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Cover Sheet

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Executive Summary

Swedish Hospital and five federally qualified health centers (FQHCs) located on the north side of Chicago have created the ***Chicago North Side Collaborative***, a partnership with a shared goal of improving access to care and services and addressing health care disparities that impact the communities in the area. As a collaborative, Swedish Hospital and the five FQHC partners – Erie Family Health Centers, Heartland Health Centers, Hamdard Healthcare, Asian Human Services Family Health Center and Howard Brown Health – will work together towards our shared goal to mitigate barriers to care and increase health equity among the communities we serve. To do this, the Chicago North Side Collaborative seeks to partner with the State of Illinois to participate in the new Healthcare Transformation Program by increasing access to specialty care within the communities we serve. Additional information about the FQHCs' financials, executive leadership, and support of the Collaborative can be found in Attachment A: IRS 990 Forms, Attachment B: Executive Biographies, and Attachment C: Letters of Commitment.

For over 134 years Swedish Hospital has served the diverse north side community. Swedish Hospital, together with the five collaborating FQHCs, will continue to provide comprehensive, high quality, and abundant access to primary care for our community. Chicago's north side community encompasses six zip codes and 15 neighborhoods. Timely access to certain clinical specialties, including but not limited to Dermatology, Endocrinology, Orthopedics, Cardiology, and Gastroenterology remains a significant barrier and reality for some members of our community, and this proposal aims to address these and other challenges.

The premise of our project is that there is a need in the local community for improved access to specialty care as well as the need for increased capacity for specialty care services. The lack of care is causing health disparities in the local population that are exacerbated by additional social issues such as lack of transportation, food insecurity, unemployment, and violence in the communities, i.e. social determinants of health that negatively impact health outcomes. Provision of this needed care will result in the improvement of health outcomes in the local community, as well as lessen health disparities in the vulnerable populations.

Over the past several decades, the lack of specialty care in the vulnerable communities has led to increased health disparities in those communities. As demonstrated in the data section of the application, the availably of specialists in the socially vulnerable communities is lower than the average in Cook County. Specialists are unwilling to practice in these areas as the Medicaid fee schedule has historically been low and the uninsured population has been higher, leading to lower revenues for the specialists, which creates a significant void between the reimbursement for physician services and the salaries being paid specialty physicians. Quality physicians are recruited to care for wealthier communities where the fees are higher and the uninsured populations are lower.

Undertaking a project of this magnitude that has not been addressed in the past requires a significant commitment of resources. The project will increase specialty care to meet an unmet need in the local community to improve health outcomes and make the population healthier

though increased health services as well as increased capacity for the social determinants of health in the community that will also improve health outcomes.

In addition to the five specialty care physicians we intend to hire, other specialty physicians will be added to this program as the demand for services increase and or additional specialty services are needed. Increases in services will require changes to the funding formula so will not be undertaken without the appropriate approval from HFS.

Our data shows that one of the significant barriers to care is the capacity and availability of appointments for specialty care. It is not uncommon in our community, Chicago, and nationally for some specialties to have a six-month wait for a patient to receive an appointment, resulting in a delay in any possible clinical intervention that could improve quality of life, reduce the risk of disease progression, and assist in overall patient and family wellbeing. There are simply not enough specialty providers in our community to serve and treat the Medicaid population. Swedish Hospital, for example, is the only provider in the area that offers dermatology services, and as such, our patients have a six-month wait until they can be seen by a provider. Each day our patients have to defer care from specialists thus increasing their risk for further complications and illness. Increasingly many of these individuals resort to using the Emergency Department as their only resource for treatment.

With this application, the Chicago North Side Collaborative proposes to reduce health disparities within our community by partnering to bring specialty healthcare services directly to the FQHC to expand access to the community. Swedish Hospital will establish contracts with each FQHC to rent clinic space and for the support and clinical staff to assist the specialty physician in the treatment of patients.

The five FQHCs that have agreed to collaborate with Swedish Hospital on this proposal are Erie Family Health Centers, Heartland Health Centers, Hamdard Healthcare, Asian Human Services Family Health Center and Howard Brown Health. Erie, which is on the campus of Swedish Hospital, will continue to refer to the hospital's specialty clinics rather than host them in Erie's space.

It is our intent to recruit and hire full time physicians for the specialty practices that are currently underserved within our communities. Those physicians will rotate through each partner clinic to lead, oversee, and support the treatment of Medicaid and self-pay patients. Recognizing that one of the keys to quality healthcare is not only availability, but consistency and knowing one's patient, our goal is to attract top talent by offering a medical school loan repayment program that can be earned for each year a physician serves in this program. In this "loan forgiveness program", the physician will earn an amount equal to their annual loan repayment for medical school for every year worked, up to a maximum of $200,000. We will designate current specialists on staff at Swedish Hospital to initiate the program, but recognize that in order to be successful we need to recruit full-time, dedicated specialists.

We believe that by bringing the specialists into the FQHC, we can build upon the community trust capital that the FQHCs have developed, and patients will have convenient, timely access to the high quality specialty care they so need and deserve. Recognizing that the Medicaid and self-pay population often rely on public transportation, and that they likely view these partner

clinics as their medical "home," it is our hope that by staffing these key specialists on-site at the patients' home clinic we will reduce additional challenges and barriers for patients, ultimately helping to decrease patients' anxiety and increase the likelihood of patients keeping their appointments.

In the event a patient needs care at Swedish Hospital, MedEx Ambulance Service, a State of Illinois certified BEP and City of Chicago certified WBE, has agreed to provide that transportation free of cost to the patient.

We understand that our community is struggling with significant medical and social issues and that the first step for a patient's healing is a healthy lifestyle which should include housing, food, safety and having access to a health provider on a regular basis. With this in mind, Swedish Hospital committed three years ago to provide additional resources to programs that offer housing, food, and protection for survivors of abuse (for additional details about these programs, refer to Attachment F: Social Determinants Program Descriptions). All of these programs have already made a difference for the people in our community and will continue to do so as we reach more community members in need of these resources at the FQHCs.

Our collaborative is unique in that it connects specialty care to expanded comprehensive resources that address the social determinants of health by bringing resources from those already existing in the FQHCs with those previously solely hospital based.

In conclusion, this program will make a significant difference in the overall health and lifestyle of Medicaid and self-pay recipients through increased access to specialty services and by meeting the physical and emotional needs; housing, food and survivorship counseling yielding improved clinical outcomes. Swedish Hospital has been proud to serve the less fortunate in the underserved communities in and around our hospital for over 134 years. Through the partnership with these five federally qualified health centers, we will deliver integrated specialty services to a much larger Medicaid and uninsured population in a setting that addresses their social determinants of health and aims to close the health equity gap in the underserved community. Reflecting on the last year and the pandemic, it is now more important for every clinician to be public health minded and using every patient encounter to "bend the curve" has never been greater. Likewise, in order to provide quality specialty care, the social determinants of health cannot be ignored and specialty encounters can reinforce the work of primary care.

The proposed program's financial requirements are presented in the budget. The budget also includes a financial projection that is a path towards sustainability at the end of the five year period. In order to accomplish this goal we are requesting $16,987,303 in transformation funding and $845,900 in state capital funding. These funds along with $3,000,000 committed on behalf of Swedish Hospital will provide the funds required to transform, specialty care in the Chicago north side area as well as reduce health disparities and continue investing in the social determinants of health.

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Community Input

Swedish Hospital's community includes each of the residential ZIP Codes that comprise the hospital's Primary Service Area (PSA) and Secondary Service Area (SSA): 60613, 60618, 60625, 60626, 60630, 60640, 60641, 60645, 60646, 60659, 60660 and 60712. These zip codes encompass the following community areas in Chicago (of the 77 total geographical divisions in Chicago): Albany Park, Avondale, Edgewater, Forest Glen, Irving Park, Jefferson Park, Lake View, Lincoln Square, North Center, North Park, Portage Park, Rogers Park, Uptown, West Ridge and Lincolnwood. This community definition was determined because the majority of the hospital's patients live in these areas.

The five FQHCs collaborating on this proposal have clinics at the following locations within Swedish Hospital's service area:

Heartland Health Centers

- 3737 W. Lawrence Ave., Chicago, IL 60625
- 1300 W. Devon Ave., Chicago, IL 60660
- 2645 W. Lawrence Ave., Chicago, IL 60625
- 2200 W. Touhy Ave., Chicago, IL 60645
- 845 W. Wilson Ave., Chicago, IL 60640

Erie Family Health Centers

- 5215 N. California, Chicago, IL 60625
- 4747 N. Kedzie, Chicago, IL 60625

Asian Human Services Family Health Center

- 2424 W. Peterson Ave., Chicago, IL 60659
- 2501 W. Peterson Ave., Chicago, IL 60659

Hamdard Healthcare Center

- 1542 W. Devon, Chicago, IL 60660

Howard Brown Health

- 6500 N. Clark St., Chicago, IL 60626
-

Establishing Needs of Swedish Hospital's Community – Community Health Needs Assessment (CHNA) Overview

Every three years, the hospital conducts a Community Health Needs Assessment (CHNA). The CHNA was completed in partnership with the Alliance for Health Equity (AHE), a collaborative of over 30 hospitals, seven health departments, and 100 community partners. Using the Mobilizing for Action through Planning and Partnerships (MAPP) model for the CHNA, AHE

emphasized the importance of community engagement, partnership development, and the dynamic interplay of factors and forces within the public health system.

AHE chose this inclusive, community-driven process to leverage and align with health department assessments and to actively engage stakeholders, including community members, in identifying and addressing strategic priorities to advance health equity. As a result, the following health needs were identified and prioritized within our community for Fiscal Year (FY)2020-2022:

1) Addressing Social and Structural Determinants of Health
2) Addressing Chronic Conditions: Risk Factors, Prevention and Management, and
3) Improving Mental Health by Enhancing Access to Resources and Services.

Swedish Hospital continues to partner with members of AHE and other key community partners within our service area to leverage existing resources and develop strategies which contribute to improving the most pressing health needs of our communities. This proposal integrates these identified priorities into the proposed model, breaking down barriers to accessing care by transforming the FQHC medical home into a space with both specialty care and robust SDOH assessment and treatment navigation.

Swedish Hospital has been an active member of AHE since June of 2017 when the Health Impact Collaborative of Cook County and the Healthy Chicago Hospital Collaborative merged to form AHE. Several hospital employees participate as active, engaged members of the following committees and workgroups:

- Steering Committee
- CHNA Committee
- Policy Committee
- Trauma-Informed Hospitals Collaborative
- Mental Health and Substance Use Disorders Committee
- Social and Structural Determinants of Health Committee
    - Subcommittee: Food Security/Food Access Workgroup
    - Subcommittee: Housing and Health Workgroup

Primary data for the CHNA was collected through four methods:

- Community input surveys
- Community resident focus groups and learning map sessions
- Health care and social service provider focus groups
- Two stakeholder assessments led by partner health departments—Forces of Change Assessment and Health Equity Capacity Assessment

Epidemiologists from the Chicago Department of Public Health (CDPH) and Cook County Department of Public Health (CCDPH) worked with the Illinois Public Health Institute (IPHI) and the steering committee to select a common set of indicators based on an adapted version of the County Health Rankings and Roadmaps Model. Secondary data used in the CHNA were compiled from a range of sources.

In alignment with the purpose, vision, and values, the AHE prioritizes engagement of community members and community-based organizations as a critical component of assessing and addressing community health needs. Community partners have been involved in the assessment and ongoing implementation process in several ways both in providing community input and in decision-making processes. The community-based organizations engaged in AHE represent a broad range of sectors such as workforce development, housing services, food security, community safety, planning, community development, immigrant rights, primary and secondary education, faith communities, behavioral health services, advocacy, policy, transportation, older adult services, health care services, higher education, and many more. All community partners work with or represent communities that are disproportionately affected by health inequities such as communities of color, immigrants, youth, older adults and caregivers, LGBTQ+, individuals experiencing homelessness or housing instability, individuals living with mental illness or substance use disorders, individuals with disabilities, veterans, and unemployed youth and adults.

Overview of data categories

Assessment findings were organized in five areas:

- Overview of health inequities
- Social and structural determinants of health
- Mental health and substance use disorders
- Access to quality health care and community resources
- Chronic conditions – risk factors, prevention, and management

The following section highlights primary data related specifically to Swedish Hospital's service area.

Primary Data: Community Input Survey and Focus Groups

Swedish Hospital worked closely with the AHE and community-based organizations that are members of the hospital's Community Leader Program to collect in-depth community input data through a community input survey and focus groups. We collected 763 surveys and conducted 8 focus groups with residents from the hospital's service area as well as three focus groups with healthcare and social service providers.

Community Input Survey

The community input survey was a qualitative tool designed to understand community health needs and assets from community members, with a focus on hearing from community members most impacted by health inequities. The community input surveys, along with focus group data, informed the priority areas and strategies for community health improvement in Chicago and suburban Cook County. There were 763 survey respondents from the Swedish service area. Nearly half (47%) of the surveys came from three zip codes: 60630, 60625, and

60618, covering the community areas of Albany Park, Avondale, Jefferson Park, Lincoln Square, North Center, and North Park.

Community Input Survey – Top Needs for a Healthy Community

All selected by more than 20% of respondents:

1) Access to healthcare and mental health services
2) Safety and low crime
3) Access to healthy food
4) Access to community services
5) Affordable housing
6) Access to transportation

This proposed project addresses five of six of the top needs identified in the Community Impact Survey.

Community Input Survey – Top Health Issues

All selected by more than 20% of respondents:

- Mental health
- Age-related illness
- Diabetes
- Substance-use
- Chronic conditions: heart disease and stroke, obesity, cancer
- Violence

This proposed project addresses all top health issues identified in the Community Impact Survey.

Focus group and secondary data complemented these top issues and needs for a healthy community. This proposal is a direct response to social and health issues revealed during the Community Input Survey. By infusing specialty medical care along with social support services based on successful SDOH programs which have already been implemented at Swedish, including food insecurity, domestic violence and housing, we enhance access to those most vulnerable. Additionally, we leverage the trusting relationships already established within the existing medical home of the FQHC.

Inclusion of Elected Officials and Key Stakeholders in Proposal Discussions

Direct feedback and discussion with key community stakeholders is a cornerstone of Swedish Hospital's engagement with the community, both while exploring new potential projects as well as throughout initiative implementation. As always, we engaged local elected officials, community based organizations and other to discuss the proposal and received overwhelming support. See the table below for a list of those whom we communicated with directly about this proposed project. Letters of support are provided in Attachment D.

Elected Official and Key Stakeholder Input

Stakeholder Name	Organization Type	Feedback
Alderman Andre Vasquez	Elected Official-40th Ward Alderman	Letter of Support
Inhe Choi, Executive Director HANA Center	Community Based Organization	Letter of Support
Commander Brendan McCrudden 20th Police District	Law Enforcement	Letter of Support
Daysi Funes, Executive Director Centro Romero	Community Based Organization	Letter of Support
Representative Greg Harris	Elected Official-13th District	Letter of Support
Alderman Maria Hadden	Elected Official-49th Ward Alderman	Letter of Support
Albany Park Community Center	Community Based Organization	Letter of Support
Friendship Center	Community Based Organization	Letter of Support

House Majority Leader Greg Harris said, "If we've learned anything from the pandemic, it's that we need to prioritize a health care system that reaches everyone, and this type of collaborative will work to do that."

In addition to the above key stakeholders, discussions and feedback from FQHC partners showcase the broad support for this proposed model. Each FQHC partner has provided a letter of commitment to participate in this project (Attachment C). Early on in our conversations with FQHCs, these potential partners understood the limitations currently faced by their diverse, uninsured or Medicaid patient populations. In one partner meeting, an FQHC Medical Director exclaimed "This is a dream come true!" as she recognized the challenges that patients encounter whenever their advanced care is delayed or moved out of the familiar FQHC setting.

The expanded care capabilities within local FQHCs will allow the most vulnerable in the community to access robust, comprehensive care within a setting they are accustomed to navigating. No longer will a patient need to wait for months before travelling many miles across the city for treatment in an unfamiliar setting. Patients will receive the care they need, when they need it within a medical home that is culturally competent providing care to patients with

diverse values, beliefs and behaviors. Their specialty care will be tailored to meet the patient's social, cultural, and linguistic needs. Ultimately, this model is recognized as an essential means of reducing racial and ethnic disparities in health care.

Data

This project addresses the need in the local community for improved access to specialty care, as well as a need for increased capacity for specialty care services. The lack of specialty care is causing health disparities in the local population that is exacerbated by additional social issues such as lack of transportation, food scarcity, unemployment, and violence in the community ("social determinants of health"). Provision of this needed care will result in the improvement of health outcomes in the local community as well as lower health disparities in vulnerable populations.

Data related to the health and socioeconomic condition of the local community were collected and analyzed. The data sources were available for various specialty services and for insurance status within the designated service areas.

These data were extracted from a series of databases and displayed in the form of univariate and bivariate maps that are included with this proposal in Attachment E.

Data sources include:

- 2015 to 2019 American Community Survey
- 2018 Agency for Toxic Substances and Disease Registry
- 2020 Esri
- 2020 Esri and GfK MRI
- 2017 CDC
- 2018 CDC

Two hundred thirty-two census tracts were identified for 14 service area zip codes located within three to five miles of Swedish Hospital. There were ten FQHCs located in the same zip code area. Five sites for Heartland Health, two sites for Erie Family Health Center, one site for Asian Human Services Family Health Center, one site for Hamdard Healthcare, and one site for Howard Brown Health.

The data from the census tract was studied to determine the unmet need for specialty care in the service area. The data analysis indicates that the adult Medicaid and uninsured populations in the service area are not getting specialty services at the same level as indicated by the Cook County averages. The magnitude of the unmet need varies by specialty type, so our proposed solution is to add specialists to reduce the unmet need and thereby lower health disparities in the local community.

The following conclusions from the data support the proposed solution as follows:

- Multiple communities within the service area are disproportionately challenged by social determinants of health that have been shown to negatively impact health outcomes. To determine this, we utilized total Social Vulnerability Index (SVI) flag themes including socioeconomic status, household composition, minority status/language, and housing type/transportation. SDOH programs for food scarcity and

violence are currently in place at the hospital with demand for these services significantly exceeding current capacity.

- The average SVI value in Cook County is a 2 (range 0-10), indicating relatively low social vulnerability. However, for several communities residing within the service area, particularly in tracts around Erie Albany Park, Heartland Uptown, and Heartland Rogers Park, SVI values range from 5 to 6, indicating that these indices are 150% higher than the average Cook County flag.
- Multiple communities within the service area, particularly around Heartland Uptown tracts, have higher Medicaid beneficiary density and higher uninsured density than the average Cook County density. These tracts are at least 700% above the average Medicaid density and 523% above the average uninsured density.
- Multiple communities within the service area are disproportionately impacted by diabetes. In the service area, particularly around Heartland Uptown and Heartland Rogers Park, as well as in Edgewater and Austin census tracts, the prevalence of diabetes is 27% to 45% above the average Cook County prevalence. Edgewater and Austin have at least 30%-50% of expected diabetes treatment levels and represent geographic opportunities to inform provider transportation deployment.
- Multiple communities within the service area have high uninsured density and low cardiology visit density, particularly around Heartland Albany Park, Erie Albany Park, Asian Human Services West Ridge, Hamdard Rogers Park, and Heartland West Ridge. Analyses of high Medicaid density and low cardiology visit density yielded similar community results.
- Multiple communities within the service area have high uninsured density and low dermatology visit density, particularly around tracts less than 1 mile to Heartland Albany Park and Heartland Rogers Park as well as in Irving Park, Avondale, Belmont Cragin, Hermosa, and Humboldt Park. These findings represent opportunities for provider transportation deployment. Analyses of high Medicaid density and low dermatology visit density yielded somewhat consistent results, particularly in the Belmont Cragin, Hermosa, and Humboldt Park communities.
- Multiple communities within the service area have high uninsured density and low gastroenterology visit density, particularly around Heartland Albany Park, Erie Albany Park, Asian Human Services West Ridge. Analyses of high Medicaid density and low gastroenterology visit density yielded similar community results.

Diversity within the service area is outlined in the Health Equity and Outcomes section of the application. Of note in the data is the Hispanic population is projected to grow in 5 years for all service area tracts.

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Health Equity and Outcomes

The Chicago North Side Collaborative Hospital serves the most ethnically diverse community in the Midwest and in discussions with our community partners, the lack of access to specialty care, including hospital-based surgery and procedures, is one of the prime drivers of healthcare inequality in their patient populations. According to the Healthy Chicago 2.0 2017 report, Rogers Park, West Ridge, Uptown, Lincoln Square, and Albany Park have life expectancies of 75, 79, 76, 79 and 79, respectively, despite being a short distance from the Near North Side that boasts a life expectancy of 82. Likewise, Far North Side deaths from all cancers, colorectal cancer, heart disease, kidney disease, chronic lower respiratory disease, diabetes, and stroke exceed Near North Side deaths significantly-- all complex conditions that require robust primary care in consultation with specialty care. Looking at the CDC social vulnerability index map (https://svi.cdc.gov/map.html), Swedish Hospital and our partner FQHCs are in neighborhoods that are almost all above .5, with several above 0.8, suggesting these are among the more vulnerable populations in Chicago. The implementation of this transformation project is a crucial step in remedying health outcome disparity on the north side.

This transformation project is designed as a partnership with our Chicago north side FQHC partners and will add to their capacity by delivering high quality specialty care. These FQHC partners respond to the unique needs of particular underserved communities in our service area and are closely connected to community leaders and organizations. Collectively, these FQHCs focus on serving the Latinx, African-American, Asian, immigrant, refugee, and LGBTQ+ north side communities who are Medicaid recipients. They have developed extensive social services to address their unique patient population's needs and provide culturally sensitive care, often in the patient's primary language. They also link closely to residents and community organizations to address the social determinants that impact health. Swedish Hospital would be providing both general specialty care as well as health care screening exams that are specialist-dependent by embedding the specialists in the FQHC. By bringing specialists into the primary care offices and local communities of our patients of color, our intent is to create linkages which will directly address these disparities and improve access to both screening and treatment of the underserved which have shown to be negatively influenced by racial factors in various studies. We would also provide specific care coordinators for these patients to help ensure treatment compliance and follow up, as well as help track outcomes.

In discussions with our FQHCs partners, and supported by data regarding wait times for specialists from these FQHCs, there are long wait times for Medicaid recipients in these neighborhood clinics, often because these specialists limit or do not accept these insurance products.

Black, Hispanic, and low socioeconomic status patients are less likely to be screened for colon cancer, more likely to be admitted for an emergent procedure, and have an increased risk of mortality and shorter overall survival time compared with wealthier, white patients.[i] The disparity across all colorectal cancer indicators calls for a novel approach to reducing these disparities by expanding access to colonoscopy and gastroenterology specialists.[ii]

Minorities experience health disparities related to skin cancer, atopic dermatitis, and eczema and compete for access to care in the midst of a national shortage of dermatologists[iii]. It is also imperative for dermatologists to gain knowledge and experience in disparities that affect patient presentation, management, and outcomes in people of color, knowledge of which may be lacking in training and research[iv]. Thus centering a dermatologic practice within an FQHC has the advantage of focus on a particular community's dermatological needs. Two common dermatologic disparities present in the LGBT communities are a higher risk for infectious dermatoses and side effects from hormone therapy. These patients also experience decreased access to dermatologic specialty care amidst a national shortage of dermatologists. Among Hispanics, non-English speakers have been found to be almost three times less likely to request a physician skin examination[v].

Similarly, inequities related to treatment of atrial fibrillation with catheter ablation, an advanced cardiac treatment, have been shown to exist for low income patients of racial and ethnic minorities. Lack of access to advanced cardiac specialty and early treatment leads to disparate morbidity and mortality from atrial fibrillation such as heart failure, thromboembolic events, and frequent hospitalization[vi].

These are just four examples, of which there is many more, indicating that the lack of specialty care to our underserved urban north side community members leads to significant disparities in care and medical outcomes ultimately resulting in a shorter life expectancy.

Our community has been especially impacted by the COVID-19 pandemic, with the zip codes in our primary and secondary service area having amongst the highest rates of illness in Illinois—and have disproportionately impacted the surrounding black and brown communities that often live in multi-generational households. As of March 16, 2021, the north side identified again as a COVID-19 hot spot (Figure 1). Our contact tracing program, which began in summer of 2020, revealed the impact of COVID-19 among multi-generational families. During the spring 2020 COVID-19 surge, Swedish Hospital ranked fourth in the city of Chicago for the number of admitted COVID patients, third for vented patients and first for overall percentage of admitted COVID-19 patients. Included in our embedded specialty program would be a cardiopulmonary evaluation for post COVID-19 "long haulers" who continue to suffer the debilitating impact of COVID-19 on these body systems. We will perform screening exams such as cardiac echocardiography and pulmonary functions tests, followed by a rehabilitation program that we have tested in our hospital employees with COVID-19, to help get patients well enough to return to employment.

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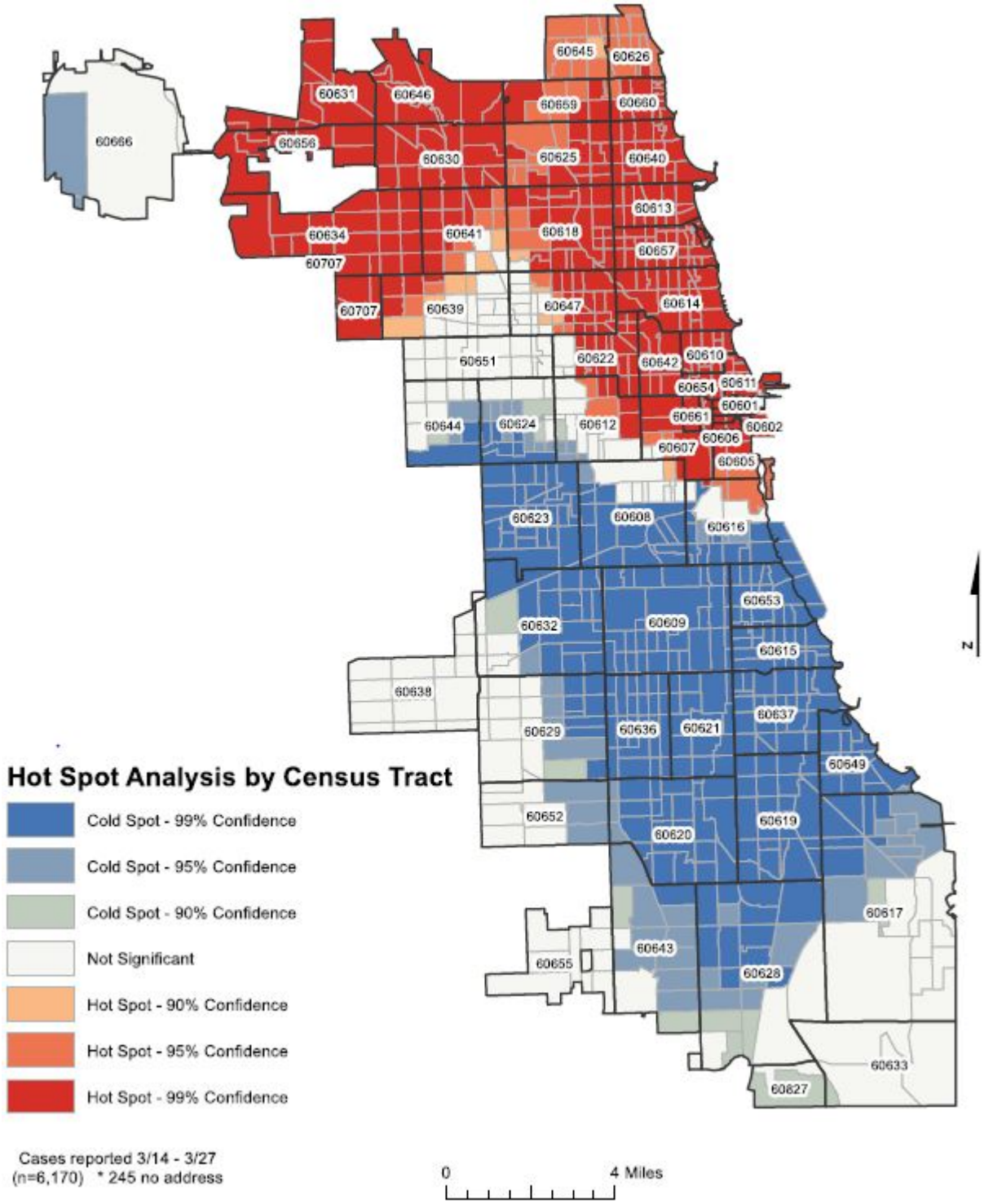
Figure 1. Impact of COVID-19 by Census Tract



Outcomes that we would expect to see improved, based on embedded specialties, would include metrics like the following:

1. Dermatology
    a. Improved % of skin cancer screening rates
    b. Skin cancers detected at an earlier stage
    c. Skin cancers treated at an earlier age
    d. Improvements of life expectancy for these conditions
    e. Increased referrals for exam findings suspicious for malignancy such as changing pigmented lesions, non-healing ulcers, hyperkeratotic or poorly healing chronic lesions or scars, and atypical appearing keloidal plaques[vii]
2. Cardiology
    a. Improved % of screening for common cardiac conditions including Congestive Heart Failure (CHF), Coronary Artery Disease (CAD) and Cardiac Arrhythmias
    b. Evidence of improved cardiac function for patients with CHF and CAD including improvement in Ejection Fraction (EF) which is directly tied to exercise tolerance and ability to work.
    c. A leveling of disparity regarding patients with underlying heart conditions who receive procedures directly linked to improvements in wellbeing: cardiac stenting, coronary bypass grafting, valvular procedures, cardiac ablation for arrhythmias
3. Endocrinology
    a. Improved diabetic management
        i. Programs focused on exercise, diet and nutrition
        ii. Access to appropriate medication management
        iii. Measured improvements in patients A1C measurements as a reflection of improved diabetic/glucose control
        iv. Decreases in known negative diabetic outcomes including Chronic Renal Failure (CRF) leading to dialysis, diabetic retinopathy leading to blindness, diabetic vascular disease leading to chronic pain and amputations
4. Orthopedic Surgery
    a. Evaluation of chronic painful conditions of the neck, spine, back and joints
    b. Integration with our chronic pain specialists leading to improvements in narcotic use among those with chronic pain syndromes
    c. Evaluation for appropriate procedures in the spine and joints to lead to improvements in pain scores
        i. Where appropriate, referral for knee replacements, hip replacements and spine procedures that can markedly impact ability to live comfortably and return to gainful employment
5. Gastroenterology

a. Assess for and improve screening colonoscopy rates for eligible Medicaid participants
b. Improve colon cancer screening via improved colonoscopy rates
c. Assess patients with reflex type symptoms for appropriate screening and treatment: H Pylori, endoscopy, conservative treatment
d. Assess vulnerable populations for both hepatitis vaccination as well as Hepatitis screening and eligibility for Hepatitis treatment
e. Active management of inflammatory bowel patients with improvement in ED visits and hospitalizations

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Quality Metrics

The program's quality metrics will demonstrate a sustainable pathway to health equity in our communities that will be anchored in community-based FQHCs that serve low income patients of color. The Chicago North Side Collaborative will focus on closing the gaps experienced by black and brown communities with regard to colon cancer screening, cardiovascular disease, and diabetes. One goal will be a reduction of readmission rates and improved management of chronic conditions for this population of patients as barriers to care coordination post discharge will decrease with the integration of specialists and primary care providers occurring in the patient's own medical home.

A comprehensive list of outcomes to be achieved over the long-term as a result of this proposal appears in the Health Equity and Outcomes section. Short-term quality goals will focus on increasing access for specialty visits at the outset of the program. One measure of success will be a decrease in the number of Emergency Department visits of our FQHC patients year over year as access to specialty care for chronic disease management and prevention of acute conditions expands. Control of diabetes and blood pressure will be tracked as iterative measures that impacts the long-term goal of increasing the life expectancy rate. Patient experience will be measured, with particular focus on reducing wait times from months to days.

Swedish Hospital will also track its hospital-based quality metrics by socio-economic status, race and ethnicity:

1. Mortality – all cause
2. Mortality - sepsis
3. Readmission rate
4. Perioperative DVT/PE rate
5. Elective total joint replacement complication rate
6. Falls with injury
7. Inpatient nurse communication
8. Inpatient physician communication
9. Inpatient staff responsiveness
10. Inpatient cleanliness
11. Pressure ulcer rate

These metrics are reviewed monthly by department chairs and hospital administrative leaders and subsequently reported to the medical staff and Board of Directors.

Specific to the Chicago North Side Collaborative, we propose an Oversight Quality Committee, which would include:

- VP Quality from Swedish Hospital
- Clinical Care Coordinator
- Quality Representative from each FQHC
- Community Member

- Health Data Analyst

Through the Oversight committee, and using the HFS Pillars of Quality Strategy as a guiding principle, we would create a quality dashboard for each specialty. We suggest the following as likely quality measures based on our understanding of current access issues and known metrics. The Oversight Quality Committee (OQC) would establish baseline for each performance metric for each FQHC with the intent to achieve overall average performance improvement over the baseline or to achieve benchmarks for specific measures as shown in the Clinical Metrics chart below. These goals are based in part on information provided from the FQHCs of currently collected data/performance:

1. **Dermatology**: with regards to the data provided by the FQHCs, none are currently tracking measures related to dermatology. Both Erie and Asian Human Services Family Health Center listed Dermatology among their most commonly referred specialties, and Asian Human Services Family Health Center listed Dermatology as the #2 specialty with regards to access need as measured by waitlist/third next available appointment. As described in the outcome section, our expectations with regards to improved access would be improvements in skin cancer screening, leading to earlier detection and treatment. The Health Data Analyst will track this data to demonstrate improvement. Given the current data available, the initial quality metric proposed would be
    a. Improvement in access as measure by 20% improvement in third-next available appointment access by end of year one of program implementation.
2. **Cardiology:** with regards to the data FQHCs, all are tracking several quality of care indicators that relate to Cardiology Care. These include use of antiplatelet medications in Ischemic Vascular Disease, statin use in prevention and treatment of CVD as well as control of high blood pressure. Asian Human Services Family Health Center listed Cardiology as the topmost common specialty requiring a specialty referral. Hamdard listed abnormal EKG and essential hypertension as two of the top 10 chronic conditions seen. Given the data available, the initial quality metrics proposed would be
    a. Improvement in access as measure by 20% improvement in third-next available appointment access by end of year one of program implementation
    b. Improvement in currently reported health outcome measures of antiplatelet use and statin use to top quartile performance for the five FQHCs by end of year one of program implementation
3. **Endocrinology:** with regards to data FQHCs, all are tracking the quality measure of Hemoglobin A1c as a measure of poor control. Endocrinology is listed among the most common specialty referrals by all the FQHCs, diabetes is listed as the second most common chronic condition seen by Asian Human Services Family Health Center and was the most common reason for chronic care visits by Erie Clinic. It is among the most common diagnoses for referral as well as identified specialty needs as measured by third next available appointment. Given the data available, the initial quality metrics proposed would be:

   a. Improvement in access as measure by 20% improvement in third-next available appointment access by end of year one of program implementation
   b. Improvement in currently reported health outcome measures of Hemoglobin A1c to top quartile performance for the five FQHCs by end of year one of program implementation

4. **Orthopedic Surgery:** with regards to data provided by the FQHCs, none are tracking specific quality measures regarding this specialty. In our conversations with FQHC leadership however, the lack of availability of this specialty leads to severe quality of life issues for their patients, including access to cutting edge treatment for low back pain, chronic joint conditions and disability pain. With regard to referrals, Hamdard lists both low back pain and knee osteoarthritis as two of the top ten chronic health conditions seen. Howard Brown lists Orthopedics as one of their 'priority specializations 'and Asian Human Services lists Ortho/Sports Medicine as among the top ten referred and needed as measured by third next-available. Given the data available, the initial quality metrics proposed would be:
   a. Improvement in access as measure by 20% improvement in third-next available appointment access by end of year one of program implementation
5. **Gastroenterology:** with regards to data provided by the FQHCs, all are tracking colorectal cancer screening. As described in the outcomes section, this is a metric that shows significant socio-economic disparity in published data. With regards to need based on specialty referral and third next- available, Asian Human Services Family Health Center, Erie and Howard Brown list GI/Hepatology as among their top ten. Given the data available, the initial quality metrics proposed would be
   a. Improvement in access as measure by 20% improvement in third-next available appointment access by end of year one of program implementation
   b. Improvement in colorectal screening rates to top quartile performance for the 5 FQHCs by end of Year One of the program implementation.

We would anticipate that entering Year Two of the program, given that we will be documenting on the robust EPIC EMR platform for all these specialties, that we will have the ability to collect and analyze data far more robustly. As discussed in the outcome section of this proposal, in collaboration with the Quality Oversight Committee, we will use this platform to collect and analyze data and with our Care Coordinators to look for more robust and far reaching quality measures that will be implemented in Year Two and beyond – as we look to integrate our other programs for these patients that help deal with homelessness, food insecurity, nutrition and health and well-being. We feel it will be essential to have the input of our FQHC partners in both analyzing this data and choosing quality metrics, while also working with HFS and following the Department Quality Strategy Pillars.

The Health Data Analyst would keep records of the Collaborative's quality performance metrics will be tracked and reviewed during Swedish Hospital's monthly quality meetings and also

during FQHCs monthly meetings. A report from the Collaborative OQC will be a standing agenda item during the Collaborative's Governance meeting.

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Clinical Metrics

CLINICAL					
YEAR 1					
MEASURES	**DERMATOLOGY**	**ENDOSCOPY**	**GASTROENTEROLOGY**	**ORTHOPEDICS**	**CARDIOLOGY**
BASELINE = 2019	*ALL MEASURES COMPARED TO BASELINE except as NOTED IN MEASURES COLUMN*				
ACCESS: 3rd NEXT AVAILABLE APPOINTMENT REDUCTION IN DAYS TO APPOINTMENT	> 20%	> 20%	> 20%	> 20%	> 20%
NO SHOW RATE REDUCED BY:	>50%	>50%	>50%	>50%	>50%
SCREENINGS: GOAL RATES AT TOP QUARTILE PERFORMANCE FOR SPECIALTY	SKIN CANCER SCREENINGS TARGET IS >30% IMPROVEMENT TOWARD GOAL OF TOP QUARTILE PERFORMANCE		COLORECTAL SCREENINGS TARGET IS >30% IMPROVEMENT TOWARD GOAL OF TOP QUARTILE PERFORMANCE		
OUTCOMES IMPROVEMENT: GOAL IS RATES AT TOP QUARTILE PERFORMANCE FOR SPECIALTY		HEMOGLOBIN A1C IMPROVEMENT TARGET IS 30% IMPROVEMENT TOWARDS GOAL OF TOP QUARTILE			ANTIPLATELET USE TARGET IS 30% IMPROVEMENT TOWARDS GOAL OF TOP QUARTILE

CLINICAL					
YEAR 1					
MEASURES	**DERMATOLOGY**	**ENDOSCOPY**	**GASTROENTEROLOGY**	**ORTHOPEDICS**	**CARDIOLOGY**
BASELINE = 2019	*ALL MEASURES COMPARED TO BASELINE except as NOTED IN MEASURES COLUMN*				
OUTCOMES IMPROVEMENT: GOAL IS RATES AT TOP QUARTILE PERFORMANCE FOR SPECIALTY					STATIN USE TARGET IS 30% IMPROVEMENT TOWARDS GOAL OF TOP QUARTILE
GROWTH IN THERAPIES: PT, HYDOTHERAPY, MASSAGE, ACUPUNCTURE				>20%	
GROWTH IN REFERRALS TO NUTRITION COUNSELING		>30%			>30%
GROWTH IN REFERRALS TO FOOD INSECURITY PROGRAM		>30%			
GROWTH IN REFERRALS TO GATE LIFE CENTER					>30%
REDUCTION IN EMERGENCY VISITS	SEE FINANCIAL TARGETS	SEE FINANCIAL TARGETS	SEE FINANCIAL TARGETS	SEE FINANCIAL TARGETS	SEE FINANCIAL TARGETS
GROWTH IN PROCEDURES			COLONOSCOPIES - SEE FINANCIAL TARGETS	JOINTS SEE FINANCIAL TARGETS	

CLINICAL					
YEAR 2					
MEASURES	**DERMATOLOGY**	**ENDOSCOPY**	**GASTROENTEROLOGY**	**ORTHOPEDICS**	**CARDIOLOGY**
BASELINE = 2019	*ALL MEASURES COMPARED TO BASELINE except as NOTED IN MEASURES COLUMN*				
ACCESS: 3rd NEXT AVAILABLE APPOINTMENT REDUCTION IN DAYS TO APPOINTMENT	>50%	>50%	>50%	>50%	>50%
NO SHOW RATE REDUCED BY:	>70%	>70%	>70%	>70%	>70%
SCREENINGS: GOAL RATES AT TOP QUARTILE PERFORMANCE FOR SPECIALTY	SKIN CANCER SCREENINGS TARGET IS >80% IMPROVEMENT TOWARD GOAL OF TOP QUARTILE PERFORMANCE		COLORECTAL SCREENINGS TARGET IS 80% IMPROVEMENT TOWARD GOAL OF TOP QUARTILE PERFORMANCE		
OUTCOMES IMPROVEMENT: GOAL IS RATES AT TOP QUARTILE PERFORMANCE FOR SPECIALTY		HEMOGLOBIN A1C IMPROVEMENT TARGET IS 80% IMPROVEMENT TOWARDS GOAL OF TOP QUARTILE			ANTIPLATELET USE TARGET IS 80% IMPROVEMENT TOWARDS GOAL OF TOP QUARTILE

CLINICAL					
YEAR 2					
MEASURES	**DERMATOLOGY**	**ENDOSCOPY**	**GASTROENTEROLOGY**	**ORTHOPEDICS**	**CARDIOLOGY**
BASELINE = 2019	*ALL MEASURES COMPARED TO BASELINE except as NOTED IN MEASURES COLUMN*				
OUTCOMES IMPROVEMENT: GOAL IS RATES AT TOP QUARTILE PERFORMANCE FOR SPECIALTY					STATIN USE TARGET IS 80% IMPROVEMENT TOWARDS GOAL OF TOP QUARTILE
GROWTH IN THERAPIES: PT, HYDOTHERAPY, MASSAGE, ACUPUNCTURE				>50%	
GROWTH IN REFERRALS TO NUTRITION COUNSELING		>60%			>60%
GROWTH IN REFERRALS TO FOOD INSECURITY PROGRAM		>60%			
GROWTH IN REFERRALS TO GATE LIFE CENTER					>50%
REDUCTION IN EMERGENCY VISITS	SEE FINANCIAL TARGETS	SEE FINANCIAL TARGETS	SEE FINANCIAL TARGETS	SEE FINANCIAL TARGETS	SEE FINANCIAL TARGETS
GROWTH IN PROCEDURES			COLONOSCOPIES - SEE FINANCIAL TARGETS	JOINTS SEE FINANCIAL TARGETS	
EPIC EMR Direct Access	**x**	**x**	**x**	**x**	**x**

CLINICAL					
YEAR 3					
MEASURES	**DERMATOLOGY**	**ENDOSCOPY**	**GASTROENTEROLOGY**	**ORTHOPEDICS**	**CARDIOLOGY**
BASELINE = 2019	*ALL MEASURES COMPARED TO BASELINE except as NOTED IN MEASURES COLUMN*				
ACCESS: 3rd NEXT AVAILABLE APPOINTMENT REDUCTION IN DAYS TO APPOINTMENT	>90%	>90%	>90%	>90%	>90%
NO SHOW RATE REDUCED BY:	>90%	>90%	>90%	>90%	>90%
SCREENINGS: GOAL RATES AT TOP QUARTILE PERFORMANCE FOR SPECIALTY	SKIN CANCER SCREENINGS at TOP QUARTILE PERFORMANCE		COLORECTAL SCREENINGS TARGET IS AT TOP QUARTILE PERFORMANCE		
OUTCOMES IMPROVEMENT: GOAL IS RATES AT TOP QUARTILE PERFORMANCE FOR SPECIALTY		HEMOGLOBIN A1C IMPROVEMENT IS AT TOP QUARTILE PERFORMANCE			ANTIPLATELET USE TARGET IS AT TOP QUARTILE PERFORMANCE
OUTCOMES IMPROVEMENT: GOAL IS RATES AT TOP QUARTILE PERFORMANCE FOR SPECIALTY					STATIN USE TARGET IS AT TOP QUARTILE PERFORMANCE

CLINICAL					
YEAR 3					
MEASURES	**DERMATOLOGY**	**ENDOSCOPY**	**GASTROENTEROLOGY**	**ORTHOPEDICS**	**CARDIOLOGY**
BASELINE = 2019	*ALL MEASURES COMPARED TO BASELINE except as NOTED IN MEASURES COLUMN*				
GROWTH IN THERAPIES: PT, HYDOTHERAPY, MASSAGE, ACUPUNCTURE				>50%	
GROWTH IN REFERRALS TO NUTRITION COUNSELING		>80%			>80%
GROWTH IN REFERRALS TO FOOD INSECURITY PROGRAM		>80%			
GROWTH IN REFERRALS TO GATE LIFE CENTER					>50%
REDUCTION IN EMERGENCY VISITS	SEE FINANCIAL TARGETS	SEE FINANCIAL TARGETS	SEE FINANCIAL TARGETS	SEE FINANCIAL TARGETS	SEE FINANCIAL TARGETS
GROWTH IN PROCEDURES			COLONOSCOPIES - SEE FINANCIAL TARGETS	JOINTS SEE FINANCIAL TARGETS	

Care Integration and Coordination

Our proposal is transformational in that we will be expanding into and creating work areas in the FQHCs for our typically hospital based specialists to work directly in FQHC offices, in our underserved communities, resulting in care that is patient-centric and located in their medical home. Patients and providers alike complain about the disconnect that often occurs between the primary care provided in FQHC offices and the specialty care provided typically at hospital-based practices. By embedding the specialists in these offices, the barriers to both access, transportation, as well as communication will be reduced or removed. Primary care practitioners will have real time access to hospital based specialists, markedly improving both integration and care coordination. We also will create communication systems that will go beyond the typical communication by EMR systems (that often don't integrate well) to provide real time communication between these FQHC devoted specialists and the primary care physicians both in-person and through E-consults so that patients receive the right care, at the right time, at the right place. . An E-consult placed by a referring primary care physician to a specialist allows for the opportunity for specialists to advise on the management of the patient's condition in preparation for or, when appropriate, in lieu of a specialty visit. For example, if a patient's condition is something that can be managed further by the primary care physician with input from the specialist via the E-consult, a specialty visit appointment becomes superfluous. Alternatively, recommendations from the specialist at the time of the E-consult such as for lab tests and imaging maximize the patient's upcoming specialty visit appointment because the specialist has all the essential elements of a disease work-up completed at the time of the patient visit, potentially reducing the frequency of return specialist appointments. Likewise, the decision for surgery made between a specialist and patient can be done in a timely fashion at the time of the initial patient visit. There is added advantage of involving specialists in ongoing care management and transitional care in a multi-specialty setting.

Swedish Medical Group physicians recently transitioned to the electronic medical record EPIC – which is the most widely-usedEMR. This EMR is used by our parent corporation NorthShore University Health Systems, as well as the academic medical centers in Chicago. Records are easily visible in this platform between these institutions – which will allow for seamless care integration across institutions for our most complex patients requiring specialty care. Erie Clinic will be converting to an EPIC EMR soon, and for those on alternative systems, we will implement systems to allow for readily available documentation of notes and results generated by Swedish specialists.

Our partner FQHCs have embedded care coordinators at their clinics, who for the first time will have specialty physicians ***in-person*** in their clinics and by year 2, direct access to Swedish Hospital's EPIC EMR system. Many of the barriers that occur as patients are sent to specialists at outside institutions, and the resultant confusion about follow- up needs and care, will dissolve in the setting of specialty physicians embedded in the FQHC facilities themselves.

In addition to the organic care coordination that will occur due to specialty integration, Swedish Hospital will hire both a Manager as well as a full-time Clinical Coordinator/Case Manager

devoted to these patients, who will be focused on our quality outcomes and HFS quality pillars of care.

Success of this coordination will be measured in our quality and outcome metrics:

- Remediation in no show rates c/w current baseline date
- Improvements in third, next-available for the embedded specialties of Dermatology, Cardiology, Endocrinology, Orthopedics and Gastroenterology

Reduction in inpatient readmissions for ambulatory care sensitive conditions

- Reduction in ED visits for symptoms related to the specialties in the proposal
- Top quartile performance in currently measured FQHS quality of care indicators:
    - Appropriate anti-platelet use
    - Appropriate statin use
    - A1c measurements as a measure of poor diabetic control
    - Colorectal screening rates

Through their participation in the Oversight Quality Committee, the Clinical Coordinator will work with our FQHC partners to look for additional opportunities to provide enhanced care coordination to lead to better outcomes. In speaking to our partners, early opportunities include:

- Enhanced skin cancer screening with early detection and treatment.
- Coordination of alternative modalities for those with the chronic orthopedic conditions of low back pain and chronic joint pain available at Swedish including physician therapy, hydrotherapy, massage therapy and acupuncture as mandatory precursors to interventions such as lumbar disc surgery and joint replacements.
- For those who require joint replacement, care coordination with our ERAS program (enhanced recovery after surgery) which has decreased length of stay, decreased opioid use and improved outcomes.
- Care coordination will also be available with our inpatient rehabilitation unit for this patient population, such as those with significant obstacles following orthopedic or spine surgery, or significant cardiac procedures
- For diabetic patients, coordination with our dieticians and nutritional counselling, as well as partnership with our food insecurity program, to provide comprehensive management of diabetic patients with improvement of both A1c measurements as well as long term impacts of diabetes including renal and vascular disease.
- For cardiology patients, coordination with nutritional counseling as well as access to our lifestyle modification programs at the Galter LifeCenter. Coordination of both diet and lifestyle will help drive outcome measurements of improved blood pressure and lipid control, advancing outcomes of decreased cardiovascular events including AMI and stroke.
- For GI patients requiring colonoscopy to drive colorectal cancer screening, the ability to coordinate obtaining and completing the required GI prep can be a known obstacle. Our care coordinator will work with our partner FQHCs to help coordinate availability of GI

prep, instructions of use in multiple languages, as well as transportation obstacles that may exist for a procedure which requires arranged transport home post sedation.

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Access to Care

At our Swedish Hospital specialty clinics, we suffer from “no show” rates as high as 30%, often highest in our underserved Medicaid minority patients referred by our FQHC partners. The reasons for this are varied, but include barriers related to time to appointment, geography, transportation, language, or perceived cost. Those barriers will be reduced by placing Swedish specialists directly into these FQHC offices. In comparing “no show” rates, the FQHCs describe much lower rates of their patients not arriving for appointments at their sites, something we would expect to be true for our embedded specialists. Lack of space for specialists to practice can be another barrier. Two FQHCs requested capital dollars to convert existing administrative space or build-out leased space to allow for the usage of this space by the specialists simply, our proposal involves bringing specialty care to the patients rather than expecting them to come to us. Clearly there will be services that will need to be performed on the hospital campus, but by making the initial specialty appointments in the patient’s medical home, we believe that a relationship of trust will have a solid foundation to help overcome many of the obstacles currently preventing care. In addition, these newly hired specialists will be specifically devoted to the care of these underserved FQHC patients, and these patients will not be ‘competing’ with other patients to enter the hospital system, streamlining their treatment and care coordination. Given the fact that many specialists do not accept many or all Medicaid insurance products or uninsured patients, this access to a Swedish specialist should be a solution to that issue for these patients which will help alleviate disparity in their access to healthcare.

In reviewing the data provided by our FQHC partners, Erie, Heartland, Howard Brown and Asian Family Services, we found the specialties either most referred, or longest next third available appointment, and our five proposed specialties of Dermatology, Endocrinology, Cardiology, Ortho/Sports Medicine and Gastroenterology were among the most frequently noted. As discussed in the quality/outcomes section, we will track both access (through third next available) as well as specialty specific outcomes for each of these specialties to ensure that this improved specialty access translates to improved outcomes.

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Social Determinants of Health

As the Chicago Health Atlas points out, life expectancy in Chicago is directly related to access to healthcare, socio-economic level, and geographic location[viii].

Both Swedish Hospital and our partner FQHCs have extensive experience developing and implementing have many programs that look to specifically address social determinants of health. What follows are descriptions of three of our premier social determinant programs as Swedish Hospital: Pathways, Food Connections and Swedish Housing Connections. The program descriptions of Swedish Hospital social determinants services are included in Attachment F.

In our proposal we are requesting resources to expand our current SDOH programs. The additional resources will facilitate care coordination and to improved clinical outcomes as measured by performance metrics identified in the quality, care coordination and health equity sections. The following information provides additional details on how expanded SDOH programs will work.

With regards to the Illinois Medicaid patients specifically seen in this program, we will work with our partner FQHCs in a variety of ways to address social determinants of health. Patients will receive screening for social determinants during FQHC visits. In addition to the embedded mental health services provided at many of these clinics, we will address these issues through the work of our care coordinator to link patients to needed services. We will leverage existing technology to ensure linkage to needed outside agencies, including current platforms in use at FQHCs such as NowPow and Aunt Bertha. This can allow us to identify and track social determinants of health data via working with these platforms and our FQHC partners.

A number of the specific specialties have direct connection to food insecurity. Multiple studies link food insecurity to unhealthful food choices that worsen underlying chronic disease. By appropriately screening these patients, and using care coordination to provide linkages to both nutritional counseling as well as provision of healthy food options, we expect to see improvement in our diabetic health outcome of A1c measurement, as well as improvements in the chronic care conditions of cardiovascular disease as seen by our embedded cardiologists, and inflammatory bowel disease seen by our GI specialists. Linking the seriously overweight/obese to nutritional counseling and food resources through our Food Connections program will also lead to weight loss that will help patients with chronic low back pain and joint pain being see by our orthopedic specialists.

Although less obvious, our Pathways Violence Prevention Program is deeply versed in helping patients overcome the scars of abuse through trauma informed care. Research has shown that victims of violence have higher levels of chronic disease and worse health outcomes, with victims of violence seen across the racial and socio-economic spectrum. Through appropriate screening, we will help identify these patients and match them to appropriate resources. Studies have revealed successful treatment of these patients leads to improved medical compliance including health screenings and other services that would be provided by our embedded specialists.

Homelessness is an issue within our service area. The Swedish Housing Connections program works with homeless patients to connect to community-based agencies. Patients seeking care from specialists will need a stable setting to comply with the medical plan developed by the specialists. For the subset of patients that need shelter we are requesting resources through this proposal to facilitate housing.

As noted in the Access section of the application, the need to travel to see a specialist is a barrier to getting care. Patients cite the need for and lack of affordable transportation as major issues. Through this proposal the CNSC and a BEP vendor, MED-EX, will provide additional transports for patients to be seen by specialists in the FQHC offices.

As outlined above, the most serious consequence of the disparities of social determinants of health is the inequity in life expectancy between neighborhoods around Swedish Hospital and those of more affluent neighborhoods to our south. We believe our partner FQHCs are doing outstanding work in providing critical primary care to these patients – but they express to us the frustration of their patients in accessing needed specialty care. By providing cancer screening by Dermatology and Gastroenterology, by improving access and medication management to hypertensive cardiovascular patients by Cardiology, and by actively improving nutrition and diabetic management by Endocrinology, we believe this program will impact life expectancy in our neighborhoods to have an impact on the most profound social determinant: life expectancy.

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Budget

Budget Year 1

HEALTHCARE TRANSFORMATION PROPOSAL BUDGETS — LINE ITEM BUDGET
Collaboration name: CHICAGO NORTH SIDE COLLABORATION — Project Period: 2022 to 2026 (Five Years)
Preparer Name/Title: Tom Garvey Senior Vice President & CFO — E-mail: tgarvey@schosp.org
Phone: 773.293.1123

	2022 YR 1	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	
SOURCES OF FUNDS														
COLLABORATOR'S FUNDS														
Physician Revenues	$593,628	$18,449	$18,449	$18,449	$18,449	$18,449	$18,449	$49,532	$61,915	$74,298	$86,680	$99,063	$111,446	$593,628
I/P Directed Payments (Medicaid Fixed to Directed)	$62,483	$1,942	$1,942	$1,942	$1,942	$1,942	$1,942	$5,214	$6,517	$7,820	$9,124	$10,427	$11,730	$62,483
O/P Directed Payments (Medicaid Fixed to Directed)	$30,918	$961	$961	$961	$961	$961	$961	$2,580	$3,225	$3,870	$4,515	$5,160	$5,804	$30,918
Uncompensated Care (Medicare)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FQHC PPS Rates for Specialty Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Directed Payment Program	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Managed Care Shared Savings	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL COLLABORATOR'S FUNDS	$687,029	$21,352	$21,352	$21,352	$21,352	$21,352	$21,352	$57,325	$71,656	$85,987	$100,319	$114,650	$128,981	$687,029
STATE CAPITAL FUNDS	$845,900													
PHILANTHROPY; Swedish Hospital Foundation	$500,000	$41,667	$41,667	$41,667	$41,667	$41,667	$41,667	$41,667	$41,667	$41,667	$41,667	$41,667	$41,667	$500,000
TRANSFORMATION FUNDS	$3,200,015	$109,315	$109,315	$109,315	$109,315	$109,315	$150,752	$407,947	$411,614	$415,281	$418,948	$422,615	$426,283	$3,200,015
TOTAL FUNDING	$5,232,944	$172,333	$172,333	$172,333	$172,333	$172,333	$213,771	$506,938	$524,937	$542,935	$560,934	$578,932	$596,931	$4,387,044
BUDGET REQUEST														
Salaries	$2,057,500	$65,104	$65,104	$65,104	$65,104	$65,104	$96,979	$272,500	$272,500	$272,500	$272,500	$272,500	$272,500	$2,057,500
Fringe Benefits	$352,313	$13,250	$13,250	$13,250	$13,250	$13,250	$22,813	$43,875	$43,875	$43,875	$43,875	$43,875	$43,875	$352,313
Total Salary and Fringe Benefits	$2,409,813	$78,354	$78,354	$78,354	$78,354	$78,354	$119,792	$316,375	$316,375	$316,375	$316,375	$316,375	$316,375	$2,409,813
Other Direct Costs														
Professional Liability Insurance	$157,909	$4,415	$4,415	$4,415	$4,415	$4,415	$4,415	$21,903	$21,903	$21,903	$21,903	$21,903	$21,903	$157,909
Loan Forgiveness	$200,000	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$16,667	$200,000
FQHCs - Rental and Staff Use/UCC Grant	$218,500	$4,750	$4,750	$4,750	$4,750	$4,750	$4,750	$31,667	$31,667	$31,667	$31,667	$31,667	$31,667	$218,500
Social Determinants of Health	$201,250	$4,375	$4,375	$4,375	$4,375	$4,375	$4,375	$29,167	$29,167	$29,167	$29,167	$29,167	$29,167	$201,250
Other Supporting Expenses i.e. E consult	$230,000	$19,167	$19,167	$19,167	$19,167	$19,167	$19,167	$19,167	$19,167	$19,167	$19,167	$19,167	$19,167	$230,000
Total Other Direct Costs	$1,007,659	$49,374	$49,374	$49,374	$49,374	$49,374	$49,374	$118,570	$118,570	$118,570	$118,570	$118,570	$118,570	$1,007,659
Uncompensated Care														
Hospital procedures	$860,541	$39,840	$39,840	$39,840	$39,840	$39,840	$39,840	$63,744	$79,680	$95,616	$111,552	$127,488	$143,423	$860,541
Ancillary services	$109,031	$4,766	$4,766	$4,766	$4,766	$4,766	$4,766	$8,250	$10,313	$12,375	$14,438	$16,500	$18,563	$109,031
Total Uncompensated Care	$969,572	$44,605	$44,605	$44,605	$44,605	$44,605	$44,605	$71,994	$89,992	$107,991	$125,989	$143,988	$161,986	$969,572
Total Costs	$4,387,044	$172,333	$172,333	$172,333	$172,333	$172,333	$213,771	$506,938	$524,937	$542,935	$560,934	$578,932	$596,931	$4,387,044
Capital Funding	$845,900													
TOTAL BUDGET REQUEST	$5,232,944													

Swedish Hospital
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Budget Year 2

HEALTHCARE TRANSFORMATION PROPOSAL BUDGETS — LINE ITEM BUDGET
Collaboration name: CHICAGO NORTH SIDE COLLABORATIVE — Project Period: 2022 to 2026 (Five Years)
Preparer Name/Title: Tom Garvey Senior Vice President & CFO — E-mail: tgarvey@schosp.org
Phone: 773.293.1123

	2022 Year 1	2023 Year 2	2024 Year 3	2025 Year 4	2026 Year 5	Cumulative 2026 Year 5	Check Total
SOURCES OF FUNDS							
COLLABORATOR'S FUNDS							
Physician Revenues	$593,628	$1,515,669	$1,545,982	$1,576,902	$1,608,440	$6,840,621	$6,840,621
I/P Directed Payments (Medicaid Fixed to Directed)	$62,483	$574,848	$661,075	$760,236	$874,271	$2,932,913	$2,932,913
O/P Directed Payments (Medicaid Fixed to Directed)	$30,918	$284,446	$368,001	$423,202	$486,682	$1,593,249	$1,593,249
Uncompensated Care (Medicare)	$0	$180,000	$240,000	$300,000	$306,000	$1,026,000	$1,026,000
FQHC PPS Rates for Specialty Services	$0	$0	$546,753	$557,688	$568,842	$1,673,284	$1,673,284
Physician Directed Payment Program	$0	$0	$0	$0	$0	$0	$0
Managed Care Shared Savings	$0	$161,857	$323,714	$404,642	$485,571	$1,375,784	$1,375,784
TOTAL COLLABORATOR'S FUNDS	$687,029	$2,716,819	$3,685,526	$4,022,670	$4,329,807	$15,441,851	$15,441,851
STATE CAPITAL FUNDS	$845,900	$0	$0	$0	$0	$845,900	$845,900
PHILANTHROPY; Swedish Hospital Foundation	$400,000	$500,000	$600,000	$700,000	$800,000	$3,000,000	$3,000,000
TRANSFORMATION FUNDS	$3,300,015	$4,320,803	$3,324,800	$3,109,966	$2,931,809	**$16,987,393**	$16,987,393
TOTAL FUNDING	**$5,232,944**	**$7,537,622**	**$7,610,326**	**$7,832,636**	**$8,061,615**	**$36,275,143**	$36,275,143
BUDGET REQUEST							
Salaries	$2,057,500	$3,368,100	$3,469,143	$3,573,217	$3,680,414	$16,148,374	$16,148,374
Fringe Benefits	$352,313	$542,295	$558,564	$575,321	$592,580	$2,621,073	$2,621,073
Total Salary and Fringe Benefits	$2,409,813	$3,910,395	$4,027,707	$4,148,538	$4,272,994	$18,769,447	$18,769,447
Other Direct Costs							
Professional Liability Insurance	$157,909	$270,720	$131,417	$135,360	$139,421	$834,827	$834,827
Loan Forgiveness	$200,000	$200,000	$200,000	$200,000	$200,000	$1,000,000	$1,000,000
FQHCs - Rental and Staff Use/UCC Grant	$218,500	$391,400	$403,142	$415,236	$427,693	$1,855,972	$1,855,972
Social Determinants of Health	$201,250	$360,500	$371,315	$382,454	$393,928	$1,709,448	$1,709,448
Other Supporting Expenses i.e. E consult	$230,000	$180,000	$185,400	$190,962	$196,691	$983,053	$983,053
Total Other Direct Costs	$1,007,659	$1,402,620	$1,291,274	$1,324,013	$1,357,733	$6,383,299	$6,383,299
Uncompensated Care							
Hospital procedures	$860,541	$1,969,682	$2,028,772	$2,089,636	$2,152,325	$9,100,955	$9,100,955
Ancillary services	$109,031	$254,925	$262,573	$270,450	$278,563	$1,175,542	$1,175,542
Total Uncompensated Care	$969,572	$2,224,607	$2,291,345	$2,360,085	$2,430,888	$10,276,497	$10,276,497
Total Costs	$4,387,044	$7,537,622	$7,610,326	$7,832,636	$8,061,615	$35,429,243	$35,429,243
Capital Funding	$845,900	$0	$0	$0	$0	$845,900	
TOTAL BUDGET REQUEST	**$5,232,944**	**$7,537,622**	**$7,610,326**	**$7,832,636**	**$8,061,615**	**$36,275,143**	$36,275,143

Swedish Hospital
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Year 3 Aggregate Expenses

HEALTHCARE TRANSFORMATION PROPOSAL BUDGETS
Collaboration name: CHICAGO NORTH SIDE COLLABORATIVE
Preparer Name/Title: Tom Garvey Senior Vice President & CFO
Phone: 773.293.1123

LINE ITEM BUDGET
Project Period: 2022 to 2026 (Five Years)
E-mail: tgarvey@schosp.org

12.00%
30.00%

						Inflation	1.03	1.03	1.03	1.03
Temporary Staff related to implementation or initial cost of permanent employees						**Year 1**	Year 2	Year 3	Year 4	Year 5
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE YR1/YR2+**	**Months of employment YR 1/YR2+**	**Total**				
Dermotologist	Specialty Physician	$500,000	$60,000	.5 /1.0	6mos/12mos					
Endocrinologist	Specialty Physician	$350,000	$42,000	.5 /1.0	6mos/12mos					
Gastroenterologist	Specialty Physician	$625,000	$75,000	.63 / 1.0	6mos/12mos					
Orthopod	Specialty Physician	$550,000	$66,000	.63 / 1.0	7.5mos/12mos					
Cardiologist	Specialty Physician	$500,000	$60,000	.63 / 1.0	7.5mos/12mos					
TOTAL	Specialty Physician	$2,525,000	$303,000	2.89 / 5.0		$1,648,500	$2,912,840	$3,000,225	$3,090,232	$3,182,939
	Medical Assistant	$50,000	$15,000	2.88 / 5.0	7.5mos/12mos	$ 203,125	$334,750	$344,793	$355,136	$365,790
	Registrar	$35,000	$10,500	2.88 / 5.0	7.5mos/12mos	$ 142,188	$234,325	$241,355	$248,595	$256,053
	Manager	$80,000	$24,000	1.00	12mos/12mos	$ 104,000	$107,120	$110,334	$113,644	$117,053
	Data Analyst	$60,000	$18,000	1.00	12mos/12mos	$ 78,000	$80,340	$82,750	$85,233	$87,790
	Clinical Coordinatorn /Case Manager	$180,000	$54,000	2.00	12mos/12mos	$ 234,000	$241,020	$248,251	$255,698	$263,369
				12.65 / 19.0						
				Total Salary and Benefits		$ 2,409,813	$3,910,395	$4,027,707	$4,148,538	$ 4,272,994

						0.575 Prorated Budget	1.03	1.03	1.03	1.03
B. Other Direct Costs					**Year 1 @ full year**	**Year 1**	Year 2	Year 3	Year 4	Year 5
Item	**Description/Justification**				**Total**	**Total**				
eConsult	Information technology used in referral process				$ 230,000	$ 230,000	$180,000	$ 185,400	$ 190,962	$ 196,691
Social Determinants:					$ -	$ -				
MedEx Transport	Transportation for program patients				$ 90,000	$ 51,750	$ 92,700	$ 95,481	$ 98,345	$ 101,296
LSSI	Wrap around Services - Homeless				$ 120,000	$ 69,000	$ 123,600	$ 127,308	$ 131,127	$ 135,061
Contract Employee	Advocate - Violence Prevention				$ 60,000	$ 34,500	$ 61,800	$ 63,654	$ 65,564	$ 67,531
Contract Employee	Nutritionist - Food Connections				$ 80,000	$ 46,000	$ 82,400	$ 84,872	$ 87,418	$ 90,041
Total Social Determinants					$ 350,000	$ 201,250	$ 360,500	$ 371,315	$ 382,454	$ 393,928
Professional Liability Insurance	For medical malpractice per physician				$ 262,835	$ 157,909	$ 270,720	$131,417	$135,360	$139,421
Loan Forgiveness					$200,000	$200,000	$200,000	$200,000	$200,000	$200,000
FQHC Support for incurred cost	Rents and support staff at sites				$380,000	$218,500	$391,400	$403,142	$415,236	$427,693
	Total Other Direct Costs				$ 1,422,835	$ 1,007,659	$1,402,620	$1,291,274	$1,324,013	$ 1,357,733

C. Consultants					**Year 1**
Name	**Organization**	**Activity**		**Fees/Travel Expenses**	**Total**
NONE					$ -
					$ -
					$ -
					$ -
				Total Consultants	$ -

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

REQUEST	#REF!

F. Revenue		
Source	**Activity Funded**	**Amount**
Transformation Funds	SEE DETAIL BUDGET YEARS	
Collaborators' Funds	SEE DETAIL BUDGET YEARS	
State Capital Funds	SEE DETAIL BUDGET YEARS	
Philanthropy	SEE DETAIL BUDGET YEARS	
Other		
Total Revenue		

Swedish Hospital
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Sustainability

HEALTHCARE TRANSFORMATION PROPOSAL SUSTAINABILITY PROJECTIONS
Collaboration name: CHICAGO NORTH SIDE COLLABORATIVE
Preparer Name/Title: Tom Garvey Senior Vice President & CFO
Phone: 773.293.1123

	Cumulative 5 YR BUDGET 2022-2026	Sustainability Projections 2027 Year 6	2028 Year 7
SOURCES OF FUNDS			
COLLABORATOR'S FUNDS			
Physician Revenues	$6,840,621	$1,640,609	$1,673,421
I/P Directed Payments (Medicaid Fixed to Directed)	$2,932,913	$1,005,412	$1,005,412
O/P Directed Payments (Medicaid Fixed to Directed)	$1,593,249	$559,684	$559,684
Uncompensated Care (Medicare)	$1,673,284	$312,120	$318,362
FQHC PPS Rates for Specialty Services	$1,673,284	$580,219	$591,823
Physician Directed Payment Program	$0	$2,625,000	$2,700,000
Managed Care Shared Savings	$1,375,784	$566,499	$647,427
TOTAL COLLABORATOR'S FUNDS	$15,441,851	$7,289,543	$7,496,130
STATE CAPITAL FUNDS	$845,900	$0	$0
PHILANTHROPY; Swedish Hospital Foundation	$3,000,000	$800,000	$800,000
TRANSFORMATION FUNDS	$16,987,393	$0	$0
TOTAL FUNDING	**$36,275,143**	**$8,089,543**	**$8,296,130**
BUDGET REQUEST			
Salaries	$16,148,374	$3,790,826	$3,904,551
Fringe Benefits	$2,621,073	$610,358	$628,669
Total Salary and Fringe Benefits	$18,769,447	$4,401,184	$4,533,220
Other Direct Costs			
Professional Liability Insurance	$834,827	$143,603	$147,912
Loan Forgiveness	$1,000,000	$0	$0
FQHCs - Rental and Staff Use/UCC Grant	$1,855,972	$440,524	$453,740
Social Determinants of Health	$1,709,448	$405,746	$417,918
Other Supporting Expenses i.e. E consult	$983,053	$202,592	$208,669
Total Other Direct Costs	$6,383,299	$1,192,465	$1,228,239
Uncompensated Care			
Hospital procedures	$9,100,955	$2,216,894	$2,283,401
Ancillary services	$1,175,542	$286,920	$295,528
Total Uncompensated Care	$10,276,497	$2,503,815	$2,578,929
Total Costs	$35,429,243	$8,097,464	$8,340,388
Capital Funding	$845,900	$0	$0
TOTAL BUDGET REQUEST	**$36,275,143**	**$8,097,464**	**$8,340,388**
Excess/Deficit		-$7,921	-$44,257

Swedish Hospital
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Capital

HEALTHCARE TRANSFORMATION PROPOSAL BUDGETS

CAPITAL BUDGET

Project Period: 2022 to 2026 (Five Years)

Collaboration name: CHICAGO NORTH SIDE COLLABORATIVE
Preparer Name/Title: Tom Garvey Senior Vice President & CFO
Phone: 773.293.1123 E-mail: tgarvey@schosp.org

Gastroenterology

Equipment Name	Unit Price
PillCam (capsule endoscopy)	$30,000
Hydrogenius Breath Test	$22,000
Manometry	$77,000
Bravo pH Monitoring	$25,000
CRH O'Regan System	$15,000
Sub-Total	**$169,000**
Dermatology	
Dermascope	$2,000
Hyfrecator	$1,100
Surgical Instruments	$10,000
Liquid Nitrogen Cost (per year)	$3,000
Body Mapping Camera	$15,000
Mayo Tray	$400
Procedure Light (ceiling mounted)	$7,000
Sub-Total	**$38,500**
Endocrinology	
Ha1c Unit	$7,000
Glucometer	$1,200
Bariatric Scale	$2,000
UA Machine	$1,200
Sub-Total	**$11,400**
Cardiology	
EKG Machine	$15,000
Portable Echocardiogram Unit	$12,000
PT/INR	$2,500
Ultrasound Machine	$45,000
Pacemaker Machine	$50,000
AED Kit	$2,500
Sub-Total	**$127,000**
FQHC'S	
Asian Family, conversion of offices to Specialty Medical Su	$250,000
Heartland Health; Albany Park; Leasehold Build-out	$250,000
Sub-Total	**$500,000**
CAPITAL BUDGET Grand Total	**$845,900**

Swedish Hospital
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Financial Metrics Milestones

	Total	Milestone Year 1 12.50%	Milestone Year 2	Milestone Year 3	Milestone Year 4	Milestone Year 5			
1) Incremental to agreed upon Base Year for Collaboration identified Patients									
Visits									
Primary Care Visits; All Specialities	14374	1800	14400	14400	14400	14400			
							APR-DRG/EAPG Defined		
Procedural Visits (Hospital Based)	1160	See Below	See Below	See Below	See Below	See Below	Incremental Hospital Procedures		
Total	15534								
Procedure Metrics									
Gastroenterology									
Medicaid Inpatient	20	4	20	20	20	20	APR-DRG	283	
Self-Pay Inpatient	20	5	20	20	20	20	APR-DRG	283	
Medicaid Outpatient	300	40	300	300	300	300	EAPGS	62-62	130-137 +149
Self-pay Outpatient	300	40	300	300	300	300	EAPGS	62-62	130-137 +149
Orthopedics									
Medicaid Inpatient	110	16	110	110	110	110	APR-DRG	301-349	
Self-Pay Inpatient	110	16	110	110	110	110	APR-DRG	301-349	
Medicaid Outpatient	75	11	75	75	75	75	EAPGS	30-49	
Self-pay Outpatient	75	11	75	75	75	75	EAPGS	30-49	
Cardiology									
Medicaid Inpatient	25	5	25	25	25	25	APR-DRG	174-175	191-192
Self-Pay Inpatient	50	8	50	50	50	50	APR-DRG	174-175	191-192
Medicaid Outpatient	25	5	25	25	25	25	EAPGS	83-89	
Self-pay Outpatient	50	8	50	50	50	50	EAPGS	83-89	
2) Financial Statements versus Budget		Annual	Annual	Annual	Annual	Annual			

Swedish Hospital
Part of NorthShore

Budget Summary

This budget represents a collaboration of five FQHCs and Swedish Hospital to improve access to care to vulnerable populations in the hospital and FQHCs local communities. The budget is for a Five Year period and reflects the following:

- Access to specialty care and other services in a more efficient coordinated manner than provided in the current system.
- Improved care coordination designed to lower wait times and improve communication between primary care, specialty care and hospital providers.
- Access to the programs at Swedish Hospital that address the social determinants of health. These programs are currently in place at the hospital and will be enhanced through this project to increase capacity in meeting the needs of the patients in this program.

In order to accomplish the goals and objectives of the program, a transformation payment of $16,987,393 to be made over the Five Year Budget period will be required from HFS to support the revenue shortfall to the expenses of this program as defined in the following paragraphs. Swedish Hospital Foundation will participate in the funding for this project by providing increasing annual philanthropic funding per annum starting at $400,000 in the first year and growing to $800,000 in the fifth year (totaling $3,000,000) to support the expenditures needed to implement and sustain the program.

The detail revenues and expenses of the program are defined in the following paragraphs. A projected financial statement is included herein as well. The financial sustainability of this project is discussed further in the sustainability section of this application.

Revenues

Physician Revenues

Physician revenues represent the billings for specialty services rendered to patients in the FQHC site or the hospital physician office/hospital sites. These revenues will be billed by the hospital's medical group and were based on current per visit billing rates and fee schedules adjusted for the expected payor mix for this new program. Visits are estimated for each specialty physician based on current volume levels for current employed physicians in each specialty. The payor mix for this program is estimated to be 70% Medicaid and 30% uninsured. Since this is significantly different than the existing payor mix, the fee per visit was lowered as the Medicaid fee schedule is lower than the other payors and for uninsured patients the fee per visit is assumed to be minimal. These fees were increased by 2% per year to reflect annual increases made by payors through rate adjustments

Directed Payments

Swedish Hospital currently receives Directed Payments for services rendered to Medicaid patients, both inpatient and outpatient. These payments are related to the Medicaid Hospital Assessment that is currently in effect in Illinois. These payments are made from Fixed

Payment Pools (Safety-Net) that pay a separate inpatient and outpatient amount based on services rendered quarterly. Any increases in services provided to patients will result in an increase in payment during the quarter the service was rendered. Additional services were estimated based upon the expected increase in patients, both Medicaid and underinsured resulting from this program. Additional hospital services related to this program will be paid from these pools and is therefore include in revenue. Revenues are estimated based upon the formulas used in the rules governing Directed Payment Pools. The amount of these payments is increased each year to reflect the annual transition from Fixed Payments to Directed Payments (approximately 15% annually). The 1st budget year reflects six months of activity as revenues from Directed Payments are based upon reported data which lags for six months.

Medicare Uncompensated Care

The Medicare program pays hospitals for uncompensated care to those hospitals that are considered Disproportionate Share Hospitals. Swedish Hospital qualifies as a Disproportionate Share Hospital for the Medicare program and receives the uncompensated care payments on an annual basis. Uncompensated care for hospital services will be increasing under this proposal as additional Medicaid and additional uninsured patients will be provided services at the hospital. These services will be for preventative services and other difficult to access services for these patient populations. Revenue is included in these financial projections based on the expected increases in uncompensated care. The increases in uncompensated care were estimated based on the new procedures to be provided to uninsured patients in connection with this program. The increased revenues are based on the formulas used in the Medicare regulations to reimburse hospitals for uncompensated care. These revenues will not begin until year 2 of the program as the reporting of this data lags for a year.

Managed Care Savings

This program will be providing preventative services and access to other services that Medicaid beneficiaries normally have a difficult time accessing. As a result, the health of the population should improve and the spending for Medicaid patients should decline. The homeless program at Swedish Hospital is an example of how addressing the social determinants of health can lower health expenditures and improve outcomes. The patients in this program have drastically reduced visits to the Emergency Room and the use of other health services. This program will produce similar results when implemented.

Therefore, budgeted revenues from the savings related to this program were estimated and included (approximately $1.4M for the first five years). The revenues would be realized through shared savings program with the Managed Care Companies who also would inure a similar benefit of $1.4M) Swedish Hospital has shared savings program with a number of commercial and Medicaid managed care payors for both physician services and hospital services. The shared savings programs will be added to the Medicaid managed care contracts in order to capture the savings from this program.

The savings from this program were based upon the occurrence of Ambulatory Sensitive Conditions at the hospital. Through improved access to preventative and other hard to access services, these ambulatory sensitive conditions should decline at the hospital and be treated in

an ambulatory setting which will generate savings to the Medicaid Managed Care companies. These savings can then be documented and shared with the hospital through a shared savings program. These revenues will not start until year 2 of the program as it will take time for these savings to be realized and for the shared savings program to be established.

FQHC Rate Differential

This program contemplates that several years into the program; the participating FQHCs involved will change their scope of service in order to allow specialty care to be delivered at the FCHC site under the FQHC license. The FQHC site will then contract with the hospital to provide the specialty services. Once the scope of service is changed, the FQHC will begin to bill for the service rather than the hospital physician group to bill for the service. Since the rates at the FQHC are higher than the physician fee schedule, a revenue differential will be created which is included as revenue in this projection.

This additional revenue will reimburse the FQHC for the specialty doctor as well as provide payment for the overhead required at the site to support the services of the specialty doctor. This revenue will not be included until year 3 of the projection as it will take time for the steps to be taken by the FQHC sites to changes the scope of service.

The scope of service change will need to be approved by Health Resources and Services Administration (HRSA) and correspondingly by Health and Family Services. Allowing the established Illinois Prospective Payment Rate to be applied along with the estimated corollary benefit of professional liability coverage under Federal Tort Claims Act Coverage provides nearly $1,700,000 in additional budgeted net revenue and savings of $400,000 in medical malpractice insurance expense for the five-year project period.

Expenses

Salaries and Wages are included as follows:

- 5 Specialist Physicians
- 5 Medical Assistants
- 5 Registration Coordinators
- 1 Program Manager
- 1 Health Data Analyst
- 1 Clinical Case Manager
- 1 SDOH Program Manager

The clinical staff will provide the services to the patients as previously described. The program manager will oversee the operation of the project including interfacing with each of the collaborating FQHCs. Several of the specialty physicians will need to be recruited and will not begin on the first day of the project. It is estimated that it will take six months to recruit several of the physicians. Therefore, the existing specialists in Swedish Medical Group will provide the coverage until the new specialists can be hired. The health data analyst will provide reporting and analysis of the program as well as provide reporting to each of the collaborating FQHCs. This analyst will also provide the reporting that will be required by HFS.

The clinical case manager will ensure care coordination for clinical services between the primary care, specialty care and hospital care required for patients in the program. Within Other Direct Costs are budgeted dollars to install the eConsult program offered by Medical Home Network. This is a proven technology that improves the referral process for specialty physicians

Also included is an SDOH program case manager who will link the patients in this program to the other programs at the hospital that are focused on the social determinants of health. The following programs exist at the hospital now and this additional coordinator will ensure access to these programs:

- Food Connections – This program is designed to address food insecurity in the local community and was launched in 2020. This program includes a full time coordinator working on understanding the effect of food security on the health of our patients.
- Housing Connections - This is a program designed with the City of Chicago's Better Health and Lutheran Social Service of Illinois to address the homeless issue in regard to use of the Emergency Room. The program targets housing for individuals that frequently visit the Emergency Department and Swedish Hospital in order to improve their health and lower their use of the Emergency Room. There are currently 16 chronically homeless patients in the program that are now housed and receive intensive case management and managed health services.
- Pathways - The Pathways program strengthens the clinical staff's ability to identify and respond to patients impacted by domestic violence, human trafficking and sexual assault. This program was established in 2014 and in the most recent year assisted 391 patients in responding to health issues related to domestic violence.
- Transportation – Transportation is currently available through MedEx ambulance service provided to patients free of charge.

Additional contributions will be provided to each of the programs designed to address the social determinants of health in order to provide opportunities for the patients of this program. The investments made in each of the programs and are reflected in the projection as Social Determinants of Health and summarized as follows:

Food Connection – Addition of a nutrition coordinator and monies toward food procurement. Total addition of $80,000.

Housing Connections – Housing and wrap around services for 10 homeless persons. Total cost of $120,000.

Pathways – Addition of an additional advocate employee to expand access to this program as well as other off-campus sites. Total addition of $60,000.

- Transportation – Addition another vehicle for transportation of the patients from this program and other off-site locations. Additional budget dollars were added to support approximately 2,400 additional scheduled trips for collaborative patients. Total cost of $90,000

Fringe benefits are reflected as a percentage of salaries (12% for the physicians and 30% for non-physician).

Professional Liability insurance is for the 5 specialty physicians and is based on the fee schedule for the NorthShore captive insurance company that provides insurance coverage to Swedish hospital physicians but reflects the denoted FTCA supplemental coverage for the physician work performed under the FQHCs scope of service

An expense for the rental of space and staff at the FQHC sites is included to reimburse the FQHCs for the time spent by the specialist physician and other support staff at each FQHC sites. Two FQHCs requested capital dollars to convert existing administrative space to allow for the usage of this space by the specialists in the program (see capital budget included in Attachment G)

In order to recruit specialist physicians to this program, an incentive will need to be offered to attract quality physicians to this inner-city program. Swedish Hospital has used loan forgiveness programs in the past to successfully recruit high quality specialty physicians to a safety net provider location. Therefore, a loan forgiveness program will be used to recruit these specialty physicians. The projection includes $200,000 for each of the 5 physicians to be forgiven over the 5-year budget period ($200,000 per year for 5 years).

Uncompensated Care

The program as described contemplates an increase in the number of uninsured patients provided services at the hospital that were previously not easily accessed. These procedures were being delayed or provided by the public hospital system after long waits. An estimate was made of the additional direct cost of these procedures resulting from the increased access to specialty care and other services. The hospital's direct cost was further discounted by 25% as an in-kind contribution (approximately $3,000,000 over the 5-year budget period).

These estimates were based upon the expected number of procedures and correlated ancillary services for each of the specialty services such as hip replacements, knee replacements, cardiac catheterizations, etc. The cost of each of these procedures was estimated based upon the historical direct cost per procedure or corollary ancillary services for these procedures at the hospital.

The physician cost for the denoted specialties are included in salaries above however all supporting physician costs such as emergency medicine, anesthesiologists, and radiologists are not considered and therefore are an in-kind contribution to the program.

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Milestones

Project Inception

On initial start date, the following specialties will be available in limited capacity

- Orthopedics
- Cardiology
- Gastroenterology

Increased capacity will be the result of additional recruitment or use of additional specialists from Swedish parent facility NorthShore University HealthSystem.

Six Months Post Inception

In order to meet the expected demand for services, several physicians will need to be recruited by Swedish Hospital and then oriented for this program. The assumption is that the following specialties will be available 6 months post initial start date:

- Dermatology
- Endocrinology

Ongoing

Other specialty physicians will be added to this program as the demand for services increase and or additional specialty services are needed. Increases in services will require changes to the funding formula so will not be undertaken without the appropriate approval from HFS.

Financial Milestones

Financial milestones included on Page 37

Quality Milestones

Clinical performance metrics milestones are included in the Quality section of this application.

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Racial Equity

The Chicago North Side Collaborative participating providers reside in a racially and ethnically diverse community. The participating FQHCs on average service 47% of their patients as racial minorities (non-white). Swedish Hospital's patient base is current almost 60% minority (non-white).

This project is targeted to populations that currently do not have access to specialty services which are typically Medicaid patients and the uninsured. In the uninsured population in Illinois, the rate of uninsured Hispanic/Latino is 21%, followed by black or African Americans at 12% and Asian American at 10%. Therefore increased services to uninsured patients would be provided primarily to minority patients. The same trend holds true for the Medicaid population in Illinois where Hispanic/Latino is 23%, Black or African American is 29% and other populations are 10%. Once again, the majority of the increased services in this program for Medicaid enrollees will be to minority patients.

The proposal will increase specialty screenings that will help identify potential diseases in early stages of the conditions to allow earlier interventions to achieve successful management of chronic conditions for minority patients.

Included in assessing progress on improving quality outcomes will be to monitor performance by racial and ethnic groups. Appropriate adjustments will be made in care coordination and outreach services as dictated by the monitoring to ensure all groups are equitably benefiting from the program.

Offering this services to Medicaid and uninsured patients in the provider's service area will improve racial equity as now services will be available to populations that previously had a difficult time accessing these services.

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Minority Participation

As a safety-net hospital servicing a very culturally and racially-diverse patient population, Swedish Hospital is committed to working collaboratively with our proposed partner organizations, all of whom are majorly controlled or managed by minority groups.

For example, the private ambulance service, MedEx, who will provide patient transportation from the FQHCs to Swedish Hospital to receive medical specialty care, who will volunteer their services to transport our patients to and from the hospital, is a women-owned, a State of Illinois certified BEP Ambulance Service. State of Illinois BEP and City of Chicago WBE certifications are included in Attachment I.

Swedish Hospital is fortunate to have 5 collaborating FQHCs through whom Swedish providers with extend specialty care to Medicaid and uninsured individuals they serve. Administrators, frontline staff and board members of the participating FQHCs reflect the cultures, race, and ethnic makeup and speak the many languages of the people they serve.

Erie Family Health Centers (Erie) is a 501c3 community health center. Erie is a healthcare home to over 80,000 patients who are served at 13 locations in medically underserved areas across the city of Chicago. Erie provides reproductive health, prenatal care, behavioral and oral health, vaccinations, and chronic disease management. Like Swedish and all our participating FQHCs Erie turn no patient because of inability to pay.

Over 90% of Erie patients are low-income; 87% of patients are Medicaid recipients or uninsured. Over 70% of patients are Latino and we also serve a wide variety of other ethnic and immigrant communities. Patients of Erie speak more than 70 different languages each year. Erie employs providers and staff who speak Spanish and other languages, allowing them to provide responsive care. Erie serves over 23,000 patients in the Swedish Hospital catchment area. Eighty seven percent (87%) are either enrolled in Medicaid or uninsured.

Howard Brown Health exists to eliminate the disparities in healthcare experienced by lesbian, gay, bisexual and transgender people through research, education and the provision of services that promote health and wellness.

Howard Brown was founded in 1974 and is now one of the nation’s largest lesbian, gay, bisexual, transgender, and queer (LGBTQ) organizations serving more than 40,000 adults and youth in its diverse health and social service delivery system focused around seven major programmatic divisions: primary medical care, behavioral health, research, HIV/STI prevention, youth services, elder services, and community initiatives. Howard Brown serves men, women, trans and gender non-conforming folks, infants, youth, and children.

Heartland Health Centers mission is to improve the well-being of the communities they serve by providing accessible, high quality healthcare. Heartland strives to be a national leader in community-based health care by advancing innovative service models and patient-centered best practices. Heartland Health Centers is a federally qualified health center.

In 2020, Heartland provided 27,000 patients with a medical home offering affordable and comprehensive primary care, oral health care, and mental health care services. As a medical

home, HHC ensures comprehensive, affordable, quality, safe, and coordinated health care that is culturally competent and orientated to addressing all the health care needs of each patient.

Heartland is open to the entire community—the uninsured as well as those who have Medicaid, Medicare, or private insurance. They offer medication discounts and free interpretation services in over 35 languages.

Asian Human Services Family Health Center (AHSFHC) was incorporated in 2001 as an independent not for profit 501 (c) 3 to increase access to primary care for underserved communities on Chicago's north side. AHSFHC offers primary medical, dental, and behavioral health services to patients spanning the life cycles. The two AHSFHC Chicago sites are located in the community, minorities are the majority.

In 2020, the three most prevalent conditions among the patient population were Diabetes, hypertension, and obesity; 80% of patients are below 200% of the FPL, while 68% are below 100% of the FPL; and 48% are on Medicaid and 33% are uninsured.

Hamdard Healthcare, a social service not-for-profit organization, was established in 1992 a proactive response to address the critical needs of its target communities. Hamdard's mission is to "promote physical and emotional well-being of individuals and families by offering hope, help, and healing." By providing culturally-tailored and multilingual services ranging from transitional housing, domestic violence, and foster care to a depression clinic for South Asian, Middle Eastern and Bosnian communities Hamdard has established deep roots within the communities. Hamdard services are open to all individuals irrespective of ethnicity, race, religion, gender, age, income or sexual orientation. Hamdard's overall goals are to improve the health of the community, strengthen families, prevent violence and promote self-sufficiency.

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Jobs

The proposed collaboration both strengthens existing community based jobs as well as creates additional jobs as a result of the expansion of services to our community.

Swedish Hospital proposes a care model that expands access to Swedish Hospital specialists and sub-specialists by both bringing providers to our partner FQHCs. Swedish Hospital will time-share space and support staff from the FQHCs. The model will not only result in the creation of additional Swedish Hospital jobs, but provides additional financial support to each of the five FQHCs that provide jobs for the community.

In order to increase access to specialty care, Swedish Hospital will hire additional medical specialists, as well as support staff, including medical assistants, patient registrars, and case managers. For each specialist recruited and added to employment, Swedish anticipates 1-3 additional support positions to be added. For each of these positions, Swedish will prioritize candidate recruitment and sourcing from our local community, as has been consistent with the hospital past employment patterns. The table below identifies the Swedish Hospital employees by zip code. It is evident the majority of employees that work at Swedish live in Chicago and the surrounding community. Recent data indicates that over 68% of Swedish Hospital employees reside in the City of Chicago.

Swedish Hospital Employees by Zip Code

Zip Code	Count	% Count
60625	339	13.4%
60618	142	5.6%
60630	119	4.7%
60659	109	4.3%
60645	96	3.8%
60640	94	3.7%
60641	82	3.2%
60076	81	3.2%
60634	81	3.2%
60646	66	2.6%
60660	65	2.6%
60077	51	2.0%
60647	50	2.0%
60714	49	1.9%
60657	48	1.9%

Zip Code	Count	% Count
60053	44	1.7%
60016	42	1.7%
60613	40	1.6%
60639	36	1.4%
60656	34	1.3%
60626	32	1.3%
60707	31	1.2%
60025	29	1.1%
60614	29	1.1%
60622	27	1.1%
60712	27	1.1%
60202	24	0.9%
60631	22	0.9%
60651	20	0.8%
60706	20	0.8%
Other	605	23.9%
Total	**2,534**	**100%**

Swedish Hospital is proud of the diversity of the workforce and the employees represent the community in which the hospital is located. In the table below, please see the employee demographics below by gender and ethnicity.

Employees by Sex and Ethnicity

Race/Ethnicity	Male	Female	Count
White	265	778	1043
Asian	200	438	638
Hispanic	117	396	513
Black	51	176	227
2 Or More	17	36	53
Not specific	15	34	49
Pacific Islander	7	9	16

Race/Ethnicity	Male	Female	Count
American Indian	1	4	5
Total	**1,871**	**673**	**2,544**

Swedish Hospital employees 2,534 individuals. These table below is a high level summary of the positions by broad category.

Jobs

Job Category	Count	% Count
Administration & Operations	829	33%
Nursing	630	25%
Allied Health	587	23%
Doctors & Physician	185	7%
Medical Imaging & Radiology	131	5%
Therapy	117	5%
Healthcare IT	34	1%
Laboratory Science	21	1%
Total	**2,534**	**100%**

Swedish Hospital will hire 19 additional staff to increase community patient access to specialists. These positions were listed in the budget narrative Swedish anticipates hiring several physicians, nurses, medical assistants, and administrative staff to support the additional volume. The forecasted positions are included in the proposed budget.

It is important to note that Swedish Hospital values and supports ongoing career development and training. While employees may start their career with Swedish as either a Medical Assistant or Administrative Support position, if they are interested, career development, educational support and on the job training opportunities are available within the organization. Career development and retention in Swedish is a core value.

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Sustainability

The premise of the project is that there is a need in the local community for improved access to specialty care as well as the need for increased capacity for specialty care services. The lack of care is causing health disparities in the local population that is exacerbated by additional social issues such as lack of transportation, food insecurity, unemployment and violence in the community ("social determinants of health"). Provision of this needed care will result in the improvement of health outcomes in the local community as well as lower health disparities in the vulnerable populations.

Undertaking a project of this magnitude that has not been addressed in the past requires a significant commitment of resources. The project will increase specialty care to meet an unmet need in the local community to improve health outcomes and make the population healthier though increased health services as well as increased capacity for the social determinants of health in the community that will also improve health outcomes.

The issue that has been developing over the past several decades is the lack of specialty care in the vulnerable communities leading to health disparities in those communities. As demonstrated in the data section of the application, the availably of specialists in the socially vulnerable communities is lower than the average in Cook County. Specialists will not practice in these areas as the Medicaid fee schedule has been low historically and the uninsured population has been higher leading to lower revenues for the specialists which creates a significant void between the reimbursement for physician services and the salaries being paid specialty physicians. The quality physicians are recruited to the wealthier communities where the fees are higher and the uninsured populations are lower.

The hospital and its partnering FQHCs have come together through this collaboration, along with other community partners such as Lutheran Social Services of Illinois, (LSSI), Apna Ghar, and our Business Enterprise Program (BEP) certified partner MedEx, to invest in this project to achieve the goals of improved health outcomes and to reach sustainability by year 5 of the program.

The largest resource commitments are the hiring of the specialty physicians and other clinicians as well as increasing the existing capacity of the programs that are currently addressing the Social Determinants of Health. The amounts invested over the five-year period are as follows:

- Salaries and Benefits – Clinicians and Support Staff: $18.8 Million
- Social Determinants of Health – New Allocation:$1.7Million
- Social Determinant of Health – Existing Ongoing Allocation:$3.2 Million

The SDOH investment will increase by approximately 50% over the existing allocation to SDOH upon completion of this program. The existing SDOH program is funded primarily by outside grants as well as grants from the hospital's foundation and hospital operating funds.

In order to reach sustainability for this project, the following actions have incorporated to augment physician reimbursement revenues over the five-year budget period:

- Investment of $3.0 million from the Swedish Hospital Foundation
- Create managed care savings that will accrue to the benefit of the Managed Care Organizations and through alternative payment methods such as shared savings arrangements will create a flow of funds to support this project in the amount of $ 1.4 million.
- Support the FQHCs in including their delivery of Specialty Care under their scope of services thereby creating $1.7 million in revenue from the HRSA program
- Taking advantage of the federal revenues available in the Medicare program for uncompensated care in the amount of $1.0 million.
- Taking advantage of the existing directed payments pools for safety net hospitals to increase Medicaid revenues by $4.5 million.
- Despite recent increases in Illinois Medicaid physician rates, reimbursement of physician services is woefully inadequate. The Centers for Medicare and Medicaid (CMS) explicitly allows Medicaid agencies to establish directed payment programs that target classes of providers. In this case, creating a directed payment program which utilizes capacity within the physician Upper Payment Limit to enhance specialty physician rates and/or Federally Qualified Health Center Rates will help enhance access to specialty care. This Directed Payment need for the years beyond the Five-Year Budget Period is approximately $2,700,000 per year. A Sustainability projection for Years 6 and 7 is provided in the Budget Summary. In summary over the five-year budget period the losses in the delivery of specialty care approximated $5.3M ($4.3M plus proposed revenue add-ons) in Year 2 versus $2.9M in Year 5. This annual decline of $2.4M reflects the multiple revenue enhancements discussed above and philanthropic contributions of the Swedish hospital foundation. However, to address the remaining annual deficit, an innovative payment program which could use a Directed Payment attached to physician services provided under a transformation collaborative would allow continued sustainability of the program.

Achieving the results over the five-year period and incorporating innovative payment methodologies will lead to project sustainability by year 6 of the project while providing jobs to the community as well as improving the health outcomes of the socially vulnerable populations. The program also contemplates a significant investment in the social determinants of health to lower the social vulnerability in the community.

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Governance

This collaboration as proposed will be an affiliation of providers to provide specialty services to the surrounding community to meet the needs of the population as access to certain specialty care is limited in the area. The program will be governed by an affiliation agreement executed by each of the parties involved in the project. The affiliation agreement will outline the duties of the parties in providing and coordinating care to the patients.

In order to monitor the day to day operation of the project, a Steering Committee will be established to manage the day to day activities. Each of the participating entities will be able to appoint a member of the steering committee and each member will have an equal vote on matters brought to the committee. A charter will be developed to guide the steering committee. The major responsibilities of the committee will be as follows:

- Review the financial performance of the project noting adherence to initial budget and projections and explaining variances.
- Determine the model of care to be provided by the specialty physicians hired to provide the needed services to the community.
- Set policy governing scheduling, record completion, billing, coding and other operational functions.
- Allocate resources to each of the participating entities in an efficient manner to ensure adequate deployment of resources across the providers.
- Set and monitor financial and operating goals.
- Review reports from the Quality Oversight Committee to ensure on track to meet clinical performance metrics

This project will not require the creation of a new legal entity. The revenues and expenses related to the project will accrue to the existing corporations of each of the providers. This will help to ensure ease of start-up form an administrative perspective as well as avoid the administrative cost involved in establishing a new organization.

The funds related to the project will flow through the existing corporations of the participating entities. The budget submitted in connection with this proposal will provide the guide for the flow of revenues to each of the participants. This budget will be used to ensure the actual flows will be directed to the appropriate organizations as stipulated in the budget.

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[i] https://health.usnews.com/health-care/best-hospitals/articles/colon-cancer-disparities-in-america From Diagnosis to Treatment: The Compounding Effect of Colon Cancer Disparities in America
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