Executive Summary

Project Title

Integrated Hub (iHub): A Home for Integrated Care for Adults (InCA)

Project Description

Egyptian Health Department (EHD) and its collaborators are seeking to implement an integrated delivery and payment model - Integrated Care for Adults (InCA) - that aims to reduce expenditures and increase quality of care for adult Medicaid beneficiaries with Behavioral Health (BH), Substance Use Disorder (SUD), and physical health needs in our five-county service area in Southeastern Illinois.

InCA is based on the evidence-based Integrated Care for Kids (InCK) model, endorsed by the Centers for Medicare and Medicare Services (CMS) and supported by the Illinois Department of Healthcare and Family Services (HFS). As part of InCA, our collaborative plans to construct an Integrated Hub (iHub), which will house the staff and resources to deploy both mental health (MH) and social support services to individuals with BH and SUD conditions throughout our community service area. The iHub will be an innovative space that will provide shared office for the InCK and InCA teams, and education space to EHD providers and flexible space for our partners to focus efforts and activities on issues driving health disparities and addressing equity challenges in our community to ensure social determinants of health are addressed and appropriate care coordination support is deployed.

Under this initiative, EHD and its collaborators plan to target 18,000 adult Medicaid beneficiaries in our community service area over the five years of the project, culminating in the development of an Alternative Payment Model (APM) that will support sustainability for the initiative. The collaborative will also support meaningful data sharing and interconnectivity between our partners to support care management, care coordination, discharge planning, referrals, and community placement.

Participation of collaborators

EHD is fortunate to be supported by several committed, established collaborators. Our collaborators have deep history and experience supporting each other. Our collaborators include the comprehensive needs of our target population.

Key Collaborators

Name	Type
Egyptian Health Department	Lead; Behavioral Health and SUD Provider
Southern Illinois HealthCare	Health system with local rural health clinic and SUD Provider
Ferrell Hospital	Critical Access Hospital
Harrisburg Medical Center	Hospital
Christopher Rural Health Clinic	Federally Qualified Health Center (FQHC) and SUD Provider
Illinois Health Practice Alliance (IHPA)	Independent Practice Association
Gallatin County Wellness Center	Rural Health Clinic

Additional Collaborators

Name	Type
Ride Mass Transit	SDoH Provider
County Housing Authorities	SDoH Provider
Emmanuel United Methodist Church	SDoH Provider
Wabash Area Development Organization	SDoH Provider
WIC program	SDoH Provider
Friends of Jesus United Methodist Church	SDoH Provider
Hawks Lunch Bunch – Ohio Valley General Baptist Fellowship	SDoH Provider
Saint Joseph Catholic Church	SDoH Provider
Ten Mile Baptist Church	SDoH Provider
Turning Point Church	SDoH Provider
Wabash Area Development, INC	SDoH Provider
Carrier Mills/Stonefort Minsterial Alliance	SDoH Provider
Choisser Soup Kitchen	SDoH Provider
Christian Community Compassion Center	SDoH Provider
Dorrisville Baptist Church	SDoH Provider
Feed my Sheep Ministries Eldorado Methodist Church	SDoH Provider
First Baptist Church of Eldorado	SDoH Provider
First Baptist Church of Harrisburg – His Table	SDoH Provider
Freddie's Food Pantry – Southeastern Illinois College	SDoH Provider
Greater Galatia Food Pantry	SDoH Provider
Heaven's Kitchen – First Presbyterian Church	SDoH Provider
Little Chapel Church	SDoH Provider
Landmark House of Praise	SDoH Provider
First Baptist Church	SDoH Provider
Food for Thought	SDoH Provider
Hope Ministries of Geff	SDoH Provider
Jesus Name Pentecostal Church	SDoH Provider
Keenes Food Pantry	SDoH Provider
Long Prairie Missionary Baptist Church	SDoH Provider
Midwest Food Pantry	SDoH Provider

St. Edwards Catholic Church	SDoH Provider
Zion Church Food Pantry	SDoH Provider
Cherry Street Baptist Church	SDoH Provider
Enfield Christian Church	SDoH Provider
Hands of Compassion – God's Kitchen Soup Kitchen	SDoH Provider
Our Savior Lutheran Church	SDoH Provider
The Roads Church	SDoH Provider
Veteran's Administration Medical Center Food Pantry	SDoH Provider
Gallatin County Schools	School District
Hamilton County Schools	School District
Saline County Schools	School District
Wayne County Schools	School District
White County Schools	School District
TRADE Industries	Shelter Workshop/BEP
Coleman Tri-County Services	Shelter Workshop/BEP
The Multicultural Center at Southern Illinois University (SIU)	Educational Partner

Complimentary Proposals

EHD's proposal is complimentary and supportive of the proposal submitted by Illinois Critical Access Hospital Network (ICAHN) - The Bridge: A Rural Health Collaborative. We envision our proposals working synergistically to transform care delivery in Southeastern Illinois, working together to ensure our projects are leveraging lessons learned and not duplicating efforts. EHD will be serving in an advisory/consulting capacity for The Bridge, providing specific support around developing a Sustainable Payment Model and utilization of SDoH technology. Our collaboration and implementation of both proposals would accelerate transformation for our greater region.

Goals of the collaboration

The main goals of our collaboration include:

- Replicate the evidence-based InCK model for the Adult Medicaid Beneficiaries in our five-county service area.
- Invest in workforce by including wellness and prevention coaches, outreach and engagement community health workers, and community engagement specialists who will work across our collaborators to improve outcomes and coordination for Adult Medicaid Beneficiaries.
- Construct the iHub to house service integration coordinators, wellness coaches, community health workers, care coordinators and SDoH intervention staff to create a dedicated delivery system focused on closing care gaps, addressing health disparities, and connecting individuals to needed care.

- Improve quality metrics for the adult population, in alignment with Illinois' comprehensive quality strategy.
- Expand utilization of a shared Population Health Tool, HealthEC, and Social Determinant of Health Data Referral Tool, NowPow, to support data sharing and effective referrals amongst our collaborators.

Community service area

Our collaborative will serve Gallatin, Hamilton, Saline, Wayne and White counties in Southeastern Illinois.

Strategy

Our initiative will support the development of a coordinated care model that reduces health disparities, increases access to wellness services, decreases non-emergency hospital utilization, and reduces system costs for adults with mental, physical and substance abuse health needs in our five-county region.

To accomplish our shared goals, we will utilize the following strategy:

- Increase the utilization of social determinants of health screening tools.
- Develop and implement targeted care coordination supports for all adults with behavioral or physical health needs and ensure connection to services for those with higher risks.
- Increase coordination of high-risk discharges between levels of care.
- Improve data flow between systems.
- Increase bidirectional referrals between primary care providers and behavioral health providers.
- Develop and execute an education campaign regarding availability and importance of primary and behavioral health care services.
- Increase access and use of mental health and substance use disorder services.
- Increase access and use of tele-behavioral health services.
- Increase physical health and preventative/routine primary care service utilization.
- Increase access to transportation services.
- Develop a more robust referral channel for all types of substance use disorder counseling.

Expected timeframe for the project

Our expected timeframe for the project from implementation to sustainability is five years. At a high level, we anticipate the following categories for planning, implementation, and sustainability for our collaborative's proposed initiatives. A detailed project plan is included within our application.

- Year 1: Pre-Implementation and Capital Improvement Investments
- Year 2 & 3: Project Implementation and APM Development
- Year 4 & 5: Ongoing Project Implementation and Sustainability

Capital improvements

Included in our budget submission, is a proposed capital improvement investment to construct an iHub structure on the EHD campus. The iHub will provide dedicated space focused on SDoH interventions and care coordination goals. Staff housed at the iHub will support the InCA initiative by targeting

improvements for the Adult Medicaid population. EHD's care coordinators, wellness coaches, individual placement and support specialists, housing & transportation specialists, and outreach and engagement specialists will be headquartered in the iHub. Additionally, the iHub will have flexible office space shared with our collaborators to enhance our ability to refer and maintain services for vulnerable populations in our service area.

To date, EHD has already engaged its Board of Directors and initiated a process with an engineer to define specifications for the iHub. Upon determination of final specifications, the engineer will assist EHD in constructing a bid proposal process for construction firms in the area. The space will be approximately 10,000 square feet.

The capital improvements will be targeted in developing this innovative space and technology that will support our collaborative's activities in transforming care delivery to Adults with the goal of improving metrics through effective care coordination, data sharing, and outreach.

New interventions

Our strategy is anchored in the development of an Integrated Hub (iHub) that will implement a coordinated care model that reduces health disparities, increases access to prevention and wellness services, decreases non-emergency hospital utilization, and reduces system costs for adults with a mental or physical health need in our 5 county region. The iHub will provide adult Medicaid beneficiaries with a single point of contact for their care across multiple providers. Adult Medicaid beneficiaries will receive a health risk assessment that will determine their risk level and the level of care that our care team will provide. The iHub will be responsible for

- monitoring long term needs for the adult Medicaid population,
- liaison and advocate for change to the InCA Partnership Council (based on need indicators),
- review screenings, stratify comprehensive needs assessment, and track beneficiary's care, and
- be the single point of contact with client and/or caregiver to integrate their care to all Core Beneficiary Services including contact with Direct Service staff for enrollment and care coordination.

Delivery redesign

Single Point of Coordination

Bringing together core community partners to provide holistic integrated care will start with an **Integrated Services iHub** established to allow for a single point of contact to access services. The iHub will assign a **Service Integration Coordinator** to stratify needs level and collaborate with the Care Coordinator. **The Service Integration Coordinator (SIC) will serve as the single point of coordination for all providers.** Adult Medicaid beneficiaries will have screenings and wellness visits to help provide early identification, direction, and prevention before the point of hospitalization or more intensive, institutionalized placement. The iHub will have one central access point (phone number) to provide coordination to ensure successful linkage to information, referral, and assistance for adult Medicaid beneficiaries to core community services. A Resource Coordinator will provide easy access to information about what is offered at each core provider. Adult Medicaid beneficiaries with BH needs who fall under higher levels will have access to tele-psychiatry services and telehealth visits with their assigned Service Coordinator depending on level of need. Adult Medicaid beneficiaries who cannot access the iHub physically will have access to EHD's virtual iHub, which operates via telehealth to engage with beneficiaries, initiate assessments and begin connections to care.

Integrated Technology

Providing an integrated experience of care for our adult Medicaid beneficiaries requires a single-platform population health management and care coordination solution that simplifies workflow for care managers, engages healthcare consumers, and optimizes quality and performance outcomes for providers.

HealthEC, LLC is a KLAS-recognized population health technology company that helps customers succeed with value-based care by offering a flexible, single-platform solution that aggregates clinical, claims and quality data and provides the actionable insights that can improve health care outcomes across multiple dimensions. Supporting a holistic view of the beneficiary, HealthEC supports complex care requirements by integrating medical and behavioral health data and factors in Social Determinants of Health, so that organizations can coordinate care plans and connect adult Medicaid beneficiaries to the services they need. Health EC is an intuitive user-friendly solution that detects gaps in care and summarizes the patient experience with absolute visibility; built-in resources that include health risk assessments, social determinants of health assessments, care team task assignment tools and value-based care program reporting assistance; automated or manual options for developing care interventions and ongoing care plan evaluations. The iHub will use the NowPow platform to track the status and outcome of all referrals for community-based services so that the iHub will know when clients are successfully engaged in services and when to follow up on an open referral. NowPow has integrated with HealthEC so that data on referral outcomes is easily uploaded for analysis and reporting in HealthEC's robust analytics module.

Innovations for Addressing SDoH

Addressing social determinants of health (SDOH) is fundamental not only to EHD's person-centered, whole-person approach to care but to our broader population health strategy focused on driving improved health outcomes for the adult Medicaid beneficiaries of our region and supporting healthier communities. Our approach to SDoH weaves together programming across the continuum of health provider and community-based interventions, targeted beneficiary supports, and community partnerships. EHD has invested in the technology that can accurately track these interventions, and produce reports that integrate diverse population analytics, individual beneficiary screenings and assessments, service utilization and closed-loop referrals. The InCA Partnership Council will use this data to inform and collaboratively address service gaps to drive toward better access to care and improve health outcomes.

Community Input

Community Service Area

Zip code or counties of your collaborative

Our collaborative will serve Gallatin, Hamilton, Saline, Wayne and White counties.

Community Needs/Input

Process to establish the needs of community including process for direct community input.

In August of 2020, EHD completed a comprehensive community needs assessment. We engaged TriWest to complete the assessment as part of our work as a Certified Community Behavioral Health Clinic (CCBHC) with two years of initial funding from Substance Abuse and Mental Health Services Administration (SAMHSA). To evaluate and understand the needs of our community in order to plan our collaborative, we leveraged this analysis, which we have also augmented with additional direct community input.

This needs assessment addresses the following questions with data collected in the five counties we will serve:

- To what degree are behavioral health services available and accessible compared to the level of behavioral health need in the community?
- To what degree does the clinical and administrative staffing plan meet the type and level of behavioral health needs and cultural and linguistic characteristics of the community?
- To what degree does EHD's management staffing plan sufficiently lead and support the clinical and non-clinical staffing plan?
- To what degree are EHD's services culturally and linguistically available and accessible, and to what degree do staff training plans realistically address the cultural and linguistic needs in the community?

The data we collected in the assessment served as an important data point in planning and aligning our project plan for this initiative. The most significant finding informing our project and its goals is the need for adult behavioral health services are greater in the area, particularly in the area of substance use disorder treatment and co-occurring substance use disorder/mental illness treatment.

Direct Community Input:

The needs assessment was completed with input from EHD and Christopher Rural Health Center staff, reports and surveys, and interviews with consumers and other community providers. When available, the analysis drew on data from other publicly available datasets to describe EHD's service region.

Key Informant Interviews

Egyptian Health Department Staff
Angie Hampton, Chief Executive Officer
Teresa Pickering, Chief Information Officer
Wanda Scates, Director of Adult Services
Stacia Penrod, Director of Child and Adolescent Services
Tammy Karnes, Director of Human Resources
Holly Frymire, Marketing Director
Rob Nelson, Director of the Assertive Community Treatment (ACT) Program
Brenda Robinson, Case Manager
Gary Hamilton, Director of Adult Substance Use Services
Christopher Rural Health Center
Brigitte Browning, Liaison/Office Manager
Other Community Contacts
Jeffrey Drake, Rides Mass Transit District, Operations Manager

Tiffany Becker, Harrisburg VA, Local Recovery Coordinator
Consumers
Two adult consumers
One parent of children receiving services (who also received EHD services as a child)

In addition to these key informant interviews, EHD's Partnership Council, which for the past year has provided input and planning for our InCK initiative has been engaged in significant implementation activities building our system of care for kids. These discussions have triggered interest and recognition of the need to replicate and adapt our model for adults.

As planning for InCA has become more formalized, EHD has held specific planning meetings to gather input and needs to inform our initiative's planning process with the following groups and organizations:

- InCK Partnership Council, March 25, 2021
    - Organizations present: WADI, Eldorado Schools, CMS, SIH
- CCBHC Governing Council, March 29, 2021
- Meeting of 11 consumers of CCBHC services, representatives from Tri-West, and staff of EHD. High level of interest was expressed in obtaining accessibility resources for Hearing and Visually impaired clients and in care coordination for those who have a moderate level of need and are not eligible for Assertive Community Treatment (ACT) services.
- EHD Board of Health, March 15, 2021

Inclusion of elected officials at all relevant levels of government in your service area as proposal was developed

EHD engaged the following elected officials as we planned our collaboration:

- Senator Dale Fowler- 59th District
- State Representative Patrick Windhorst-118th District
- Rocky James-Eldorado Mayor
- Becky Mitchell-Ridgway Mayor
- Rona Bramlet-Saline County Board Member
- Jay Williams-Saline County Board Chairman
- Sheriff Whipper Johnson-Saline County
- Sheriff Shannon Bradley-Gallatin County
- Sheriff Randy Graves-White County
- Lisa Smith-EHD Board President & Shawneetown City Council member

Data

Data used to design/plan proposal

As mentioned in the prior section, EHD engaged TriWest to complete a Community Needs Assessment in August 2020 to help define the needs of our community. Data sources for this assessment include:

- Key Informant Interviews, including consumer interviews
- Organizational documents and reports, including:
    - Egyptian Health Department. (2020, February 13). Strategic Plan: 2020–2022. [Report]
    - Egyptian Health Department. (2020). Project Connect 2.0: Cultural & Linguistic Competency Self-Assessment. [Report]
    - Egyptian Health Department. (2019). 2019 Annual report. [Report]
    - Egyptian Health Department (2016). Illinois Project for the Local Assessment of Needs (IPLAN). [Report]
- Service utilization data, including:
    - Utilization data from electronic health records and administrative datasets to inform the degree to which services address level of behavioral health needs in the community
- Client satisfaction surveys administered to all clients
- Publicly available datasets, including:
    - Most recently available census data published by the U.S. Census Bureau's Population Estimates Program to summarize the demographics and characteristics of our service region
    - County-level estimates for demographics, including age, race, ethnicity, and sex

Additionally, EHD reviewed and analyzed data from County Health Rankings developed by University of Wisconsin Population Health Institute.

Methodology of Data Collection

The process of estimating capacity and unused capacity varied by service type and level of care. The available data offers a point-in-time analysis of utilization. In the assessment, we applied the most recent epidemiological data to local population estimates to examine the level of behavioral needs within the region. Datasets included sub-state, state-level, and national data from the National Survey on Drug Use, Behavioral Risk Factor Surveillance System, and the Youth Risk Behavior Surveillance System. For some estimates, such as the prevalence of serious emotional disturbances and other psychiatric conditions among children, and the prevalence of adults with complex needs that require intensive services, we utilized the National Comorbidity Survey Replication and more recent and smaller epidemiological studies conducted in the United States.

Results of Analysis

- **Attached:** Egyptian Health Department Certified Community Behavioral Health Clinic (CCBHC) Needs Assessment, August 26, 2020.
- EHD consulted https://www.countyhealthrankings.org/ for additional county-level health data.

Health Equity and Outcomes

How the revised delivery system is designed to improve health outcomes and reduce healthcare disparities

One key element identified as needed in the five-county service area are Social Determinants of Health (SDoH) that exacerbate disparities in outcomes for our population. The service region experiences barriers to treatment access, including transportation and other disparities commonly faced by rural communities. EHD recognizes transportation as a major barrier to services for clients in its service area and therefore has included Rides Mass Transit District (RMTD) as a collaborator in our transformation grant project.

Case workers/outreach specialists and our dedicated Housing & Transportation Specialists will facilitate access to transportation in Southern Illinois. RMTD's mission is "to provide affordable safe, accessible public transportation for all residents of the communities served by promoting independence, self-sufficiency and economic opportunity." RMTD offers set routes as well as residential pick-ups with at least one-hour advance notice.

According to a 2018 assessment of RMTD's 18-county service area:

- 62% of riders had either Medicaid or a managed care provider,
- 51% of riders typically needed transportation assistance with medical appointments,
- 66% of riders had to reschedule their appointment times around available transportation,
- 86% of riders indicated Rides Mass Transit District provided service within their area,
- 38% of riders were not Medicaid eligible, and
- 40% of riders traveled with a mobility device.

Key informants from the needs assessment stressed that although the available public transportation system is crucial for covering the rural areas, it is inconvenient for many people, requiring them to arrive for appointments hours early and potentially wait hours more after an appointment to get transportation back home. EHD is providing transportation for some consumers in certain programs (e.g., those on the ACT team, Community Support services, and for some SUD programs) to help address these barriers. Staff at the iHub will screen all adult Medicaid beneficiaries for transportation challenges and will connect individuals to transportation resources to ensure accessibility to care. In addition, individuals who are eligible for outreach services can receive certain services in their home or in the community (assuming confidentiality can be maintained), including assessment, to determine alternatives to overcome transportation barriers, including possible telehealth access.

There is also a need to help adult Medicaid beneficiaries access services and the continuum of care that exists in the community. Reducing fragmentation between health care providers to integrate services for adults with a common approach to care coordination to create a more seamless service experience is needed. Through this project, we will hire additional coordinators to ensure better care coordination between adult mental health and SUD.

As we address equity challenges and disparities, we want to ensure the quality of care that is rendered is consistent and of high quality. With this project, we will continue to disseminate SUD best practices to inform treatment and enhance integration within the EHD's ACT team and provide training and technical assistance in SUD treatment best practices to the adult SUD treatment providers. This project will increase the availability of recovery coaching from Certified Recovery Support Specialists by supporting

the recruitment and training of peers who have the lived experience of substance use and are prepared to receive CRSS training.

Discuss the specific disparities and outcomes you are targeting, including by race and ethnicity

Specific Disparities and Outcomes

Significant disparities exist in EHD's counties of focus. Our communities represent some of the most rural and underserved in terms of access to primary and behavioral health care. We see significant gaps between the rural populations we serve and the rest of the State. For example, according to the USDA Economic Research Service, the average per capita income for Illinoisans in 2019 was $58,764, with the rural per capita income at $43,286. The ERS reports, based on 2019 ACS data, that the poverty rate in rural Illinois is 13.2%, compared with 11.2% in urban areas of the state. The unemployment rate in rural Illinois is at 4.4% while in urban Illinois it is at 3.9% (USDA-ERS, 2019).

Our entire service area, according to the Health Resources and Service Administration (HRSA) is considered both a mental health and primary care shortage area. Our service area, particularly Saline and Gallatin counties, also see significantly higher rates of overdose death than urban parts of the state.

According to countyhealthrankings.org in 2021, individuals residing in our five-county service area reported experiencing more poor mental health days than the statewide average and more poor and fair health than the statewide average.

Additionally, four of the five counties we will serve under this initiative (Gallatin, Hamilton, Saline, and White) see more preventable hospitalizations than the statewide average. Further, all five counties have lower rates of receiving the flu vaccine than the statewide average.

Disparity	**Outcome**
Reduced access to mental health services and SUD treatment	Increase access and follow-up rates for individuals in need of mental health services, including SUD.
Reduced access to primary care services	Increase access and referral to primary care services.
Higher than average preventable hospitalizations	Reduce preventable and avoidable hospitalizations through improved referral, outreach, and care coordination.
Higher overdose death rate	Improve connectivity to SUD treatment for at-risk populations.
Reduced access to preventative and wellness services	Improve access to preventative and wellness services through referral to primary care and wellness resources.

Race and Ethnicity Considerations'

When reviewing County Health Ranking Data, we see significant disparities in access to care and outcomes for our black population. For example, in Saline county, the rate of preventable hospitalizations for the black population is 11,333 compared to 6,346 for the white population. EHD will focus significant effort and focus on ensuring coordination resources reach communities that experience health disparities. Further evidence of these disparities can be seen in preventive care, for example rate of mammography screenings and flu vaccinations. Across our service area, the data shows that black communities see lower rates of these important screenings and inoculations, which indicates less

connection to primary care. Our initiative will outreach to communities of color to create better linkages and connection to primary care. There is a significant lack of quantitative and qualitative data on the racial minority groups in our region. One of the aims of this project will be to collect and disseminate data on the impact of our initiative on minority populations.

When we conducted our community needs assessment, EHD found that several residents age six and older do not speak English as their primary language; of these residents, half speak English less than "very well" and may be considered to have limited English proficiency (LEP). There is a relatively small community of Indo-European language speakers who indicated that they speak English less than "very well." EHD has an on-call Spanish interpreter and an American Sign Language interpreter to provide in-person interpretation. EHD also contracts with Certified Languages to provide remote interpreting (over the telephone), as needed, and provides materials in other languages upon request. EHD routinely reviews resources available and updates materials, based on Cultural and Linguistic Competency (CLC) self-assessment responses. EHD materials reflect appropriate literacy levels. The EHD website is also compliant with the Web Content Accessibility Guidelines (WCAG) 2.1, which provides greater access and readability to a wide range of people with disabilities (e.g., blindness and low vision, deafness and hearing loss, limited movement, speech disabilities, photosensitivity) and some accommodation for learning disabilities and cognitive limitations.

Through Project Connect 2.0, a SAMHSA system of care grant, EHD conducted CLC self-assessments in 2018 and 2020 to identify areas to address through training or other strategies, and to raise awareness of cultural competency needs within the organization. 14% of respondents were system of care partners or community members.

In response to these results, EHD brought back the *OUCH!* training program *(Ouch! That Stereotype Hurts* and *Ouch! Your Silence Hurts)* for all EHD employees and agency partners in 2018. This training is conducted annually. Staff report noticeable improvements since increasing cultural and linguistic competency trainings.

Through this initiative we will continue to work with the local pastoral board to spread positive mental health messages to the faith communities in the service area. The mental health needs of the congregants of historically black churches in EHD's service area are being addressed with a blend of in-house counseling and referrals to EHD. Overall, consumers indicate that they are presented with different choices and options during treatment planning and that they feel like staff listen to their input.

The Multicultural Center at Southern Illinois University (SIU) has agreed to form a partnership around promoting education and inclusivity in our community and throughout our initiative. We are building our collaborative with the goal of nurturing a climate of social justice and equity.

To this end, our initiative will focus on the following race and ethnicity-focused outcomes for our population:

- Improve coordination with pastoral healthcare providers to ensure outreach initiatives reach high-need communities that see greater disparities and access challenges.
- Improve connection to Primary Care for communities of color in our service area.
- Improve avoidable hospitalization rate for communities of color in our service area.
- Ensure access to translation services and bilingual staff (where applicable) for adult Medicaid beneficiaries with Limited English Proficiency and who speak American Sign Language (ASL).
- Ensure accessibility in materials to individuals with disabilities and accommodations for individuals with learning disabilities and cognitive limitations.

- Ensure workforce aligns with diversity in the service region.
- Continue cultural and linguistic competency trainings for all employees and agency partners to reduce stigma and ensure accessibility to all cultures and communities in our service area.

Quality Metrics

Alignment with Department's Quality Strategy Pillars

EHD's proposed approach aligns with the Adult Behavioral Health (BH), Equity and Improving Community Placement pillars of the HFS' Quality Framework. Our approach targets the adult Medicaid beneficiary population in our rural, five-county region. Our model of care supports targeted goals, objectives and defined activities that drive improvements in adult BH, equity and community placement.

Our proposed model leverages the care coordination roles, services, practices, and tools that have been built for the InCK program and applies it for adult Medicaid beneficiaries across all levels of need. The primary drivers for our InCA model support three of the five pillars of the Department's Quality Strategy and the alignment is presented in the table below.

InCA Driver and Summary of Activity	Pillar: Adult BH	Pillar: Equity	Pillar: Improving Community Placement
Improve Coordination across Systems of Care • Our iHub will act as a single point of access with a team of assessors, care coordinators and peer support specialists who will conduct universal assessments for all adult Medicaid beneficiaries with BH needs with both IM+CANS and SDoH screening tools (Health Related Social Needs Screening Tool) to target the right services, at the right time, by the right provider, at the right frequency • The integration of our technology platforms Health EC, 3M and NowPow enables risk stratification, assignment of service levels based on risk and closed-loop referrals, thus enhancing the integration, efficiency, and coordination of multiple providers for people with complex needs	✓	✓	

InCA Driver and Summary of Activity	Pillar: Adult BH	Pillar: Equity	Pillar: Improving Community Placement
Improve the Efficacy of high-tier services • Increasing the coordination of high-risk discharges by using ADT alerts to catalyze care coordination workflows that include collaborative discharge planning and intensive activities to support successful transitions of care • Enhance access to care using telehealth • Defined care coordination service levels include increased intensity of services, with the initiation of Care Planning team meetings, and higher beneficiary visit frequency • Established partnerships with a range of providers that span hospitals, FQHCs, SDoH-servicing organizations, etc. sets up an efficient network for collaboration as well as diversity in services that can address multiple complex needs	✓		✓
Reduce non-life-threatening, potentially avoidable emergency room visits and inpatient hospitalizations (admissions and length of admissions) • Established partnerships with a range of providers that span hospitals, FQHCs, SDoH-servicing organizations, etc. sets up an efficient network for increasing access to primary care		✓	
Increase utilization of preventative services • Single point of access, universal comprehensive needs assessment enables targeting of needs and support with engagement in preventive and wellness services		✓	
Reduce Rate of Substance use disorders • The iHub model -universal screening and referral to appropriate services based on risk level; all levels receive basic wellness/ preventive services • EHD also has a two generational approach for screening moms for substance use when they bring their babies in for WIC/Family Case Management services. • Referrals for SUD are supported by existing infrastructure as a licensed Substance Use, Prevention and Recovery (SUPR) provider for over 35 years, with and operational Recovery Resource Center that serves as a resource for individuals with SUD to access services.	✓		

Proposed Measurable Quality Metrics

The proposed metrics for the InCA program consist of those in the HFS Quality Strategy as well as those that are specifically program-defined. Some of these overlap with HEDIS measures as well. Metrics are listed in the table below, along with their tracking status and alignment with HFS and HEDIS. Metrics listed as not currently tracked (marked with "N" below), are either currently self-reported or received for a small population subset, but we aim to collect these data through a planned ADT subscription or through claims, pending collaborations with HFS. Also, certain metrics are proposed for Level 2 and 3 beneficiaries only; collaborations with data sources will inform the final list. Metrics labeled as "Additional InCA deliverables" are proposed for collection through HealthEC and NowPow.

Metric	Currently Tracked?	HFS Pillar: Adult BH	HFS Pillar: Equity	HFS Pillar: Community Living	HFS Quality Strategy Core Set	HEDIS	Additional InCA deliverables
1. *Follow-Up After Hospitalization for Mental Illness (FUH), 7 day and 30 day*	*Y*	*x*			*x*	*x*	
2. *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA), 7-day and 30-day*	*Y*	*x*			*x*	*x*	
3. *Follow-Up After High-Intensity Care for Substance Use Disorder (FUI), and Pharmacotherapy for Opioid Use Disorder (POD)*	*Y*	*x*				*x*	
4. *Pharmacotherapy for Opioid Use Disorder (POD)*	*Y*				*x*	*x*	
5. *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*	*Y*				*x*	*x*	
6. *Annual PCP Visit*	*N*					*x*	
7. *Behavioral health ED visits*	*N*					*x*	
8. *Behavioral health inpatient hospitalizations*	*N*					*x*	
9. *Behavioral health 30-day readmissions*	*N*					*x*	
10. *Acute Hospital Utilization*	*N*					*x*	
11. *Plan All-Cause Readmissions (PCR)*	*N*					*x*	
12. *Emergency Department Utilization (EDU)*	*N*					*x*	
13. *Hospitalization for Potentially Preventable Complications (HPC)*	*N*					*x*	
14. *Adult access to preventive/ambulatory health services (AAP)*	*Y*		*x*			*x*	
15. *Notification of Inpatient Admission. Documentation in the medical record of receipt of notification of inpatient admission on the day of admission or the following day.*	*N*			*x*		*x*	
16. *Receipt of Discharge Information. Documentation in the medical record of receipt of discharge information on the day of discharge or the following day.*	*N*			*x*		*x*	
17. *Patient Engagement After Inpatient Discharge. Evidence of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.*	*N*			*x*		*x*	

18. *Medication Reconciliation Post-Discharge. Medication reconciliation on the date of discharge through 30 days after discharge (31 total days).*	***N***			***x***		***x***	
19. *Controlling High Blood Pressure**	***N***				***x***		
20. *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control*	***N***				***x***		
21. *Number of SDOH screenings completed*	***Y***						***x***
22. *Transitions of Care forms completed*	***Y***						***x***
23. *Number of closed-loop referrals (defined as referrals made and appointments kept)*	***Y***						***x***
24. *Number of Services completed on population*	***Y***						***x***
25. *Telehealth visits completed*	***Y***						***x***
26. *Number of participants in wellness programs*	***Y***						***x***
27. *Number of RIDES/ Housing & Transportation Specialist users*	***Y***						***x***
28. *Referrals for substance use/abuse services*	***Y***						***x***
29. *Employment*	***Y***						***x***
30. *Housing Status and progress.*	***Y***						***x***
31. *Number of individuals trained on NARCAN*	***Y***						***x***

Process for Data Collection, Monitoring and Evaluation

The iHub will collect a majority of the data from the Comprehensive Needs Assessment. To optimize the robust analytics available within HealthEC, access to claims data is preferred. However, a multi-pronged strategy to enhance data available has been contemplated.

1. Preferred Approach: Leverage existing DUA with HFS to expand claims data request to include 18K adults in five counties. This approach would enable a seamless data strategy and consistency of risk stratification methodologies across populations.
2. Secondary Approach: Request ADT subscription feed through HealthEC.
3. Tertiary Approach: Exchanging data through CareQuality, which is an add-on module to HealthEC. EHD plans to use the HealthEC platform to query clinical data available from multiple hospitals and ambulatory services providers through CareQuality and CommonWell, the two national data exchange frameworks. This data can be ingested into the HealthEC platform and combined with data from assessment and screening tools and then run through a risk analysis algorithm that assigns individuals to the most appropriate risk level.

The CQI team (CQI Director and CQI Assistant) will devote at least fifty percent of their time (two and half days/week) to the InCA model to support data collection/integration/quality improvement work. Beginning in budget year 2, the CQI department will be reporting all data to the InCA Partnership Council at each meeting. Service Integration Coordinators will have reports to complete regarding their monthly tasks and the CQI department will utilize the electronic systems in place for tracking data. These reports will also include all data measures listed on the AIMS Driver diagram (attached). In line with the agency policy on Quality Improvement and Strategic Planning, the data presented at the InCA Partnership Council meetings will be used to select areas for improvement and a PDSA cycle will be implemented for any measures that are under their goal. The CQI Director and Assistant are both full time employees of Egyptian Health Department and are committed to ensuring proper data collection and quality services

across EHD programs that are integral to the InCA model and therefore will be flexible in the time spent on each area week to week.

All data will be subject to the agency's ongoing utilization management reviews and included in continuous quality improvement processes. EHD foresees no substantive issues with performance measure collection for performance measures tied to funding.

Care Integration and Coordination

Strategy and Approach

Egyptian Health Department will work with all community partners including the State of Illinois to bring together related reform efforts and reduce the "siloed" approach to serving adults in our service region. Leveraging the system of care approach we have implemented for our child/family population in our federally awarded InCK program, we will use a non-categorical approach across agencies and program boundaries with a focus on the total population of adults receiving Medicaid across these systems. This program will be called InCA, with the goal to provide integrated care coordination and case management to minimize fragmented care and enhance the quality experience of integrated care for the population of focus.

Our strategy is anchored in the development of an iHub that will implement a coordinated care model that reduces health disparities, increases access to prevention and wellness services, decreases non-emergency hospital utilization, and reduces system costs for adults with a mental or physical health need in our 5 county region. The iHub will provide adult Medicaid beneficiaries with a single point of contact for their care across multiple providers. Adult Medicaid beneficiaries will receive a health risk assessment that will determine their risk level and the level of care that our care team will provide. The iHub will be responsible for:

- monitoring long term needs for the adult Medicaid population;
- liaison and advocate for change to the InCA Partnership Council (based on need indicators);
- review screenings, stratify comprehensive needs assessment, and track beneficiary's care;
- and be the single point of contact with client and/or caregiver to integrate their care to all Core Services including contact with Direct Service staff for enrollment and care coordination.

The InCA model will aim to maintain adult Medicaid beneficiaries with medical complexities and behavioral health needs in the community, or the least restrictive environment. These adult Medicaid beneficiaries will have access to a Care Coordinator and HealthEC portal to develop a Universal Care Plan, Crisis Safety Plan, Care Mapping and work together as a team with Core providers and supports. Wellness Coaches will be employed to assist adult Medicaid beneficiaries with chronic and medically complex conditions to provide health education and motivational programming. The Wellness Coaches will be integrated at the iHub and provide home visiting services to work with the beneficiary on healthy options such as nutrition, exercise and stress management. Primary Care Providers serving these adult Medicaid beneficiaries will have access to the Illinois Doc Assist model for phone consultation with a psychiatric specialist on treatment and medication decisions.

EHD will leverage the infrastructure of our CCBHC to provide integrated physical and behavioral health services for those adults with more intensive behavioral health needs. Our CCBHC infrastructure enables access to universal screening, assessment and monitoring of mental health, substance use, and physical health conditions; access to primary care; access to an array of recovery-oriented psychosocial supports and rehabilitation services; access to intensive community -based behavioral health services, including,

crisis, Assertive Community Treatment (ACT) and outpatient treatment. Most importantly, the CCBHC structure promotes and supports continuity of care especially for adult Medicaid beneficiaries with complex needs, and for beneficiaries at higher levels of risk. The CCBHC will serve as a referral source for the InCA program, which will provide robust care connection and coordination that enables adult Medicaid beneficiaries to receive the right care, at the right time, by the right provider, and at the right frequency.

EHD is an accredited Integrated Health Home by COA and well positioned to implement IHH when the State moves forward with the State Plan Amendment. The InCA Partnership Council will advocate for system change guided by needs of population reports from the iHub.

Crisis Response is connected through a 1-800-345-9049 Cares Line number or 911 dispatches. The EHD iHub will have Care Coordinators assigned to adult Medicaid beneficiaries based on a tiering system in the InCA Model levels. EHD will adhere to the criteria outlined with the InCA model to stratify and coordinate care.

Efficiency and Coordination through a Single Point of Contact and Technology

Single Point of Contact

Bringing together core community partners to provide holistic integrated care will start with an **Integrated Services i-Hub** established to allow for a single point of contact to access services. The iHub will assign a **Service Integration Coordinator** to stratify needs level and collaborate with the Care Coordinator. **The Service Integration Coordinator (SIC) will serve as the single point of coordination for all providers.** SICs will initiate the relationship with all adult Medicaid beneficiaries with the SDoH screening and will be available for clients who self-refer as well. The Care Coordinator will provide direct care coordination services by conducting a Health Risk Assessment (HRA), and a comprehensive assessment, and care plan, focusing on physical health, behavioral health, and non-health related social risk factors, such as food security. The Care Coordinator will partner with the beneficiary and other identified supports e.g. family, providers to develop an integrated care plan.

Adult Medicaid beneficiaries will have screenings and wellness visits to help provide early identification, direction, and prevention before the point of hospitalization or more intensive, institutionalized placement. The iHub will have one central access point (phone number) to provide coordination to ensure successful linkage to information, referral, and assistance for adult Medicaid beneficiaries to core community services. A Resource Coordinator will provide easy access to information about what is offered at each core provider.

Adult Medicaid beneficiaries with BH needs who fall under higher risk levels will have access to tele-psychiatry services and telehealth visits with their assigned Service Coordinator depending on level of need. They will receive care coordination from ACT or a CCBHC RN Care Manager. The iHub will be located on the same campus as our behavioral health department which will enhance opportunities for collaboration with treatment providers who are managing and treating the higher risk population.

Higher risk beneficiaries with chronic medical needs will receive care coordination through our primary care provider network.

Adult Medicaid beneficiaries who cannot access the iHub physically will have access to EHD's virtual iHub, which operates via telehealth to engage with beneficiaries, initiate assessments and begin connections to care.

Technology: HealthEC, NowPow and HealthEC Portal

Providing an integrated experience of care for our adult Medicaid beneficiaries requires a single-platform population health management and care coordination solution that simplifies workflow for

care managers, engages healthcare consumers, and optimizes quality and performance outcomes for providers.

HealthEC

HealthEC, LLC is a KLAS-recognized population health technology company that helps customers succeed with value-based care by offering a flexible, single-platform solution that aggregates clinical, claims and quality data and provides the actionable insights that can improve health care outcomes across multiple dimensions. With industry-leading capabilities to cross walk and normalize data from any system, any setting, or in any format, HealthEC ensures easy access to needed data and 360-degree views of individual adult Medicaid beneficiaries and cohorts. An enterprise master person index (eMPI) that establishes a complete longitudinal record for each patient managed within the platform, streamlines workflow and gives decision makers the comprehensive information they need to deliver quality outcomes, mitigate risk, and manage costs—while driving beneficiary engagement and satisfaction.

Health "EC" represents everyone connected. **Beneficiaries, providers, labs, hospitals, pharmacies and government and commercial payers – all communicating on one platform**. The HealthEC 3D Analytics module empowers stakeholders to deliver high-quality care: intuitive, customizable dashboards and widgets; flexible drill-down capabilities – facility/practice, prescriber, payer, and patient; identification of patterns and care intervention guidance; risk stratification models that incorporate the Johns Hopkins Adjusted Clinical Groups (ACG) tool; and cost and utilization metrics.

HealthEC 3D Analytics provides an enterprise-wide view of patient data. Custom Key Performance Indicators can benchmark performance across prescribers, practices, organizations and service providers. With population-wide data, healthcare teams can stratify adult Medicaid beneficiaries to identify high-cost, high-risk beneficiaries that warrant targeted, preventative care plans to help drive better outcomes. Contract Monitoring can evaluate contract performance against all measures and requirements. Utilization Optimization with **organization-wide insight into utilization trends allows identification of gaps in the care cycle which might benefit from more resource allocation**. HealthEC helps healthcare teams transform clinical and operational analytics into informed action streamline care coordination and achieve better outcomes. HealthEC has Role-Base Access for Users. Each user is assigned a role and granted access to the facility they are associated with and given authorized access to PHI data based on approved roles and permission levels. Health EC has Automatic Gap Closers. **Health EC's integrated predictive analytics engine extends across all practices to identify gaps in care, cost discrepancies, opportunities for care management optimization, and patterns related to utilization, provider performance and patient behavior.**

Fueled by the insights derived from HealthEC's analytics, **HealthEC CareConnect enables care managers to streamline workflow, engage patients in their care, and optimize quality and performance outcomes**. Based on established clinical guidelines, the CareConnect module helps care managers coordinate across case management, disease management, utilization and health and wellness functions. It also allows them to deliver holistic care with individualized care plans that factor in comorbidities, risk factors and potential barriers to care. On a single platform, care managers can proactively identify the most effective interventions; perform disease-based risk stratification; create new care plans that are tailored and "risk aware"; record and access beneficiary communications and interact with adult Medicaid beneficiaries via secure, HIPAA-compliant messaging; perform assessments for social determinants of health and behavioral health; take actions based on automated platform alerts; identify and refer adult Medicaid beneficiaries to relevant community resources. HealthEC's population health management platform includes several CMS certifications and approvals, so

government agencies can have confidence in addressing evidence-based measurements and outcomes for quality performance of all providers.

HealthEC provides the ability to aggregate data from disparate organizations (Medicaid Managed Care organizations, Federally Qualified Health Centers, pharmacists and other provider types), risk stratify beneficiary populations, and develop tailored care plans that address the specific needs of adult Medicaid beneficiaries – while reducing unnecessary costs and closing gaps in care. **Supporting a holistic view of the beneficiary, HealthEC supports complex care requirements by integrating medical and behavioral health data and factors in Social Determinants of Health, so that organizations can coordinate care plans and connect** adult Medicaid beneficiaries **to the services they need.** Health EC is an intuitive user-friendly solution that detects gaps in care and summarizes the patient experience with absolute visibility; **built-in resources that include health risk assessments, social determinants of health assessments, care team task assignment tools and value-based care program reporting assistance; automated or manual options for developing care interventions and ongoing care plan evaluations.**

The Patient Engagement Mobile App is secure, HIPAA-compliant messaging to help patients stay on top of their health through real time medication alerts. Other features of Health EC that will be extremely important components for the InCA Model will be patient alerts regarding appointments and labs as well as multiple modes of beneficiary communication, telephone, text, or email that make staying connected easy and customizable. **There are six built-in assessments, which include screenings for high risk, disease management, falls risk, depression and social determinants of health, help formulate a holistic view of patients' overall health status.** Care Coordinators are automatically alerted to areas of concern and gaps in care based on the answers to these assessments. A comprehensive, individualized care plan is pre-populated when required information is received and includes sections such as: high cost diagnoses; medication list including history for active and inactive medications; prescription history; claims history; status of gaps in care and a self-management plan.

NowPow

The iHub will use the NowPow platform to track the status and outcome of all referrals for community-based services so that the iHub will know when clients are successfully engaged in services and when to follow up on an open referral. NowPow has integrated with HealthEC so that data on referral outcomes is easily uploaded for analysis and reporting in HealthEC's robust analytics module.

HealthEC Portal

A HealthEC Portal for adult Medicaid beneficiaries will improve access and information sharing, especially at higher levels of care. adult Medicaid beneficiaries using the portal would be able to view and share (via email or text)– Care Plans, Safety Crisis Plans, Assessments, and other healthcare documents to enhance their care. The beneficiary would be able to view their services and areas of need, such as screenings, wellness visits tasks, assessments, and key patient documents.

Data to Inform Risk Stratification

The data that the iHub collects during the Comprehensive Needs Assessment will inform beneficiary assignment of risk. To optimize the robust analytics available within HealthEC, access to claims data is preferred. However, a multi-pronged strategy to enhance data available has been contemplated.

1. Preferred Approach: Leverage existing DUA with HFS to expand claims data request to include 18K adults in five counties. This approach would enable a seamless data strategy and consistency of risk stratification methodologies across populations.
2. Secondary Approach: Request ADT subscription feed through HEC.

3. Tertiary Approach: Exchanging data through CareQuality, which is an add-on module to HEC. EHD plans to use the HealthEC platform to query clinical data available from multiple hospitals and ambulatory services providers through CareQuality and CommonWell, the two national data exchange frameworks. This data can be ingested into the HealthEC platform and combined with data from assessment and screening tools and then run through a risk analysis algorithm that assigns individuals to the most appropriate risk level.

Staffing Plan

Role	Education/ Qualifications	Care Coordination Activities
Service Integration Coordinator	Bachelor's degree in human service or related field	•Single point of coordination for all providers through the iHub •Conducts Comprehensive Needs Assessments and Screenings for all adult beneficiary referrals/ walk-ins •Supports and tracks linkages/referrals to community-based resources •Tracks beneficiaries assigned to Level 1
Wellness Coach	Illinois Licensed Practical Nurse; Graduate of Accredited Practical Nursing Program	•Supports all risk levels depending on beneficiary needs •Conducts health screenings •Acts as liaison to external systems •Supports and tracks linkages/referrals to community-based resources •Connects beneficiaries to PCPs and other medical services •Develops wellness plans in support of care plan, supports care transitions, medication monitoring, crisis planning, SDoH referrals, and daily living skills training •May provide transportation to clients •Provide interventions to beneficiaries in Level 3 with complex medical needs
Community Health Worker/ Peer Recovery Support Specialist	High school diploma or equivalent	•Supports all risk levels for beneficiaries with mental health issues depending on needs •Conducts screenings •Supports and tracks linkages/referrals to community-based resources

Role	Education/ Qualifications	Care Coordination Activities
		•Conducts home visits to support engagement in services, including post-hospitalization/ED follow-ups •Supports development of wellness plans •May provide transportation to clients •Daily living skills training
Integrated Care Coordinator	Bachelor's or Master's in human service field and 3-5 years working with adults with SMI or SUD	•Conducts comprehensive needs assessments and screenings •Acts as liaison to external systems •Supports and tracks linkages/referrals to community-based resources •Connects beneficiaries to PCPs and other medical services •Develops care plans, supports care transitions, medication monitoring, crisis planning, SDoH referrals, and daily living skills training •May provide transportation to clients •Coordinates care for Levels 2 & 3 beneficiaries
Housing and Transportation Specialist	High school diploma or equivalent	•Supports all risk levels •Will identify clients with transportation needs and/or housing needs and ensure they receive appropriate services
Supported Employment Specialist	Bachelor's degree with at least one-year paid experience working with agencies or businesses in the community as well as consumers with severe mental illness	•Provides work-related supportive services •Provides job coaching, job placement and vocational skills training •Connect beneficiaries to competitive employment. •Supports and tracks linkages/referrals to community-based resources •Conducts home visits to support engagement in services •Contributes to treatment plan •May provide transportation to clients

Service Integration through our Stratification Model

Assessment

A key objective of InCA is improving the quality of care through early identification and intervention of client physical and behavioral health needs to progress toward recovery and healthier lives. EHD plans to use routine assessments and screenings for physical and psychosocial problems across adult Medicaid beneficiaries to alert appropriate referrals so timely interventions will be initiated. Population-wide, risk-stratification tools will be utilized by Service Integration Coordinators along with Care Coordinators, Community Health Workers, Wellness Coaches and Peer Specialists working in tandem with Core Service Providers in the communities to screen, assess and enroll adult Medicaid beneficiaries into appropriate services. Wellness visits across the population will be a focal point of initiating engagement and outreach along with other key providers of client health and SDoH services such as hospitals, food pantries, transportation providers, shelters, churches, schools, and housing providers.

Service intensity and type will be stratified into levels, as determined by our Comprehensive Needs Assessment that consists of a health risk assessment and our established set of mental health, SUD and SDoH screening tools. These tools and their sources are listed in the table below:

Assessment Tool	Use
HealthEC HRA	Health Risk Assessment for all adult Medicaid beneficiaries
IM+CANS	Health Risk Assessment for BH population
IM+CANS	Mental Health Screening Tools
ASAM **CAGE-AID**	SUD Screening and Risk assessment
Health Related Social Needs Screening Tool	Screening for SDoH needs
IM+CATS	Crisis evaluation (based on clinical need only)

The iHub will be the source for all screenings to be channeled and reviewed/tracked for referral to either a needs assessment or determined that usual care remains in place.

Screeners often encounter barriers on how to integrate or establish pathways and infrastructure with core providers to address all the identified unmet needs of adult Medicaid beneficiaries once a screening is completed. EHD will establish one contact number to reach the iHub to either initiate a screening or follow-up on a Partner screening. Current certified staff in office (EHD sites) and proposed mobile assessors (MA) in community will be scheduled by the iHub or a Care Coordinator.

A Mobile assessment team is available to administer a comprehensive needs assessment at a location chosen by the beneficiary and Care Coordinators are available to help the beneficiary population connect to services.

EHD will use the IM+CANS across adult Medicaid beneficiaries who have an identified BH need through the HealthEC HRA.

IM+CATS will be utilized specifically for BH crisis evaluation. IM+CATS not completed at or by the iHub – assessment will be completed by the correct clinical team, in the appropriate setting. Results of the assessment will be uploaded into HealthEC immediately to ensure iHub can quickly follow-up on indicated areas, including SDoH.

Stratification Eligibility Definitions

Below outlines our proposed risk stratification levels. Service Integration levels increase according to risk severity and trigger more intensive levels of service and service coordination. Final definitions of each level will depend on the data that EHD will be able to access as explained above in the "Data to Inform Risk Stratification" section. EHD will also implement the 3M risk stratification software to enhance its ability to effectively risk stratify all clients and assign them to the appropriate risk level within HealthEC.

Level Eligibility	Screening Frequency and Processes
Service Integration Level 1	
Entire population of focus (Adult Medicaid beneficiaries) providing basic, preventive care and active surveillance for developing needs and functional impairments.	•Annual screenings using aforementioned assessment tools •If changes in yearly screening require a Comprehensive Needs Assessment, stratification processes will determine if referral to Level 2 or 3 is required. •Any beneficiary that opts out of Level 2 or 3 integrated care coordination and case management will continue to receive usual care (Level 1) through existing providers and programs
Service Integration Level 2:	
Beneficiary must show evidence of points 1E and 2 below: 1) Exhibited a need for at least two of the following Core Services within the previous 12 months: a. Physical health services; b. Behavioral health services; c. Home and community based/social services; AND 2) Exhibits a functional symptom OR impairment as follows: a. Evidence of symptoms or functioning related to at least one of the following: i. Substance use ii. Serious mental illness; iii. Chronic medical condition; iv. Medically complex condition b. Functional impairments in two or more of the following capacities:	• Complete IM+CANS every 6 months to evaluate progress (for active BH beneficiaries) • Move (with iHub & CC coordination) within appropriate Level of Care • Assess for new needs and referrals to Core Providers • Update treatment plan (at least every 6 months) • Are eligible for care coordination, which includes an integrated, strengths-based, and beneficiary-driven Plan of Care

• Functioning in self-care: consistent inability to perform self-care activities such as personal grooming, hygiene, or nutritional needs; • Functioning in the community: consistent lack of appropriate decision-making or behavioral controls; • Functioning in social relationships: consistent inability to develop and sustain satisfactory relationships. Includes inability to communicate needs or engage in appropriate interactions • Functioning at employment, vocational or educational settings: consistent inability to pursue goals within average time frame due to consistent inability to maintain volunteer service, job training, employment, or educational pursuits e.g., GED. • Housing Instability defined as lack of consistent and safe housing over the last three months	
Service Integration Level 3	
The beneficiary must show evidence of points 1 and 2 below: 1) Level 2 eligibility AND 2) The beneficiary either a. currently resides in or is at imminent risk of more intensive, institutionalized or hospital-based care OR b. has had prolonged or multiple inpatient admissions as a result of chronic or medically complex conditions during the previous 12 months OR c. Chronic homelessness defined according to the HUD definition: *A homeless individual or head of household with a disability that meets the HUD definition of a disability who* *(a) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter;* *AND* *(b) has been homeless and living in one of these places continuously for at least 12 months OR on at least 4 separate occasions in the last 3 years,*	• Complete a comprehensive needs assessment (IM-CANS) every 6 months to evaluate progress, and: • Move (with SIC & CC coordination) within appropriate Level of Care. • Assess for new needs and referrals to Core Providers every 4-6 weeks during Care Planning Team meetings. • Update treatment plan prn (but at least 6 months).

	as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living in one of the aforementioned places.	

Level 1 Services

Service Integration Coordinators (SIC) will be responsible for ensuring screening, surveillance, and tracking of beneficiaries stratified in Service Integration Level 1. Level 1 beneficiaries will have:

- Access to Clinical Care (Physical, Behavioral/Emotional), including wellness visits
- Access to Core service referrals and case management as needed

Level 2 Services

Level 2 features integrated care coordination across Core Beneficiary Services to facilitate individualized, person-centered, and ethnically, culturally, and linguistically appropriate care delivery. Activities at the care coordination level foster a supportive, collaborative relationship with the beneficiary while organizing and matching services across model providers and systems to enable the beneficiary to be served in the home and community.

Care Coordination (CC) functions include:

- Helping adult Medicaid beneficiaries enroll in health programs, including evidence-based programs like Courage to Quit Tobacco Cessation, Diabetes Self-Management, Chronic Disease Self-Management and several evidence informed wellness groups including walking and healthy lifestyles groups.
- Arranging service appointments, conducting follow-up, and coordinating the beneficiary's care on an ongoing basis with service providers; and
- Facilitating effective communication across systems, state and local government agencies and adult Medicaid beneficiaries.

The following care coordination services will take place.

Comprehensive Care Management will include completing a comprehensive health assessment/reassessment inclusive of medical/behavioral/rehabilitative and long term care and social service needs; complete/revise an individualized person-centered plan of care with the beneficiary to identify personal needs/goals and include family members and other social supports as appropriate; consult with multidisciplinary team on beneficiary's care plan/needs/goals; consult with primary care provider and/or any specialists involved in the treatment plan; conduct outreach and engagement activities to assess ongoing emerging needs and to promote continuity of care and improve health outcomes; and prepare beneficiary's crisis intervention plan.

Care Coordination and Health Promotion will include coordination with service providers and health plans as appropriate to secure necessary care, share crisis intervention (provider) and emergency info; Link/refer beneficiary's to needed services to support care services to support care plan/treatment goals, including medical/behavioral health care; patient education and self- help/recovery and self-management; Conduct case reviews with interdisciplinary team to monitor/evaluate beneficiary status/service needs; Advocate for services and assist with scheduling of needed services; Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or

medical conditions are addressed; Monitor/support/accompany the beneficiary's to scheduled medical appointments; revise care plan/goals required.

Transitional Care will include follow up with hospitals/ER upon notification of a beneficiary's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting; facilitate discharge planning from an ER, hospital/residential/rehabilitative setting to a safe transition/discharge where care needs are in place; notify/consult with treating clinicians, schedule follow up appointments and assist with medication reconciliation; link beneficiary and caregiver with community supports to assure that needed services are provided; and follow up post discharge with beneficiary to assist care plan needs/goals.

Beneficiary Support will include develop/review/revise the individual's plan of care with the beneficiary ensure that the plan reflects the individual's preferences, education and support for self- management; consult with beneficiary on advanced directives and educate on rights and health care issues, as needed; meet with beneficiary, inviting any other providers to collaborate on care planning; refer beneficiary to peer supports, support groups, social services, entitlement programs as needed; and collaborate/coordinate with community based providers to support effective utilization of services based on beneficiary need.

Referral to Address Social Determinants of Health will include identifying resources and linking beneficiary with community supports as needed and collaborating/coordinating with community-based providers to support utilization of services. The iHub will track all referrals that are paired with successful engagement in services using the NowPow platform. NowPow has integrated with HealthEC so that data is easily uploaded for analysis and reporting in HealthEC's robust analytics module.

Evidence-Based Practices

EHD currently provides comprehensive outpatient mental health and substance use disorder services, including psychological assessments, prescription medication monitoring, outpatient medication assisted treatment (MAT; suboxone), group treatment for individuals with methamphetamine addiction (the Anchor program), and psychotherapeutic interventions for individuals, groups, and families.

EHD provides a comprehensive array of EBPs to address the needs of the adult Medicaid beneficiary population and the goals of this project. This combination of EBPs constitutes a service array for successfully assessing and treating individuals with SMI, SUD, and/or COD to achieve:

- Improved access to and engagement in SUD and mental health treatment
- Reductions in substance use relapse
- Fewer instances of relapse in substance abuse and mental illness
- Better management of symptoms of trauma and mental illness
- Greater independence and stability in the community
- Improved functioning and quality of life

Description of the Evidence-Based Practices to Be Provided to Beneficiaries in Need of Them
ACT (Assertive Community Treatment) is a comprehensive community-based model for providing treatment, recovery support, and rehabilitation to people with SMI who have functional challenges and histories of placement in restrictive settings.
Cognitive Behavioral Interventions. Cognitive behavioral interventions have proven to reduce symptoms of trauma and anxiety, prevent substance use relapse. EHD provides Dialectical Behavioral Therapy, Cognitive Behavioral Therapy (CBT), and Trauma Focused-CBT. TF-CBT is an indicated intervention for veterans, active military, and military families. CBT-P will be provided within the ACT

team.
Eye Movement Desensitization and Reprocessing (EMDR) is an effective treatment for PTSD, used with success among combat veterans and civilians. It has been recommended by the Department of Veterans Affairs and the Department of Defense.
Individual Placement and Support (IPS) is an alternative approach to traditional vocational rehabilitation that emphasizes helping individuals living with BH conditions to gain and sustain competitive work in the community.
Medication Assisted Treatment (MAT), is an effective combination of medication and behavioral therapies to treat SUD and sustain recovery. CRHC, a DCO, provides MAT with Buprenorphine (Suboxone) for adult Medicaid beneficiaries with opioid use disorders.
Motivational Interviewing (MI) techniques help people with SUDs to develop and maintain motivation to engage in treatment and recovery. It is also helpful in developing therapeutic alliances with beneficiaries.
Self-Management Programs such as Diabetes Self-Management (Stanford model), Chronic Disease Self-Management, and Self-Management and Recovery Training (SMART) improve health outcomes and self-management of physical health and BH among individuals with mental illness and SUD.
Wellness Programs for adults with mental illness and SUD, including Wellness Recovery Action Planning (WRAP), Whole Health Action Management (WHAM), and Nutrition and Exercise for Wellness and Recovery (NEW-R), are group EBPs or best practices that improve physical health and self-advocacy, and reduce symptoms.
Tobacco Cessation program encourages tobacco users to quit using motivational interviewing techniques and quit aids (i.e., nicotine replacement therapy) depending on beneficiary needs and preference. EHD serves as the lead agency in a regional tobacco cessation coalition and provides nicotine replacement therapy and Courage to Quit services on site.
Home Health is a skilled nursing care program that offers home visits made by RN's LPN's, and Licensed Social Workers, under a physician's direction. We also offer teaching and supportive care for families and patients with various illnesses. Physical therapy, occupational therapy and speech therapy and are also available. EHD Home Health Services are State licensed and Medicare certified serving Gallatin, Hardin, Hamilton, Pope, Saline and White counties in Illinois.

Substance abuse remains one of the top health priorities in these communities. EHD provides a comprehensive approach to fighting the opioid epidemic as well as creating a Recovery Oriented System of Care (ROSC) Council. ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families and communities to achieve recovery and improved health, wellness, and quality of life for those with or at risk of substance use disorders. The central focus of ROSC is to create an infrastructure, or "system of care", with the resources to effectively address the full range of substance use problems within communities. The vision is aligned with the Substance Abuse Mental Health Services Administration' s (SAMHSA) recovery capital areas of health, home, purpose and community focusing on health, community, home and purpose. The InCA program will leverage ROSC's established network of supports by acting as a strong referral source. EHD's reputable foundation of SUD services will benefit any beneficiary referred by InCA with SUD needs. ROSC's ongoing priorities include assessing and increasing capacity and infrastructure for recovery and supports in the community for individuals with SUD; increasing transitional housing access and employment supports; filling transportation service gaps; and increasing access to care, EHD also provides Narcan training and distribution to the community at large in the Drug Overdose Prevention Program with State Targeted Response funding. The agency also promotes the

utilization of the Illinois Prescription Monitoring Program Outpatient treatment services are provided through the agency as well as a new Recovery Center for support, employment, and education services.

EHD partners with the local federally qualified health center, Christopher Rural Health Planning Corp for many services including psychiatry services for adults with mental illness but also partners for Medication Assisted Treatment (MAT) services. EHD is also in the process of opening ***Recovery Harbor,*** which is a recovery center that will serve as a hub to provide support and resources for individuals seeking treatment and recovery services. In addition, EHD provides substance abuse treatment services to individuals involved with the child welfare system, DCFS Recovery Partnership, which supports parents who have lost their child or at risk of having their child removed due to substance use

Cooperative relationships with judicial officials/court systems: EHD provides jail-based crisis, peer recovery support, SUD treatment (***Road to Recovery)*** and transition services and maintains relationships with the local jail, drug courts, probation offices, and the state's attorney's offices.

Social support opportunities through established models: Case managers provide community supports and therapeutic interventions to facilitate resilience and recovery, self-management, skill building, and the identification and use of natural supports. Peer Recovery Support Specialists (PRSSs) help adult Medicaid beneficiaries obtain HUD vouchers, homeless services, and other resources. The Housing and Transportation Specialist will identify clients with transportation needs and/or housing needs and ensure they receive appropriate services.

Crisis mental health services: EHD's state-certified 24-hour mobile crisis response teams respond to crises with crisis assessment, referral, and crisis stabilization services. Services are peer-involved and include suicide prevention intervention. For adult Medicaid beneficiaries, EHD provides Mobile Crisis Response (MCR) a crisis mental health service program that includes intensive counseling, crisis intervention, and case management. MCR utilizes a PRSS/Community Health Worker to follow up with beneficiaries within 24 hours of crisis calls and within 72 hours of all hospital discharges to ensure linkage to resources and engagement with appropriate services. Adult Medicaid beneficiaries are linked to a Peer Recovery Support Specialist (PRSS) after each crisis involving substance use or Community Health Worker for mental health.

Level 3 Services

Adult Medicaid beneficiaries at Level 3 will:

- Have Access to Integrated Case Management services including Community Support Services, and/or ACT or home and community-based services or Chronic disease management services through our Core network for at least 6 months.
- Are eligible for care coordination which includes a Plan of Care, Safety Crisis Plan and Flex Funds (a small pool of funding available on a case by case basis to assist clients in overcoming temporary barriers to recovery such as medical co-pays, enrollment fees for gym and other wellness activities, emergency needs clothing for job interviews, and other such barriers that can be removed with a small amount of financial backing)
- Be offered services that support home and community re-integration.

Level 3 beneficiaries will have access to all services provided at Level 2 as well as **integrated team-based care through a client- driven care planning team.** ACT teams support those with BH needs and are multi-disciplinary teams that include the client and/or relevant caregivers, meet regularly to undertake a collaborative process of assessment, planning, facilitation, care coordination, and evaluation for options and services to address the beneficiary's comprehensive health needs. The care planning team is led by a trained, dedicated individual whose function is to convene and coordinate the care planning team and

provide an initial and ongoing point of contact and coordination for the client. The goal of Level 3 is integrated care coordination that is providing quality services in the most integrated and least restrictive setting appropriate. Many of the values of care planning team will be reflected in Level 2 care coordination as well. However, the care planning team in Level 3 has a higher intensity of face-to-face meetings with beneficiaries, more frequent convening care planning teams, and care coordinators with small caseloads (1:10).

The Care Planning Team functions include collaborative care planning for the improvement of the beneficiary's outcomes and functioning (every client at this level has a Person-Centered Care Plan, Crisis Safety Plan, Flex Funds); working to ensure that the client receives the individualized and appropriate care and support they need in order to be healthy; and serving as the beneficiary's main point of contact for coordination and management of care should convene the appropriate team members to form a beneficiary's care planning team.

For adult Medicaid beneficiaries currently residing in a more intensive, institutionalized or hospital-based care placement, Level 3 integrated case management will work to help address the beneficiary's needs such that they are able to return to their home or community. EHD will provide transition and access to all services available including Mobile Crisis Response, Intensive Therapy/Counseling, Intensive Care Planning, medication monitoring, ACT, MAT, post-hospitalization/ ED follow-up and other relevant services.

Adult Medicaid beneficiaries eligible for Level 3 but receiving necessary services available only in an institutional setting may still be considered "in Level 3" for the purposes of this model, with the goal of reducing their length of stay in higher levels of care. Both beneficiaries in Level 3 receiving services in a community setting and in institutional settings will be re-assessed at a minimum of every 6 months while they remain in Level 3.

Access to Care

EHD will work collaboratively with its partners to increase access to preventive, primary and specialty care in our service region. As part of this application, our strategies include:

- Universal screening and assessment conducted regularly to target appropriate care
- iHub operational structure that is optimized to handle walk-ins
- Marketing campaign for the iHub that encourages walk-ins for screening, assessment and appropriate referral
- Tiered structure of Care Coordination and iHub screening center enables targeting the right care, right place, at the right frequency. The iHub single point of contact and care coordination model will enable efficient access to EHD's existing infrastructure of collaborative partnerships including:
    - The InCA Partnership Council is a robust network of key collaborators that are providers of client health and SDoH services such as hospitals FQHCs, food pantries, transportation providers, shelters, churches, schools, and housing providers. The network's unified vision enables the effective identification of gaps in care through shared data, practices, timely communication and targeted referral streams.
    - Recovery Oriented System of Care (ROSC) Council: a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families and communities to achieve recovery

and improved health, wellness, and quality of life for those with or at risk of substance use disorders. ROSC provides an infrastructure, or "system of care", with the resources to effectively address the full range of substance use problems within communities. The vision is aligned with the Substance Abuse Mental Health Service Administration's (SAMHSA) recovery capital areas of health, home, purpose and community focusing on health, community, home and purpose.

  - EHD partners with the local federally qualified health center, Christopher Rural Health Planning Corp for many services including psychiatry services for adults with mental illness and also partners for Medication Assisted Treatment (MAT) services.

- Telehealth - As part of this initiative, EHD will be implementing stronger telehealth opportunities with the possible expansion of rural health clinic services provided to a rural health clinic (Gallatin County Wellness Center) via a telehealth platform and specialty medical telehealth services to overcome barriers presented in serving a large rural area.
- EHD provides comprehensive recovery supports through the Recovery Resource Center, a part of the region's Recovery Oriented System of Care. Additionally, individuals in recovery have access to peers with lived experiences.
- EHD provides Narcan training and distribution to the community at large in the Drug Overdose Prevention Program with State Targeted Response funding. The agency also promotes the utilization of the Illinois Prescription Monitoring Program.
- Care Planning Teams – collaboratively work with beneficiaries to identify specialty care needs in the community and provide education and supports in obtaining care in the community, thus preventing use of EDs; monitoring risk throughout a beneficiary's care and addressing dynamic needs in the community to avoid unnecessary hospitalization

Social Determinants of Health

Addressing social determinants of health (SDOH) is fundamental not only to EHD's person-centered, whole-person approach to care but to our broader population health strategy focused on driving improved health outcomes for the adult Medicaid beneficiaries of our region and supporting healthier communities. Our approach to SDoH weaves together programming across the continuum of health provider and community-based interventions, targeted beneficiary supports, and community partnerships. EHD has invested in the technology that can accurately track these interventions, and produce reports that integrate diverse population analytics, individual beneficiary screenings and assessments, service utilization and closed-loop referrals. The InCA Partnership Council will use this data to inform and collaboratively address service gaps to drive toward better access to care and improve health outcomes.

Specific Social Determinants of Health.

Integrated Services iHub will act as a single point of contact to access services. Service Integration Coordinators in the iHub, will administer the Health-Related Social Needs Screening Tool to all referred adult Medicaid beneficiaries; the tool documents and needs for all SDoH and will specifically track needs for transportation, employment and housing.

Transportation	Housing	Employment
• Lack of transportation to medical appointments	• Current housing status • Current housing type	• Connection to meaningful employment

• Travel Distance to providers • Number of RIDES/ Housing & Transportation Specialist users	• Loss of housing	• Retained employment
Impact on Health and Personal Outcomes Quality of Life, Psychosocial Outcomes, Health Status Engagement in Services & Care, Reduced Acute Care Utilization (hospitalizations, ED Visits)		

The iHub will have the existing resources to support linkages to SDoH services:

- Housing and Transportation Specialist: will identify clients with transportation needs and/or housing needs and ensure they receive appropriate services
- IPS Employment Specialist: works withing the Supported Employment model – Individual Placement and Support (IPS), which is included in SAMHSA Evidence Based Practices Resource Center for those with SMI and for which recent research supports its application with those who have opioid use disorders. The person in this role will support beneficiaries with BH needs to gain competitive employment and work toward integrating competitive employment and systematic job development from potential employers.
- Peer Recovery and Support Specialists: Supports and tracks linkages/referrals to community-based resources; may provide transportation to medical appointment for beneficiaries based on need
- Partnership with SDoH providers in the InCA Partnership Council: sets up an efficient network for collaboration as well as diversity in services that can address multiple complex needs
    - Ride Mass Transit
    - County Housing Authorities
    - Four C's Homeless Shelter
    - Food Pantries
    - Wabash Area Development Organization
    - WIC program

Measuring Impact on Social Determinants

HealthEC supports complex care requirements by integrating medical and behavioral health data and factors in Social Determinants of Health, so that organizations can coordinate care plans and connect adult Medicaid beneficiaries to the services they need. Health EC is an intuitive user-friendly solution that detects gaps in care and summarizes the patient experience with absolute visibility; built-in resources that include health risk assessments, social determinants of health assessments, care team task assignment tools and value-based care program reporting assistance; automated or manual options for developing care interventions and ongoing care plan evaluations.

HealthEC 3D Analytics provides an enterprise-wide view of patient data. Custom Key Performance Indicators can benchmark performance across prescribers, practices, organizations and service providers. With population-wide data, healthcare teams can stratify adult Medicaid beneficiaries to identify high-cost, high-risk beneficiaries that warrant targeted, preventative care plans to help drive better outcomes. Contract Monitoring can evaluate contract performance against all measures and requirements. Utilization Optimization with **organization-wide insight into utilization trends allows**

identification of gaps in the care cycle which might benefit from more resource allocation. HealthEC helps healthcare teams transform clinical and operational analytics into informed action streamline care coordination and achieve better outcomes. HealthEC has Role-Base Access for Users. Each user is assigned a role and granted access to the facility they are associated with and given authorized access to PHI data based on approved roles and permission levels. Health EC has Automatic Gap Closers. **Health EC's integrated predictive analytics engine extends across all practices to identify gaps in care, cost discrepancies, opportunities for care management optimization, and patterns related to utilization, provider performance and patient behavior.**

The iHub will use the NowPow platform to track the status and outcome of all referrals for community-based services so that the iHub will know when clients are successfully engaged in services and when to follow up on an open referral. NowPow has integrated with HealthEC so that data on referral outcomes is easily uploaded for analysis and reporting in HealthEC's robust analytics module.

Data Integration

HealthEC's eConnectors facilitate the data integration process of extracting, normalizing, and integrating data from disparate sources into the Hosted System. Under this process, HealthEC connects with various third-party data vendors to extract provider information, patient demographics, and clinical data in the form of minimally quantifiable data sets. Successful data integration, both in the initial load and in subsequent cycles, is critical to the functionality and value of the platform, and the Services being provided to the Client.

The iHub will collect a majority of the data from the Comprehensive Needs Assessment. To optimize the robust analytics available within HealthEC, access to claims data is preferred. However, a multi-pronged strategy to enhance data available has been contemplated.

1. Preferred Approach: Leverage existing DUA with HFS to expand claims data request to include 18K adults in five counties. This approach would enable a seamless data strategy and consistency of risk stratification methodologies across populations.
2. Secondary Approach: Request ADT subscription feed through HealthEC.
3. Tertiary Approach: Exchanging data through CareQuality, which is an add-on module to HealthEC. EHD plans to use the HealthEC platform to query clinical data available from multiple hospitals and ambulatory services providers through CareQuality and CommonWell, the two national data exchange frameworks. This data can be ingested into the HealthEC platform and combined with data from assessment and screening tools and then run through a risk analysis algorithm that assigns individuals to the most appropriate risk level.

Milestones

Year 1 Milestones

Activity	1st Quarter			2nd Quarter			3rd Quarter			4th Quarter		
Month	1	2	3	4	5	6	7	8	9	10	11	12
Meet with all staff and partners to inform team of award	X	X										
Bid out and select construction management	X	X										

team for the iHub												
Construction of the iHub			X	X	X	X	X	X	X	X	X	X
Convene InCA Partnership Council	X	X	X									
Hire InCA Director, iHub Manager, Receptionist, IT Specialist	X	X	X									
Hire Service Integration Coordinators, Care Coordinators, Community Health Workers, Wellness Coaches						X	X	X				
Implementation of Health EC and NOWPOW across partners							X	X	X	X	X	X

Years 2-5 Milestones

Milestones	2nd Year				3rd Year				4th Year				5th Year			
Quarter	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Assess required number of consumers per year	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Develop Sustainability Plan	X	X	X	X												
Collect and Report on Program Data	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Analyze Program Data and CQI process	X				X				X				X			
End of Year Performance Assessment	X				X				X				X			
Develop APM																
Implement APM																

Commented [KB1]: Breakout for each year, by month, Angie concur with needing much more detail, things to consider including
- Implementation of HEC across partners
-iHUB construction completed
-program starts
-frequency of partner mtgs
-annual review of program impacts and needed changes (CQI in action)
-something related to payment flow and how monitored in new governance structure

Commented [KB2]: application states in months from the award

Commented [CH3]: Need timeframes for these 2 lines.

Racial Equity

How your partnership/collaboration will incorporate racial equity in the project

We recognize the need to address racial equity and advance social justice and inclusion as part of our initiative. We must ensure that all communities in the counties we serve are able to access equitable, high quality services. We have for the past 10+ years been outreaching to various community members, including faith leaders, to enhance and adapt our outreach and engagement activities to better engage minority community members in our population. Included in this initiative is a partnership with SIU Multicultural Center to inform our efforts to incorporate racial equity and improve cultural competence training in our project.

Our collaborative will include the following elements across our staff and all partners:

- Continue and expand training to educate staff on cultural competence and unconscious and/or implicit bias.
- Continue and expand partnership with pastoral health providers to inform our approach to outreach and behavioral health services to minority populations.
- Continue to seek staffing models and workforce/recruitment strategies, that reflect the community we treat. Relatedly, we will continue to explore additional pathways for employment and training for members of our community.

Attachment: Racial Equity Questionnaire

Minority Participation

List of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise Program (BEP) and/or not-for-profit entities majorly controlled and managed by minorities that will be used on the project, as subcontractors or equity partners, and describe how they will be used

EHD has a hiring practice reflective of the racial and socioeconomic and behavioral health need makeup of the community.

EHD will make every effort to coordinate and use services of business that are recognized as BEPs or majorly controlled/managed by minorities. Additionally, we plan to hire a faith-based outreach and engagement provider.

- **Pinoy Construction:** Pinoy is a black-owned construction firm and will be invited to bid on construction of the iHub as a subcontractor under this initiative.
- **BEP Sheltered workshops:** There are two BEP Sheltered workshops located in our service area. One is co-located in our offices in Gallatin County and offered janitorial services which could be contracted for the iHub pending availability. Both Trade Industries and Coleman Tri-County Services will be included as SDoH collaborators in our initiative.

Indicate whether their role is only during the implementation of your proposal (e.g., construction, consulting, etc.) or if they will have a role in the ongoing operation of your transformed delivery system.

Entities identified above will have an ongoing role in the operation of our transformed delivery system. Our intent is to increase the volume of work for BEP certified firms and not-for-profit entities controlled or managed by minorities above the services provided to the collaborating members. As members of

our local chamber of commerce and past partners of the small business development center we are committed to work toward increasing the number of BEP firms in our community. There are nearly 200 minority owned businesses in our 5 counties but only 5 recognized as BEPS.

Jobs

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

EHD and its collaborating providers currently employ individuals who reside in the following zip codes: 62995, 62987, 62985, 62984, 62982, 62979, 62977, 62974, 62972, 62967, 62966, 62960, 62959, 62958, 62954, 62952, 62951, 62948, 62947, 62946, 62943, 62938, 62935, 62934, 62941, 62930, 62928, 62922, 62920, 62919, 62918, 62917, 62914, 62910, 62902, 62896, 62890, 62887, 62871, 62869, 62867, 62860, 62859, 62837, 62835, 62828, 62821, 62817, 62816, 62812, 62221, 47710, 47620, 47591, 42437, 42003, 42001, and 40342.

36% of EHD employees reside in zip code 62946, 12% reside in 62930, and 4% reside in both 62917 and 62959, respectively. The remaining zip codes have 2% or fewer employees residing in them.

Job categories represented across our organizations include:

- C-Suite/Leadership/Management
- Directors/Administrators
- Administrative/Clerical
- Finance/Accounting
- Licensed Practitioners/Clinicians (Behavioral Health and Medical)
- Non-Licensed Practitioners/Clinicians (Behavioral Health and Medical)
- Coordinators/Navigators (Behavioral Health and Medical)
- Peer Specialists

We propose to keep stable local employment rates tied to zip codes in our service area to promote employment and job opportunities in the communities we serve. Our current hiring practices are reflective of the racial and socioeconomic and behavioral health need makeup of the community.

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

The iHub will hire 26 positions and will house XX existing EHD positions. EHD is an equal employment opportunity agency that actively seeks minorities to fill positions within the organization to be reflective of those served in our communities. Temporary jobs will also be given to individuals who work for the Construction Management team and vendors. BEPs will be utilized for construction, janitorial, and shelter services at the iHub and the Construction Management team will also be required to utilize BEPs.

Commented [CH4]: EHD Please Complete

Describe any retraining, innovative ideas or other workforce development planned for the new project.

Under this initiative, we will increase cultural competence training across partners. We have partnered with the Multicultural Center at SIU who will be a key education provider. We also plan to add faith-

based community outreach position, who will prioritize people of color and partner with churches to ensure connectivity to medical and behavioral health services.

Sustainability

For any new or increased services, include an explanation of how those services will be sustainable in the future without subsidization by transformation funds.

EHD and our Core Service Partners are currently contracted with managed care organizations available in the service area. EHD will achieve sustainability through expanded billable service opportunities with Medicaid Managed Care organizations building on our existing contracts and relationships.

Additionally, EHD plans to introduce an Alternative Payment Model (APM) modeled after our sustainability approach that is currently underway for InCK. EHD is a partnering member–owner of the statewide behavioral health Independent Provider Association (IPA) called Illinois Health Practice Alliance (IHPA), leveraging the expertise and resources of other providers and a managed care organization. The goals of the IPA include supporting members to be successful within value-based payment arrangements. The knowledge and experience gained from being part of the IPA, will inform the development of our Alternative Payment Model (APM).

Include how, through alternative payment methodologies for Medicaid services or other sources, services that address social determinants of health will be funded on an ongoing basis.

An Alternative Payment Model (APM)will provide opportunities for providers to earn incentive dollars for achieving cost and quality targets and evolves to account for increasing provider accountability in the changing health care environment. The APM will also provide reimbursement opportunities for providers addressing SDoH. The proposed model will provide incentives through defined incentive pools.

We will empanel an APM working group who will inform the design of our APM model. The proposed APM will leverages the existing fee-for-service (FFS) system and provide additional performance-based incentive payments. The incentive pools would be funded through a shared savings program to be developed, and other funding provided by MCOs.

EHD will review claims and encounter data for all covered services under the Medicaid program and other EHR or other patient-related data from providers to support these efforts. These could include but would not be limited to: Inpatient, Outpatient, Primary Care, Behavioral Health, and Pharmacy.

We will partner with MCOs to seek funding for their portion of the gain-share earned under the program and also seek funding under separate bonus programs to the extent they overlap with this program (e.g., HEDIS or quality bonus plan). With regard to the IPA and MCO Quality Element, the MCOs would also contribute funding to the incentive pool for amounts that would have been earned under separate bonus programs.

EHD will work with MCOs on sharing reports and data so that the pools could be calculated and tracked at least quarterly. They could also make regular payments to the core pool to streamline the payments to providers based on their performance across all health plans.

A standard scorecard will be developed containing cost and quality metrics. The standard scorecard will be a product of the APM Working Group, established with representatives from EHD and local InCA providers that will be responsible for establishing the Quality of Care and APM refinement, as needed.

Governance Structure

Governance structure of your collaboration.

Upon award, EHD proposes to incorporate the InCA Partnership Council for the Target Area to ensure a local focus of control and leadership during the planning and ongoing implementation phases of the model. The Partnership Council will be responsible for reviewing key data analysis, continuous quality improvement activities, and ensuring that the consumer and provider feedback loops are providing active and near-real-time information to EHD. In addition, various sub-committees and working groups shall be formed to address specific issues and topics as necessary to achieve the goals of the InCA Model. A Primary Care Clinical Subcommittee will be formed from the InCA Partnership Council that will be led by a primary care provider and will target screenings to be conducted and engage providers to participate in the APM by being incentivized to conduct these screenings. Upon gaining consensus in the committee, we will develop the necessary training and dissemination platforms needed to provide training and ongoing support to primary care providers in the community – increasing local buy-in by allowing the committee to drive the decision making and then pushing those decisions forward with state and provider-level resources to support their decision making. Additional subcommittees will be formed as necessary to support the development of the InCA Model with state-level and local level participation along with a strong beneficiary-voice presence in each of the committees.

How are decisions made and how do you intend to monitor and enforce adherence to the policies and practices you put in place.

Under its charter, all members of the Partnership Council agree to comply fully with applicable policies and procedures in addition to provisions of state and federal law. Partners also agree to participate in evaluation efforts and that results of evaluation efforts will be shared to support continuous quality improvement and monitoring and adherence to policies and practices put in place by the collaborative.

By-Laws for Committees and Councils ensure that each individual or organizational member has one vote on matters brought forward to the council. To be eligible to vote, the individual or organizational member must not have missed more than two consecutive meetings. Voting can occur both in-person or by electronic mail, if necessary. Members with potential conflict of interest must abstain from participating in actions or votes on affected items. 51% of active, voting members present and properly announced shall constitute a quorum for voting purposes. It is likely that transformation funds for proposals will come in the form of utilization based Directed Payments to the various providers in your collaboration. Collaborations will receive a report of payments going to each provider. Explain how you will ensure that the funds are used for your proposed program's intended purpose.

Under our charter for the partnership council, partners agree that time, money, and human capital invested in the InCA model will be reported and tracked so that accurate cost estimates and outcomes can be fully evaluated, including the distribution and investment of funds into our program's intended purpose. Our council will establish policies governing confidentiality and disclosure of all confidential information. Further, partners commit to work to eliminate barriers to communication through the development of working agreements, data sharing agreements, partnership charters, and consents for disclosure of information.