Application for Funding
Healthcare Transformation Collaboratives

March 2021

Application for Transformation

Funding Cover Sheet

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The most recent IRS 990 for all participants in the collaboration can be found here.

The South Side Healthy Community Model

Proposal for Transforming the Health of Chicago's South Side

Table of Contents

Executive Summary

Please provide a narrative description of your overall project, including participation of collaborators, goals of the collaboration, community service area, strategy and expected timeframe for the project, capital improvements, new interventions, delivery redesign, etc.

For decades, the 900,000 residents of the South Side of Chicago have experienced health disparities ranging from materially higher disease incidence and comorbidities to significantly lower life expectancy. These health disparities reflect a history of racial inequities and underinvestment – both of which have contributed to a fragmented healthcare delivery landscape with limited resources. Today, over 50% of all South Side residents leave the South Side to receive their care. In an unprecedented initiative to address these challenges, which are only growing more acute, the care providers of Chicago's South Side have formed a comprehensive coalition of FQHCs, safety net hospitals and health systems – driven by community input and dedicated to fundamentally advancing health care access and better health outcomes for Chicago's South Side residents.

The coalition -- comprised of Advocate Trinity Hospital, Beloved Community Family Wellness Center, Chicago Family Health Center, Christian Community Health Center, Friend Health, Jackson Park Hospital, Near North Health, The New Roseland Community Hospital, Saint Bernard Hospital, Sinai Chicago – Holy Cross Hospital, South Shore Hospital, TCA Health, and University of Chicago Medicine -- plans to establish a new, 501(c)(3) not for profit organization – the South Side Healthy Community Organization ("SSHCO") as the vehicle by which it will facilitate – in partnership with the community -- health care transformation on Chicago's South Side.

The SSHCO will do so by implementing a comprehensive Healthy Community Model focused on primary and specialty care access, preventive and chronic care management, care coordination and management, provider collaboration, community engagement, and a connected digital and technological infrastructure. Such models have had demonstrable success as evidenced most recently in Dallas, Texas[1]. The coalition expects that through this approach, Chicago has the potential to be a national model in community health transformation.

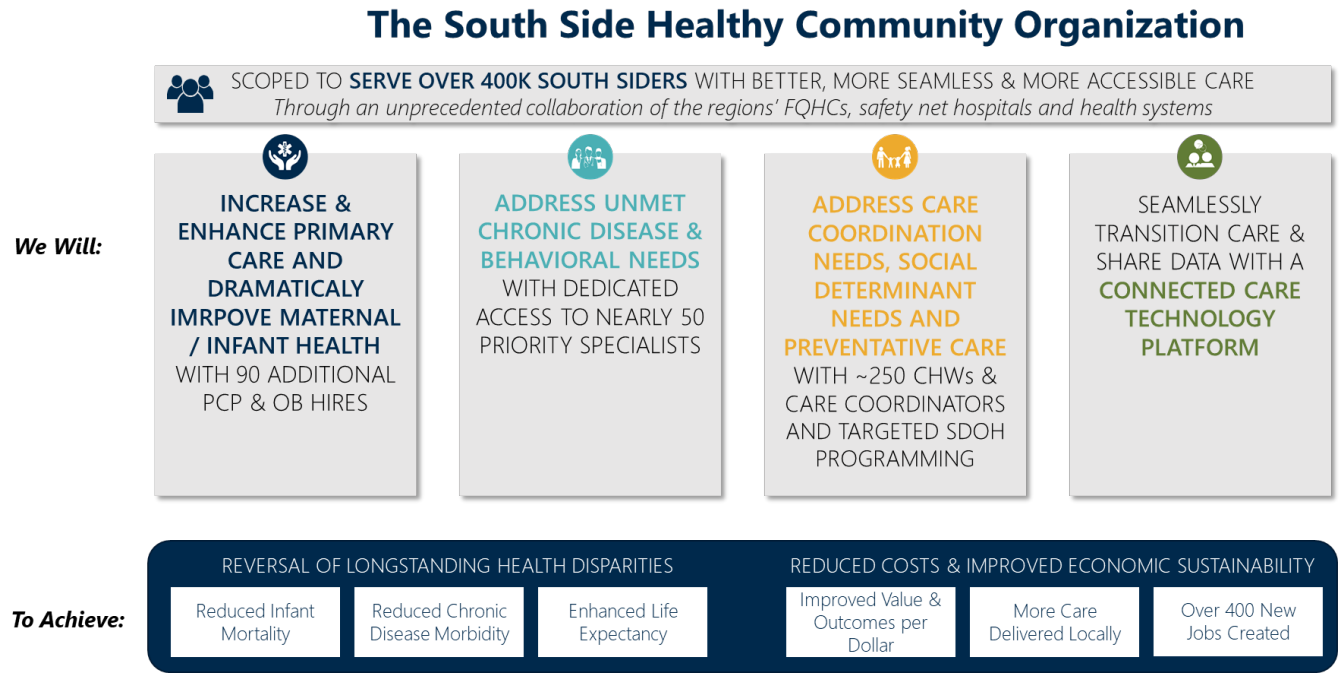
As depicted below in Figure 1, the SSHCO will:

1. Specifically expand primary care access and address maternal & infant health by adding 90 PCP and OB providers;
2. Address chronic disease and mental health by increasing specialty care access to 50 providers and putting in place a community-based specialty care coordination program and platform;
3. Meet social determinants of health (SDoH) needs and drive preventative care by adding over 250 community health workers and care coordinators to the South Side in the context of a comprehensive care coordination & community health program; and

[1] Parkland Health & Hospital System and Dallas County Health has successfully deployed an approach with similar elements to our model – see the PCCI Model

4. Implement a connected care technology platform that enhances care, communication and the care experience.

Figure 1: Components of The South Side Healthy Community Organization



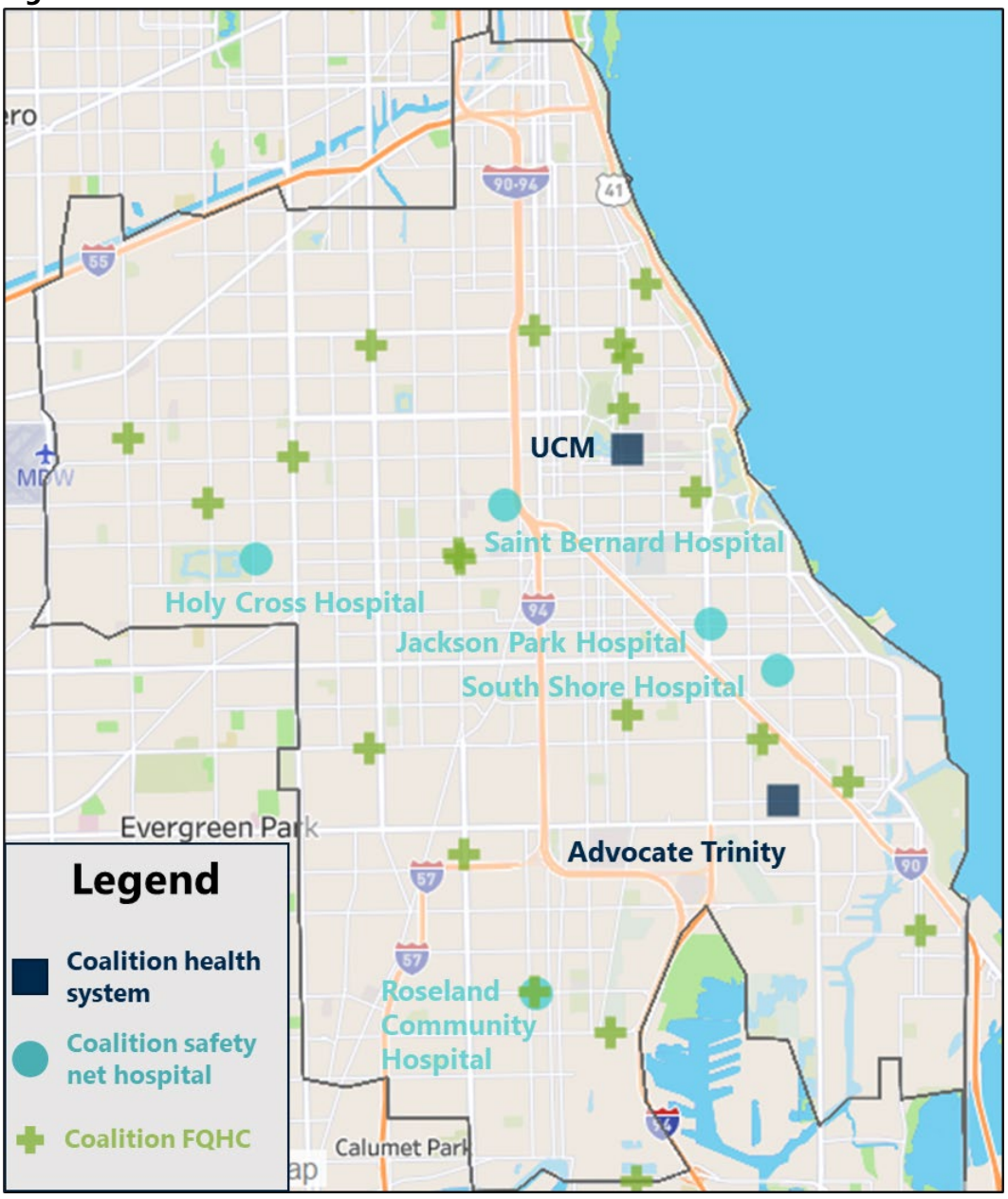
The SSHCO will be governed by a 17-member board that will include representatives from all coalition members, 3 independent community members and the CEO as members of the board in full capacity. It is the intention and plan of the coalition and SSHCO that it will be self-sustaining within 60 months following commencement of its operations. In its first 60 months, the SSHCO and coalition will seek $30 million in Healthcare Transformation Collaboratives funding per year for five years from the state to help finance its broad-based community-wide start up, roll-out and adoption. Accordingly, in the current fiscal year, the coalition seeks $30 million in Year 1 Transformation Funds, of which $12 million will fund first-year technology and capital needs and $18 million will fund startup operations.

1. Healthy Community Model and Organization Overview

Context: The South Side Community and Its Health Challenges

The SSHCO and this coalition will be targeting a service area spanning 15 zip codes and approximately 900,000 residents on Chicago's South Side, with area boundaries and coalition presence illustrated in Figure 2[2]:

Figure 2: SSHCO Service Area



[2] Esri data based on the American Community Survey, 2019. See Community Input Section for list of zip codes.

Chicago's South Side faces a nexus of challenges across care delivery and health outcomes. A history of inequity and disinvestment has culminated in poverty rates of over 60% in some neighborhoods and population loss of one in five residents in the past thirty years[3]. This has both caused and been compounded by insufficient, inadequate and declining medical services: there is an estimated shortage of approximately 100 primary care providers and 60 OB providers[4]; the CMS star rating for most hospitals on the South Side falls below the national average; and there has been over a dozen inpatient service or hospital closures in the past ten years – all contributing a 50%+ rate of South Side residents leaving their community for care[5]. Paradoxically, this dearth of care has partly contributed to overutilization as high as 60% in expensive emergency and inpatient settings, even as local hospitals continue to see occupancy of less than 60% due to outmigration[6]. The end result of these care delivery challenges is a staggering disparity in health outcomes: compared to North Side residents, South Siders in some neighborhoods have a 30 year lower life expectancy, are at a ten times higher risk of infant mortality, and have four times the rate of deaths from diabetes [7]. These tolls have been further exacerbated by the COVID-19 pandemic, as evidenced in the highly disparate unemployment and death rates relative to white residents and North Side neighborhoods [8]. There is no silver bullet to address these issues; they require a solution that is both comprehensive and transformative.

The Healthy Community Model and The South Side Healthy Community Organization: Objectives and Program Elements

To address these challenges, Advocate Trinity Hospital, Beloved Community Family Wellness Center, Chicago Family Health Center, Christian Community Health Center, Friend Health, Jackson Park Hospital, Near North Health, The New Roseland Community Hospital, Saint Bernard Hospital, Sinai Chicago – Holy Cross Hospital, South Shore Hospital, TCA Health, and University of Chicago Medicine have formed an unprecedented coalition and, working closely with the community, have developed a plan for healthcare delivery transformation on Chicago's South Side entitled The South Side Healthy Community Model.

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[3] Sources: 1. Esri data based on the American Community Survey, 2019 2. IPUMS National Historic GIS Data, 1990 3. Block, Matthew et al. "Mapping Poverty in America". New York Times Infographic, January 2014.

[4] Source: Analysis by The Chartis Group. See Data Section for sources used to inform analyses.

[5] Source: Illinois COMP state inpatient encounter data, CY2019

[6] Sources: Illinois COMP state inpatient encounter data, CY2019; Esri data based on the American Community Survey, 2019; coalition ED visit data, 2019; New York University ED Severity Visit Algorithm, 2015; 2018 AHQ Data File. Note: normal newborns excluded.

[7] Sources: NYU Langone City Health Dashboard based on 2015 data, Chicago Health Atlas 2015 data

[8] Sources: 1. Chicago Data Portal, Accessed 8/12/20 2. New York Times: "In These Neighborhoods, the Jobless Rate May Top 30 Percent" 8/5/20

The objectives of the South Side Healthy Community Model are to:

- Address the most pressing health needs and disparities experienced by South Side residents;
- Solve for social determinants of health by going beyond traditional healthcare provision; and
- Enhance the economic wellbeing of the community by both improving the health of the South Side workforce, strengthening participating care provider organizations on the South Side and creating new high-quality South Side jobs

The South Side Healthy Community Model will achieve these objectives through four core program elements:

1. **Expanded and enhanced access to primary care**, building on the strength of the existing FQHC networks;
2. Increased access to high-need, high-quality **integrated specialty programs** close to home;
3. Deployment of a **comprehensive care coordination and SDoH platform** to address social needs and drive preventative care; and
4. Establishment of a **connected care technology platform** enabling better care access, coordination and delivery across providers and services.

The South Side Healthy Community Organization: Enacting the South Side Healthy Community Model

The coalition plans to establish, a new, 501(c)(3) not for profit organization – the SSHCO as the vehicle by which it will facilitate – in partnership with the community -- health care transformation on Chicago's South Side.

The SSHCO will enact the Healthy Community Model through the following mechanisms to achieve its outcomes:

1. ***Primary Care:*** the SSHCO will **subsidize two years of ramp-up costs** for FQHCs and, potentially, other community-based providers to hire ~ **90 additional primary care and obstetric providers,** thereby meeting upwards of 50% of the estimated unmet demand in South Side communities [9]. Additionally, the SSHCO will augment the capabilities of

[9] Source: Analysis by The Chartis Group. See Data Section for sources used to inform analyses.

existing PCPs through supporting technology, care coordination and dissemination of best practices. The SSHCO will work with HFS to establish baseline quality and performance measures at participating sites and will work with participants to achieve enhanced primary care outcomes across population segments and disease states. In addition to subsidizing costs, the SSHCO will provide recruitment assistance with a focus on providers of color. The SSHCO will also lead the dissemination of trainings and best practices to create a consistent care experience, including a focus on cultural competency training.

2. ***Specialty Care:*** The SSHCO will **fund subsidies of lease, coverage or hiring arrangements for ~50 specialists at FQHC and safety net sites,** overcoming network insurance barriers by making providers from provider groups such as Sinai Medical Group, Advocate Medical Group and others available at community-based sites with broad insurance networks. Specialists focused on diabetes, heart disease, infectious disease, behavioral care and maternal / prenatal care will be prioritized, thereby supporting the Healthy Community Model in substantively enhancing outcomes across conditions such chronic illness, premature birth, infant mortality, HIV/AIDS and post-traumatic stress disorder (PTSD). In addition to subsidizing provider costs, the SSHCO will subsidize needed diagnostic capabilities tied to disease-based interventions at community-based sites.

3. ***Care Coordination, Community Health and SDoH:*** The SSHCO will **fund, train and deploy a care coordination team of community health workers, care managers and social workers** to enact disease and population-based interventions and to coordinate the delivery of the right care and services at the right place and the right time. Additionally, the SSHCO will provide **targeted funding for SDoH programming** that will increase the capacity of community-based organizations (CBOs) and partners to address key social needs such as food, housing and transportation. The following sub-components are envisioned:

    - ***Care Coordination, Community Health and Preventative Care:*** The care coordination team will be split into a centralized team employed by the HCO who coordinate across entities and a decentralized team that is embedded in and comanaged by participating FQHCs, safety net hospitals and community benefit organizations. The SSHCO will work with local training programs and public health partners to recruit, hire and train a community-based workforce that is inclusive of worker reentry. The centralized care coordination team will connect patients to the right care at the right place and the right time while also linking patients to needed social services. Embedded care coordinators will work with their respective primary care, specialty care and acute care teams in leveraged models that proactively identify and address patient health needs while

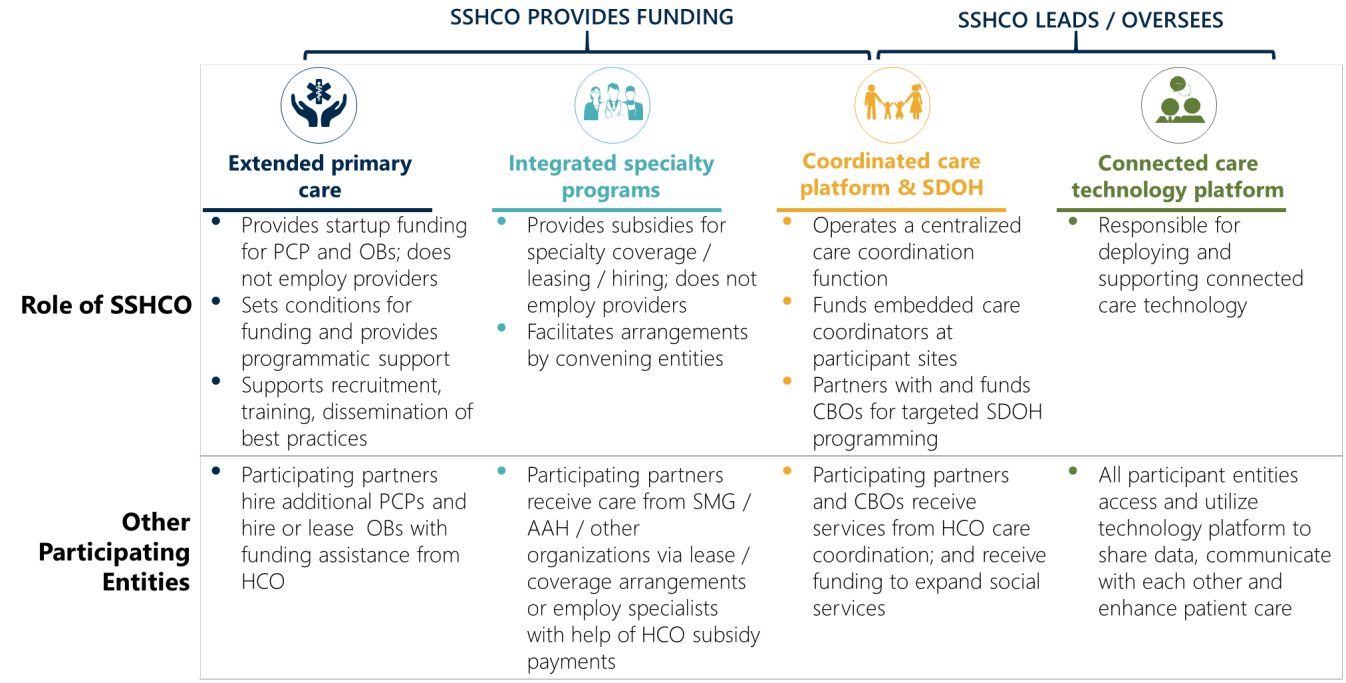
facilitating communication between providers and across services. Community health workers deployed in this model will be leveraged to drive interventions tied to maternal and infant health, chronic illness, preventative health and mental health such as: cancer screenings; behavioral health screenings; connecting pregnant women, young mothers and infants to needed services; patient education, health coaching and assistance with medication adherence. Preventative care funding may also be deployed in home-based interventions – both through the community health worker platform and, potentially, through targeted funding to expand home health services.

- ***SDoH:*** Through the work of care coordinators and community health workers, patients will be better linked to needed social services. In addition to this linking function, the SSHCO will provide direct funding to targeted programs that address housing, food, transportation and other key needs as needed to advance the SSHCO's health outcome objectives. To develop targeted programs or target funds, the SSHCO will partner with the community health departments of coalition members and may directly leverage and expand community services provided by coalition members such as Sinai Community Institute (SCI) and the St. Bernard Housing Development Corporation.

4. ***Connected Care Technology:*** The SSHCO will **oversee a technology platform** to support interoperable information sharing and coordinated care delivery across all participating entities. In addition, the technology platform will offer some patient-facing digital services to enable telehealth visits and improved patient health management for entities that do not currently have access to these technologies. All participating entities are expected to share appropriate information and communicate with one another on patient health status as permitted by law.

Across these four components, **the role of the SSHCO will be segmented into a funder / convener role and an overseer / operator role**, as illustrated in Figure 3. For primary care and specialty care, the SSHCO's main role is to convene and fund participating organizations, support provider recruitment or leasing, and facilitate best practice sharing; whereas for care coordination and connected care technology, the SSHCO will not only fund but also oversee and potentially operate programs and services:

Figure 3: The Role of the SSHCO vs. Other Entities in the Healthy Community Model



Together, these four components are greater than the sum of their parts, and will create a proactive, coordinated, comprehensive and accessible system of care for raising the health of the South Side's most vulnerable populations.

2. Community Input

Identify the community service area by zip code or county of your collaborative and the process you have followed or intend to follow to establish the needs of your community including the process for direct community input. Also describe how you have included elected officials at all relevant levels of government in your service area in discussions as you developed your proposal.

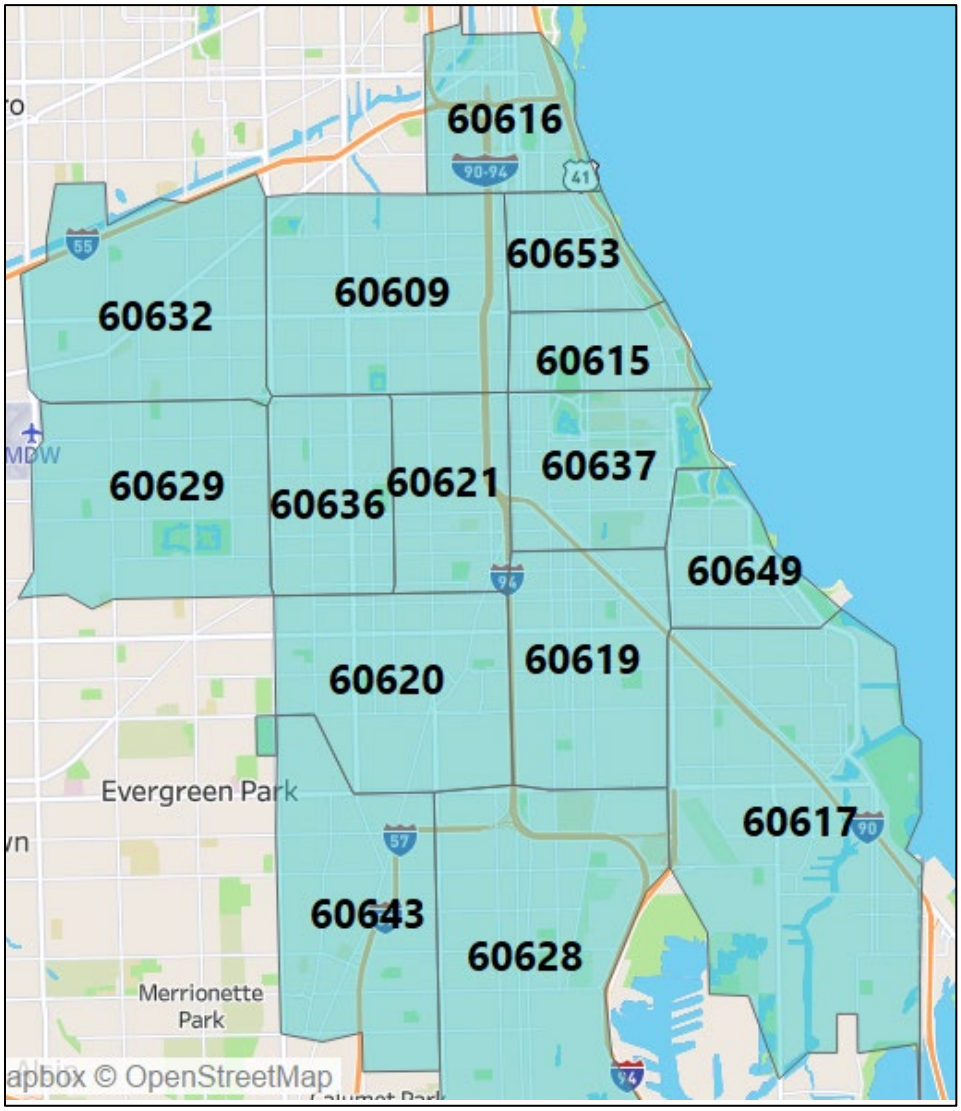
Planning for this community-wide effort was predicated upon extensive community input around needs and solutions, steady governmental engagement throughout the planning process, and rigorous data analysis (all further described below).

Community Service Area

The South Side Healthy Community Model is focused on a community service area defined by the 15 zip codes listed in the figure below and encompassing total population of approximately 900,000 residents as of 2019[10].

[10] Source: Esri Data based on the American Community Survey, 2019

Figure 4: SSHCO Community Service Area by Zip Code



Direct Community Input

The South Side Healthy Community Model was built on community input. From its inception and over the past eight months, more than 900 South Side healthcare providers, faith leaders, community organizations, elected leaders, patients, and residents have been actively engaged in an effort to gather thoughts and ideas on what makes a healthy community. This input formed the foundation of the Healthy Community Model, designed to address long-time health disparities that have plagued the South Side community.

In September 2020, the first South Side Health Transformation community meeting was held. Nearly 150 South Side community stakeholders gathered virtually in a townhall format and in ten smaller break-out rooms to offer their perspectives on healthcare needs in South Side

neighborhoods. Community leaders then hosted 12 smaller community listening sessions over the next several weeks where residents could share their personal stories and the need for better access to quality care in their neighborhoods.

From there, a broad-based approach to community input and engagement was rolled out:

- A website was created where visitors can learn about the needs on the South Side, explore summary reports from the listening sessions, find answers to their questions, watch videos featuring community testimonials, review aspects of the transformation model, and share their feedback through an open Google Form.

- A broad-based community survey was conducted to better understand the gaps residents experience when receiving care on the South Side. The survey was available both digitally and in hard copy at 12 convenient locations, like South Side churches and community hubs, and 240 community members shared their feedback.

- On October 8th, 2020, a large group community update was held and attended by more than 100 community stakeholders to introduce an early concept for a transformation model and allow more community input, feedback and suggestions.

- In addition, a community stakeholder email listserv of more than 900 people was amassed through which communications were deployed through a regular cadence of emails and Zoom reconvening sessions to share project updates.

Throughout this process, many community leaders, such as pastors of significant South Side congregations and directors of community organizations, have been integral partners in engaging the community, often championing the South Side Health Transformation Project to contemporaries, colleagues, community members, personal and professional networks, and the media. Nearly 40 community partners wrote their elected representatives, urging them to vote to approve the allocation of $150 million in state and federal funding earmarked for health transformation .Additionally, there have been 11 news stories illustrating the goals and grassroots nature of the project—several include quotes from community leaders, and one op-ed was authored by four particularly involved community advocates. Figure 5 summarizes the many forums and occasions in which community input was received.

Figure 5: Direct Community Input Received

Government and Stakeholder Engagement

Engagement with elected officials has been multimodal. Leaders of the coalition held virtual briefings with legislators as the project developed, and legislators were also kept abreast of progress via email and phone over these months. Additionally, many elected officials opted to participate in virtual town hall meetings and breakout sessions with stakeholders and residents.

South Side state legislators that the coalition has engaged include: Senators Jacqueline Collins, Mattie Hunter, Emil Jones III, Robert Peters, and Elgie Sims, Jr. as well as Representatives Kam Buckner, Marcus Evans, Jr., Sonja Harper, Lamont Robinson Jr., Nick Smith, and Curtis Tarver, II.

Additionally, members of the Legislative Medicaid Work Group were engaged, and South Side coalition members appeared before the group twice to discuss the coalition's process and plans. The coalition also briefed staff from the Governor's Office, the health policy team representing Congressman Bobby Rush, key staff from the offices of Mayor Lori Lightfoot, and Senator Dick Durbin. Additionally, the coalition briefed South Side aldermen on its plans to transform health care.

3. Data

Describe the data used to design/plan your proposal, methodology of collection, and submit the results of the analysis.

The coalition used various data sources to inform the prioritization of needs, the scale of needs and the right program design to address these needs. Data sources and uses included the following:

Figure 6: Data Sources and Uses

Data Source	Uses
Community engagement listening sessions and community survey	Identify and prioritize areas of greatest need across the service area and inform program design
Most recent community health needs assessments (CHNAs) performed by hospitals in the coalition	Identify and prioritize areas of greatest need across the service area
Secondary research on health needs of the South Side – e.g., from the NYU Langone City Health Dashboard, the Chicago Data Portal (accessed in 2020), various news reports	Identify greatest need and health disparities – e.g., infant mortality rates, life expectancy gaps, chronic disease morbidity and mortality
Most recently available annual emergency visit data from hospitals in the coalition; NYU ED Visit Severity Algorithm, 2015; HCUP CCSR clinical definitions, 2019	Establish degree of avoidable or preventable emergency visits; identify the underlying conditions driving avoidable or preventable emergency visits

Secondary research on the broader history of racial inequity and disinvestment on Chicago's South Side – e.g., review of research by writers and scholars such as such as Natalie Moore and Robert J. Sampson and by institutions such as the Chicago Community Trust and HFS	Understand the broader context of historical racism and disinvestment underpinning presently observed trends such as population decline, economic disparities and health outcome disparities
Inpatient encounter data from IHA COMPdata; Elixhauser Comorbidity Index	Identify utilization patterns overall and by clinical service (e.g., deliveries), outmigration rates; identification of comorbidities driving avoidable inpatient admissions
American Community Survey (ACS) data, accessed through ESRI Demographics ESRI population growth projections	Identify total population of the service area, breakdown of population by demographic characteristics (age, race), population projected growth
Medicare Compare	Identify CMS star ratings and HCAHPS ratings for hospital facilities in the service area in order to identify pain points that the coalition should address
Health Facilities and Services Review Board data, 2012-2018	Identify the closure of delivery services in the service area and disparities in CON approved investment across the city of Chicago
Rosters of physician supply by specialty and location from our coalition members, website scrapes and confidential white-label market provider rosters	Establish existing supply of primary care providers and specialists in the service area
National benchmarks on providers per 100K U.S. residents from: • Dartmouth Atlas of Healthcare • American Board of Pediatrics • The American Medical Association • AAMC Recommendations on primary care panel size from: • HRSA	Estimate the demand for primary care and specialty care services on the South Side for prioritized specialties

- Journal of the American Board of Family Medicine

Age and insurance adjusted utilization patterns from the Medical Expenditure Panel Survey (MEPS)

Data on monthly referrals to specialists from coalition member FQHCs and data on referral fulfillment by payor

Estimate the unmet need for specialty care for high-needs patients

As an appendix to this proposal, the coalition has provided select results from its analyses. A key input emerging from the coalition's analysis was an estimation of provider supply and demand in the target community service area for priority clinical specialties, summarized below:

Figure 7: Estimated Provider Supply and Demand for Prioritized Specialties

Prioritized Provider Specialty	Estimated Provider Demand	Estimated Provider Supply	Estimated Unmet Demand	Incremental Need To Be Met by SSHCO
Primary Care, Non-OB	454	351	103	60 (~60% of Need)
OBGYN	139	76	30	30 (~100% of Need)
Psychiatry	80	61	19	19 (~100% of Need)
Cardiology	48	33	15	7 (~50% of Need)
Endocrinology	16	10	6	3 (~50% of Need)
Ophthalmology	40	14	26	13 (~50% of Need)
Nephrology	23	17	6	3 (~50% of Need)
Infectious Disease	19	13	6	3 (~50% of Need)
Total, Priority Specialties	**615**	**447**	**168**	**138**

Notes:

1. *Supply and demand are listed in estimated clinical full-time equivalents (cFTEs)*
2. *Priority specialties were identified based on their alignment with key population needs identified in CHNAs, literature review and community listening sessions: primary care, maternal / infant health; behavioral health; chronic illness (heart disease, diabetes) and HIV/AIDS*

Based on the identification and prioritization of needs, the SSHCO will address ~60% of unmet primary care needs as well as ~50% of unmet needs in obstetric care, psychiatry / behavioral health and chronic disease related needs by subsidizing hiring, leasing or coverage arrangements for an incremental 90 PCPs / OBs and nearly 50 other specialists. The SSHCO will consider other specialty needs as well based on local needs or pain points.

4. Health Equity Outcomes

Describe how the revised delivery system in your proposal is designed to improve health outcomes and reduce healthcare disparities. Discuss the specific disparities and outcomes you are targeting, including by race and ethnicity.

Based on findings from community listening sessions, community health needs assessments and other data sources described above, the coalition is choosing to target three specific health disparities for focused programming to improve health outcomes. These are: maternal and infant health; mental health; and chronic disease morbidity / mortality. The South Side's African American and Latinx communities are disproportionately affected by very poor outcomes in these conditions, reflecting the scale of needed change across the healthcare and social service delivery ecosystem.

Maternal & Infant Health

The South Side experiences tremendous disparities in maternal & infant health relative to the rest of the city. Premature birth incidence is twice as high in Washington Park as in the Loop; low birth weight births are four times as likely in Avalon Park as in Norwood Park; and infant mortality incidents is a staggering ten times as high in Fuller Park as in Lakeview[11]. While the causes of these disparities are multifactorial, they are likely a reflection to some extent of healthcare access and delivery. The South Side faces a growing desert of OB programs, with four of the seven hospitals that performed deliveries in 2018 south of I-55 having since closed delivery services[12]. Additionally, pregnant women on the South Side receive up to 29% less prenatal care than in North Side neighborhoods[13].

The coalition's solution to the maternal and infant health crisis spans across the four components of the Healthy Community Model. Starting with primary and OB care, the SSHCO will fund 30 additional OB providers (MDs, midwives, doulas and others) to work in FQHC networks – thereby closing the estimated gap in OB provider demand. These providers will work closely in coordination with existing open delivery centers at The New Roseland Community Hospital, University of Chicago Medical Center and Advocate Trinity to help all pregnant women achieve the highest level of prenatal care, delivery care and postpartum care. On the specialty side, pregnant women and mothers who are at high risk for complications will receive greater access to specialist care for heart diseases, diabetes and other chronic diseases, as well as for mental health. The care coordination and SDOH platform will also be highly targeted towards meeting the needs of high-risk pregnant women and mothers through the deployment of standardized assessments and evidence-based interventions, the identification and removal of

[11] Source: Chicago Health Atlas, 2015 data
[12] Sources: 1. 2018 IPDH Annual Hospital Questionnaire Data 2. Press releases
[13] Source: Chicago Health Atlas, 2015 data

barriers to prenatal and maternal health services, the creation of one-stop comprehensive services at accessible community-based sites and the provision of key social services. Coalition-based comprehensive sites will also serve as access points or referral points for meeting social determinant needs of vulnerable women and mothers such as food and housing. Clinical and service providers across all these programs will be trained in culturally responsive care and will be better linked through the shared technology platform. Over time, the coalition expects these interventions will reduce both the most extreme events of maternal and infant mortality, reduce premature and low weight births, reduce labor and postpartum complications and improve infant health.

Mental Health

Mental health is a critical need in the South Side, and access to mental health services has been reduced with the city's closure of multiple community mental health clinics on the South Side since 2012. ED visits due to mental health are 2-2.5 times higher in South Side zip codes than on average in Chicago [14] – a symptom of the lack of preventative, proactive services. The SSCHO' will expand access to mental health services beginning with its primary care platform, whose providers will be uptrained to recognize, screen for, diagnose and treat needs including anxiety, depression, substance use disorders, trauma and other conditions. These primary care providers will be integrated with behavioral health providers at FQHCs, safety nets and other sites – including social workers / therapists as well as psychiatrists. Case management services will be increased at other critical access points such as EDs and hospitals. The SSHCO's broader community-facing platform of community health workers will be embedded, in part, in community-based sites and trained to deliver culturally appropriate, evidence-based mental health interventions as peer support specialists – providing lower levels of care to patients with depression, anxiety, PTSD and substance use disorders. CHWs will provide this care as an extension of professional clinical providers (psychiatrists, therapists), in part through multi-disciplinary Assertive Community Treatment (ACT) teams to serve patients at high risk of hospitalization or other adverse life events. In addition to accessing these in-person interventions, patients on the South Side will have better access to telehealth visits for behavioral health with FQHCs thanks to the digital capabilities of the Connected Care Platform. Together, this programming will dramatically improve patient mental health engagement and wellbeing across areas such as depression, anxiety, substance use disorders and trauma.

Chronic Illness

South Side residents are disproportionately affected by chronic disease morbidity and mortality – with the rate of diabetes deaths, for example, being four times higher in South Side neighborhoods than in North Side neighborhoods. The excess burdens of diabetes, heart disease, HIV / AIDS and other morbidities requires better preventative and primary care, more

[14] Source: Chicago Department of Public Health, 2015-2017 data. ED visits per 10K for mental health were 205 in zip code 60636, 262 in zip code 60621 and 110 for Chicago as a whole.

comprehensive services to address social determinant needs, better matching of patients to the right care setting and better communication between providers. The SSHCO's enhanced recruitment of PCPs will enable care models that are best suited for vulnerable, chronically ill patients with multiple co-morbidities by limiting panel size and leveraging broad care teams (inclusive of physicians, APPs, RNs, MAs, CHWs, social workers). The specialist platform that the SSHCO will grow at safety-net and community hospital sites will address unmet demand for chronic disease related specialties – endocrinology, cardiology, nephrology, infectious disease, ophthalmology. The broad platform of centralized and embedded CHWs will proactively interact with patients through evidence-based interventions that support patient education, coaching, self-management, testing and monitoring, and medication adherence. The SSHCO will actively partner with and provide targeted financial support to CBOs that address root cause social determinants including food and nutrition, housing, and transportation. Through care coordination and the connected care technology platform, the SSHCO will reduce fragmentation between providers and better direct patients to the appropriate care setting to avert avoidable ED visits or hospitalizations. Through all of these measures, the coalition expects to eventually see reductions in deaths from diabetes and heart disease as well as a dramatic increase in patient quality of life.

5. Quality Metrics

Tell us how your proposal aligns with the pillars in the Department's Quality Strategy found here [pdf]. Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy for each of the pillars you identified. Once metrics are agreed upon in the negotiated funding agreement, HFS will proceed to establish a baseline for the service community and a tracking process as well as negotiated improvement targets. For metrics currently not tracked, propose a method for tracking.

Alignment with HFS Quality Pillars

The coalition's proposal aligns to all five HFS quality pillars:

I. **Adult Behavioral Health:** Behavioral health will be a key focus of specialty care programming as well as community health interventions. As a part of this plan, the SSHCO will address half of the estimated unmet need for psychiatric and behavioral health services by adding 19 psychiatry and behavioral health providers. In addition, through the SSHCO's care coordination platform, it will enhance care navigation, follow-up and connection to social services for patients with mental health needs.
II. **Child Behavioral Health:** The specialty behavioral health, care coordination and community health worker platform will be tailored to address acute child and adolescent mental health needs in addition to adult behavioral health needs.
III. **Maternal and Child Health:** The SSHCO-enabled growth of OB care and the deployment of CHWs for maternal and infant health interventions will directly address

this pillar through interventions that increase prenatal and postpartum care as well as through the growth of infant health focused programming.

IV. **Equity:** The Healthy Community Model will address key health disparities in diseases and chronic conditions such as heart disease and diabetes. In addition, the Healthy Community Model will have a large focus on preventative care through increased screenings and proactive visits.

V. **Improving Community Placement:** The Healthy Community Model will address this pillar by funding increased access to primary and specialty care while removing barriers such as insurance, transportation and care navigation. Collectively, these actions will enable South Side residents to receive more needed care, more quickly, in the right setting.

Proposed Metrics

In accordance with this alignment of the model to the HFS quality pillars, the coalition puts forth the following metrics for year 1 accountability and year 2 accountability as well as additional, separate metrics for monitoring and tracking (as shown in Figure 8). These metrics represent a combination of HFS metrics and the coalition's suggested metrics, which the SSHCO would work with HFS to track and collect. The suggested baseline target population would consist of Medicaid enrollees residing in the SSHCO's community service area zip codes who are currently empaneled with a primary care provider from the coalition.

Figure 8: Suggested Metrics for Accountability Beginning in Year 1, Accountability in Beginning Year 2, or for Monitoring and Tracking

Pillar		Suggested Metric *Black Text = Existing HFS Metric; Blue Text = New Proposed Metric*	Accountable Beginning Y1	Accountable Beginning Y2	Monitor & Track
I.	Adult Behavioral Health	1. % 7-day and 30-day follow-up after IP/ED MH or SUD visit (adult)		●	
II.	Child Behavioral Health	2. % 7-day and 30-day follow-up after IP/ED MH or SUD visit (child)		●	
III.	Maternal & Child Health	3. Access to prenatal and postnatal care: increase number of prenatal & postpartum visits per 1,000	●		
		4. Childhood immunizations		●	
		5. Well-Child visits within 30 days		●	
IV.	Equity	6. Access to preventable/ambulatory health services: increase number of PCP visits per 1,000	●		
		7. Access to preventable/ambulatory health services: reduce number of avoidable ED visits per 1,000	●		
		8. Improve patient experience and trust: increase number of providers of color	●		
		10. Improve patient experience and trust: increase number of providers trained in culturally responsive care	●		
		11. Improved % of HTN patients whose BP is controlled		●	
		12. Improved Hemoglobin A1c for patients with poor control		●	
		13. Cervical cancer screening		●	
		14. Breast cancer screening		●	
		15. Reduce avoidable hospital readmissions			●
		16. Reduce risk-adjusted Medicaid & uninsured hospitalizations per 1,000			●
		17. Healthy Days Index (BRFSS)			●
V.	Improving Community Placement	18. Getting Care Quickly (CAHPS measure)			●
		19. Getting Needed Care (CAHPS measure)			●
		20. Number of closed loop referrals for SDoH (housing, food security, transportation)			●

Suggested Methodology for Tracking Metrics

For metrics 6, 7, 15 and 16, the coalition proposes that HFS track outcomes on the SSHCO's baseline population using Medicaid claims data. For metrics 8 and 10, the coalition commits to reporting the race and ethnicity of newly recruited or newly funded providers, as well as reporting the number of providers who have been trained in culturally responsive care. For metric 17, the coalition proposes that HFS launch the Healthy Days questionnaire from the

Centers for Disease Control for the SSHCO's target population. Lastly, metric 20 can be tracked via the new Connected Care Technology Platform once it is fully operational.

6. Care Integration & Coordination

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

A key objective of the SSHCO is to reduce fragmentation and improve coordination of care and services across community sites, primary care, specialty care, acute care (ED, inpatient) and post-acute or non-acute care. This fragmentation today drives high wait times, results in avoidable utilization of high-acuity settings, contributes to outmigration for care and ultimately worsens health outcomes. Through the coalition's community and stakeholder listening sessions, a number of contributing pain points have been identified:

- The lack of communication and technology to support closed loop referrals for specialty care or social services
- The lack of shared information on patient health between providers to ease communication
- The lack of resources to support discharge planning, care coordination or case management
- The absence of formalized collaboration between providers to address shared patient populations and resolve common issues

The Healthy Community Model addresses these pain points in part through specific SSHCO program components and in part through the overarching model of convening providers and facilitating better collaboration. Program components that most directly address care integration and coordination are:

Care Coordination

As part of the third pillar, the SSHCO will embed care coordinators into community sites, FQHCs and safety net hospitals to better integrate care at each site. In addition, a centralized team of care coordinators will be trained to more seamlessly transition patients along their care journey and to ease communication between outgoing and incoming providers.

Connected Care Technology

The Connected Care Technology platform will support interoperable care coordination across participating organizations through the sharing of relevant information. This will include

standardized, user-friendly tools to create and manage referrals; order and results management; and status tracking or alerts to drive closed loop referrals.

This technology will provide access to real time and relevant data that will inform decision-making with more complete views of social determinants and access gaps, provider care management needs and patient medical records. Functionalities could include, for example, visibility into specialty referral fulfillment; enhanced scheduling; enhanced results communication; and enhanced communication between providers. The platform will equip providers in this coalition with tools to improve coordination, communication, patient experience and care quality.

Beyond these specific program components, a key function of the SSHCO will be to convene all participants, facilitate working groups to drive collaboration, hold providers accountable to shared outcomes and standards, and facilitate enhanced communication and collaboration between providers.

7. Access to Care

Describe how your proposal will increase access to preventive, primary or specialty care in your community.

The coalition's proposal is designed to substantially enhance access to care across preventative, primary and specialty care. The Healthy Community Model addresses gaps in provider supply as well as barriers to access such as insurance, transportation and virtual delivery.

Addressing Supply Gaps and Referral Challenges

Currently, a significant amount of medical care provided to residents of the South side of Chicago is delivered in other regions of the city and in the suburbs. In significant measure this is due to lack of access to high-quality healthcare providers on the South Side. Having analyzed provider supply and demand on the South Side, the coalition estimates that there is a shortage of approximately 100 PCPs, 60 OBs, 40 psychiatrists and 50 specialists related to diabetes, heart disease and HIV / AIDS. By driving outmigration or delayed treatment, these shortages worsen fragmentation and contribute to health outcome disparities. For example, FQHCs in the coalition see only 36% of referrals for cardiology care being fulfilled.

The coalition proposes to address this issue by facilitating and subsidizing the addition of 90 primary care and OB providers as well as 50 specialists in areas including psychiatry / behavioral health, cardiology, endocrinology and other specialties. These additional providers will increase capacity to provide care at local South Side sites, particularly safety net hospitals and federally qualified health centers, and will add to existing capacity. It is anticipated that this will provide

greater choice to patients and with more timely access to the high-quality care patients will choose to obtain at local South Side community sites. As part of the specialty care platform, the SSHCO will also dedicate access specifically to FQHC referrals in order to meet the needs of the most vulnerable patients and enhance referral completion rates. In addition, the care coordination platform will be leveraged to create a centralized access referral program that will help patients clear scheduling hurdles and navigate care.

Addressing Insurance Barriers

By partnering with FQHCs and safety net hospitals as care delivery access points, the Healthy Community Model removes many potential contracting barriers for Medicaid enrollees as well as for the uninsured. The SSHCO-subsidized specialty lease and coverage arrangements at safety net sites will open access to much-needed specialty care to patients who have historically experienced challenges in accessing care. The same will be true of primary and OB care provided at FQHCs.

Addressing Physical Barriers

The coalition members intend to address physical barriers to accessing care with three solutions. First, the SSHCO will identify programmatic solutions to providing transportation services to the most vulnerable patients, in partnership with community vendors and CBOs. Second, the coalition plans to conduct home and community-based interventions through the SSHCO's CHW platform. Third, the SSHCO will expand access to virtual appointments for primary and specialty care through its technology platform.

As a result of these measures, the coalition anticipates that patients will both get more needed care and will get care more quickly, leading to better patient satisfaction as well as better health outcomes.

8. Social Determinants

Describe how your proposal addresses specific social determinants of health and how you propose to measure your proposal's impact on those social determinants.

Addressing social determinants of health is important for improving health and reducing health disparities. Though health care is essential to health, it is a relatively weak health determinant[15]. Data and research indicate that the social determinants of health have a higher impact on population health than healthcare and that a higher ratio of social service spending versus healthcare spending results in improved population health.

[15] Source: Kaiser Family Foundation

Examples of social determinants of health include:

- Income level
- Educational opportunities
- Occupation, employment status, and workplace safety
- Gender inequity
- Racial segregation
- Food insecurity and inaccessibility of nutritious food choices
- Access to housing and utility services
- Early childhood experiences and development
- Social support and community inclusivity
- Crime rates and exposure to violent behavior
- Availability of transportation
- Neighborhood conditions and physical environment
- Access to safe drinking water, clean air, and toxin-free environments
- Recreational and leisure opportunities

While the proposed plan does not address all SDoH, the coalition's plan is to focus on four which are believed to have a high impact on access to health services and overall health of the South Side community: Transportation, Housing, Food Insecurity, and Employment. The coalition has deep expertise reaching beyond the clinical interventions to address the "whole person health" of patients. The coalition plans to leverage that expertise and experience to scale those programs focused in priority areas (see figure 9 below):

Figure 9: Approach to Prioritizing SDoH

The South Side neighborhoods suffer from both deep fragmentation of social service and community benefit organizations and overall capacity constraints. Via the care coordination and technology platform, the coalition plans to address some of the fragmentation by using CHWs to screen for social determinants, link to local social service organization, and enhance the capacity to meet the community's needs.

Screening

The Healthy Community Model CHWs will be placed at point-of-service (e.g. emergency departments, primary care offices, hospital care management programs) and imbedded within the community to provide standardize screening for social services needs and make referrals directly to CBO organizations. Employing a standardized screening like the *Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences* (PRAPARE) from the National Association of Community Health Centers (NACHC). PRAPARE provides an implementation and action toolkit that is being used by providers nation-wide to gather data that will allow them to assess their patients' social needs, so they can take measures to address them. The evaluation tool asks social health questions in areas ranging from demographic data and housing status to social-emotional health and physical security.

Trusted Connectors

The CHWs will also be responsible for confirming that referrals to clinical or social services are not just one-way, and for helping to alleviate any barriers residents would have to getting to an appointment, completing paperwork or otherwise fulfilling referrals. Ultimately the coalition believes that CHWs must be positioned as care providers focused on developing "authentic healing relationships" (a paradigm developed by the Camden Coalition)[16] with patients to address their complicated health needs and social requirements through proactive primary care and social services rather than costly emergency department visits. As noted by the Camden Coalition's Better Care Playbook, "The authentic healing relationship is a respectful, trusting and non-judgmental partnership between the Care Team and the patient that serves as the foundation for progress toward long-term health management."[17] With the CHW on the frontlines, the care teams are well positioned to empower patients to take ownership of their health and help them to build support networks through community organizations as well as friends and family.

Enhancing Capacity

To increase the capacity within CBO and social service partners, the coalition plans to imbed care coordination resources to help alleviate and scale for increased referrals. By imbedding CHWs within partner organizations, the SSHCO will strengthen network of CBOs serving the South Side and help to bolster the workforce dedicated to meeting the needs of residents.

[16] Grinberg C, Hawthorne M, LaNoue M, Brenner J, Mautner D. The Core of Care Management: The Role of Authentic Relationships in Caring for Patients with Frequent Hospitalizations. Popul Health Manag. 2016 Aug;19(4):248-56. doi: 10.1089/pop.2015.0097. Epub 2015 Nov 13. PMID: 26565379; PMCID: PMC4965703.
[17] Source: Better Care Playbook by the Camden Coalition

The coalition also plans to partner with local colleges and training programs to train and create an employment pipeline for community health workers; LPN/RNs; social workers; medical assistants and other roles to be filled by either the SSHCO or its partner organizations.

Measuring Success

The coalition and the SSHCO will track and measure the model's success by tracking four metrics:

1. Number of patients screened for social determinants of health
2. Number of closed-loops referrals (completed appointments) made to social service and community benefit organizations
3. Number of participants in training programs
4. Number of new jobs created by SSHCO

9. Budget

Please provide a detailed budget for your proposal that shows all costs associated with implementing the proposal along with a monthly timeline for when the costs will be incurred in the first year of funding and annual amounts needed in future years. The timeline should be in months from award. Specify the dollar amount of transformation or capital funds you are requesting from the state and the source of all other funds that will cover the costs of your proposal. An Excel budget form is available online at HFS.illinois.gov/Transformation. However, Proposers should amend or alter the form in a way that best sets forth their budget. If a budget has been prepared in another format it may be submitted in that format. Some aspects of your proposal may be better suited for funding from available capital dollars. Your budget should distinguish your request from transformation dollars as opposed to capital dollars.
The appropriations for Healthcare Transformation Collaboratives and for the Healthcare Capital Program are both limited. Not every proposal received in a particular fiscal year may be funded. For projects that the Department decides to fund, funding may not be at the full level requested.

Illustrated below is a monthly budget for implementing the first year of the Healthy Community Model, accompanied by a yearly five-year budget. These budgets correspond to the milestones that are listed in the following section. Capital dollars listed in the budget in the first year are for beginning IT build-out and for purchasing additional diagnostic equipment; all subsequent capital expenditures are for IT only.

Expense Categories

The following expense categories are in subsequent budgets:

- **PCP & OB Ramp-Up Subsidies:** Subsidies to participant organizations to cover ramp-up costs for PCP and OB providers – 15 providers in year 1, 90 providers by year 5
- **Specialty Lease & Ramp-Up Subsidies:** Subsidies to participant organizations to incrementally grow access to specialties such as psych, cardiology, endocrinology – 7 providers in year 1, 48 providers by year 5

- **Care Coordination / CHW Salary & Benefits:** Salary costs of centralized and embedded care coordinators and CHWs: 81 in year 1, 244 by year 5
- **SDOH & CHW Programming:** Costs that include community engagement activities, CHW training and activities, targeted funding for addressing SDoH
- **Demonstration Pilots:** Funding for demonstration interventions in year 1 focused on social determinants, access to care, improving health outcomes and reducing avoidable costs that will inform future-year program scale-up
- **Data Platform Operating Costs:** Costs of technology platform. First three years of costs are projected to be capitalized build-out; operating expenses are first incurred in year 3.
- **Population Health Analytics Costs:** Costs tied to analytics to target populations, track impacts and improve outcomes
- **Management & admin:** Management / administration salary and general costs
- **Startup Contingency Funding:** Funding for initial startup expenses such as legal, consulting, purchased services as well as for unforeseen initial expenses

Monthly Budget for Year 1

Figure 10: Monthly Cash Expenses, Months 1-6

Year 1 Monthly Operating Budget	1	2	3	4	5	6
PCP & OB Ramp-Up Subsidies	-	-	-	-	-	-
Specialty Lease & Ramp-Up Subsidy	-	-	-	-	-	-
Care Coordination / CHW Salary & Benefits	-	-	-	-	0.27M	0.27M
SDOH & CHW Programming	-	-	0.25M	0.25M	0.25M	0.25M
Demonstration Pilots	-	-	-	-	0.50M	0.50M
Data Platform Operating Costs	-	-	-	-	-	-
Population Health Analytics Costs	0.06M	0.06M	0.06M	0.06M	0.06M	0.06M
Management & Admin	0.17M	0.17M	0.17M	0.17M	0.17M	0.17M
Startup Contingency Expenses	0.57M	0.57M	0.57M	0.57M	0.29M	0.29M
Monthly Cash Operating Expenses	**0.8M**	**0.8M**	**1.1M**	**1.1M**	**1.5M**	**1.5M**
Cumulative Cash Operating Expenses	**0.8M**	**1.6M**	**2.7M**	**3.7M**	**5.3M**	**6.8M**

Year 1 CapEx Budget	1	2	3	4	5	6
Diagnostic CapEx	-	-	-	-	-	-
Technology CapEx	-	-	-	-	-	-
Capital Expenses	**-**	**-**	**-**	**-**	**-**	**-**

Year 1 Total Cash Expenses & Working Capital	1	2	3	4	5	6
Total Monthy Cash Expenses	**$0.8M**	**$0.8M**	**$1.1M**	**$1.1M**	**$1.5M**	**$1.5M**
Cumulative Monthly Cash Expenses	**$0.8M**	**$1.6M**	**$2.7M**	**$3.7M**	**$5.3M**	**$6.8M**
Available Working Capital	**$29.2M**	**$28.4M**	**$27.3M**	**$26.3M**	**$24.7M**	**$23.2M**

Figure 11: Monthly Cash Expenses, Months 7-12 and Cumulative Year 1 Expenses

Year 1 Monthly Operating Budget	7	8	9	10	11	12	Cumulative Y1
PCP & OB Ramp-Up Subsidies	-	-	-	0.10M	0.10M	0.10M	0.3M
Specialty Lease & Ramp-Up Subsidy	-	-	0.05M	0.05M	0.05M	0.05M	0.2M
Care Coordination / CHW Salary & Benefits	0.27M	0.27M	0.27M	0.27M	0.27M	0.27M	2.1M
SDOH & CHW Programming	0.25M	0.25M	0.25M	0.25M	0.25M	0.25M	2.5M
Demonstration Pilots	0.50M	0.50M	0.50M	0.50M	0.50M	0.50M	4.0M
Data Platform Operating Costs	-	-	-	-	-	-	-
Population Health Analytics Costs	0.06M	0.06M	0.06M	0.06M	0.06M	0.06M	0.7M
Management & Admin	0.17M	0.17M	0.17M	0.17M	0.17M	0.17M	2.0M
Startup Contingency Expenses	0.29M	0.29M	0.14M	0.14M	0.14M	0.14M	4.0M
Monthly Cash Operating Expenses	**1.5M**	**1.5M**	**1.4M**	**1.5M**	**1.5M**	**1.5M**	**15.9M**
Cumulative Cash Operating Expenses	**8.3M**	**9.9M**	**11.3M**	**12.8M**	**14.4M**	**15.9M**	**15.9M**

Year 1 CapEx Budget	7	8	9	10	11	12	Cumulative Y1
Diagnostic CapEx	-	-	3.96M	-	-	-	4.0M
Technology CapEx	-	-	7.60M	-	-	-	7.6M
Capital Expenses	**-**	**-**	**11.6M**	**-**	**-**	**-**	**11.6M**

Year 1 Total Cash Expenses & Working Capital	7	8	9	10	11	12	Cumulative Y1
Total Monthy Cash Expenses	**$1.5M**	**$1.5M**	**$13.0M**	**$1.5M**	**$1.5M**	**$1.5M**	**$27.5M**
Cumulative Monthly Cash Expenses	**$8.3M**	**$9.9M**	**$22.9M**	**$24.4M**	**$25.9M**	**$27.5M**	**$27.5M**
Available Working Capital	**$21.7M**	**$20.1M**	**$7.1M**	**$5.6M**	**$4.1M**	**$2.5M**	**$2.5M**

Note: available working capital at the end of year 1 is reserved for expenses hitting in the first month of Y2 (projected to be higher with new recruits that are onboarded at the start of Y2).

Five-Year Budget and Pro-Forma

Figure 12: Yearly Pro-Forma, Years 1-5

Program Pro Forma	2021	2022	2023	2024	2025
Revenue					
State Transformation Funds	$30.0M	$30.0M	$30.0M	$30.0M	$30.0M
Supplementary Philanthropy and Grant Funding	-	2.0M	6.0M	6.0M	6.0M
Total Annual Revenue	**$30.0M**	**$32.0M**	**$36.0M**	**$36.0M**	**$36.0M**
Programmatic Expenses					
PCP & OB Ramp-Up Subsidies	0.3M	5.1M	6.2M	3.2M	1.9M
Specialty Lease & Ramp-Up Subsidy	0.2M	2.7M	3.6M	3.3M	3.2M
Care Coordination / CHW Salary & Benefits	2.1M	6.6M	8.7M	11.8M	12.0M
SDOH, Care Coordination & CHW Programming	2.5M	2.6M	2.6M	2.7M	2.7M
Demonstration Pilots	4.0M	-	-	-	-
Data Platform Operating Costs	-	0.7M	1.5M	6.3M	6.4M
Population Health Analytics Costs	0.7M	1.0M	1.1M	1.3M	1.3M
Management & Admin	2.0M	3.4M	4.0M	4.8M	4.9M
Startup Contingency Expenses	4.0M	4.0M	1.5M	-	-
Depreciation & Amortization	1.2M	1.9M	2.7M	2.7M	2.9M
Total Annual Operating Expenses	**17.1M**	**28.0M**	**31.8M**	**36.1M**	**35.3M**
Annual Operating Income	**$12.9M**	**$4.0M**	**$4.2M**	**$(0.1M)**	**$0.7M**
Annual Capital Expenses	**$11.6M**	**$7.6M**	**$7.6M**	**$2.0M**	**$2.0M**
Annual Cash Expenses	**$27.5M**	**$33.7M**	**$36.7M**	**$35.4M**	**$34.4M**
Annual Cash Flow	**$2.5M**	**$(1.7M)**	**$(0.7M)**	**$0.6M**	**$1.6M**
End of Year Working Capital	**$2.5M**	**$0.8M**	**$0.1M**	**$0.7M**	**$2.3M**

Note: $4M of Y1 capex is for diagnostics. All other and subsequent capex is technology related.

10. Milestones

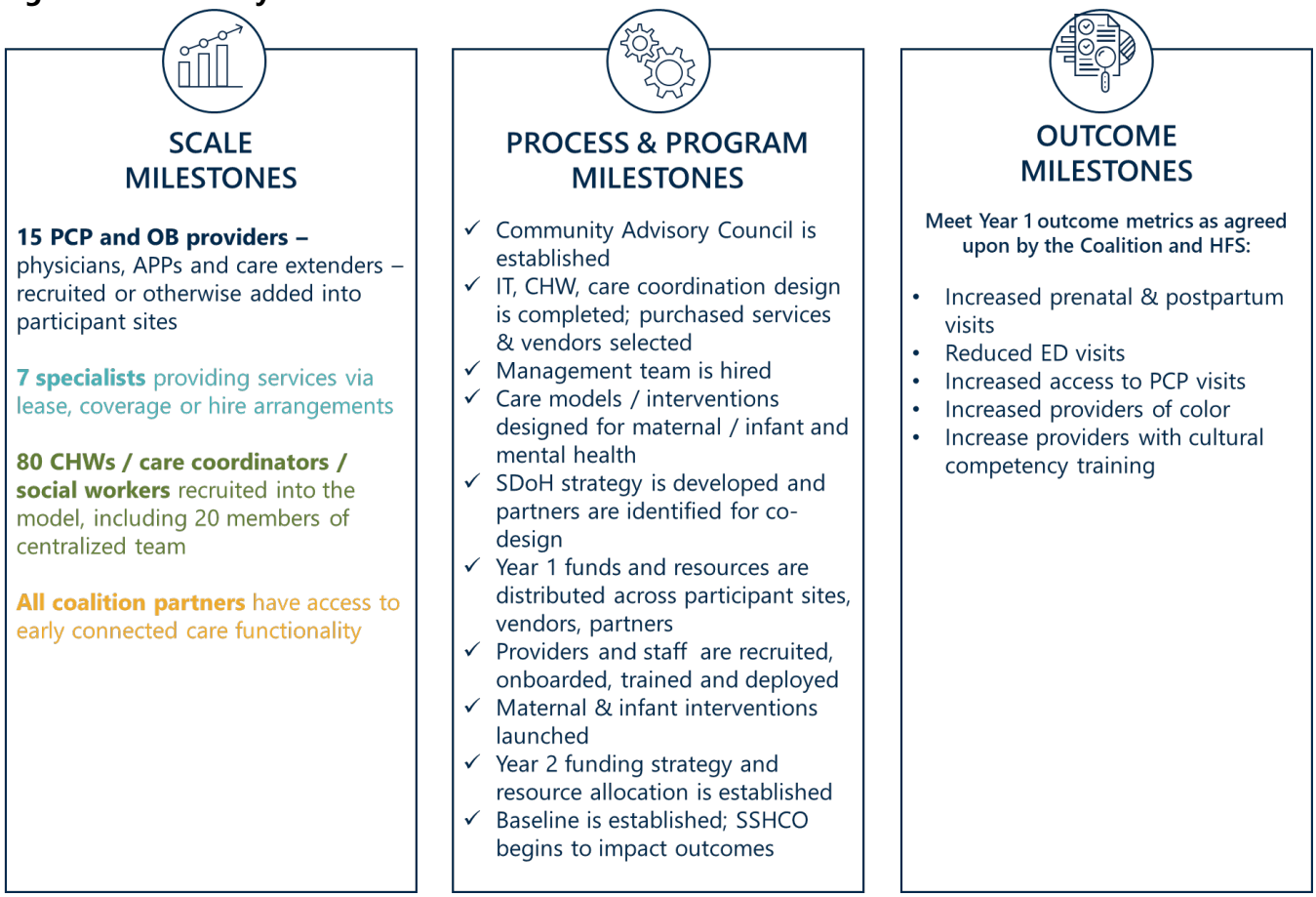
For all activities described in your proposal, please provide a calendar of milestones to show progress (e.g., when IT will be purchased, when IT will be operative, when construction projects will begin and end, when people will be hired, etc.) The timeline should be in months from award.

The coalition has put forth an ambitious timeline of milestones for the first twelve months and the following five years.

Year 1 Monthly Milestones

In the first year, the coalition intends to achieve the following high-level scale, programmatic and outcome milestones:

Figure 13: Summary of Year 1 Milestones



These milestones will be sequenced along the following detailed timeline.

Figure 14: Detailed Monthly Milestones for Year 1

	Month 1	Month 2
MANAGEMENT & GOVERNANCE	• Finalize board; finalize bylaws • **Put in place interim management team including any interim purchased services** • Define target population segments for year 1 interventions	• Establish working structure for Healthy Community Model spanning all participants including coalition members, provider groups, CBOs, additional vendors & partners • Establish Community Advisory Committee
PRIMARY CARE	• Validate FQHC provider and facility capacity & access at coalition FQHC and safety net locations	• Prioritize PCP & OB hiring for year 1 by location based on agreed-upon criteria • Convene collaboratives to begin identifying and disseminating best practices
SPECIALTY CARE	• Identify Year 1 priority specialty mix for hiring / lease / coverage	• Convene specialty specific collaboratives to begin identifying and disseminating best practices • Assemble provider groups to lease out specialists or provide coverage at sites • Determine target specialty mix by site
CARE COORDINATION & SDOH	• Conduct pre-implementation design of care coordination and related interventions based on target population segments • Identify SDOH to address intensively in Year 1 programming, by target population segment	• Identify CBO partners for programming around SDOH and / or for placement of CHWs • Align prospective CHWs to PCPs and specialists by site based on agreed-upon criteria • Select partners for workforce development, recruitment; initiate joint planning
TECHNOLOGY & ANALYTICS	• Begin technology pre-implementation design; identify key use cases, gather requirements • Enact data sharing & license agreements across all coalition partners	• Inventory existing tech and solutions across participant sites • Identify empaneled target patient populations across all participant sites using each partner's data

	Month 3	Month 4
MANAGEMENT & GOVERNANCE	• Finalize establishment of legal entity and 501(c)(3) status • Finalize executive search for CEO • Finalize year 1 funding & available working capital by month	• Finalize funds flow arrangements with HFS, fund recipients and SSHCO • Finalize year 1 resource allocation across coalition sites for primary care, specialty care, care coordination & CHWs
PRIMARY CARE	• Develop clinical and operational protocols for enacting best practices across HCM care sites	• Target population segments, design segment specific interventions • Begin recruiting ~10K new patients to empanel
SPECIALTY CARE	• Establish standards and comms for access and referrals • Develop clinical and operational protocols for enacting best practices across HCM care sites • Review workflows to support referrals between PCPs, other institutions and new specialists; identify opportunity areas	• Prioritize target specialty mix and count by site based on agreed-upon criteria
CARE COORDINATION & SDOH	• Prioritize care coordination gaps amongst participant sites and determine embedded care coordination needs by participant site • Select partners for training / management / deployment of CHWs • Develop / adapt curriculum for CHW training	• Target population segments, design segment specific interventions
TECHNOLOGY & ANALYTICS	• Develop gap analysis; engage and evaluate vendors; conduct vendor demonstrations • Working with HFS, measure baseline health outcomes of target population and develop interim quality dashboard	• Select vendors across use cases

	Month 5	Month 6
MANAGEMENT & GOVERNANCE	• Initiate Year 2 financial planning and fundraising, resource allocation planning • Hire management team: clinical, finance, IT, analytics, strategy & operations, other key functions	
PRIMARY CARE	• Develop workflows to support bringing on new patients and potential transitions/referrals to new specialists and other health systems • Begin recruitment for year 2	• Recruit or add first wave of PCP and OB providers; initiate onboarding, credentialing & training
SPECIALTY CARE	• Identify mix of hiring / lease / coverage / practice arrangements to be enacted and accompanying subsidy levels • Begin planning for year 2	• Specialty Collaboratives: target population segments, design segment specific clinical interventions
CARE COORDINATION & SDOH	• Initiate programming to address SDOH with CBO partners • Begin recruitment for year 2	• Recruit ~20 care coordinators and CHWs into centralized care coordination program • Recruit ~60 care coordinators and CHWs into embedded program
TECHNOLOGY & ANALYTICS	• Finalize vendor selection • Deploy existing available technology to segment interventions	

	Months 7-9	Months 10-12
MANAGEMENT & GOVERNANCE	• Finalize funds flow arrangements with HFS; finalize budget and working capital for year 2	• Initiate MCO discussions and discussions with state around alternative payment models • Review Year 1 outcomes for maternal & infant health interventions
PRIMARY CARE	• Finalize recruitment or addition of PCP and OB providers; initiate onboarding, credentialing & training	• Complete all provider credentialing and medical staff privileges; initiate care provision
SPECIALTY CARE	• Fulfill all hiring / lease / coverage arrangements; initiate funding • Identify and fund incremental diagnostic needs	• Finalize design of behavioral health population interventions in concert with PCPs and community sites • Complete all provider credentialing & medical staff privileges for new specialty hires (in psychiatry and behavioral health); initiate care provision
CARE COORDINATION & SDOH	• Train and deploy care coordinators and CHWs in targeted interventions for maternal and infant health	• Launch centralized access referral program
TECHNOLOGY & ANALYTICS	• Vendors to lay foundation for interoperable data sharing, provider functionalities, patient facing functionalities – gather requirements, survey existing system, conduct testing and development • Develop outcome reporting and quality metrics for ongoing measurement	• Pilot early functionality with partner sites

Year 2-5 Milestones

The year 1 milestones will be followed with the following milestones for year 2-5:

Year	Scale	Program / Process	Outcomes
2	**PCP & OB: 55 providers** **Specialty Care: 30 providers** **Care Coordination & CHW: ~140 workers**	• Participant site growth • **Program refinement based on pilots** • **Mental health & chronic care interventions launched** • **New measures launched (e.g., Healthy Days)** • **Fundraising scaled up**	*Improvements to Year 1 outcomes and:* • Increased breast & cervical cancer screening • Increase in mental health follow-up • Increased child immunizations + well visits • Improvements for HTN and diabetes
3	**PCP & OB: 70 providers** **Specialty Care: 40 providers** **Care Coordination & CHW: ~180 workers**	• Empaneled patient growth • Iterative program refinement • **Expanded scope of specialty care** • **IT / connected care platform fully functional**	*Improvements to Year 2 outcomes*
4	**PCP & OB: 90 providers** **Specialty Care: ~50 providers** **Care Coordination & CHW: ~250 workers**	• Empaneled patient growth • Iterative program refinement • **APM arrangements explored or launched**	*Improvements to Year 3 outcomes*
5	**PCP & OB: 90 providers** **Specialty Care: ~50 providers** **Care Coordination & CHW: ~250 workers**	• Iterative program refinement • **Sustainable funding path is realized** **Bolded = New Features By Year**	*Improvements to Year 4 outcomes*

11. Racial Equity

A major focus of transformation is racial equity. Please describe how your partnership/collaboration will incorporate racial equity in the project. In addition, please complete the attached Racial Equity Questionnaire and return it with your application

The South Side of Chicago is a storied and unique collection of vibrant, resilient, culturally rich, and diverse communities. Steeped in African American and Latinx heritage and history, the South Side is marked by deep social bonds and anchored by vital community and faith-based organizations.

Generations of structural inequality and neglect have contributed to the erosion of the critical social, economic, and health-promoting infrastructure necessary to adequately meet the needs of this community. Today, the South Side of Chicago suffers among the worst economic, health, social, and violence outcomes in the United States. Nearly 900,000 residents live in South Side communities, the majority of whom are historically underserved and minority (59% African American, 28% Latinx)[18].

The current unemployment rate on the South Side more than quadruples the national rate. Thirty-one percent of community members receive Supplemental Nutrition Assistance Program (SNAP) aid. Residents suffer significantly higher rates of chronic health conditions, including

[18] Source: Esri Data, 2019 based on American Community Survey Data

asthma, diabetes, obesity, breast cancer, sexually transmitted diseases, and HIV infections and others.

Amidst these poor chronic health outcomes, stark economic challenges, and high incidence of violence, data suggest that residents living on the South Side are not seeking or accessing behavioral health services at levels commensurate with national averages. COVID-19 has further exacerbated the needs of community members. The pandemic itself, loss of jobs, loss of necessary resources for daily living, and the impact that it has had on the mental health of the South Side community, has left individuals in a greater dire situation.

The coalition members are committed to racial equity. The coalition represents a longstanding collection of health care providers caring for the predominantly racially and ethnically diverse population of the South Side. Coalition member organizations intentionally and actively engage in efforts to ensure racial equity and reduce health disparities for South Side residents through each member's respective culturally competent care delivery methods and by directly providing or linking patients to wrap-around support services that address the issues related to social determinants of health. Coalition members work in and experience the history of the South Side through their practices every day. Coalition staff are representative of the community that they serve, with many being residents of the South Side neighborhoods.

The members of this coalition will pursue a racial equity strategy further enhanced as the SSHCO reduces the fragmentation of care delivery services and systems. The coalition's ability to design integrated care delivery models that directly address the needs of the diverse populations served by the coalition's members serve will have a profound effect on racial equity and the reduction of health disparities for South Side residents. SSHCO funded providers will require training in cultural competence and trauma informed care focusing on historical social- political issues that have confronted the South Side communities and resulted in structural forms of racism.

The coalition will collectively embed equity, cultural competence and health literacy into the Healthy Community Model's clinical models, and support services. The SSHCO's care management and population health programs and initiatives will focus on addressing the social determinants of health, a key component of racial equity.

The lack of jobs is a key root cause of racial inequity. The Healthy Community Model will create significant jobs for South Side residents. The coalition's goal is to hire approximately 430 new staff including CHWs, physicians, Advance Practice Providers, nurses, MAs, administrative staff, and other positions. The coalition will set targets to ensure racial equity in the SSHCO's hiring practices at all levels, including recruitment, hiring, promotion, and retention practices. The coalition will ensure that hiring directly from the South Side community is the priority of the SSHCO and participant organizations.

The SSHCO Board of Directors is a diverse body comprised of 17 individuals who either live or work within the South Side community. Detailed Director profiles are included in Section 16 of this document.

The SSHCO and its collective members will set targets for MBE/WBE utilization for vendor purchasing that exceed the minimal targets set by the State of Illinois. The coalition's goal is to leverage minority and women owned businesses to support the SSHCO's endeavors to achieve racial equity.

The Healthy Community Model was developed with South Side community members. Each component of the model was based on input given by South Side community residents, community and faith-based organizations, elected officials, etc. The Healthy Community Model was reviewed by and iterated through multiple stakeholder engagements to refine and ensure that it will meet the needs of South Side community members as expressed by them. The Healthy Community Model is also supported by secondary data that validates the needs as outlined by community stakeholders.

The goal of the SSHCO is to impact the health and wellbeing of South Side community members by reducing longstanding health disparities and inequities created by structural and interpersonal forms of racism, disenfranchisement and divestment in the health and wellbeing of the south side health care ecosystem. The coalition is confident that its racial equity strategy will enhance its member's capabilities to achieve the metrics and outcomes set forth in this application.

12. Minority Participation

Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise Program (BEP) and/or not-for-profit entities majorly controlled and managed by minorities that will be used on the project, as subcontractors or equity partners, and describe how they will be used. Indicate whether their role is only during the implementation of your proposal (e.g., construction, consulting, etc.) or if they will have a role in the ongoing operation of your transformed delivery system. To the extent one of the members of your collaboration already contracts with a BEP certified firm, only include the services of the BEP firm that will be used on the project. To be included, these services must increase the volume of work of the BEP certified firm or not-for-profit entity that is majorly controlled and managed by minorities above the services provided to the collaborating member.

Much of this coalition's success in creating transformative health delivery hinges on the SSHCO's ability to work with businesses and not-for-profit organizations with deep expertise and who reflect the communities that this coalition serves. Robust supplier diversity aligns with the coalition's goal of driving investment in the South Side, and that the members believe will ultimately give the SSHCO a differentiated advantage to achieve the sought-after impact**.** The

coalition includes multiple not for profit entities that are majorly controlled and/or managed by minorities:

- Beloved Community Family Wellness Center
- Chicago Family Health Center
- Christian Community Health Center
- Friend Family Health Center
- Jackson Park Hospital
- Near North Health
- TCA Health

As a reflection of the coalition's commitment to minority participation, the SSHCO will target channeling at least 36% of its operating spend and funding subsidies to minority-owned businesses and minority managed or controlled not for profit organizations, as well as at least 7% on women-owned businesses or women managed / controlled not for profit organizations. Examples of these purchased services and funding subsidies include but are not limited to direct care provision, education and training, care coordination, and community services focused on social determinants of health. These services are central components of The Healthy Model and this coalition looks forward to partnering with leading organizations and businesses to serve the residents of the South Side of Chicago.

13. Jobs

For collaborating providers, please provide data on the number of existing employees delineated by job category and including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these levels. Please describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve. The proposal should also describe any retraining, innovative ideas or other workforce development planned for the new project.

Existing Employment Levels and Future Opportunities

Collectively, the providers in this coalition employ approximately 15,000 employees, including approximately 5,000 employees who are residents of the South Side community service area zip codes. If successful, the interrelated components and programs of the SSHCO will keep more care locally in the community and strengthen the coalition's employment base, thereby enhancing job security for the approximately 5,000 South Side employees and furthering the broader economic well-being of the South Side.

In addition to stabilizing existing employment, the SSHCO will directly add approximately 430 new jobs in the next five years by hiring, funding or subsidizing providers, care coordinators, community health workers and staff. This figure includes:

- Funding for 90 anticipated new physician, APP and midwife providers in primary care and obstetric care
- Funding for nearly 50 psychiatrists, behavioral health providers and specialists to provide expanded care; some portion of whom are envisioned to be net-new hires
- Funding for nearly 250 community health workers and care coordinators, and
- Over 40 SSHCO staff to manage and administer programs

In accordance with the coalition's commitment to advancing racial equity, health equity and economic investment on the South Side, the SSHCO makes the following commitments:

- In Year 1, we commit to at least 33% of these new hires being minority hires; by the end of Year 5, we commit to at least 45% of our employees being minorities.
- In Year 1, we commit to at least 33% of these new hires being residents of the South Side zip codes in the defined community service area; by the end of Year 5, we commit to at least 45% of our employees being residents of those zip codes.

Achievement of these targets will be facilitated through new, innovative workforce training and workforce development partnerships as well as through targeted pipeline programs, as detailed further below.

Workforce Training, Workforce Development and Pipeline Programs

Employment is a key issue in the Economic Stability domain of the Healthy People 2020 Social Determinants of Health topic areas. Community-based, neighborhood-focused workforce development strategies have the potential both to assist individual residents improve their economic standing and to improve neighborhood conditions. By combining individualized assistance with systematic links to top-notch training, education, work supports and jobs, neighborhood-focused employment programs stimulate neighborhood revitalization and create important links to the urban workforce development programs for residents. Neighborhood-focused employment programs have the potential to connect both employed and unemployed low-income residents to better jobs, training, education and support services throughout the South Side.

As part of the SSHCO's care coordination platform, the organization will explore partnerships with local colleges and community-based organizations to develop innovative community health worker recruitment pipelines and training programs. Through these pipelines, the SSHCO will elevate opportunities to engage and employ South Side residents, with a special focus on

underserved individuals such as people re-entering the workforce. To help develop these pipelines and workforce development programs, the SSHCO will leverage coalition expertise such as the Sinai Urban Health Institute as well as identify other potential partners with a South Side focus.

14. Sustainability

For any new or increased services, include an explanation of how those services will be sustainable in the future without subsidization by transformation funds. Include how, through alternative payment methodologies for Medicaid services or other sources, services that address social determinants of health will be funded on an ongoing basis.

The coalition is proposing a dynamic and scalable model in which the State finances the establishment and roll-out of a program that will fundamentally transform Chicago's South Side healthcare delivery landscape, closing longstanding gaps in access, care, and health outcomes. Doing so will require material Transformation funding -- specifically $30 million per year over the SSHCO's first five years.

Over that five year period, the SSHCO will concurrently establish its path to self-sustainability, predicated on transitioning from Transformation funding to alternate payment mechanisms (APMs) from the State that support care coordination, population health management, and care access for the community and in return enhance primary and chronic care access and achieve utilization improvements. To do so, the coalition envisions partnering with HFS to transform how public funds are distributed, using the SSHCO as a demonstration project. During the five-year transformation period, the coalition would work in partnership with the State and HFS to begin to create APM offsets for Transformation funds as a demonstration project, so that sufficient momentum exists by the end of year 5 to transition Transformation funds to APM-based payment models that will provide ongoing SSHCO support. Together with the State, the SSHCO will have created an APM that has been tested and refined.

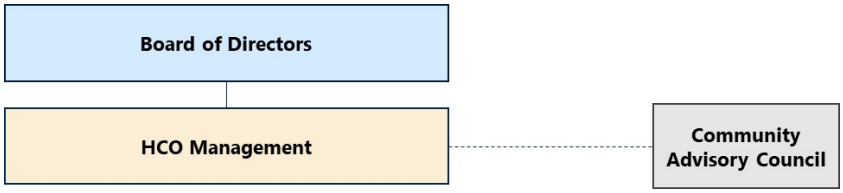
15. Governance Structure

Please describe the governance structure of your collaboration. How are decisions made and how do you intend to monitor and enforce adherence to the policies and practices you put in place.
If a new umbrella legal entity is created please give details on the Board of Directors, including its racial and ethnic make-up.
It is likely that transformation funds for proposals will come in the form of utilization based Directed Payments to the various providers in your collaboration. Collaborations will receive a report of payments going to each provider. Explain how you will ensure that the funds are used for your proposed program's intended purpose.

Organizational Model, Decision Rights and Responsibilities

The Healthy Community Model will be administered via a new independent 501(c)(3) organization, the South Side Healthy Community Organization (SSHCO). The SSHCO will have a dedicated management team supported by two external bodies as illustrated below:

Figure 16: HCO Governance Structure



Board of Directors Composition

The Board of Directors has responsibilities including, but not limited to:

- Approve strategic plan and funding criteria
- Approve annual budget and operating plan
- Hold SSHCO management team accountable for execution of strategic plan
- Hire/fire the SSHCO CEO

This diverse and community-oriented coalition is expressed via the size and composition of the Board. There are 17 members of the SSHCO Board: one from each of the coalition's member organizations, three independent/community members, and the SSHCO CEO. The initial Board of Directors is described in detail below:

Seat	Name	Organization	Race / Ethnicity	Gender
1	Rashard Johnson	Advocate Aurora Healthcare	Black / African American	Male
2	Margie Johnson	Beloved Community Family Wellness Center	Black / African American	Female
3	Barrett Hatches	Chicago Family Health Center	Black / African American	Male
4	Kenneth Burnett	Christian Community Health Center	Black / African American	Male
5	Verneda Bachus	Friend Family Health	Black / African American	Female
6	William Dorsey, MD	Jackson Park Hospital and Medical Center	Black / African American	Male
7	Berneice Mills-Thomas	Near North Health	Black / African American	Female

8	Tim Egan	The New Roseland Community Hospital Association	White	Male
9	Airica Steed	Sinai Chicago	Black / African American	Female
10	Leslie Rogers	South Shore Hospital Corporation	Black / African American	Male
11	Diahann Sinclair	St. Bernard Hospital	Black / African American	Female
12	Veronica Clarke	TCA Health	Black / African American	Female
13	Brenda Battle	The University of Chicago Medical Center	Black / African American	Female
14	Cecile DeMello	Teamwork Englewood	Black / African American	Female
15	Christa Hamilton	Centers for New Horizons	Black / African American	Female
16	Rev. Otis Moss III	Trinity United Church of Christ	Black / African American	Male
17	CEO	South Side Healthy Community Organization		

Community Advisory Council

The Community Advisory Council is a formal channel for community engagement and input into the direction of the SSHCO. The ~20 members of the Council will be independent community members and leaders who provide input and guidance to the SSHCO management team. The coalition also envisions that this Council could serve as a source for future independent/community Board members. The coalition expects to begin extending invitations to potential members immediately.

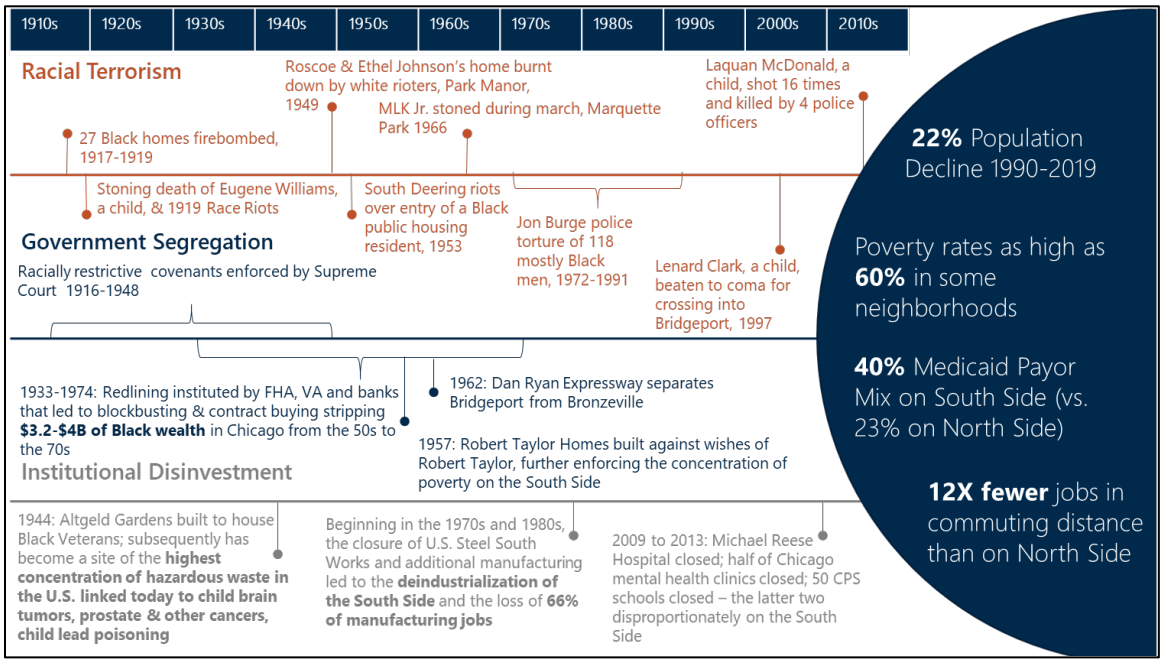
Directed Payments

The coalition understands that the funding mechanism for the State's Healthcare Transformation Collaboratives funding is that Transformation funds will be distributed according to the State's Directed Payments mechanism. While the coalition will ultimately negotiate the final terms and mechanisms for the Transformation Funding Agreement, coalition members have agreed to certain principles to reconcile the funds flow back to the SSHCO:

1. The management team and governing Board of the SSHCO will be responsible for using State Transformation funds to execute against the goals, objectives and programmatic priorities of the SSHCO as described in the attached RFP Response.
2. The coalition's intent is to designate a single designated fiscal agent (i.e., a single member of the coalition) to receive the Healthcare Transformation Collaborative Funds from the State for the SSHCO and the Healthy Communities Model.
3. The fiscal agent will transfer Healthcare Transformation Collaborative Funds to the SSHCO in an appropriate manner, as may be memorialized by written agreement between the fiscal agent and fiscal agent.
4. Both the SSHCO and the fiscal agent will establish sufficient controls and reporting mechanisms to allow SSHCO management to account for all Healthcare Transformation Collaborative funds that are received by the fiscal agent.

Appendix A: Select Results of Data Analysis and Research

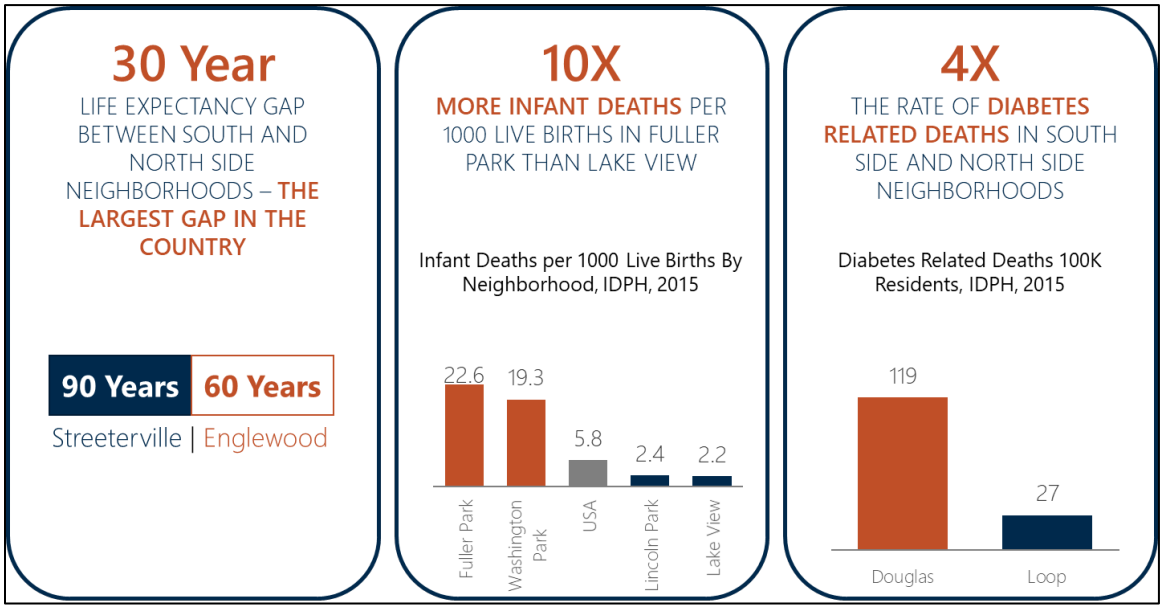
Appendix Exhibit 1. Historical Context of South Side Racial Inequities



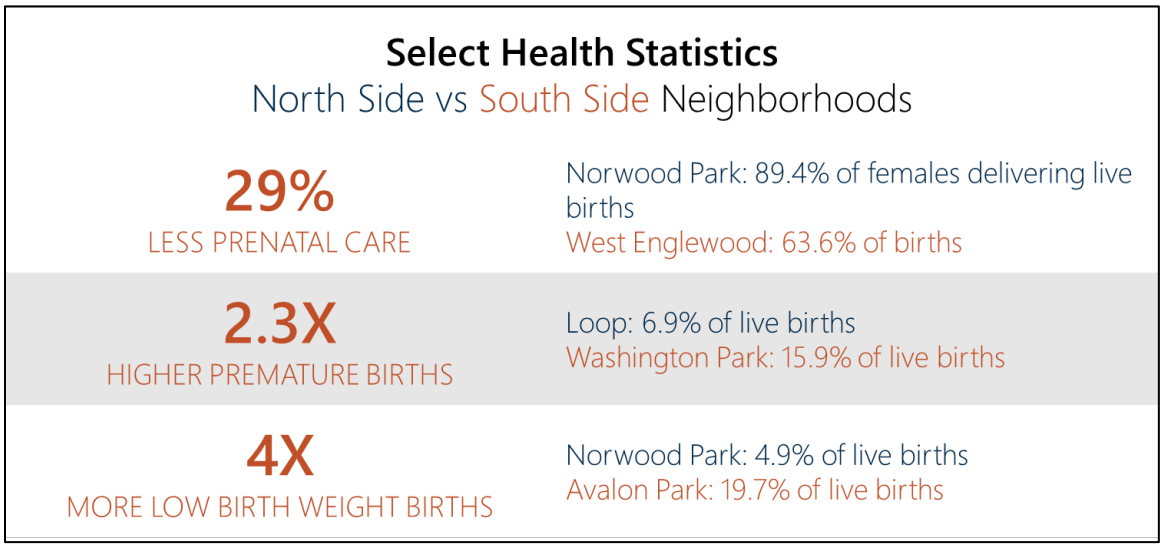
See footnote below for sources. [19]

[19] Sources: **1.** Banfield, Edward. Political Influence. 1961. **2.** Castro, Martin, et al. Food Deserts In Chicago. Oct. 2011.Corliss, Carlton. Main Line of Mid-America: The Story of the Illinois Central. 1950**. 3.** Dodge, John. Poverty Rates In Many Chicago Neighborhoods Near 60 Percent. 2014. **4.** Itagouri, Marwa. "Black Exodus Accelerates in Cook County, Census Shows." 22 June 2017. **5.** Gooch, Kelly. Health Disparities among Chicago Hospitals' Most Pressing Public Health Concerns. 3 Feb. 2020. **6.** Gretham, David. Chicago's Wall: Race, Segregation and the Chicago Housing Authority. Senior Independent Theses, 2013. **7.** Gross, Terry. A "Forgotten History" Of How The U.S. Government Segregated America. NPR, 3 May 2017. Radio Show. **8.** Hirsch, Arnold. Making the Second Ghetto: Race and Housing in Chicago, 1940-1960. 1983. **9.** Large Life Expectancy Gaps in U.S. Cities Linked to Racial & Ethnic Segregation by Neighborhood. NYU Langone News, 5 June 2019. **10.** Moore, Natalie Y. The South Side: A Portrait of Chicago and American Segregation. New York, N.Y., Picador, 2017. **11.** Moser, Whet. "How Redlining Segregated Chicago, and America." Chicago Magazine,

Appendix Exhibit 2: Health Disparities on the South Side[20]



Appendix Exhibit 3: Additional Disparities in Infant Health[21]



22 Aug. 2017. Accessed 5 Aug. 2020. **12.** Sampson, Robert J. Great American City Chicago and the Enduring Neighborhood Effect. Chicago [U.A.] Univ. Of Chicago Press, 2013. **13.** Schencker, Lisa. 60 Years vs. 90 Years: A New Analysis Calls Chicago's Life-Expectancy Gap the Largest in the US Credit: CC0 Public Domain. 2019. **14.** Semuels, Alana. Chicago's Awful Divide. The Atlantic, 28 Mar. 2018. Accessed 5 Aug. 2020. **15.** Terry, Don. Chicago Neighborhood Reveals an Ugly Side. The New York Times, 27 Mar. 1997. **16.** The Chicago Community Trust. About the Racial Wealth Gap. 2020. **17.** Washington, Harriet. Medical Apartheid. Anchor Books, 2006. **18.** Yoon-Ji Kang, Esther. Chicago Neighborhoods Continue To Shift In Size and Race. NPR, 2019 June 2019. **19.** IPUMS National Historic GIS Data, 1990 **20.** ESRI Data, 2019 **21.** Illinois Comp Inpatient State Data, 2019

[20] 1. Illinois Department of Public Health- via Chicago Health Atlas 2. NYU Langone City Health Dashboard

[21] 1. Illinois Department of Public Health- via Chicago Health Atlas

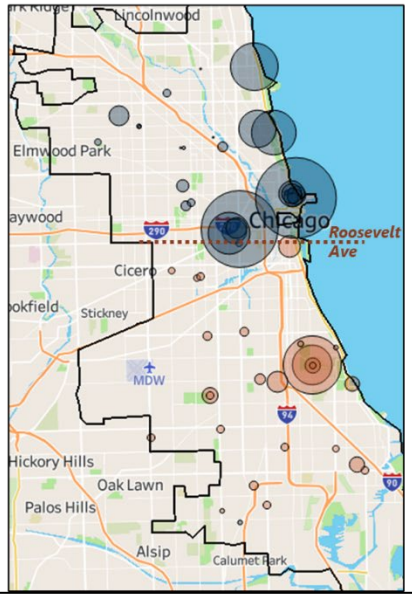
Appendix Exhibit 4: Disparities in Healthcare Investment[22]

3X As More Capital Approved by the State CON Board North of Roosevelt than South of Roosevelt

Total Certificate of Need (CON) Approved Permit Amounts for New Construction
CON Applications Filed for Chicago, 2012-2018

Area of Chicago	Permit Amount	Percent of Total
North of Roosevelt	$1.87B	76%
South of Roosevelt	$0.60B	24%
Total	**$2.47B**	**100%**

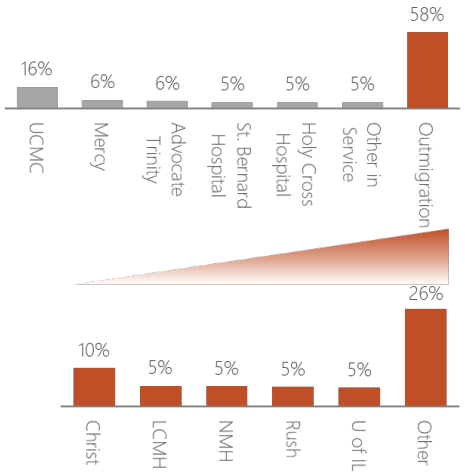
MAP LEGEND
- Represents $200M Approved North of Roosevelt
- Represents $200M Approved South of Roosevelt



Appendix Exhibit 5: Care Delivery Challenges[23]

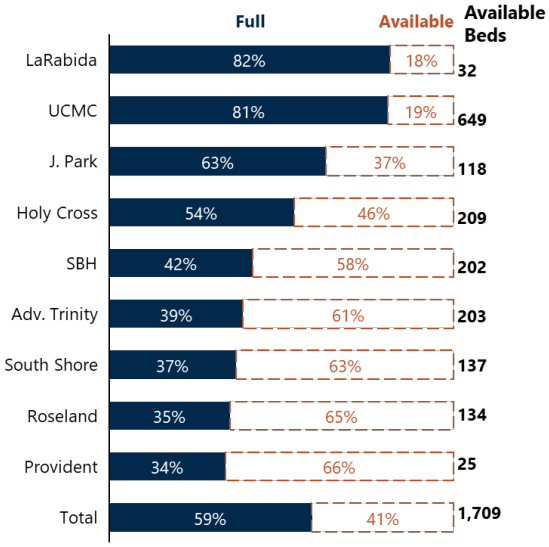
NEARLY 60% OUTMIGRATION RATE

Inpatient Share of South Side Resident Encounters, 2019
In Service Area | Outmigration



UNDER 60% BED UTILIZATION

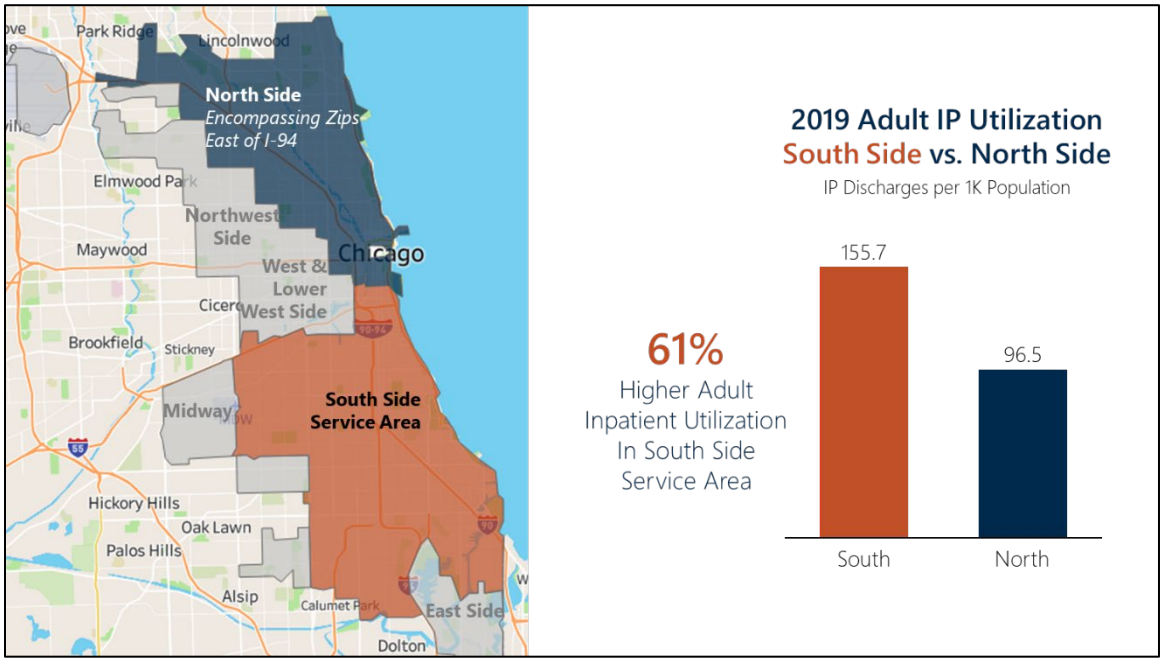
Bed Utilization by Hospital 2018



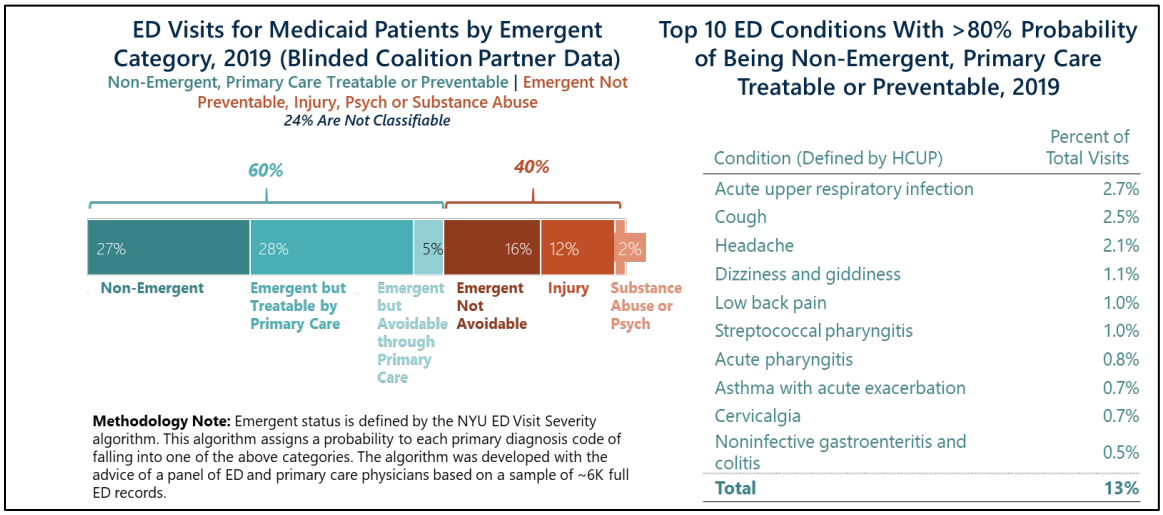
[22] Source: Health Facilities and Services Review Board

[23] Sources: 1. IL Comp IP State Data 2. Coalition service area definition (see Community Input section of proposal for zip codes) 3. 2018 AHQ Data file. Note: Normal Newborns excluded. Note: "available beds" refers to beds available as reported in the AHQ data file.

Appendix Exhibit 6: Higher Utilization of Inpatient Care on South Side[24]



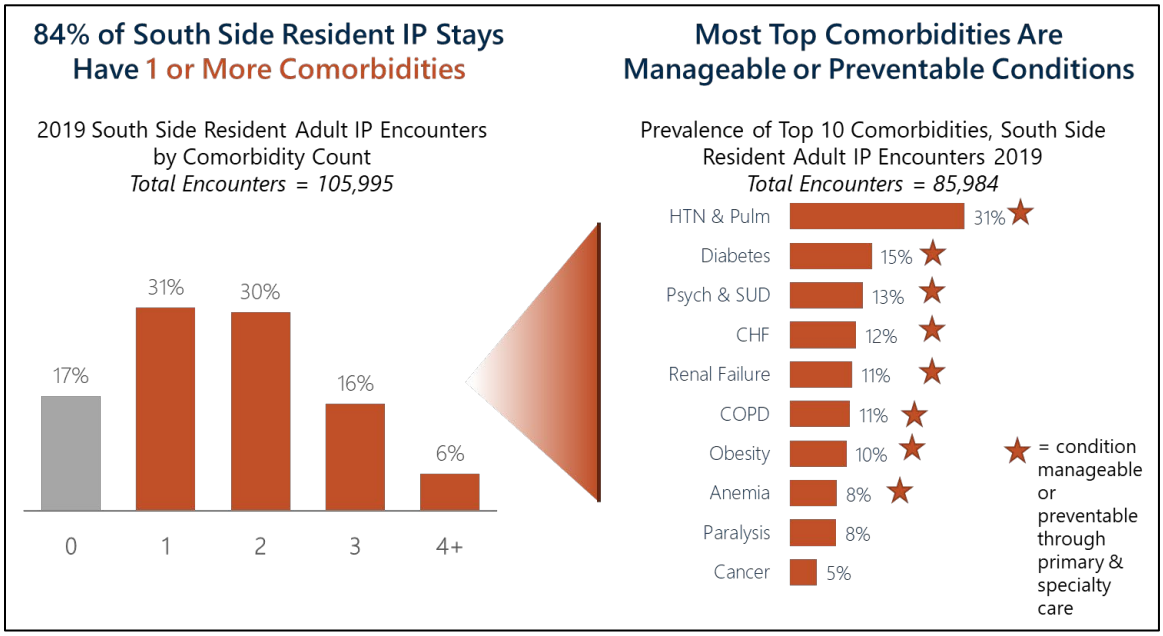
Appendix Exhibit 7: Preventable Conditions Driving Emergency Visits[25]



[24] Sources: 1. Coalition service area definitions 2. IL Comp IP State Data 3. ESRI Population Data

[25] Sources: 1. Blinded coalition partner ED data, 2019 2. HCUP CCSR Clinical Definitions, 2019 3. NYU ED Visit Severity Algorithm, 2015

Appendix Exhibit 8: Preventable or Manageable Conditions Driving Inpatient Admissions[26]



Appendix Exhibit 9: Estimated Supply and Demand of Providers[27]

Prioritized Provider Specialty	Estimated Provider Demand	Estimated Provider Supply	Estimated Unmet Demand	Incremental Need To Be Met by SSHCO
Primary Care, Non-OB	454	351	103	60 (~60% of Need)
OBGYN	139	76	30	30 (~100% of Need)
Psychiatry	80	61	19	19 (~100% of Need)
Cardiology	48	33	15	7 (~50% of Need)
Endocrinology	16	10	6	3 (~50% of Need)
Ophthalmology	40	14	26	13 (~50% of Need)
Nephrology	23	17	6	3 (~50% of Need)
Infectious Disease	19	13	6	3 (~50% of Need)
Total, Priority Specialties	**615**	**447**	**168**	**138**

[26] Sources: 1. ILCOMP State Data, 2019 2. Elixhauser Comorbidities Index 3. Coalition South Side Service Area Definition

[27] Source: analysis by The Chartis Group

Appendix B: Responses To The Racial Equity Impact Assessment Guide

1. Identifying Stakeholders

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

The community service area targeted by the proposed South Side Health Community Organization (SSHCO) comprises approximately 900,000 residents, of whom 92% are non-white and/or minority residents, including 59% African American residents and 28% Latinx residents of any race[28]. Both African American and Latinx populations have experienced longstanding health disparities such as worse maternal and infant health, higher chronic disease incidence, lower access to mental health services and materially lower life expectancies[29]. These health disparities reflect a history of racial inequities and significant underinvestment, which also drive high poverty rates and high unemployment rates that have been further exacerbated by the COVID-19 pandemic[30].

The SSHCO will directly address these issues through the implementation of the Healthy Community Model. This model will enhance access to preventative, primary, behavioral and specialty care; improve chronic care management and care coordination; foster enhanced provider collaboration and communication; increase jobs for South Side residents and minority populations; increase access to providers of color and culturally competent providers; and target the greatest areas of racial and ethnic health outcome & access disparities – including maternal and infant health, mental health, and chronic illness.

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's missing and how can they be engaged?

As detailed in our proposal, the coalition has built the Healthy Community Model based on the direct community input of South Side residents and leaders reflective of the community. These

[28] Esri data based on the American Community Survey, 2019. See Community Input Section for list of zip codes.
[29] Sources: 1. Chicago Health Atlas 2. Community Health Needs Assessments of Coalition Partners (see data appendix)
[30] Sources: 1. Chicago Data Portal, Accessed 8/12/20 2. New York Times: "In These Neighborhoods, the Jobless Rate May Top 30 Percent" 8/5/20

residents and leaders included patients, residents, healthcare organization leaders, pastors of significant South Side congregations, executive directors of South Side community-based organizations (CBOs) as well as local and state elected representatives. From the inception of this coalition's planning efforts and over the past eight months, over 900 South Side residents and leaders have been engaged in community listening sessions, surveys, email communications, virtual group meetings and more to gather thoughts and ideas on what makes a healthy community.

Engagement with elected officials has been multimodal. South Side state legislators that the coalition has engaged include: Senators Jacqueline Collins, Mattie Hunter, Emil Jones III, Robert Peters, and Elgie Sims, Jr. as well as Representatives Kam Buckner, Marcus Evans, Jr., Sonja Harper, Lamont Robinson Jr., Nick Smith, and Curtis Tarver, II. Additionally, members of the Legislative Medicaid Work Group were engaged, and South Side coalition members appeared before the group twice to discuss the coalition's process and plans. The coalition also briefed staff from the Governor's Office, the health policy team representing Congressman Bobby Rush, key staff from the offices of Mayor Lori Lightfoot, and Senator Dick Durbin. Additionally, the coalition briefed South Side aldermen on its plans to transform health care.

In addition to this engagement of South Side residents and leaders, the coalition of leaders that is planning the Healthy Community Model and that will form the governing board of the SSHCO is itself a highly diverse group, with over 80% of governing board members being African American. Moving forward, this coalition will further engage and empower diverse stakeholders through the following means:

- Formation of a Community Advisory Council to channel community input and engagement. The 20-member body will be significantly comprised of minority membership, especially African American and Latinx membership.

- A commitment that 36% of outside operating spend will go to minority business enterprises and minority managed or controlled nonprofit entities

- A hiring commitment that in Year 1, at least 33% of jobs directly funded or created by the SSHCO will be filled by minority individuals; by Year 5, at least 45% of our employees will be minorities.

- A commitment to increasing the number of providers of color through funding provided by the SSHCO

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?

There is overwhelming quantitative and qualitative evidence of racial inequities in healthcare access, health outcomes and social conditions facing the predominantly African American and Latinx residents of the South Side. As detailed in-depth in the proposal and additional data attachments, there is evidence of disparate outcomes in life expectancy, diabetes, maternal and infant health, and access to mental health care. Infant mortality rates, for example, are 10 times higher in some predominantly African American zip codes on the South Side than in other, predominantly white North Side zip codes[31]. Life expectancy is 30 years lower in predominantly African American Englewood than in predominantly white Streeterville[32]. Unemployment, poverty and other social conditions follow similar patterns. There is no shortage of evidence to demonstrate the undeniable racial inequities in health and social outcomes facing South Side residents. These inequities are worsened and compounded by disinvestment and insufficient services: the last 12 years have seen over a dozen hospital or service closures on or near the South Side; there has been three times less CON-approved capital invested south of Roosevelt Ave than north of Roosevelt Ave between 2012 and 2018; and South Side residents face a shortage of primary care, obstetric care and specialty care[33]. Focused investment in evidence-based community-based preventive, primary and specialty health programs and interventions is needed to address and reverse these longstanding disparities. These models have had demonstrable success, as evidenced most recently in the Dallas, Texas PCCI model which has successfully increased access, improved health outcomes and improved value for cost-of-care. Investment in the SSHCO presents the opportunity for Chicago to be a national model in community health transformation.

4. 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 factors producing these racial health and social inequities are multifactorial but are rooted in a history of racial inequity. Over a century of racial violence, governmental segregation and institutional disinvestment have led to lack of access to local employment, over-strained public services, high poverty rates[34], and food and housing insecurity. This has both caused and been compounded by insufficient, inadequate and declining medical services: in terms of primary care access there is an estimated shortage of approximately 100 primary care providers and 60 OB providers[35]; the CMS star rating for most hospitals on the South Side falls below the national

[31] Source: Chicago Health Atlas 2015 data
[32] Source: NYU Langone City Health Dashboard based on 2015 data
[33] 1. News releases 2. Health Facilities and Services Review Board, 2012-2018 data 3. Supply-Demand analysis by The Chartis Group (see proposal data section and appendix materials for details).
[34] See data appendix for additional detail and citations
[35] Source: Analysis by The Chartis Group. See Data Section for sources used to inform analyses.

average; and there has been over a dozen inpatient service or hospital closures in the past ten years – all contributing to 50%+ of South Side residents leaving the South Side in order to receive their care[36]. Paradoxically, this dearth of care has partly contributed to overutilization of as much as 60-80% in expensive emergency and inpatient settings, even as local hospitals continue to see occupancy of just 50% due to outmigration[37]. The end result of these care delivery challenges is a staggering disparity in health outcomes: compared to North Side residents, South Siders in some neighborhoods have a 30 year lower life expectancy, are at a ten times higher risk of infant mortality, and have four times the rate of deaths from diabetes[38]. These tolls have only been further exacerbated by the COVID-19 pandemic, as evidenced in the highly disparate unemployment and death rates relative to white residents and North Side neighborhoods [39].

The SSHCO certainly does not address the deeply entrenched and multilayered root causes of these inequities, nor can any single program or solution. However, the scope and scale of the SSHCO is both comprehensive and transformative, and the effort will constitute a major step in reversing the longstanding health and economic disparities of Chicago's South Side.

5. The Purpose

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

The proposal for the Healthy Community Model and the SSHCO is expressly focused on reducing health disparities, improving access to care, improving economic wellbeing and improving the value of care, as illustrated in Figure 1.

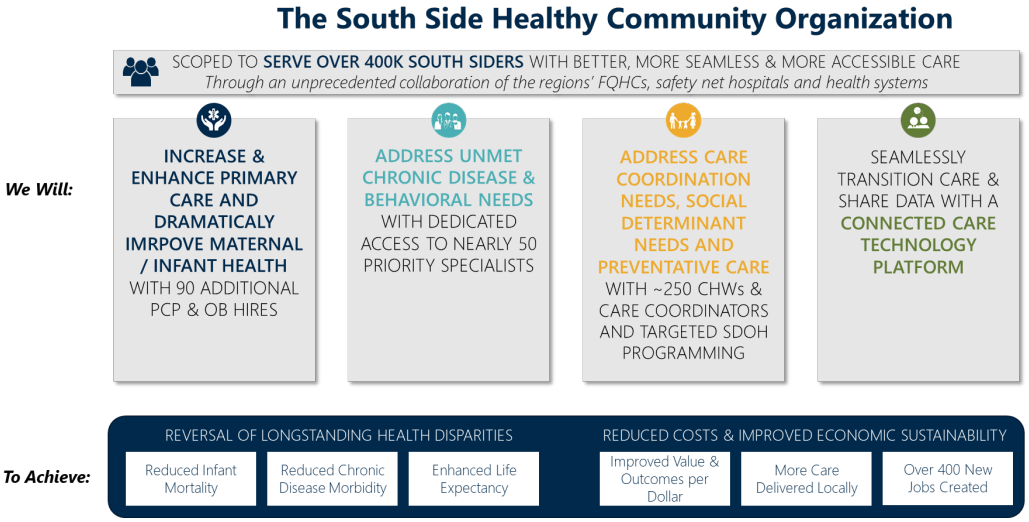
Figure 1: Components of The South Side Healthy Community Organization

[36] Source: Illinois COMP state inpatient encounter data, CY2019

[37] Sources: Illinois COMP state inpatient encounter data, CY2019; Esri data based on the American Community Survey, 2019; coalition ED visit data, 2019; New York University ED Severity Visit Algorithm, 2015; 2018 AHQ Data File. Note: normal newborns excluded.

[38] Sources: NYU Langone City Health Dashboard based on 2015 data, Chicago Health Atlas 2015 data

[39] Sources: 1. Chicago Data Portal, Accessed 8/12/20 2. New York Times: "In These Neighborhoods, the Jobless Rate May Top 30 Percent" 8/5/20



If successful, the SSHCO will, over time, reverse long standing health disparities, improve the health and wellbeing of the most vulnerable South Side residents; contribute to stabilizing and growing the South Side's employment base, leverage and elevate minority managed, controlled and owned organizations, create a provider workforce that is more reflective of the community, and enhance care access and experience for individuals facing the highest barriers to high quality care.

6. Considering Adverse Events

What adverse impacts or unintended consequences could result from this policy? Which racial/ethnic groups could be negatively affected? How could adverse impacts be prevented or minimized?

An adverse impact that this coalition seeks to avoid is that state funding for the SSHCO be viewed as a reallocation of existing and current support rather than being understood as a necessary addition to the overall healthcare safety net for Chicago's South Side and its most vulnerable residents. The Healthy Community Model is not intended to replace existing supports, but rather is meant to augment them, working in concert with existing institutions, providers and organizations.

7. Advancing Equitable Impacts

What positive impacts on equity and inclusion, if any, could result from this proposal? Which racial/ethnic groups could benefit? Are there further ways to maximize equitable opportunities and impacts?

The SSHCO will embody and advance equity and inclusion on multiple dimensions:

- **More equitable access to care:** The SSHCO will enhance access to care for the South Side's most vulnerable residents, regardless of payor status. Barriers including insurance, transportation, access to care and supply gaps, and scheduling will be directly addressed through the Healthy Community Model.
- **Focus on racial health disparities:** The SSHCO will prioritize key health disparities impacting African American and Latinx residents of the South Side, including maternal and infant health outcomes, mental health, and chronic disease morbidity and mortality.
- **Increased jobs:** The SSHCO will directly fund or add approximately 430 jobs at scale. The coalition is committed to having at least 33% of the Year 1 hires be minorities and by the end of Year 5, 45% of the SSHCO employees will be minorities. As part of this commitment, the SSHCO will explore innovative clinical / community health workforce development partnership opportunities that elevate historically disenfranchised individuals such as individuals re-entering the workforce.
- **Increased minority spend:** The SSHCO is committed to having at least 36% of its outside operating spend go to minority controlled, managed or owned organizations or enterprises.
- **Increased providers of color and culturally competent providers** Through its primary care, specialty care and care coordination platform, the SSHCO will work to enhance patient experience for South Side residents of color by increasing access to both providers of color who are reflective of the community as well as to an overall provider workforce that is more culturally responsive and culturally competent.
- **Governance and community input:** The SSHCO is committed to equity and inclusion in both its governance model and community advisory model. Of the 17 envisioned members in the initial governing board, the 16 already identified members include 14 who are people of color. Additionally, the Community Advisory Council will be reflective of the South Side in chosen members, with especial focus on African American and Latinx membership.

8. Examining Alternatives or Improvements

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

Given the scale of change necessary to truly reduce racial disparities and advance racial equity, the coalition's perspective is that many coexisting (rather than alternative) measures must be taken. The coalition has worked tirelessly to jointly develop a comprehensive, multipronged and transformative model for addressing the health and economic racial disparities affecting the South Side. The members of the coalition are committed to their patients, to the State and to each other to work together in shaping as impactful a program as possible.

9. Ensuring Viability and Sustainability

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

This proposal is scoped to achieve transformative change on Chicago's South Side. The coalition is proposing a dynamic model in which the State and the 13 South Side partners work in collaboration to revise reimbursement and payment models based on our common goal of closing longstanding gaps in access, care, and health outcomes, thereby fundamentally transforming Chicago's South Side healthcare delivery landscape.

The coalition is proposing a dynamic and scalable model in which the State finances the establishment and roll-out of a program that will fundamentally transform Chicago's South Side healthcare delivery landscape, closing longstanding gaps in access, care, and health outcomes. Doing so will require material Transformation funding -- specifically $30 million per year over the SSHCO's first five years.

Over that five year period, the SSHCO will concurrently establish its path to self-sustainability, predicated on transitioning from Transformation funding to alternate payment mechanisms (APMs) from the State that support care coordination, population health management, and care access for the community and in return enhance primary and chronic care access and achieve utilization improvements. To do so, the coalition envisions partnering with HFS to transform how public funds are distributed, using the SSHCO as a demonstration project. During the five-year transformation period, the coalition would work in partnership with the State and HFS to begin to create APM offsets for Transformation funds as a demonstration project, so that sufficient momentum exists by the end of year 5 to transition Transformation funds to APM-based payment models that will provide ongoing SSHCO support. Together with the State, the SSHCO will have created an APM that has been tested and refined.

As outlined in the five-year budget detailed in the proposal, the coalition believes that the funding being requested is sufficient to support the South Side Healthy Community Model it intends to establish.

The coalition has put forth a series of metrics that align with the HFS quality pillars and that will be gradually rolled out as the Healthy Community Model is implemented. The SSHCO will work with HFS to ensure ongoing data collection, public reporting and public accountability. In addition, the coalition will engage with a broader set of stakeholders through the Community Advisory Council to ensure stakeholder participation.

10. Identifying Success Indicators

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

The following quality and performance metrics are proposed for year 1 accountability, year 2 accountability, and ongoing monitoring, as illustrated in Figure 2:

Figure 2: Proposed Metrics for Accountability Beginning in Year 1, Accountability in Beginning Year 2, or for Monitoring and Tracking

Pillar	Suggested Metric *Black Text = Existing HFS Metric; Blue Text = New Proposed Metric*	Accountable Beginning Y1	Accountable Beginning Y2	Monitor & Track
I. Adult Behavioral Health	1. % 7-day and 30-day follow-up after IP/ED MH or SUD visit (adult)		●	
II. Child Behavioral Health	2. % 7-day and 30-day follow-up after IP/ED MH or SUD visit (child)		●	
III. Maternal & Child Health	3. Access to prenatal and postnatal care: increase number of prenatal & postpartum visits per 1,000	●		
	4. Childhood immunizations		●	
	5. Well-Child visits within 30 days		●	
IV. Equity	6. Access to preventable/ambulatory health services: increase number of PCP visits per 1,000	●		
	7. Access to preventable/ambulatory health services: reduce number of avoidable ED visits per 1,000	●		
	8. Improve patient experience and trust: increase number of providers of color	●		
	10. Improve patient experience and trust: increase number of providers trained in culturally responsive care	●		
	11. Improved % of HTN patients whose BP is controlled		●	
	12. Improved Hemoglobin A1c for patients with poor control		●	
	13. Cervical cancer screening		●	
	14. Breast cancer screening		●	
	15. Reduce avoidable hospital readmissions			●
	16. Reduce risk-adjusted Medicaid & uninsured hospitalizations per 1,000			●
	17. Healthy Days Index (BRFSS)			●
V. Improving Community Placement	18. Getting Care Quickly (CAHPS measure)			●
	19. Getting Needed Care (CAHPS measure)			●
	20. Number of closed loop referrals for SDoH (housing, food security, transportation)			●

The coalition is committed to working with HFS and the State to establish a baseline, set targets and report these measures. In addition, the coalition will work with HFS and the State to track and report all commitments relating to equity and diversity not listed above, including

- Operating spend minority participation
- Minority hires for SSHCO funded jobs
- Minority participation in governance and the Community Advisory Council

Within each of these measures, the SSHCO will commit to full transparency in reporting – ensuring that data on performance, outcomes and targets is reported by race and ethnicity as well as in aggregate.

Appendix C: Data on Number of Existing Employees By Job Category and Zip Code

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
South Side Service Area	60609	121	30	151
	60615	361	58	419
	60616	248	28	276
	60617	496	165	661
	60619	402	119	521
	60620	349	86	435
	60621	89	53	142
	60628	318	121	439
	60629	227	69	296
	60632	91	11	102
	60636	91	30	121
	60637	406	74	480
	60643	267	65	332
	60649	316	75	391
	60653	197	34	231
South Side Service Area Sub-Total		**3979**	**1,018**	**4,997**
Other	2048	1	0	1
	2130	1	0	1
	4261	1	0	1
	7078	1	0	1
	7503	1	0	1
	8067	1	0	1
	10016	1	0	1

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other (Continued)	10301	1	0	1
	12210	1	0	1
	14620	1	0	1
	14640	1	0	1
	15201	1	0	1
	18702	1	0	1
	20009	1	0	1
	20876	1	0	1
	21045	0	1	1
	21120	1	0	1
	22903	1	0	1
	26508	1	0	1
	27516	1	0	1
	29302	1	0	1
	29585	1	0	1
	29607	1	0	1
	30080	1	0	1
	30114	0	1	1
	31401	1	0	1
	32963	1	0	1
	33140	1	0	1
	33144	1	0	1
	33176	1	0	1
	35406	1	0	1
	35901	1	0	1
	37122	0	1	1
	37203	1	0	1
	37208	1	0	1
	40228	1	0	1
	43015	0	1	1
	43023	1	0	1
	44143	1	0	1
	44610	1	0	1
	44643	1	0	1
	45244	0	1	1
	46062	1	0	1

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other (Continued)	46203	0	1	1
	46301	1	1	2
	46303	15	3	18
	46304	30	6	36
	46307	80	28	108
	46308	1	0	1
	46310	1	1	2
	46311	72	11	83
	46312	22	6	28
	46319	28	8	36
	46320	16	7	23
	46321	52	21	73
	46322	40	8	48
	46323	33	15	48
	46324	49	14	63
	46327	21	8	29
	46341	1	3	4
	46342	19	6	25
	46349	1	0	1
	46350	7	0	7
	46356	11	1	12
	46360	8	1	9
	46368	32	7	39
	46373	39	8	47
	46375	45	13	58
	46381		2	2
	46383	24	5	29
	46385	22	3	25
	46391	2	0	2
	46392	1	0	1
	46393	1	0	1
	46394	34	10	44
	46396	1	0	1
	46403	14	2	16
	46404	12	0	12
	46405	5	3	8

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other (Continued)	46406	9	0	9
	46407	5	0	5
	46408	4	1	5
	46409	2	2	4
	46410	51	15	66
	46411	2	0	2
	46552	1	0	1
	46574	1	0	1
	46613	1	0	1
	46614	0	1	1
	46637	1	0	1
	46706	1	0	1
	46825	1	0	1
	46902	1	0	1
	47387	1	0	1
	47963	0	1	1
	48036	1	0	1
	48103	1	0	1
	48104	0	1	1
	48135	0	1	1
	48176	1	0	1
	48178	1	0	1
	48214	2		2
	48323	1	0	1
	48327	1	0	1
	48363	1	0	1
	48374	0	1	1
	48397	1	0	1
	49024	0	1	1
	49031	1	1	2
	49048	1	0	1
	49065	1		1
	49083	1	0	1
	49106	1	0	1
	49111	1	0	1
	49301	1	0	1

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other (Continued)	49507	1	0	1
	49546	0	1	1
	49651	1	0	1
	49660	1	0	1
	53045	1	0	1
	53144	1	0	1
	53158	1	0	1
	53168	1	0	1
	53179	1	0	1
	53181	0	1	1
	53202	2	0	2
	53209	0	1	1
	53211	0	1	1
	53221	1	0	1
	53818	1	0	1
	54304	1	0	1
	54568	0	1	1
	54701	1	0	1
	55901	1	0	1
	57108	1	0	1
	59937	0	1	1
	60002	2	0	2
	60004	6	1	7
	60005	8	2	10
	60007	8	1	9
	60008	3	0	3
	60010	9	0	9
	60012	1		1
	60013	1	1	2
	60014	3	0	3
	60015	4	1	5
	60016	25	2	27
	60018	16	0	16
	60021	1	0	1
	60022	2	0	2
	60025	9	6	15

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other (Continued)	60026	9	1	10
	60030	1	1	2
	60031	3	1	4
	60035	4	0	4
	60041	0	1	1
	60042	1	0	1
	60044	1	0	1
	60045	1	1	2
	60047	5	1	6
	60048	2	0	2
	60050	1	0	1
	60051	0	1	1
	60053	22	1	23
	60056	18	0	18
	60060	2	0	2
	60061	4	0	4
	60062	15	0	15
	60067	3	2	5
	60068	9	0	9
	60069	1	0	1
	60073	1	2	3
	60074	7	1	8
	60076	30	2	32
	60077	26	3	29
	60081	1	0	1
	60084	1	0	1
	60085	3	1	4
	60089	10	1	11
	60090	6	0	6
	60091	11	2	13
	60093	2	2	4
	60098	1	0	1
	60101	8	2	10
	60102	1	0	1
	60103	11	2	13
	60104	10	2	12

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other (Continued)	60106	5	0	5
	60107	3	7	10
	60108	4	1	5
	60115	2	0	2
	60118	2	0	2
	60119	1	2	3
	60120	2	1	3
	60123	2	1	3
	60124	1	0	1
	60126	27	2	29
	60130	21	3	24
	60131	4	1	5
	60133	5	1	6
	60134	4	3	7
	60136	1	0	1
	60137	17	4	21
	60139	8	2	10
	60140	1	0	1
	60142	3	0	3
	60143	1	1	2
	60145	1	1	2
	60148	26	7	33
	60153	16	2	18
	60154	13	3	16
	60155	8	3	11
	60156	2	1	3
	60157	1	0	1
	60159	1		1
	60160	7	2	9
	60162	9	3	12
	60163	2	0	2
	60164	3	1	4
	60169	6	1	7
	60171	2	3	5
	60172	8	2	10
	60173	3	0	3

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other (Continued)	60174	0	1	1
	60175	1	0	1
	60176	3	1	4
	60177	4	0	4
	60178	3	0	3
	60181	10	1	11
	60185	3	2	5
	60187	3	4	7
	60188	8	2	10
	60189	8	0	8
	60190	1	2	3
	60191	4	0	4
	60192	3	0	3
	60193	6	0	6
	60194	2	0	2
	60201	35	5	40
	60202	37	3	40
	60203	5	0	5
	60301	4	1	5
	60302	37	3	40
	60304	24	9	33
	60305	9	0	9
	60401	13	2	15
	60402	47	14	61
	60403	9	1	10
	60404	7	1	8
	60406	49	18	67
	60407	1	0	1
	60408	1	0	1
	60409	204	36	240
	60410	5	3	8
	60411	130	31	161
	60415	33	5	38
	60416	1	0	1
	60417	47	5	52
	60418	19	7	26

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other (Continued)	60419	134	29	163
	60421	2	0	2
	60422	56	7	63
	60423	77	15	92
	60425	37	11	48
	60426	60	12	72
	60428	31	14	45
	60429	65	11	76
	60430	92	13	105
	60431	15	4	19
	60432	10	0	10
	60433	7	0	7
	60435	18	3	21
	60436	7	0	7
	60438	128	28	156
	60439	25	6	31
	60440	40	15	55
	60441	36	6	42
	60442	13	3	16
	60443	113	34	147
	60445	54	15	69
	60446	43	13	56
	60447	3	0	3
	60448	52	12	64
	60449	26	7	33
	60450	1	0	1
	60451	54	10	64
	60452	94	12	106
	60453	182	36	218
	60454	1	1	2
	60455	28	7	35
	60456	4	1	5
	60457	23	2	25
	60458	24	3	27
	60459	53	8	61
	60461	26	6	32

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other (Continued)	60462	121	13	134
	60463	36	5	41
	60464	24	1	25
	60465	32	4	36
	60466	61	10	71
	60467	71	8	79
	60468	6	1	7
	60469	10	1	11
	60471	69	17	86
	60472	12	4	16
	60473	133	24	157
	60475	13	2	15
	60476	6	0	6
	60477	114	21	135
	60478	63	14	77
	60480	11	1	12
	60482	15	0	15
	60484	20	1	21
	60487	88	13	101
	60490	26	9	35
	60491	27	3	30
	60501	12	0	12
	60502	5	2	7
	60503	3	4	7
	60504	9	3	12
	60505	1	1	2
	60506	4	1	5
	60507	1	0	1
	60510	3	1	4
	60513	25	8	33
	60514	3	0	3
	60515	12	3	15
	60516	26	6	32
	60517	32	13	45
	60521	10	6	16
	60523	14	2	16

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other (Continued)	60525	29	9	38
	60526	14	2	16
	60527	44	9	53
	60531	0	1	1
	60532	8	6	14
	60534	16	0	16
	60540	21	4	25
	60541	2	0	2
	60542	2	1	3
	60543	5	0	5
	60544	17	4	21
	60545	3	1	4
	60546	17	4	21
	60554	1	0	1
	60555	4	3	7
	60558	9	2	11
	60559	18	10	28
	60560	3	0	3
	60561	33	10	43
	60563	14	3	17
	60564	24	4	28
	60565	17	1	18
	60585	14	4	18
	60586	27	8	35
	60601	33	8	41
	60602	5	1	6
	60603	4	0	4
	60604	4	0	4
	60605	362	34	396
	60606	10	1	11
	60607	103	16	119
	60608	150	22	172
	60610	71	12	83
	60611	74	10	84
	60612	53	14	67
	60613	98	17	115

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other (Continued)	60614	106	21	127
	60618	87	17	104
	60622	104	17	121
	60623	51	11	62
	60624	34	7	41
	60625	52	11	63
	60626	53	6	59
	60627	1	1	2
	60630	47	4	51
	60631	21	5	26
	60633	48	18	66
	60634	49	4	53
	60635	1	0	1
	60638	92	19	111
	60639	44	9	53
	60640	84	13	97
	60641	31	8	39
	60642	72	4	76
	60644	41	8	49
	60645	39	9	48
	60646	24	0	24
	60647	101	16	117
	60651	45	14	59
	60652	162	41	203
	60654	36	1	37
	60655	100	14	114
	60656	11	2	13
	60657	131	15	146
	60658	0	1	1
	60659	32	6	38
	60660	51	2	53
	60661	38	7	45
	60674	1	0	1
	60680	1	0	1
	60681	0	1	1
	60706	8	1	9

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other (Continued)	60707	27	6	33
	60712	16	2	18
	60714	17	2	19
	60799	1	0	1
	60803	76	11	87
	60804	33	11	44
	60805	89	22	111
	60827	123	35	158
	60901	4	0	4
	60914	16	3	19
	60915	3	0	3
	60935	1	0	1
	60940	4	0	4
	60950	8	2	10
	60954	4	0	4
	60955	1	0	1
	60958	1	0	1
	60964	1	0	1
	61008	1	0	1
	61047	1	0	1
	61065	1	0	1
	61088	0	1	1
	61107	2	0	2
	61108	1	0	1
	61114	2	0	2
	61301	1	0	1
	61354	1	0	1
	61704	1	0	1
	61865	1	0	1
	62203	1	0	1
	62702	1	0	1
	62704	1	0	1
	62711	1	0	1
	62712	1	0	1
	62832	1	0	1
	63011	1	0	1

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other (Continued)	63131	1	0	1
	64116	1	0	1
	66224	1	0	1
	67147	0	1	1
	74011	1	0	1
	75035	1	0	1
	75056	0	1	1
	75237	1		1
	76034	1	0	1
	76092	1	0	1
	77388	1	0	1
	77407	1	0	1
	80906	1	0	1
	83642	0	1	1
	84105	2	0	2
	85718	1	0	1
	85719	1	0	1
	90262	0	1	1
	92656	0	1	1
	92867	1	0	1
	93626	1	0	1
	93711	1	0	1
	95405	1	0	1
	95650	1	0	1
	98661	1	0	1
	98665	0	1	1
	38002	1	0	1
	60321	1	0	1
	60530	1	1	2
	40473		1	1
	53217	1		1
	43035		1	1
	60110	1	0	1
	60412	1	0	1
	60538	1	0	1
	61832	1	0	1

Community Service Area	Zip Code	Clinical Employees	Nonclinical Employees	Total Employees
Other Sub-Total		**8,551**	**1,681**	**10,232**
Total		**12,530**	**2,699**	**15,229**