Wellness West

Partnering for Health Equity

Bridging the Gap

How Our Community-Led Health Collaborative is Implementing Health Care Transformation and Achieving Health Equity on Chicago's West Side

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About Wellness West

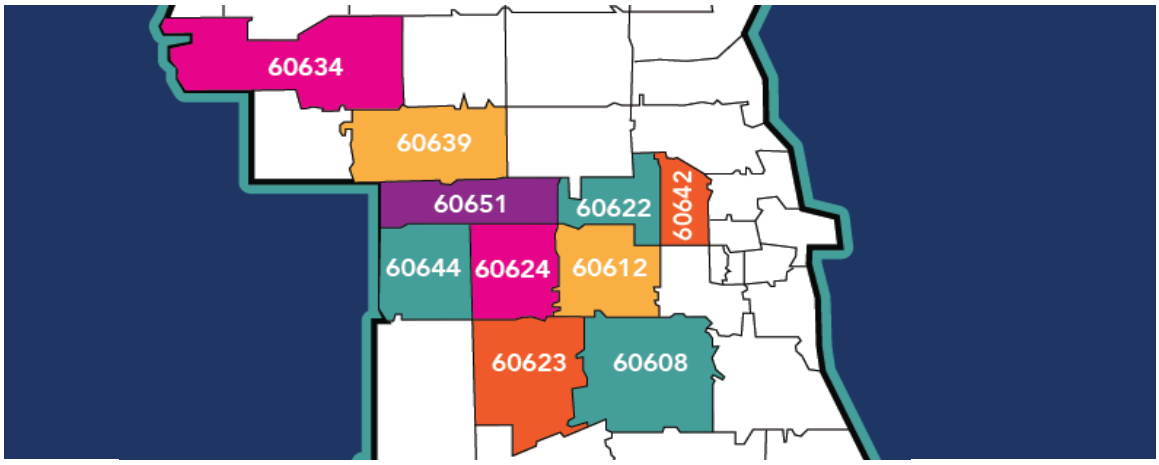
Who We Are

Wellness West is a coming together of proven, mission-driven health care and social service providers who have deep experience serving the diverse communities on Chicago's West Side. Founded in 2020, Wellness West is creating a transformational provider network of six hospitals, 14 community health centers, four community mental health centers, and 17 community-based organizations (CBO) who are known and trusted in our communities. We employ more than 100 community health workers, most of whom live in the 10 zip codes that comprise our service area. Our collaborative care approach is principled on the idea that wellness is achieved when services are delivered at the community level, in-person, and by people with learned, similar experience.

Who/Where We Serve

With a population of nearly 600,000 people, the 10 zip codes we serve on Chicago's West Side are diverse, comprising a population that is 36.4% Black, 33.8% Latinx, 24.7% White, and 5.1% other races/ethnicities. Life expectancy on the West Side averages only 71.4 years. The gap in life expectancy between the Chicago Loop and West Garfield Park is 12 years.

There are approximately 163,000 patients assigned to the primary care providers (PCP) in the Wellness West provider network; 74% of them are enrolled in Medicaid and 26% are uninsured. We are currently serving more than 10,000 patients in disease management programs. The average age of our patients is 32.



36.4% Black	33.8% Latinx	27.7% White	5.1% Other

Challenges We Came Together to Solve

We know from serving these communities for decades that well-documented health disparities are driven only in part by the inadequacies of the health care system and how it is funded. Our experience indicates that disparities are driven to an even greater degree by structural inequities influenced by social and political drivers of health.

Wellness West is funded through the Healthcare Transformation Collaborative (HTC) program, which was established by the State of Illinois to invest in care innovations to achieve health equity. The HTC program is managed by the Illinois Department of Healthcare and Family Services (HFS). Our organizations collectively developed community-based disease management solutions and integrated care coordination strategies that include screening for and addressing health related social needs (HRSN), to treat the most prevalent health conditions on the West Side: hypertension (HTN); diabetes mellitus (DM), severe mental illness (SMI), substance use disorder (SUD), and mild to moderate depression.

[1]Transformation Data and Community Needs Report, Chicago-West, October 2022, https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/transformationdataandcommunityneedsreportdecember2022westchicago.pdf

Our Solutions and Key Success Factors

Deploying Community Health Workers

Effective utilization of community health workers (CHW) is a critical factor in Wellness West's success improving health outcomes for patients; we don't just retain CHW services, we optimize their role in culturally responsive care delivery. Our CHWs are directly employed by the Wellness West providers and CBOs using HTC funding, and physically located at the primary care practices, CBOs, and hospital emergency departments (ED) that participate in the collaborative. We provide our patients with a dedicated CHW who acts as their personal health advocate and guide through the complex maze of benefits and resources that are available, but difficult for patients to navigate and access on their own. Wellness West CHWs receive certification training and ongoing professional development opportunities.

CHWs located at the CBOs and ED navigators identify people who are not engaged in primary care and work with those individuals to engage them with a PCP who is accessible and provides culturally competent care. For individuals who have behavioral health conditions but are not engaged in treatment, peer recovery specialists based in community mental health centers and ED navigators based in EDs similarly work with those individuals to engage them in primary care, mental health, and/or substance use disorder treatment services offered by our network providers.

The network uses a web-based care management platform that supports the interdisciplinary care team (CHW, peer recovery specialist, behavioral health care management and ED navigators) in coordinating care and facilitating care collaboration. Care teams have access to patients' historical and real-time health care utilization to ensure that appropriate follow-up care begins immediately.

Integrating Mental Health and Substance Use Disorder Services with Physical Health and Social Services

Wellness West screens all participants for mental health and substance use disorders and refers those who have a need to a CHW working at their assigned PCP or behavioral health provider. Primary care or community mental health center-based behavioral health care managers are an extension of the care teams and facilitate engagement with traditionally unreachable patients following hospitalization and ED visits. The behavioral health care managers team up with ED navigators to facilitate post-discharge care, including peer recovery support to better enable care navigation.

Standardized Screening

Wellness West implemented a standardized Health Risk Assessment (HRA) that screens for health-related social needs in nine domains. All network providers use the HRA tool at regular intervals and data are standardized for care coordination, reporting, and analysis. All providers are using the same, evidenced-based collaborative care model for each of the health conditions in the Wellness West program, essentially controlling for the steps of care intervention and allowing us to better identify the factors that are contributing to improved outcomes and additional factors that may need to be incorporated into the model. As of April 1, 2024, Wellness West had completed more than 26,000 HRAs. We continuously aggregate and analyze data from those assessments.

Focus on the most prevalent HRSN needs and conditions

The HRA results show that 85% of the people Wellness West serves have at least one HRSN need. The most prevalent need cited was food insecurity, followed by transportation and housing insecurity.

HRSN Prevalence in Wellness West Service Area

Wellness West used the results of our first program year HRA screenings to quantify needs, and then expanded our traditional provider network by contracting with CBOs and other entities that collaborate with the network providers in the delivery of social care services that addressed HRSN.

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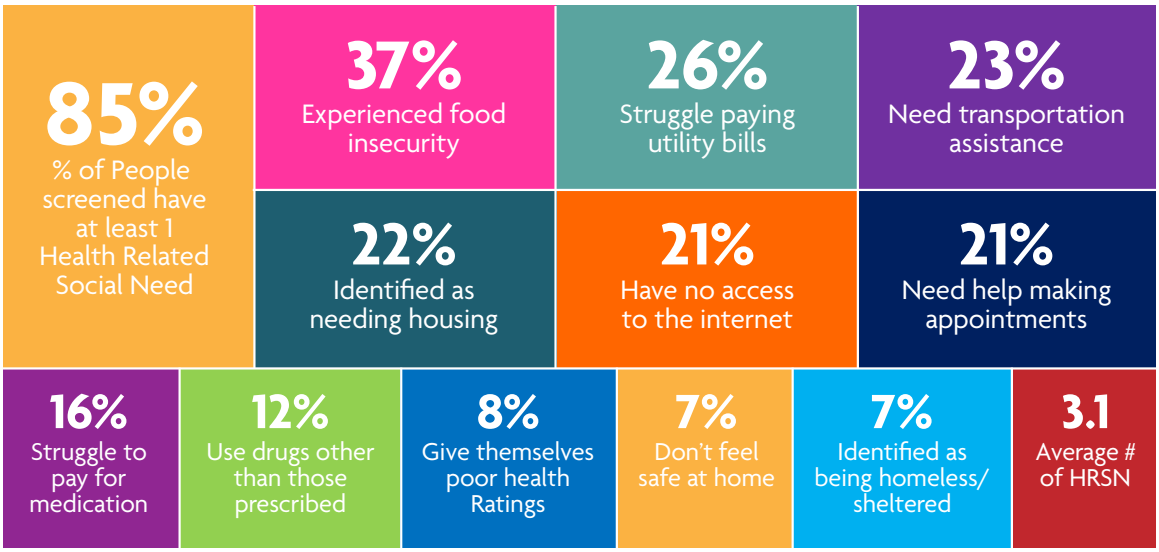

Case Example: Addressing HRSN Through the Flexible Housing Pool

Maximizing the positive impact of housing support was a critical driver in designing the Wellness West model because while we know that demand for housing far exceeds supply, our community partnerships create opportunities to weave together resources that can make a rapid and measurable impact on health outcomes and chronic conditions. Wellness West currently funds 76 slots in the Center for Housing and Health Flexible Housing Pool, through which patients can access permanent supportive housing. Care teams use the web-based care management platform to identify people with housing needs who are high cost and high utilizers of hospital ED and inpatient services and have chronic health conditions. This is an evidenced-based strategy developed from the data and experience of our partner providers who understand that for this subset of the population, no amount of clinical intervention will be effective in managing their conditions and reducing dependence on hospital services until their housing situations are stabilized.

Those who are identified as high cost, high utilizers and housing insecure receive a referral for housing services and our community partners who are experienced in housing navigation and delivering culturally competent services on the West Side work cooperatively to support the patient through the tenancy process. We leverage the care management platform throughout the process, documenting actions, needs and communicating across the team members in different agencies. To-date, Wellness West providers have identified nearly 600 patients who would benefit from permanent supportive housing or housing stability support. The impact of housing services in our collaborative care model is detailed in the Model Impact section below.

[2]https://housingforhealth.org/our-work/flexible-housing-pool/
[3]High-cost, high-utilizer criteria were at least:
$75k or more in total medical spend, three ED visits, or two inpatient stays within one year.

Model Impact

Wellness West continuously measures the impact of its community-based interventions on the utilization of high-cost, low impact services, as well as on control of hypertension, diabetes, and depression, and has noted significant improvement across all disease management categories.

Improved Chronic Disease Management Control

Hypertension control is defined as patients having blood pressure readings below 140/90 mm Hg. After six months of engagement, 80% of Wellness West patients enrolled in our hypertension program achieved controlled hypertension. Diabetes control is defined as patients having HbA1C levels below 9%. After six months of engagement, 62% of Wellness West patients enrolled in our diabetes program achieved controlled HbA1C levels.

	Hypertension		Diabetes	
	Initial Percent of patients controlled at enrollment	**Long-Term Impact** Percent of patients controlled at 6 months engagement	**Initial** Percent of patients controlled at enrollment	**Long-Term Impact** Percent of patients controlled at 6 months engagement
Overall IL FQHC Average at 12 months	53%	80%	46%	62%
	63.35%		**68%**	

Improved Mental Health Outcomes

Remission of depression is defined as patients having a score of less than five on the PHQ-9. As of April 2024, 16% of patients achieved remission of depression, and 88% of patients showed improvement, with 11% of patients experiencing a significant improvement in their PHQ-9 scores.

Wellness West also tracks its impact on the clinical quality measures of how often patients with a diagnosis of mental illness or SUD receive a follow-up behavioral health outpatient service with seven and 30 days of having gone to the ED. Our disease management program for patients diagnosed with SMI and SUD showed positive impact on follow up performance measures with 30% of patients completing a follow up behavioral health visit within seven days and 36% completing follow up within 30 days.

Overall, performance data collected to date demonstrates that the longer patients with diabetes, hypertension, mental health conditions, or SUD stay in the Wellness West collaborative care model, the greater the probability they will increase their control rate and remain controlled.

	Depresion Improvement Rate		
	Initial Percent controlled at enrollment	Last PHQ-9> 5 and not significantly improved (Less than 50% improvement from the initial PHQ-9)	Last PHQ-9> 5 and not significantly improved (50% improvement or more from the initial PHQ-9)
Overall	**16%**	**77%**	**11%**

HRSN Impact Case Example: Housing Support Drove Major Reductions in Hospital Stays and ED Visits

The first year of data demonstrated significant positive impact for Wellness West patients receiving housing support. ED visits decreased by 80%, the number of hospital days decreased by 86%, hospital readmissions decreased by 100%, and paid ED visits decreased by 93%.

Housing Support: Baseline and Outcome Data (Nov 22 – Oct 23)

	Avg # of ED Visits	Avg $ of Paid ED Visits	Avg # of Hospital Days	Avg # of Readmits
Pre-housed	**5**	**$4,898**	**7**	**2**
Post-housed	**<1**	**$340**	**<1**	**0**

Lessons Learned and Challenges Remaining

Payment Strategy for CHW Services

Although it was important to invest in providers while they were building their caseloads, Wellness West found we could have accelerated enrollment and follow-up contacts with patients by transitioning to productivity-based reimbursement earlier in the project. Within two months of transitioning to encounter-based reimbursement, total enrollment increased by 21% and the number of enrollees with at least one contact in the month increased by 23%.

Governance

Our founding organizations were very deliberate in their recruitment of Board member institutions whose leadership, missions, and record of service to the community aligned with the goals of the collaborative. We have experienced several changes in executive leadership at our member organizations since then, but because of the careful planning that went into the governance structure and composition of the Board, we have been able to successfully navigate these changes in leadership, preserve continuity in decision-making and oversight, and avoid implementation delays caused by turnover. In addition, we soon recognized the value that social service agency providers added not just to our model, but to decision-making for the collaborative, so they were offered seats on the Board as well.

Engagement with Payers

Wellness West began outreach to Medicaid managed care organizations (MCOs) in its first few months of operation. We explored opportunities to collaborate in ways that would benefit our patients. The earliest success engaging with MCOs was identifying high-cost members whose housing instability was contributing to low-value utilization of health care services and poor health outcomes. Through continued discussions, we have come to realize that our care coordination model may need to align more closely with those of the MCOs if we hope to develop future contractual arrangements. We continue to share information and encourage HFS to participate in discussions between Wellness West and MCOs and then establish specific expectations for how the MCOs and collaboratives like Wellness West should work together.

Sustaining Community-led Services

Although unmet HRSNs make it difficult for individuals to follow their individualized care plans, resulting in otherwise avoidable costs and adverse outcomes, based on our experience implementing the collaborative care model, it is unrealistic to expect that funding of those HRSNs can be dependent solely on savings in health care expenditures. Funding to address HRSNs must come from multiple sources and must be coordinated more effectively in an integrated model of care, but expansion of such services should be based on identified need and should not be determined solely by how much of a reduction in health care costs there might be.

Scaling the Wellness West Model

Wellness West hopes to bring this collaborative model of care to a broader network of safety net providers and believes that it can be successful in addressing these and other conditions such as breast cancer, or in areas of care including maternal and child health. It can have the same positive impact anywhere there are partners willing to commit to the same principles of collaboration, communication, and community-based services.

As this paper has demonstrated, the effective recruitment, training, and deployment of CHWs are key factors in the success of the Wellness West model and sustaining our ability to continually improve health outcomes and reduce health disparities. Although CHW services are currently provided to Wellness West participants through our HTC funding, Illinois continues to plan for the eventual inclusion of CHW services as a covered benefit for eligible Medicaid customers. Illinois law authorized the reimbursement of CHWs through the Medicaid program in 2021, and while this Medicaid benefit has not yet been implemented, Wellness West plans to deploy its proven model to provide those services to people enrolled in Medicaid. We will leverage our experience to incorporate CHW services into value-based payment arrangements with Medicaid MCOs.

As this paper has also demonstrated, incorporating HRSNs into a comprehensive, integrated, and collaborative model of care can have a dramatic, positive impact on chronic health conditions and health outcomes. Illinois' Medicaid 1115 Demonstration waiver application to the Centers for Medicare and Medicaid (CMS) covering HRSN benefits for people enrolled in Medicaid was recently approved. CMS has also approved similar proposals in several other states, signaling an important shift in understanding the need to incorporate HRSN benefits into the Medicaid program as a core strategy to address health disparities and achieve health equity. Wellness West is committed to leveraging and expanding its proven model of delivering HRSNs to improve outcomes and health inequity as Illinois implements its 1115 Demonstration.

The Wellness West network of community providers continues to demonstrate the positive impact of collaborative care and investments targeted specifically to reduce health disparities. We welcome additional partners who are interested participating in and supporting our collaborative and invite you to visit us at www.wellnesswest.org for additional information.

[4]410 ILCS 67/5-20

wellnesswest.org

HTC
Healthcare Transformation Collaboratives

HFS
Illinois Department of Healthcare and Family Services