

Temporary Staff related to implementation or initial cost of permanent employees							
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**	
	Behavioral Health Navigator	$59,987	$17,996	340%		$ 265,143	Wellbeing
	Advanced Practice Provider	$128,544	$25,709	360%		$ 555,310	Virtual UC
	SIM Program Developmt Spec	$85,696	$25,709	100%		$ 111,405	CHW Training
	Educator	$128,750	$25,750	100%		$ 154,500	APP Fellowship
	Fellows	$103,000	$20,600	500%		$ 618,000	APP Fellowship
	Registered Nurse	$89,981	$26,994	960%		$ 1,122,960	Connect
	Advanced Practice Provider	$128,544	$25,709	960%		$ 1,480,827	Connect
	Digital Health Worker	$40,706	$12,212	2000%		$ 1,058,346	Connect
	Medical Office Assitant	$53,560	$16,068	960%		$ 668,429	Connect
	Registered Nurse	$89,981	$26,994	1638%		$ 1,916,051	Connect
			Total Salary and Benefits			$ 7,950,971	

B. Other Direct Costs				
Item	**Description/Justification**		**Total**	
Silver Cloud Annual Licenses fee	Behavioral Health Software to help treat patients with mental health conditions		$ 102,485	Wellbeing
Modern OB Supplies/Outreach	Supplies for program including scales, BP cuffs, Fetal Heartrate monitors, software		$ 778,653	Connect
Chronic Disease Managmenet Mediu	Costs include supplies, software, and current OSF staff oversight based on historic		$ 2,957,183	Connect
Chronic Disease Managmenet High C	Costs include supplies, software, and current OSF staff oversight based on historic		$ 2,560,084	Connect
Chronic Disease Management Low T	BP Cuffs and Software as well as patient outreach		$ 1,388,574	Connect
Zipnosis Urgent Care Platform	Virtual Platform to host OnCall Urgent Care visits		$ 469,680	Virtual UC
Pieces Connect	Software to communicate with the patients in communities		$ 257,500	SMS Outreach
OCC Platform Development	Costs needed to develop OSF software support system for Health Workers		$ 710,000	CHW
Patient Data Cost	Costs needed to monitor patient data		$ 108,150	CHW
Comms Enabled Trucks Maintenance	Gas, Repairs, and general maintenance		$ 48,000	CHW
APP Fellowship Program Costs	Supplies and Education Costs		$ 292,276	APP Fellowship
Administration and OnCall Building	Administration oversight and new building occupancy costs such as depreciation, r		$ 1,609,402	
OSF Support/Unexpectant Costs	HR, IT, Accounting, etc support from corporate plus unexpectant costs		$ 2,131,662	
		Total Other Direct Costs	$ 13,413,648	

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
				Total Consultants	$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
			Total Subcontract(s)	$ -

TOTAL BUDGET REQUEST	$ 21,364,619

F. Revenue			
Source	**Activity Funded**	**Amount**	
Transformation Funds	Operations of programs	$ 21,364,619	
Collaborators' Funds			
State Capital Funds	Building, Tech Bar, and Vans	$ -	
Philanthropy			
Other	CHW subscription and van leas	500,500	
	Total Revenue	$ 21,865,119.50	

Temporary Staff related to implementation or initial cost of permanent employees							
Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Total	
	Behavioral Health Navigator	$61,787	$18,536	340%		$ 273,098	Wellbeing
	Advanced Practice Provider	$132,400	$26,480	360%		$ 571,969	Virtual UC
	SIM Program Developmt Spec	$88,267	$26,480	100%		$ 114,747	CHW Training
	Educator	$132,613	$26,523	100%		$ 159,135	APP Fellowship
	Fellows	$106,090	$21,218	500%		$ 636,540	APP Fellowship
	Registered Nurse	$92,680	$27,804	960%		$ 1,156,649	Connect
	Advanced Practice Provider	$132,400	$26,480	960%		$ 1,525,252	Connect
	Digital Health Worker	$41,927	$12,578	2000%		$ 1,090,096	Connect
	Medical Office Assitant	$55,167	$16,550	960%		$ 688,482	Connect
	Registered Nurse	$92,680	$27,804	1638%		$ 1,973,533	Connect
				Total Salary and Benefits		$ 8,189,500	

B. Other Direct Costs				
Item	Description/Justification		Total	
Silver Cloud Annual Licenses fee	Behavioral Health Software to help treat patients with mental health conditions		$ 105,560	Wellbeing
Modern OB Supplies/Outreach	Supplies for program including scales, BP cuffs, Fetal Heartrate monitors, software		$ 1,047,930	Connect
Chronic Disease Managmenet Mediu	Costs include supplies, software, and current OSF staff oversight based on historic		$ 3,188,235	Connect
Chronic Disease Managmenet High C	Costs include supplies, software, and current OSF staff oversight based on historic		$ 2,760,109	Connect
Chronic Disease Management Low T	BP Cuffs and Software as well as patient outreach		$ 1,589,290	Connect
Zipnosis Urgent Care Platform	Virtual Platform to host OnCall Urgent Care visits		$ 483,770	Virtual UC
Pieces Connect	Software to communicate with the patients in communities		$ 265,225	SMS Outreach
Patient Data Cost	Costs needed to monitor patient data		$ 111,395	CHW
Comms Enabled Trucks Maintenance	Gas, Repairs, and general maintenance		$ 48,000	CHW
APP Fellowship Program Costs	Supplies and Education Costs		$ 301,044	APP Fellowship
Administration and OnCall Building	Administration oversight and new building occupancy costs such as depreciation, r		$ 1,657,684	
OSF Support/Unexpectant Costs	HR, IT, Accounting, etc support from corporate plus unexpectant costs		$ 2,188,860	
		Total Other Direct Costs	$ 13,747,101	

C. Consultants					
Name	Organization	Activity	Fees/Travel Expenses		Total
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	Contact Person	Activity		Total
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST		$ 21,936,602

F. Revenue		
Source	Activity Funded	Amount
Transformation Funds	Operations of programs	$ 21,936,602
Collaborators' Funds		
State Capital Funds	Building, Tech Bar, and Vans	$ -
Philanthropy		
Other	CHW subscription and van leas	500,500
	Total Revenue	$ 22,437,101.56

Temporary Staff related to implementation or initial cost of permanent employees							
Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Total	
	Behavioral Health Navigator	$63,640	$19,092	340%		$ 281,291	Wellbeing
	Advanced Practice Provider	$136,372	$27,274	360%		$ 589,128	Virtual UC
	SIM Program Developmt Spec	$90,915	$27,274	100%		$ 118,189	CHW Training
	Educator	$136,591	$27,318	100%		$ 163,909	APP Fellowship
	Fellows	$109,273	$21,855	500%		$ 655,636	APP Fellowship
	Registered Nurse	$95,461	$28,638	960%		$ 1,191,349	Connect
	Advanced Practice Provider	$136,372	$27,274	960%		$ 1,571,009	Connect
	Digital Health Worker	$43,185	$12,955	2000%		$ 1,122,799	Connect
	Medical Office Assitant	$56,822	$17,047	960%		$ 709,136	Connect
	Registered Nurse	$95,461	$28,638	1638%		$ 2,032,739	Connect
			Total Salary and Benefits			$ 8,435,185	

B. Other Direct Costs				
Item	Description/Justification		Total	
Silver Cloud Annual Licenses fee	Behavioral Health Software to help treat patients with mental health conditions		$ 108,726	Wellbeing
Modern OB PMPY Costs	Projected Costs for Modern OB Program Per Member Per Year		$ 1,327,483	Connect
Chronic Disease Managmenet Mediu	Projected Costs for Chronic Disease Per Member Per Year		$ 3,427,489	Connect
Chronic Disease Managmenet High R	Projected Costs for Chronic Disease Per Member Per Year		$ 2,967,235	Connect
Chronic Disease Management Low T	Projected Costs for Chronic Disease Per Member Per Year		$ 1,797,448	Connect
Zipnosis Urgent Care Platform	Virtual Platform to host OnCall Urgent Care visits		$ 498,284	Virtual UC
Pieces Connect	Software to communicate with the patients in communities		$ 273,182	SMS Outreach
Patient Data Cost	Costs needed to monitor patient data		$ 114,736	CHW
Comms Enabled Trucks Maintenance	Gas, Repairs, and general maintenance		$ 48,000	CHW
APP Fellowship Program Costs	Supplies and Education Costs		$ 310,075	APP Fellowship
Administration and OnCall Building	Administration oversight and new building occupancy costs such as depreciation, r		$ 1,707,415	
OSF Support/Unexpectant Costs	HR, IT, Accounting, etc support from corporate plus unexpectant costs		$ 2,329,695	
	Total Other Direct Costs		$ 14,909,769	

C. Consultants					
Name	Organization	Activity	Fees/Travel Expenses		Total
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	Contact Person	Activity		Total
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST		$ 23,344,954

F. Revenue		
Source	Activity Funded	Amount
Transformation Funds	Operations of programs	$ 23,344,954
Collaborators' Funds		
State Capital Funds	Building, Tech Bar, and Vans	$ -
Philanthropy		
Other	CHW subscription and van leas	500,500
Total Revenue		$ 23,845,453.97

Temporary Staff related to implementation or initial cost of permanent employees							
Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Total	
	Behavioral Health Navigator	$65,550	$19,665	340%		$ 289,729	Wellbeing
	Advanced Practice Provider	$140,463	$28,093	360%		$ 606,802	Virtual UC
	SIM Program Developmt Spec	$93,642	$28,093	100%		$ 121,735	CHW Training
	Educator	$140,689	$28,138	100%		$ 168,826	APP Fellowship
	Fellows	$112,551	$22,510	500%		$ 675,305	APP Fellowship
	Registered Nurse	$98,324	$29,497	960%		$ 1,227,089	
	Advanced Practice Provider	$140,463	$28,093	960%		$ 1,618,140	
	Digital Health Worker	$44,480	$13,344	2000%		$ 1,156,483	
	Medical Office Assitant	$58,526	$17,558	960%		$ 730,410	
	Registered Nurse	$98,324	$29,497	1638%		$ 2,093,721	
				Total Salary and Benefits		$ 8,688,241	

B. Other Direct Costs				
Item	Description/Justification		Total	
Silver Cloud Annual Licenses fee	Behavioral Health Software to help treat patients with mental health conditions		$ 111,988	Wellbeing
Modern OB PMPY Costs	Projected Costs for Modern OB Program Per Member Per Year		$ 1,617,193	Connect
Chronic Disease Managmenet Mediu	Projected Costs for Chronic Disease Per Member Per Year		$ 3,674,946	Connect
Chronic Disease Managmenet High R	Projected Costs for Chronic Disease Per Member Per Year		$ 3,181,463	Connect
Chronic Disease Management Low T	Projected Costs for Chronic Disease Per Member Per Year		$ 2,012,997	Connect
Zipnosis Urgent Care Platform	Virtual Platform to host OnCall Urgent Care visits		$ 513,232	Virtual UC
Pieces Connect	Software to communicate with the patients in communities		$ 281,377	SMS Outreach
Patient Data Cost	Costs needed to monitor patient data		$ 118,178	CHW
Comms Enabled Trucks Maintenance	Gas, Repairs, and general maintenance		$ 48,000	CHW
APP Fellowship Program Costs	Supplies and Education Costs		$ 319,378	APP Fellowship
Administration and OnCall Building	Administration oversight and new building occupancy costs such as depreciation, r		$ 1,758,637	
OSF Support/Unexpectant Costs	HR, IT, Accounting, etc support from corporate plus unexpectant costs		$ 2,475,292	
		Total Other Direct Costs	$ 16,112,683	

C. Consultants					
Name	Organization	Activity	Fees/Travel Expenses		Total
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	Contact Person	Activity		Total
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST		$ 24,800,924

F. Revenue		
Source	Activity Funded	Amount
Transformation Funds	Operations of programs	$ 24,800,924
Collaborators' Funds		
State Capital Funds	Building, Tech Bar, and Vans	$ -
Philanthropy		
Other	CHW subscription and van leas	500,500
	Total Revenue	$ 25,301,424.14

Collaboration name	**Aunt Marthas**	**Project Period:**	**2021-2026**
Primary Contact			
Preparer Name/Title:			
Phone:		**Email:**	

Temporary Staff related to implementation or initial cost of permanent employees

Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Total
	Community Health Worker	$29,000	$7,680	300%		$ 110,040
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
			Total Salary and Benefits			$ 110,040

B. Other Direct Costs

Item	Description/Justification		Total
Mobile Technology Van	CHW Transportation and Patient Outreach		$ 48,000
		Total Other Direct Costs	$ 48,000

C. Consultants

Name	Organization	Activity	Fees/Travel Expenses		Total
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)

Organization	Contact Person	Activity		Total
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST $ 158,040

F. Revenue

Source	Activity Funded	Amount
Transformation Funds	Operations of programs	$ 110,040
Collaborators' Funds		
State Capital Funds		$ 48,000
Philanthropy		
Other		
Total Revenue		$ 158,040.00

Item from Tab 1	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Community Health Worker	9,170.00	9,170.00	9,170.00	9,170.00	9,170.00	9,170.00	9,170.00	9,170.00	9,170.00	9,170.00	9,170.00	9,170.00
Mobile Technology Van	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00	4,000.00

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Community Health Worker	$29,000	$7,680	300%		$ 110,040
						$ -
						$ -
						$ -
						$ -
						$ -
				Total Salary and Benefits		$ 110,040

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
			$ -
		Total Other Direct Costs	$ -

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST	$ 110,040

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 110,040
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 110,040

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Community Health Worker	$29,000	$7,680	300%		$ 110,040
						$ -
						$ -
						$ -
						$ -
						$ -
				Total Salary and Benefits		$ 110,040

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
			$ -
		Total Other Direct Costs	$ -

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST	$ 110,040

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 110,040
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 110,040

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Community Health Worker	$29,000	$7,680	300%		$ 110,040
						$ -
						$ -
						$ -
						$ -
						$ -
				Total Salary and Benefits		$ 110,040

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
			$ -
		Total Other Direct Costs	$ -

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST	$ 110,040

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 110,040
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 110,040

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Community Health Worker	$29,000	$7,680	300%		$ 110,040
						$ -
						$ -
						$ -
						$ -
						$ -
				Total Salary and Benefits		$ 110,040

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
			$ -
		Total Other Direct Costs	$ -

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST	$ 110,040

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 110,040
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 110,040

Collaboration name	**Chestnut**	**Project Period:**	**2021-2026**
Primary Contact			
Preparer Name/Title:			
Phone:		**Email:**	

Temporary Staff related to implementation or initial cost of permanent employees

Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Total
	Community Health Worker	$29,000	$7,680	500%		$ 183,400
	CHW Coordinator	$32,000	$9,920	100%		$ 41,920
	Associate Director Community C	$56,000	$12,120	20%		$ 13,624
	Wellness Program Coordinator	$32,000	$9,920	100%		$ 41,920
	Dental Manager	$55,000	$17,050	100%		$ 72,050
	Dentist	$180,000	$55,800	100%		$ 235,800
	Dental Hygienist	$115,000	$36,960	100%		$ 151,960
	Dental Assistant	$57,000	$16,360	100%		$ 73,360
	Psychiatric APN	$115,000	$29,100	50%		$ 72,050
	Administration	$64,383	$19,959	100%		$ 84,342
				Total Salary and Benefits		$ 970,426

B. Other Direct Costs

Item	Description/Justification		Total
Laptops	For nondental Staff		$ 9,100
Cell Phones	For nondental Staff		$ 3,695
Patient Engagement	Costs associated with patient engagement		$ 35,000
Dental Equipment	Supplies for 4 operatories		$ 517,926
EPIC Build	POINTcore EPIC Build Costs		$ 1,000,000
Vehicle Leasing	Vehicle leasing for CHW staff		$ 18,000
	Total Other Direct Costs		$ 1,583,721

C. Consultants

Name	Organization	Activity	Fees/Travel Expenses		Total
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)

Organization	Contact Person	Activity		Total
Home Sweet Home Ministries	Matt Burgess	Food Pharmacy		$ 36,500
BabyFold	Dianne Schultz	lease of space/training		$ 8,000
Boys and Girls Club	Tony Morstatter	lease of space/training		$ 8,000
				$ -
		Total Subcontract(s)		$ 52,500

TOTAL BUDGET REQUEST	$ 2,606,647

F. Revenue

Source	Activity Funded	Amount
Transformation Funds	Operations of programs	$ 2,088,721
Collaborators' Funds		
State Capital Funds	Dental Equipment	$ 517,926
Philanthropy		
Other		
Total Revenue		$ 2,606,646.50

Item from Tab 1	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Community Health Worker	15,283.33	15,283.33	15,283.33	15,283.33	15,283.33	15,283.33	15,283.33	15,283.33	15,283.33	15,283.33	15,283.33	15,283.33
CHW Coordinator	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33
Associate Director Community Care	1,135.33	1,135.33	1,135.33	1,135.33	1,135.33	1,135.33	1,135.33	1,135.33	1,135.33	1,135.33	1,135.33	1,135.33
Wellness Program Coordinator	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33	3,493.33
Dental Manager	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17
Dentist	19,650.00	19,650.00	19,650.00	19,650.00	19,650.00	19,650.00	19,650.00	19,650.00	19,650.00	19,650.00	19,650.00	19,650.00
Dental Hygienist	12,663.33	12,663.33	12,663.33	12,663.33	12,663.33	12,663.33	12,663.33	12,663.33	12,663.33	12,663.33	12,663.33	12,663.33
Dental Assistant	6,113.33	6,113.33	6,113.33	6,113.33	6,113.33	6,113.33	6,113.33	6,113.33	6,113.33	6,113.33	6,113.33	6,113.33
Psychiatric APN	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17	6,004.17
Administration	7,028.46	7,028.46	7,028.46	7,028.46	7,028.46	7,028.46	7,028.46	7,028.46	7,028.46	7,028.46	7,028.46	7,028.46
Laptops	758.33	758.33	758.33	758.33	758.33	758.33	758.33	758.33	758.33	758.33	758.33	758.33
Cell Phones	307.92	307.92	307.92	307.92	307.92	307.92	307.92	307.92	307.92	307.92	307.92	307.92
Wellness Program Expenses	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67
Dental Equipment	43,160.50	43,160.50	43,160.50	43,160.50	43,160.50	43,160.50	43,160.50	43,160.50	43,160.50	43,160.50	43,160.50	43,160.50
EPIC Build	83,333.33	83,333.33	83,333.33	83,333.33	83,333.33	83,333.33	83,333.33	83,333.33	83,333.33	83,333.33	83,333.33	83,333.33
Vehicle leasing	1,500.00	1,500.00	1,500.00	1,500.00	1,500.00	1,500.00	1,500.00	1,500.00	1,500.00	1,500.00	1,500.00	1,500.00
Food Pharmacy Expenses	3,041.67	3,041.67	3,041.67	3,041.67	3,041.67	3,041.67	3,041.67	3,041.67	3,041.67	3,041.67	3,041.67	3,041.67
BabyFold lease & training	666.67	666.67	666.67	666.67	666.67	666.67	666.67	666.67	666.67	666.67	666.67	666.67
Boys and Girls Club lease and training	666.67	666.67	666.67	666.67	666.67	666.67	666.67	666.67	666.67	666.67	666.67	666.67

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Community Health Worker	$29,000	$7,680	1200%		$ 440,160
	CHW Coordinator	$33,000	$10,778	100%		$ 43,778
	Associate Director Community Care	$56,000	$12,120	20%		$ 13,624
	Wellness Program Coordinator	$33,000	$10,778	100%		$ 43,778
	Dental Manager	$55,000	$17,050	40%		$ 28,820
	Dentist	$180,000	$55,800	40%		$ 94,320
	Dental Hygienist	$58,000	$17,980	40%		$ 30,392
	Dental Assistant	$28,000	$8,680	40%		$ 14,672
	Psychiatric APN	$145,000	$35,125	20%		$ 36,025
	Productivity Coordinator	$56,000	$17,360	100%		$ 73,360
	Administrative staff	$64,383	$19,959	100%		$ 84,342
				Total Salary and Benefits		$ 903,271

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Laptops	For nondental Staff		$ 3,900
Cell Phones	For nondental Staff		$ 1,155
Wellness Program Exp	costs associated with wellness programming		$ 35,000
Vehicle Leasing	leasing vehicles for CHW		$ 30,000
	Total Other Direct Costs		$ 70,055

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
Home Sweet Home Min	Matt Burgess	Food Pharmacy		$ 36,500
The BabyFold	Dianne Schultz	space leasing and training		$ 8,000
Boys and Girls Club	Tony Morestatter	space leasing and training		$ 8,000
				$ -
		Total Subcontract(s)		$ 52,500
		TOTAL BUDGET REQUEST		$ 1,025,826

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 1,025,826
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 1,025,826

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Community Health Worker	$29,000	$7,680	1200%		$ 440,160
	CHW Coordinator	$33,000	$10,778	100%		$ 43,778
	Associate Director Community Care	$56,000	$12,120	20%		$ 13,624
	Wellness Program Coordinator	$33,000	$10,778	100%		$ 43,778
	Dental Manager	$55,000	$17,050	40%		$ 28,820
	Dentist	$180,000	$55,800	40%		$ 94,320
	Dental Hygienist	$58,000	$17,980	40%		$ 30,392
	Dental Assistant	$28,000	$8,680	40%		$ 14,672
	Psychiatric APN	$145,000	$35,125	20%		$ 36,025
	Productivity Coordinator	$56,000	$17,360	100%		$ 73,360
	Administrative staff	$64,383	$19,959	100%		$ 84,342
				Total Salary and Benefits		$ 903,271

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Laptops	For nondental Staff		$ 3,900
Cell Phones	For nondental Staff		$ 1,155
Wellness Program Exp	costs associated with wellness programming		$ 35,000
Vehicle Leasing	leasing vehicles for CHW		$ 30,000
	Total Other Direct Costs		$ 70,055

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
Home Sweet Home Min	Matt Burgess	Food Pharmacy		$ 38,325
The BabyFold	Dianne Schultz	space leasing and training		$ 8,000
Boys and Girls Club	Tony Morestatter	space leasing and training		$ 8,000
				$ -
		Total Subcontract(s)		$ 54,325

TOTAL BUDGET REQUEST	$ 1,027,651

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 1,027,651
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
Total Revenue		$ 1,027,651

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Community Health Worker	$29,000	$7,680	1200%		$ 440,160
	CHW Coordinator	$33,000	$10,778	100%		$ 43,778
	Associate Director Community Care	$56,000	$12,120	20%		$ 13,624
	Wellness Program Coordinator	$33,000	$10,778	100%		$ 43,778
	Dental Manager	$55,000	$17,050	40%		$ 28,820
	Dentist	$180,000	$55,800	40%		$ 94,320
	Dental Hygienist	$58,000	$17,980	40%		$ 30,392
	Dental Assistant	$28,000	$8,680	40%		$ 14,672
	Psychiatric APN	$145,000	$35,125	20%		$ 36,025
	Productivity Coordinator	$56,000	$17,360	100%		$ 73,360
	Administrative staff	$64,383	$19,959	100%		$ 84,342
				Total Salary and Benefits		$ 903,271

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Wellness Program Exp	costs associated with wellness programming		$ 35,000
Vehicle Leasing	leasing vehicles for CHW		$ 30,000
		Total Other Direct Costs	$ 65,000

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
				Total Consultants	$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
Home Sweet Home Min	Matt Burgess	Food Pharmacy		$ 38,325
The BabyFold	Dianne Schultz	space leasing and training		$ 8,000
Boys and Girls Club	Tony Morestatter	space leasing and training		$ 8,000
				$ -
			Total Subcontract(s)	$ 54,325

TOTAL BUDGET REQUEST	$ 1,022,596

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 1,022,596
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
Total Revenue		$ 1,022,596

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Community Health Worker	$29,000	$7,680	1200%		$ 440,160
	CHW Coordinator	$33,000	$10,778	100%		$ 43,778
	Associate Director Community Care	$56,000	$17,360	20%		$ 14,672
	Wellness Program Coordinator	$33,000	$10,778	100%		$ 43,778
	Dental Manager	$55,000	$17,050	40%		$ 28,820
	Dentist	$180,000	$55,800	40%		$ 94,320
	Dental Hygienist	$58,000	$17,980	40%		$ 30,392
	Dental Assistant	$28,000	$8,680	40%		$ 14,672
	Psychiatric APN	$145,000	$35,125	20%		$ 36,025
	Productivity Coordinator	$56,000	$17,360	100%		$ 73,360
	Administrative staff	$64,383	$19,959	100%		$ 84,342
				Total Salary and Benefits		$ 904,319

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Wellness Program Exp	costs associated with wellness programming		$ 35,000
Vehicle Leasing	leasing vehicles for CHW		$ 30,000
		Total Other Direct Costs	$ 65,000

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
				Total Consultants	$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
Home Sweet Home Min	Matt Burgess	Food Pharmacy		$ 38,325
The BabyFold	Dianne Schultz	space leasing and training		$ 8,000
Boys and Girls Club	Tony Morestatter	space leasing and training		$ 8,000
MarcFirst	Brian Wipperman	EMR support		$ 12,000
		Total Subcontract(s)		$ 66,325
		TOTAL BUDGET REQUEST		$ 1,035,644

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 1,035,644
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 1,035,644

Collaboration name	**Eagle View**	**Project Period:**	**2021-2026**
Primary Contact			
Preparer Name/Title:			
Phone:		**Email:**	

Temporary Staff related to implementation or initial cost of permanent employees

Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Total
	Dentist	$150,000	$37,725	100%		$ 187,725
	Dental Hygienist	$56,000	$14,084	100%		$ 70,084
	Dental Assistants	$31,200	$7,847	200%		$ 78,094
	Receptionist	$28,188	$7,089	100%		$ 35,277
	LCSW	$64,000	$16,096	100%		$ 80,096
	Substance Use Counselor	$55,000	$13,533	100%		$ 68,533
	Community Health Workers	$43,680	$10,986	200%		$ 109,331
	Community Health Worker Salar	$49,920	$12,555	100%		$ 62,475
						$ -
						$ -
						$ -
			Total Salary and Benefits			$ 691,614

B. Other Direct Costs

Item	Description/Justification		Total
Rent and Utilities	CHW space to meet with clients and CHW home base		$ 12,000
Site Specific Equipment	Laptops, Printers, iPad for translation services, desks		$ 100,000
Bus Transportation Vehicle			$ 65,000
Broadband Vehicles			
EPIC Build	POINTcore Costs to Build EPIC		$ 1,221,500
		Total Other Direct Costs	$ 1,398,500

C. Consultants

Name	Organization	Activity	Fees/Travel Expenses		Total
					$ -
					$ -
					$ -
					$ -
				Total Consultants	$ -

E. Subcontract(s)

Organization	Contact Person	Activity		Total
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST $ 2,090,114

F. Revenue

Source	Activity Funded	Amount
Transformation Funds	Operations of programs	$ 2,025,114
Collaborators' Funds		
State Capital Funds	Bus	$ 65,000
Philanthropy		
Other		
Total Revenue		$ 2,090,114.30

Item from Tab 1	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Dentist	15,643.75	15,643.75	15,643.75	15,643.75	15,643.75	15,643.75	15,643.75	15,643.75	15,643.75	15,643.75	15,643.75	15,643.75
Dental Hygienist	5,840.33	5,840.33	5,840.33	5,840.33	5,840.33	5,840.33	5,840.33	5,840.33	5,840.33	5,840.33	5,840.33	5,840.33
Dental Assistants	6,507.80	6,507.80	6,507.80	6,507.80	6,507.80	6,507.80	6,507.80	6,507.80	6,507.80	6,507.80	6,507.80	6,507.80
Receptionist	2,939.77	2,939.77	2,939.77	2,939.77	2,939.77	2,939.77	2,939.77	2,939.77	2,939.77	2,939.77	2,939.77	2,939.77
LCSW	6,674.67	6,674.67	6,674.67	6,674.67	6,674.67	6,674.67	6,674.67	6,674.67	6,674.67	6,674.67	6,674.67	6,674.67
Substance Use Counselor	5,711.04	5,711.04	5,711.04	5,711.04	5,711.04	5,711.04	5,711.04	5,711.04	5,711.04	5,711.04	5,711.04	5,711.04
Community Health Workers	9,110.92	9,110.92	9,110.92	9,110.92	9,110.92	9,110.92	9,110.92	9,110.92	9,110.92	9,110.92	9,110.92	9,110.92
Community Health Worker Salary	5,206.24	5,206.24	5,206.24	5,206.24	5,206.24	5,206.24	5,206.24	5,206.24	5,206.24	5,206.24	5,206.24	5,206.24
Rent and Utilities	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00
Site Specific Equipment	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33	8,333.33
Bus Transportation Vehicle	5,416.67	5,416.67	5,416.67	5,416.67	5,416.67	5,416.67	5,416.67	5,416.67	5,416.67	5,416.67	5,416.67	5,416.67
Broadband Vehicles	-	-	-	-	-	-	-	-	-	-	-	-

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Dentist	$150,000	$37,725	100%		$ 187,725
	Dental Hygienist	$56,000	$14,084	100%		$ 70,084
	Dental Assistants	$31,200	$7,847	200%		$ 78,094
	Receptionist	$28,188	$7,089	100%		$ 35,277
	LCSW	$64,000	$16,096	100%		$ 80,096
	Substance Use Counselor	$55,000	$13,533	100%		$ 68,533
	Community Health Workers	$43,680	$10,986	200%		$ 109,331
	Community Health Worker Salary	$49,920	$12,555	100%		$ 62,475
						$ -
				Total Salary and Benefits		$ 691,614

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Rent and Utilities	CHW space to meet with clients and CHW home base		$ 12,000
EPIC Annual Operating	Annual Costs for EMR software		$ 129,600
			$ -
		Total Other Direct Costs	$ 141,600

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
				Total Consultants	$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
			Total Subcontract(s)	$ -

TOTAL BUDGET REQUEST	$ 833,214

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 833,214
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
Total Revenue		$ 833,214

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Dentist	$150,000	$37,725	100%		$ 187,725
	Dental Hygienist	$56,000	$14,084	100%		$ 70,084
	Dental Assistants	$31,200	$7,847	200%		$ 78,094
	Receptionist	$28,188	$7,089	100%		$ 35,277
	LCSW	$64,000	$16,096	100%		$ 80,096
	Substance Use Counselor	$55,000	$13,533	100%		$ 68,533
	Community Health Workers	$43,680	$10,986	200%		$ 109,331
	Community Health Worker Salary	$49,920	$12,555	100%		$ 62,475
						$ -
				Total Salary and Benefits		$ 691,614

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Rent and Utilities	CHW space to meet with clients and CHW home base		$ 12,000
EPIC Annual Operating	Annual Costs for EMR software		$ 129,600
			$ -
		Total Other Direct Costs	$ 141,600

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
				Total Consultants	$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
			Total Subcontract(s)	$ -

TOTAL BUDGET REQUEST	$ 833,214

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 833,214
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
Total Revenue		$ 833,214

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Dentist	$150,000	$37,725	100%		$ 187,725
	Dental Hygienist	$56,000	$14,084	100%		$ 70,084
	Dental Assistants	$31,200	$7,847	200%		$ 78,094
	Receptionist	$28,188	$7,089	100%		$ 35,277
	LCSW	$64,000	$16,096	100%		$ 80,096
	Substance Use Counselor	$55,000	$13,533	100%		$ 68,533
	Community Health Workers	$43,680	$10,986	200%		$ 109,331
	Community Health Worker Salary	$49,920	$12,555	100%		$ 62,475
						$ -
				Total Salary and Benefits		$ 691,614

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Rent and Utilities	CHW space to meet with clients and CHW home base		$ 12,000
EPIC Annual Operating	Annual Costs for EMR software		$ 129,600
			$ -
		Total Other Direct Costs	$ 141,600

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
				Total Consultants	$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
			Total Subcontract(s)	$ -

TOTAL BUDGET REQUEST	$ 833,214

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 833,214
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
Total Revenue		$ 833,214

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Dentist	$150,000	$37,725	100%		$ 187,725
	Dental Hygienist	$56,000	$14,084	100%		$ 70,084
	Dental Assistants	$31,200	$7,847	200%		$ 78,094
	Receptionist	$28,188	$7,089	100%		$ 35,277
	LCSW	$64,000	$16,096	100%		$ 80,096
	Substance Use Counselor	$55,000	$13,533	100%		$ 68,533
	Community Health Workers	$43,680	$10,986	200%		$ 109,331
	Community Health Worker Salary	$49,920	$12,555	100%		$ 62,475
						$ -
				Total Salary and Benefits		$ 691,614

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Rent and Utilities	CHW space to meet with clients and CHW home base		$ 12,000
EPIC Annual Operating	Annual Costs for EMR software		$ 129,600
			$ -
		Total Other Direct Costs	$ 141,600

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
				Total Consultants	$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
			Total Subcontract(s)	$ -

TOTAL BUDGET REQUEST	$ 833,214

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 833,214
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
Total Revenue		$ 833,214

Collaboration name	**Heartland**	**Project Period:**	**2021-2026**
Primary Contact	**Sharon Adams**		
Preparer Name/Title:	**Sharon Adams/CEO**		
Phone:	**309-680-7657**	**Email:**	S.Adams@hhsil.com

Temporary Staff related to implementation or initial cost of permanent employees

Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Total
	5 CHW @ 18.25/hour	$189,800	$47,450	5.0%		$ 237,250
	Administration	$35,000		0.3%		$ 35,000
				Total Salary and Benefits		$ 272,250

B. Other Direct Costs

Item	Description/Justification		Total
Rent	Rent for space to open 3 pop up navigator locations at the following locations		$ 36,000
Equipment/Technology	Laptop and site specific equipment		$ 159,075
Data	Mobile diagnostic annual/Zoom/Phone		$ 8,520
Communication/Marketing	Outreach		$ 10,000
Care Message			
Care Message			
Supplies	Office, Outreach, Uniforms		$ 11,680
		Total Other Direct Costs	$ 225,275

C. Consultants

Name	Organization	Activity	Fees/Travel Expenses		Total
					$ -
					$ -
					$ -
					$ -
				Total Consultants	$ -

E. Subcontract(s)

Organization	Contact Person	Activity		Total
				$ -
				$ -
			Total Subcontract(s)	$ -

TOTAL BUDGET REQUEST	$ 497,525

F. Revenue

Source	Activity Funded		Amount
Transformation Funds	Operations of programs	$	338,450
Collaborators' Funds			
State Capital Funds	Laptops and site specific equipm	$	159,075
Philanthropy			
Other			
	Total Revenue	$	497,525.00

Item from Tab 1	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
5 CHW @ 18.25/hour	19,770.83	19,770.83	19,770.83	19,770.83	19,770.83	19,770.83	19,770.83	19,770.83	19,770.83	19,770.83	19,770.83	19,770.83
Administration	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67	2,916.67
Rent	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	3,000.00
Equipment/Technology	13,256.25	13,256.25	13,256.25	13,256.25	13,256.25	13,256.25	13,256.25	13,256.25	13,256.25	13,256.25	13,256.25	13,256.25
Data	710.00	710.00	710.00	710.00	710.00	710.00	710.00	710.00	710.00	710.00	710.00	710.00
Communication/Marketing	833.33	833.33	833.33	833.33	833.33	833.33	833.33	833.33	833.33	833.33	833.33	833.33
Care Message	-	-	-	-	-	-	-	-	-	-	-	-
Care Message	-	-	-	-	-	-	-	-	-	-	-	-
Supplies	973.33	973.33	973.33	973.33	973.33	973.33	973.33	973.33	973.33	973.33	973.33	973.33

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Total
	5 CHW @ 18.80/hour	$195,520	$48,880	5.0%		$ 244,400
	Administration	$35,000		0.3%		$ 35,000
				Total Salary and Benefits		$ 279,400

B. Other Direct Costs			
Item	Description/Justification		Total
Rent	Rent for space to open 3 pop up navigator locations at the following locations		$ 36,000
Data	Mobile diagnostic annual/Zoom/Phone		$ 8,520
Communication/Marketi	Outreach		$ 10,000
Care Message			
Care Message			
Supplies	Office, Outreach, Uniforms		$ 11,500
	Total Other Direct Costs		$ 66,020

C. Consultants					
Name	Organization	Activity	Fees/Travel Expenses		Total
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	Contact Person	Activity		Total
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST	$ 345,420

F. Revenue		
Source	Activity Funded	Amount
Transformation Funds	Operations of programs	$ 345,420
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 345,420

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	5 CHW @ 19.36/hour	$201,344	$50,336	5.0%		$ 251,680
	Administration	$35,000		0.3%		$ 35,000
				Total Salary and Benefits		$ 286,680

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Rent	Rent for space to open 3 pop up navigator locations at the following locations		$ 36,000
Data	Mobile diagnostic annual/Zoom/Phone		$ 8,520
Communication/Marketi	Outreach		$ 10,000
Care Message			
Care Message			
Supplies	Office, Outreach, Uniforms		$ 11,500
	Total Other Direct Costs		$ 66,020

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST	$ 352,700

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 352,700
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 352,700

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	5 CHW @ 19.94/hour	$207,376	$51,844	5.0%		$ 259,220
	Administration	$35,000		0.3%		$ 35,000
				Total Salary and Benefits		$ 294,220

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Rent	Rent for space to open 3 pop up navigator locations at the following locations		$ 36,000
Data	Mobile diagnostic annual/Zoom/Phone		$ 8,520
Communication/Marketi	Outreach		$ 10,000
Care Message			
Care Message			
Supplies	Office, Outreach, Uniforms		$ 11,500
		Total Other Direct Costs	$ 66,020

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
				Total Consultants	$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
			Total Subcontract(s)	$ -

TOTAL BUDGET REQUEST	$ 360,240

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 360,240
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 360,240

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Total
	5 CHW @ 20.54/hour	$213,616	$53,404	5.0%		$ 267,020
	Administration	$35,000		0.3%		$ 35,000
				Total Salary and Benefits		$ 302,020

B. Other Direct Costs			
Item	Description/Justification		Total
Rent	Rent for space to open 3 pop up navigator locations at the following locations		$ 36,000
Data	Mobile diagnostic annual/Zoom/Phone		$ 8,520
Communication/Marketi	Outreach		$ 10,000
Care Message			
Care Message			
Supplies	Office, Outreach, Uniforms		$ 11,500
	Total Other Direct Costs		$ 66,020

C. Consultants					
Name	Organization	Activity	Fees/Travel Expenses		Total
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	Contact Person	Activity		Total
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST	$ 368,040

F. Revenue		
Source	Activity Funded	Amount
Transformation Funds	Operations of programs	$ 368,040
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 368,040

Collaboration name	**Miles Square**	**Project Period:**	**2021-2026**
Primary Contact			
Preparer Name/Title:			
Phone:		**Email:**	

Temporary Staff related to implementation or initial cost of permanent employees

Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Total
	Project Coordinator	$78,000	$2,340	100%		$ 80,340
	Regional Medical Director	$190,000	$5,700	20%		$ 39,140
	LCSW	$65,000	$1,300	200%		$ 132,600
	Psych APN	$105,000	$2,000	200%		$ 214,000
	Emergency Department Navigat	$40,000	$800	100%		$ 40,800
						$ -
						$ -
						$ -
						$ -
						$ -
				Total Salary and Benefits		$ 506,880

B. Other Direct Costs

Item	Description/Justification		Total
Patient Supplies	Patient Visit Supplies		$ 147,000
IT Supplies	4 laptops at $2,200 and 6 phones at $300		$ 10,600
Miles Square Auburn Gresham Buildo	The expanded Immediate Care services will support immediate care needs of patier		$ 300,000
		Total Other Direct Costs	$ 457,600

C. Consultants

Name	Organization	Activity	Fees/Travel Expenses		Total
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)

Organization	Contact Person	Activity		Total
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST $ 964,480

F. Revenue

Source	Activity Funded	Amount
Transformation Funds	Operations of programs	$ 664,480
Collaborators' Funds		
State Capital Funds	Buildout	$ 300,000
Philanthropy		
Other		
	Total Revenue	$ 964,480.00

Item from Tab 1	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Project Coordinator	6,695.00	6,695.00	6,695.00	6,695.00	6,695.00	6,695.00	6,695.00	6,695.00	6,695.00	6,695.00	6,695.00	6,695.00
Regional Medical Director	3,261.67	3,261.67	3,261.67	3,261.67	3,261.67	3,261.67	3,261.67	3,261.67	3,261.67	3,261.67	3,261.67	3,261.67
LCSW	11,050.00	11,050.00	11,050.00	11,050.00	11,050.00	11,050.00	11,050.00	11,050.00	11,050.00	11,050.00	11,050.00	11,050.00
Psych APN	17,833.33	17,833.33	17,833.33	17,833.33	17,833.33	17,833.33	17,833.33	17,833.33	17,833.33	17,833.33	17,833.33	17,833.33
Emergency Department Navigator	3,400.00	3,400.00	3,400.00	3,400.00	3,400.00	3,400.00	3,400.00	3,400.00	3,400.00	3,400.00	3,400.00	3,400.00
Patient Supplies	12,250.00	12,250.00	12,250.00	12,250.00	12,250.00	12,250.00	12,250.00	12,250.00	12,250.00	12,250.00	12,250.00	12,250.00
IT Supplies	883.33	883.33	883.33	883.33	883.33	883.33	883.33	883.33	883.33	883.33	883.33	883.33
Miles Square Auburn Gresham Buildout	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Project Coordinator	$79,000	$2,120	100%		$ 81,120
	Regional Medical Director	$191,000	$6,600	20%		$ 39,520
	LCSW	$66,000	$1,600	200%		$ 135,200
	Psych APN	$107,000	$2,200	200%		$ 218,400
	Emergency Department Navigator	$40,800	$800	100%		$ 41,600
						$ -
				Total Salary and Benefits		$ 515,840

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Patient Supplies	Patient Visit Supplies		$ 149,940
IT Supplies	Laptops and Phones		$ 10,812
			$ -
		Total Other Direct Costs	$ 160,752

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST	$ 676,592

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	Operations of programs	$ 676,592
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 676,592

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Project Coordinator	$80,000	$2,680	100%		$ 82,680
	Regional Medical Director	$194,000	$7,400	20%		$ 40,280
	LCSW	$67,000	$1,900	200%		$ 137,800
	Psych APN	$109,000	$2,300	200%		$ 222,600
	Emergency Department Navigator	$41,600	$800	100%		$ 42,400
						$ -
				Total Salary and Benefits		$ 525,760

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Patient Supplies	Patient Visit Supplies		$ 152,239
IT Supplies	Laptops and Phones		$ 11,028
			$ -
		Total Other Direct Costs	$ 163,267

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST		$ 689,027

F. Revenue

Source	Activity Funded	Amount
Transformation Funds	Operations of programs	$ 689,027
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 689,027

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Project Coordinator	$81,000	$3,333	100%		$ 84,333
	Regional Medical Director	$197,000	$8,430	20%		$ 41,086
	LCSW	$68,000	$2,283	200%		$ 140,566
	Psych APN	$111,000	$2,526	200%		$ 227,052
	Emergency Department Navigator	$42,000	$1,248	100%		$ 43,248
						$ -
				Total Salary and Benefits		$ 536,285

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Patient Supplies	Patient Visit Supplies		$ 155,284
IT Supplies	Laptops and Phones		$ 11,249
			$ -
		Total Other Direct Costs	$ 166,533

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST		$ 702,818

F. Revenue

Source	Activity Funded	Amount
Transformation Funds	Operations of programs	$ 702,818
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 702,818

Temporary Staff related to implementation or initial cost of permanent employees						
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**
	Project Coordinator	$82,000	$4,020	100%		$ 86,020
	Regional Medical Director	$200,000	$9,535	20%		$ 41,907
	LCSW	$69,000	$2,689	200%		$ 143,377
	Psych APN	$112,000	$3,797	200%		$ 231,593
	Emergency Department Navigator	$42,500	$1,613	100%		$ 44,113
						$ -
				Total Salary and Benefits		$ 547,010

B. Other Direct Costs			
Item	**Description/Justification**		**Total**
Patient Supplies	Patient Visit Supplies		$ 158,390
IT Supplies	Laptops and Phones		$ 11,474
			$ -
		Total Other Direct Costs	$ 169,864

C. Consultants					
Name	**Organization**	**Activity**	**Fees/Travel Expenses**		**Total**
					$ -
					$ -
					$ -
					$ -
			Total Consultants		$ -

E. Subcontract(s)				
Organization	**Contact Person**	**Activity**		**Total**
				$ -
				$ -
				$ -
				$ -
		Total Subcontract(s)		$ -

TOTAL BUDGET REQUEST		$ 716,874

F. Revenue

Source	Activity Funded	Amount
Transformation Funds	Operations of programs	$ 716,874
Collaborators' Funds		
State Capital Funds		
Philanthropy		
Other		
	Total Revenue	$ 716,874

DISTRICT OFFICE:
300 E. WAR MEMORIAL DRIVE
SUITE 303
PEORIA, IL 61614
PHONE: (309) 681-1992

SPRINGFIELD ADDRESS:
632 STATE HOUSE
SPRINGFIELD, IL 62706
PHONE: (217) 782-3186

Jehan Gordon-Booth
DEPUTY MAJORITY LEADER
STATE REPRESENTATIVE • 92ND DISTRICT

April 6, 2021

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

Support for OSF HealthCare Medicaid Transformation Collaborative

Dear Director Eagleson,

I am writing today to express my strong support for the OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC), including Heartland Health in my district, represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with on the ground community-based programs which will open new avenues of access and improve quality for Medicaid patients in my district. FQHCs, using community health workers supported with digital tools and AI technology, will also address social determinants of health as well as the health disparities most prevalent in my district. Finally, this innovative proposal provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. The collaborative is designed to create scalable solutions that can improve access and quality for Medicaid patients throughout the state while at the same time providing local resources that are specific to the needs identified by the communities being served. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is truly responsive to the needs of local communities.

It was these partner entities, with input from Medicaid participants that helped to identify the needs specific to their community or region that the collaborative proposes to address. It will be

these same entities that will be employing those from the community tasked with outreach to those most vulnerable in our communities.

What excites me the most is that this collaboration is designed to play to every partner entity's strength. For OSF HealthCare it is their experience with innovation, analytics, and the deployment of new digital technologies to improve quality and access to care. For the FQHC partners it is their existing relationships with the Medicaid population, their focus on care coordination, and the ability to understand the concerns of the populations they are serving. The partnering Community Based Organizations have been strong advocates for solutions that address the health disparities and other challenges faced by the communities this collaborative plans to serve.

As one who supported the legislation that created the Medicaid Transformation fund and its criteria, I am happy to support the OSF HealthCare Medicaid Transformation Collaborative and their request for funding.

Sincerely,

Jehan Gordon Booth
IL State Representative
Deputy Majority Leader
Speaker Pro Tempore

400 NE Jefferson, Suite 200
PEORIA, IL 61603
(309) 673-0120
www.senatordavekoehler.com

M323B State Capitol
Springfield, IL 62706
(217) 782-8250
(217) 782-2115 fax
www.senatordavekoehler.com

ILLINOIS STATE SENATE
DAVID KOEHLER
STATE SENATOR • 46TH DISTRICT
ASSISTANT MAJORITY LEADER

April 2, 2021

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

Support for OSF HealthCare Medicaid Transformation Collaborative

Dear Director Eagleson:

I am writing today to express my strong support for the OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC), including Heartland Health Services in my district, represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with on the ground community based programs which will open new avenues of access and improve quality for Medicaid patients in my district. FQHCs, using community health workers supported with digital tools and AI technology, will also address social determinants of health as well as the health disparities most prevalent in my district. Finally, this innovative proposal provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. The collaborative is designed to create scalable solutions that can improve access and quality for Medicaid patients throughout the state while at the same time providing local resources that are specific to the needs identified by the communities being served. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is truly responsive to the needs of local communities.

It was these partner entities, with input from Medicaid participants that helped to identify the needs specific to their community or region that the collaborative proposes to address. It will be these same entities that will be employing those from the community tasked with outreach to those most vulnerable in our communities.

What excites me the most is that this collaboration is designed to play to every partner entity's strength. For OSF HealthCare it is their experience with innovation, analytics, and the deployment of new digital technologies to improve quality and access to care. For the FQHC partners it is their existing relationships with the Medicaid population, their focus on care coordination, and the ability to understand the concerns of the populations they are serving. The partnering Community Based Organizations have been strong advocates for solutions that address the health disparities and other challenges faced by the communities this collaborative plans to serve.

As one who supported the legislation that created the Medicaid Transformation fund and its criteria I am happy to support the OSF HealthCare Medicaid Transformation Collaborative and their request for funding.

Sincerely,

State Senator Dave Koehler
46th Legislative District

CITY OF
PEORIA

OFFICE OF THE MAYOR
JIM ARDIS

March 30, 2021

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

Support for OSF HealthCare Medicaid Transformation Collaborative

Dear Director Eagleson:

I am writing today to express my strong support for the OSF HealthCare Medicaid Innovation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC), including Heartland Health Services in Peoria, IL represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with on the ground community-based programs which will open new avenues of access and improve quality for Medicaid patients in my City. FQHCs, using community health workers supported with digital tools and AI technology, will also address social determinants of health as well as the health disparities most prevalent in my district. Finally, this innovative proposal provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. The collaborative is designed to create scalable solutions that can improve access and quality for Medicaid patients throughout the state while at the same time providing local resources that are specific to the needs identified by the communities being served. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is truly responsive to the needs of local communities.

As the Mayor of Peoria which has many of our residents enrolled in Medicaid I am very supportive of efforts to improve quality and access to care for our citizens. I am happy to support the Medicaid Innovation Collaborative put forth by OSF HealthCare and Heartland Health and ask that you fund this proposal.

Sincerely,

Jim Ardis

Jim Ardis, Mayor

Peoria City Hall
419 Fulton Street, Room 207, Peoria, IL 61602
Phone 309.494.8519 Fax 309.494.8556

ILLINOIS HOUSE OF REPRESENTATIVES

SPRINGFIELD OFFICE
314 CAPITOL BUILDING
SPRINGFIELD, IL 62706
(217) 782-1118

DISTRICT OFFICE
104 W. NORTH STREET
NORMAL, IL 61761
(309) 662-1100
FAX (309) 662-1150
WWW.REP-DANBRADY.COM

DANIEL P. BRADY
STATE REPRESENTATIVE · 105TH DISTRICT
DEPUTY REPUBLICAN LEADER

April 7, 2021

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

Re: Support for OSF HealthCare Medicaid Transformation Collaborative

Dear Director Eagleson:

I am writing today to express my support for the OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC), including Chestnut Health Systems/Chestnut Family Health Center in my district, represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with on the ground community based programs which will open new avenues of access and improve quality for Medicaid patients in my district. FQHCs, using community health workers supported with digital tools and AI technology, will also address social determinants of health as well as the health disparities most prevalent in my district. Finally, this innovative proposal provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. The collaborative is designed to create scalable solutions that can improve access and quality for Medicaid patients throughout the state while at the same time providing local resources that are specific to the needs identified by the communities being served. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is truly responsive to the needs of local communities.

It was these partner entities, with input from Medicaid participants that helped to identify the needs specific to their community or region that the collaborative proposes to address. It will be these same entities that will be employing those from the community tasked with outreach to those most vulnerable in our communities.

What excites me the most is that this collaboration is designed to play to every partner entity's strength. For OSF HealthCare it is their experience with innovation, analytics, and the deployment of new digital technologies to improve quality and access to care. For the FQHC partners it is their existing relationships with the Medicaid population, their focus on care coordination, and the ability to understand the concerns of the populations they are serving. The partnering Community Based Organizations have been strong advocates for solutions that address the health disparities and other challenges faced by the communities this collaborative plans to serve.

As one who supported the legislation that created the Medicaid Transformation fund and its criteria I am happy to support the OSF HealthCare Medicaid Transformation Collaborative and their request for funding.

Sincerely,

Representative Dan Brady
Illinois House District 105

DISTRICT OFFICE
5144 W. 95TH STREET
OAK LAWN, IL 60453
708.425.0571
708.425.0642 FAX

CAPITOL OFFICE
246-W STRATTON OFFICE BUILDING
SPRINGFIELD, IL 62706
217.782.0515
217.558.4553 FAX

KELLY BURKE
STATE REPRESENTATIVE
36TH DISTRICT

April 7, 2021

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

Support for OSF HealthCare Medicaid Transformation Collaborative

Dear Director Eagleson:

I am writing today to express my strong support for the OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC) represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with on the ground community-based programs which will open new avenues of access and improve quality for Medicaid patients in my district. FQHCs, using community health workers supported with digital tools and AI technology, will also address social determinants of health as well as the health disparities most prevalent in my district. Finally, this innovative proposal provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. The collaborative is designed to create scalable solutions that can improve access and quality for Medicaid patients throughout the state while at the same time providing local resources that are specific to the needs identified by the communities being served. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is truly responsive to the needs of local communities.

It was these partner entities, with input from Medicaid participants that helped to identify the needs specific to their community or region that the collaborative proposes to address. It will be

these same entities that will be employing those from the community tasked with outreach to those most vulnerable in our communities.

What excites me the most is that this collaboration is designed to play to every partner entity's strength. For OSF HealthCare it is their experience with innovation, analytics, and the deployment of new digital technologies to improve quality and access to care. For the FQHC partners it is their existing relationships with the Medicaid population, their focus on care coordination, and the ability to understand the concerns of the populations they are serving. The partnering Community Based Organizations have been strong advocates for solutions that address the health disparities and other challenges faced by the communities this collaborative plans to serve.

As one who supported the legislation that created the Medicaid Transformation fund and its criteria, I am happy to support the OSF HealthCare Medicaid Transformation Collaborative and their request for funding.

Sincerely,

Kelly Burke

Kelly Burke
State Representative

ILLINOIS HOUSE OF REPRESENTATIVES

DISTRICT OFFICE:
275 NORTH DIVISION STREET
PO BOX 173
WOODHULL, IL 61490

PRINCETON OFFICE:
CITY OF PRINCETON
CITY HALL
2 SOUTH MAIN ST.
PRINCETON, IL 61356
(815) 875-2631 EXT. 1013

SPRINGFIELD OFFICE:
200-3N STRATTON BUILDING
SPRINGFIELD, IL 62706
(217) 782-8032

DANIEL M. SWANSON
STATE REPRESENTATIVE • 74TH DISTRICT

- AGRICULTURE & CONSERVATION
- APPROPRIATIONS - PUBLIC SAFETY
- ELEMENTARY & SECONDARY EDUCATION - SCHOOL CURRICULUM & POLICIES
- MENTAL HEALTH & ADDICTION
- POLICE & FIRE
- VETERANS' AFFAIRS

April 6, 2021

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

Support for OSF HealthCare Medicaid Transformation Collaborative

Dear Director Eagleson:

I am writing today to express my strong support for the OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC), including Eagle View Community Health System in my district, represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with on the ground community based programs which will open new avenues of access and improve quality for Medicaid patients in my district. FQHCs, using community health workers supported with digital tools and AI technology, will also address social determinants of health as well as the health disparities most prevalent in my district. Finally, this innovative proposal provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. The collaborative is designed to create scalable solutions that can improve access and quality for Medicaid patients throughout the state while at the same time providing local resources that are specific to the needs identified by the communities being served. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is truly responsive to the needs of local communities.

It was these partner entities, with input from Medicaid participants that helped to identify the needs specific to their community or region that the collaborative proposes to address. It will be

these same entities that will be employing those from the community tasked with outreach to those most vulnerable in our communities.

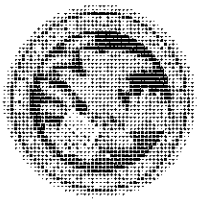
What excites me the most is that this collaboration is designed to play to every partner entity's strength. For OSF HealthCare it is their experience with innovation, analytics, and the deployment of new digital technologies to improve quality and access to care. For the FQHC partners it is their existing relationships with the Medicaid population, their focus on care coordination, and the ability to understand the concerns of the populations they are serving. The partnering Community Based Organizations have been strong advocates for solutions that address the health disparities and other challenges faced by the communities this collaborative plans to serve.

As one who supported the legislation that created the Medicaid Transformation fund and its criteria I am happy to support the OSF HealthCare Medicaid Transformation Collaborative and their request for funding to better serve my communities.

Sincerely,

Daniel M. Swanson
State Representative, 74th District
275 North Division Street
PO Box 173
Woodhull, IL 61490
(309) 334-7474

ILLINOIS HOUSE OF REPRESENTATIVES



NORINE K. HAMMOND
STATE REPRESENTATIVE
93RD DISTRICT

SPRINGFIELD OFFICE:
203-N STRATTON OFFICE BUILDING
SPRINGFIELD, ILLINOIS 62706
217-782-0416
217-782-1141 (FAX)

DISTRICT OFFICE:
331 NORTH LAFAYETTE
MACOMB, ILLINOIS 61455
309-836-2707
309-836-2231 (FAX)
EMAIL: rephammond@macomb.com

April 1st, 2021

Edward Murphy
Eagle View Community Health System
1204 Highway 164 East
Oquawka, IL 61469

Support for OSF HealthCare Medicaid Transformation Collaborative

Dear Mr. Murphy:

I am writing today to express my strong support for the OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC), including Eagle View Community Health System in my district, represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with on the ground community based programs which will open new avenues of access and improve quality for Medicaid patients in my district. FQHCs, using community health workers supported with digital tools and AI technology, will also address social determinants of health as well as the health disparities most prevalent in my district. Finally, this innovative proposal provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. The collaborative is designed to create scalable solutions that can improve access and quality for Medicaid patients throughout the state while at the same time providing local resources that are specific to the needs identified by the communities being served. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is truly responsive to the needs of local communities.

It was these partner entities, with input from Medicaid participants that helped to identify the needs specific to their community or region that the collaborative proposes to address. It will be these same entities that will be employing those from the community tasked with outreach to those most vulnerable in our communities.

ILLINOIS HOUSE OF REPRESENTATIVES

NORINE K. HAMMOND
STATE REPRESENTATIVE
93RD DISTRICT

SPRINGFIELD OFFICE:
203-N STRATTON OFFICE BUILDING
SPRINGFIELD, ILLINDIS 62706
217-782-0416
217-782-1141 (FAX)

DISTRICT OFFICE:
331 NORTH LAFAYETTE
MACOMB, ILLINOIS 61455
309-836-2707
309-836-2231 (FAX)
EMAIL: rephammond@macomb.com

What excites me the most is that this collaboration is designed to play to every partner entity's strength. For OSF HealthCare it is their experience with innovation, analytics, and the deployment of new digital technologies to improve quality and access to care. For the FQHC partners it is their existing relationships with the Medicaid population, their focus on care coordination, and the ability to understand the concerns of the populations they are serving. The partnering Community Based Organizations have been strong advocates for solutions that address the health disparities and other challenges faced by the communities this collaborative plans to serve.

As one who supported the legislation that created the Medicaid Transformation fund and its criteria I am happy to support the OSF HealthCare Medicaid Transformation Collaborative and their request for funding.

Sincerely,

Norine K. Hammond

Norine K Hammond
State Representative
93rd District

DISTRICT OFFICE:
3821 N. VERMILION, SUITE 5
DANVILLE, IL 61832
(217) 477-0104

ILLINOIS HOUSE OF REPRESENTATIVES

SPRINGFIELD OFFICE:
208-N STRATTON BUILDING
SPRINGFIELD, IL 62706
(217) 782-4811
www.repmarron.com

MIKE MARRON

STATE REPRESENTATIVE • 104TH DISTRICT

April 5, 2021

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

Support for OSF HealthCare Medicaid Transformation Collaborative

Dear Director Eagleson:

I am writing today to express my strong support for the OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC), including Aunt Martha's in my district, represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with on the ground community-based programs which will open new avenues of access and improve quality for Medicaid patients in my district. FQHCs, using community health workers supported with digital tools and AI technology, will also address social determinants of health as well as the health disparities most prevalent in my district. Finally, this innovative proposal provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. The collaborative is designed to create scalable solutions that can improve access and quality for Medicaid patients throughout the state while at the same time providing local resources that are specific to the needs identified by the communities being served. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is truly responsive to the needs of local communities.

It was these partner entities, with input from Medicaid participants that helped to identify the needs specific to their community or region that the collaborative proposes to address. It will be these same entities that will be employing those from the community tasked with outreach to those most vulnerable in our communities.

What excites me the most is that this collaboration is designed to play to every partner entity's strength. For OSF HealthCare it is their experience with innovation, analytics, and the deployment of new digital technologies to improve quality and access to care. For the FQHC partners it is their existing relationships with the Medicaid population, their focus on care coordination, and the ability to understand the concerns of the populations they are serving. The partnering Community Based Organizations have been strong advocates for solutions that address the health disparities and other challenges faced by the communities this collaborative plans to serve.

As one who supported the legislation that created the Medicaid Transformation fund and its criteria, I am happy to support the OSF HealthCare Medicaid Transformation Collaborative and their request for funding.

Sincerely,

Michael T. Marron

Michael T. Marron
State Representative 104th District

DISTRICT OFFICE:
121 W. JEFFERSON STREET
MORTON, ILLINOIS 61550
309/263-9242
FAX: 309/263-8187

SPRINGFIELD OFFICE:
STRATTON BUILDING
SPRINGFIELD, ILLINOIS 62706
217/782-0221
FAX: 217/557-1098

KEITH P. SOMMER
STATE REPRESENTATIVE

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

April 7, 2021

Dear Director Eagleson:

I am writing today to express my strong support for the OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC), including Chestnut Health Care in my district, represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with on the ground community based programs which will open new avenues of access and improve quality for Medicaid patients in my district. FQHCs, using community health workers supported with digital tools and AI technology, will also address social determinants of health as well as the health disparities most prevalent in my district. Finally, this innovative proposal provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. The collaborative is designed to create scalable solutions that can improve access and quality for Medicaid patients throughout the state while at the same time providing local resources that are specific to the needs identified by the communities being served. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is truly responsive to the needs of local communities.

It was these partner entities, with input from Medicaid participants that helped to identify the needs specific to their community or region that the collaborative proposes to address. It will be these same entities that will be employing those from the community tasked with outreach to those most vulnerable in our communities.

What excites me the most is that this collaboration is designed to play to every partner entity's strength. For OSF HealthCare it is their experience with innovation, analytics, and the deployment of new digital technologies to improve quality and access to care. For the FQHC partners it is their existing relationships with the Medicaid population, their focus on care coordination, and the ability to understand the concerns of the populations they are serving. The partnering Community Based Organizations have been strong advocates for solutions that address the health disparities and other challenges faced by the communities this collaborative plans to serve.

As one who supported the legislation that created the Medicaid Transformation fund and its criteria I am happy to support the OSF HealthCare Medicaid Transformation Collaborative and their request for funding.

Sincerely,

Keith P. Sommer

E-Mail: sommer@mtco.com

Jason A. Barickman
State Senator

3004 G.E. Road, Suite 1B
Bloomington, IL 61704
309/661-2788

309L State Capitol
Springfield, IL 62706
217/782-6597

E-mail: jason@jasonbarickman.org
Website: www.jasonbarickman.org

April 1, 2021

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

Dear Director Eagleson:

I am writing today to express my strong support for the OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC), including Chestnut Health Systems/Chestnut Family Health Center in my district, represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with on the ground community based programs which will open new avenues of access and improve quality for Medicaid patients in my district. FQHCs, using community health workers supported with digital tools and AI technology, will also address social determinants of health as well as the health disparities most prevalent in my district. Finally, this innovative proposal provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. The collaborative is designed to create scalable solutions that can improve access and quality for Medicaid patients throughout the state while at the same time providing local resources that are specific to the needs identified by the communities being served. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is truly responsive to the needs of local communities.

It was these partner entities, with input from Medicaid participants that helped to identify the needs specific to their community or region that the collaborative proposes to address. It will be these same entities that will be employing those from the community tasked with outreach to those most vulnerable in our communities.

What excites me the most is that this collaboration is designed to play to every partner entity's strength. For OSF HealthCare it is their experience with innovation, analytics, and the deployment of new digital technologies to improve quality and access to care. For the FQHC partners it is their existing relationships with the Medicaid population, their focus on care coordination, and the ability to understand the concerns of the populations they are serving. The partnering Community Based Organizations have been strong advocates for solutions that address the health disparities and other challenges faced by the communities this collaborative plans to serve.

As one who supported the legislation that created the Medicaid Transformation fund and its criteria I am happy to support the OSF HealthCare Medicaid Transformation Collaborative and their request for funding.

Sincerely,

Jason A. Barickman
State Senator

ILLINOIS STATE SENATE

☐ CAPITOL OFFICE:
M114 STATE CAPITOL
SPRINGFIELD, ILLINOIS 62706
(217) 782-1607

☑ DISTRICT OFFICE:
1155 WEST 79TH STREET
CHICAGO, ILLINOIS 60620
(773) 224-2830

COMMITTEES:
- FINANCIAL INSTITUTIONS VICE-CHAIRPERSON
- CRIMINAL LAW
- TRANSPORTATION

Jacqueline Y. Collins
STATE SENATOR · 16TH DISTRICT
ASSISTANT MAJORITY LEADER

April 6, 2021

Director Theresa Eagleson
Illinois Department of Healthcare and Family Services
Prescott Bloom Building
201 South Grand Avenue, East
Springfield, Illinois 60607

Dear Director Eagleson:

I am writing to express my support for UI Health Mile Square Auburn Gresham Center for Health Equity. This collaboration with OSF HealthCare and the Auburn Gresham Greater Development Corporation will transform healthcare in the Auburn Gresham community by increasing access to quality care, decreasing health disparities, and addressing social determinants of health. By combining advances in telehealth with on-the-ground community based programs, this collaboration will not only improve access to care, but will also generate employment opportunities in the healthcare field for the community.

This integrated health care model is desperately needed in the Auburn Gresham community, which suffers from some of the greatest health inequities in the city of Chicago due in part to a the lack of affordable and accessible health care. This access disparity is further exacerbated by the lack of culturally sensitive healthcare workforce, who understand the interconnectedness of social inequities and poor health outcomes. The Auburn Gresham community faces unmet needs related to mental and behavioral health issues, including substance use disorder, which is further compounded by other chronic health conditions. The lack of investment from healthcare stakeholders in this community has resulted in the need for integrated and coordinated community health that address care across the life cycle, and that is equipped to address the impact of social inequities of healthcare outcomes, including the over-utilization of local emergency departments. The partnership between OSF HealthCare, Mile Square Health Center, and the Auburn Gresham Greater Development Corporation is needed to address the complex challenges facing the Auburn Gresham community.

I have witnessed firsthand the need for improved access to integrated health care, provided by trusted health care providers. Investment in the Auburn Gresham Center for Health Equity partnership with Mile Square Health Center, OSF HealthCare, and the Auburn Gresham Greater Development Corporation will help address the health inequities facing the Auburn Gresham community, improving the health of community members from birth through advanced age. This collaboration will create an approach to healthcare delivery that is truly responsive to the needs of the local community. Thank you for your consideration.

Sincerely,

Jacqueline Y. Collins

Jacqueline Y. Collins
State Senator, 16th District

SPRINGFIELD OFFICE
311C CAPITOL BUILDING
SPRINGFIELD, IL 62706
TEL: 217/782-2507

CHAMPAIGN OFFICE
45 E. UNIVERSITY
SUITE 206
CHAMPAIGN, IL 61820
TEL: 217/355-5252

DANVILLE OFFICE
201 N. VERMILION ST.
SUITE 323
DANVILLE, IL 61832
TEL: 217/442-5252

www.senatorbennett.com

COMMITTEES:
-AGRICULTURE
CHAIRPERSON
-APPROPRIATIONS II
-CRIMINAL LAW
VICE CHAIRPERSON
-HIGHER EDUCATION
-LABOR
-STATE GOVERNMENT

SCOTT BENNETT
STATE SENATOR • 52ND DISTRICT

March 30, 2021

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

Support for OSF HealthCare Medicaid Transformation Collaborative

Dear Director Eagleson:

I am writing today to express my strong support for the OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC), including Aunt Martha's Health and Wellness in my district, represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with on the ground community based programs which will open new avenues of access and improve quality for Medicaid patients in my district. FQHCs, using community health workers supported with digital tools and AI technology, will also address social determinants of health as well as the health disparities most prevalent in my district. Finally, this innovative proposal provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. The collaborative is designed to create scalable solutions that can improve access and quality for Medicaid patients throughout the state while at the same time providing local resources that are specific to the needs identified by the communities being served. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is truly responsive to the needs of local communities.

It was these partner entities, with input from Medicaid participants that helped to identify the needs specific to their community or region that the collaborative proposes to address. It will be these same entities that will be employing those from the community tasked with outreach to those most vulnerable in our communities.

What excites me the most is that this collaboration is designed to play to every partner entity's strength. For OSF HealthCare it is their experience with innovation, analytics, and the deployment of new digital technologies to improve quality and access to care. For the FQHC partners it is their existing relationships with the Medicaid population, their focus on care coordination, and the ability to understand the concerns of the populations they are serving. The partnering Community Based Organizations have been strong advocates for solutions that address the health disparities and other challenges faced by the communities this collaborative plans to serve.

As one who supported the legislation that created the Medicaid Transformation fund and its criteria I am happy to support the OSF HealthCare Medicaid Transformation Collaborative and their request for funding.

Sincerely,

Scott M. Bennett

Scott Bennett
State Senator
52nd District

WIN STOLLER

STATE SENATOR • 37TH DISTRICT

SENATORSTOLLER@GMAIL.COM • WWW.SENATORSTOLLER.COM

CAPITOL OFFICE:
105B STATE HOUSE
SPRINGFIELD, IL 62706
(217) 782-1942

DISTRICT OFFICE:
5415 N. UNIVERSITY
SUITE 105
PEORIA, IL 61614
(309) 693-4921

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

Dear Director Eagleson:

I am writing on behalf of OSF HealthCare and their proposed OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC) represents a great opportunity to transform Medicaid delivery in the state and has my full support.

This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with community based programs to help open new avenues of access and improved quality for Medicaid patients. FQHCs, using community health workers will also address social determinants of health as well as the most prevalent health disparities. Additionally, this proposal will provide employment opportunities in the healthcare field for those from marginalized communities.

The OSF HealthCare Medicaid Transformation Collaborative has put together a very impressive partnership with a combination of FQHCs, Community Based Organizations, and other community groups in order to create an approach to healthcare delivery that is truly responsive to the needs of local communities. This partnership was designed to take advantage of each partner entities' strength. The collaborative will benefit from OSF HealthCare's experience with innovation, analytics, and the deployment of new digital technologies, while using the partner FQHC's existing relationships with the Medicaid population and their focus on care coordination. Finally, the plan will utilize the partnering Community Based Organizations' advocacy for solutions that address the health disparities and other challenges that the collaborative communities face.

Again, I strongly support OSF HealthCare's Medicaid Transformation Collaborative and thank you for your consideration of this important application.

Respectfully,

Win Stoller
State Senator, 37th District

April 6, 2021

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

Dear Director Eagleson:

I am writing today to express my strong support for the OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC), including Eagle View Health System in my district, represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with on the ground community-based programs which will open new avenues of access and improve quality for Medicaid patients in my district. FQHCs, using community health workers supported with digital tools and AI technology, will also address social determinants of health as well as the health disparities most prevalent in my district. Finally, this innovative proposal provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. The collaborative is designed to create scalable solutions that can improve access and quality for Medicaid patients throughout the state while at the same time providing local resources that are specific to the needs identified by the communities being served. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is truly responsive to the needs of local communities. It was these partner entities, with input from Medicaid participants that helped to identify the needs specific to their community or region that the collaborative proposes to address. It will be these same entities that will be employing those from the community tasked with outreach to those most vulnerable in our communities.

This collaboration is designed to play to every partner entity's strength. For OSF HealthCare, it is their experience with innovation, analytics, and the deployment of new digital technologies to improve quality and access to care. For the FQHC partners, it is their existing relationships with the Medicaid population, their focus on care coordination, and the ability to understand the concerns of the populations they are serving. The partnering Community Based Organizations have been strong advocates for solutions that address the health disparities and other challenges faced by the communities this collaborative plans to serve.

As one who supported the legislation that created the Medicaid Transformation fund and its criteria, I am happy to support the OSF HealthCare Medicaid Transformation Collaborative and their request for funding.

Sincerely,

State Senator Jil Tracy
47th District

SENATOR SALLY J. TURNER
44TH SENATE DISTRICT

M103A STATE HOUSE
SPRINGFIELD, IL 62706
PHONE: 217/782-6216

April 7, 2021

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

Dear Director Eagleson:

I am writing today to express my strong support for the OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC), including Chestnut Health Care in my district, represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will open new avenues of access and improve quality for Medicaid patients in my district, addresses social determinants of health as well as the health disparities most prevalent in my district, and provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is responsive to the needs of local communities.

It was these partner entities, with input from Medicaid participants that helped to identify the needs specific to their community or region that the collaborative proposes to address. It will be these same entities that will be employing those from the community tasked with outreach to those most vulnerable in our communities.

Best of all is that this collaboration is designed to play to every partner entity's strength. The partnering Community Based Organizations have been strong advocates for solutions that address the health disparities and other challenges faced by the communities this collaborative plans to serve.

Sincerely,

Sally Turner

Sally J. Turner
State Senator, 44th District

CAPITOL OFFICE:
ROOM 329B STATE CAPITOL
SPRINGFIELD, IL 62706
PHONE: 217-782-5145

DISTRICT OFFICES:
10400 SOUTH WESTERN AVE.
CHICAGO, IL 60643
PHONE: 773-445-8128
FAX: 773-672-5143

16033 SOUTH 94TH AVE.
ORLAND HILLS, IL 60487
PHONE: 708-233-9703

ILLINOIS STATE SENATE
BILL CUNNINGHAM
PRESIDENT PRO TEMPORE
STATE SENATOR • 18TH DISTRICT
WWW.SENATORBILLCUNNINGHAM.COM

April 7, 2021

Director Theresa Eagleson
Healthcare and Family Services
201 South Grand Ave., East
Springfield, IL 62763

Support for OSF HealthCare Medicaid Transformation Collaborative

Dear Director,

I am writing today to express my strong support for the OSF HealthCare Medicaid Transformation Collaborative. This collaborative between OSF HealthCare and several Federally Qualified Health Centers (FQHC) in my district represents a great opportunity to transform Medicaid delivery in the State of Illinois. This collaborative will take advantage of the latest tools and techniques in telehealth medicine and pair them with on the ground community-based programs which will open new avenues of access and improve quality for Medicaid patients in my district. FQHCs, using community health workers supported with digital tools and AI technology, will also address social determinants of health as well as the health disparities most prevalent in my district. Finally, this innovative proposal provides employment opportunities in the healthcare field for those from marginalized communities.

While OSF HealthCare is the lead entity applying for the Medicaid Transformation dollars, it will be the partner entities that will be the face of the collaboration in the community. The collaborative is designed to create scalable solutions that can improve access and quality for Medicaid patients throughout the state while at the same time providing local resources that are specific to the needs identified by the communities being served. By partnering with a combination of FQHCs, Community Based Organizations, and other community groups this collaborative will create an approach to healthcare delivery that is truly responsive to the needs of local communities.

It was these partner entities, with input from Medicaid participants that helped to identify the needs specific to their community or region that the collaborative proposes to address. It will be these same entities that will be employing those from the community tasked with outreach to those most vulnerable in our communities.

What excites me the most is that this collaboration is designed to play to every partner entity's strength. For OSF HealthCare it is their experience with innovation, analytics, and the deployment of new digital technologies to improve quality and access to care. For the FQHC partners it is their existing relationships with the Medicaid population, their focus on care coordination, and the ability to understand the concerns of the populations they are serving. The partnering Community Based Organizations have been strong advocates for solutions that address the health disparities and other challenges faced by the communities this collaborative plans to serve.

As one who supported the legislation that created the Medicaid Transformation fund and its criteria I am happy to support the OSF HealthCare Medicaid Transformation Collaborative and their request for funding.

Sincerely,

Senator Bill Cunningham
Illinois District 18