LCHC's foundation partner, Washington Square Health Foundation, requests the following Community Health Report be available for public viewing on LCHC's website.

Lawndale Christian Health Center
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The mission of Lawndale Christian Health Center is to show and share the love of Jesus by promoting wellness and providing quality, affordable health care for Lawndale and the neighboring communities.

1. Identify the high risk/underserved and/or disadvantaged populations in the community(ies) that you serve and describe specifically the actions you have taken, based on relevant assessment data, to increase their accessibility to health services.

LCHC serves patients in neighborhoods throughout the west side of Chicago primarily North and South Lawndale, Garfield Park, Cicero, and Archer Heights. These community areas have a rich history in Chicago, with decades of social activism, community organizing, and neighborhood improvement. However, decades of systemic disinvestment, both public and private, have caused a significant loss in community population and grown the number of adverse social determinants of health. The zip codes corresponding to these neighborhoods include 281,006 residents that face unemployment rates as high as 21.9%. High unemployment rates contribute significantly to challenges paying for medical care. The impact of low labor force participation and high unemployment results lower than average incomes. North and South Lawndale and East and West Garfield Park average household incomes average $31,681.

Despite provisions from the Affordable Care Act, there are still more than 40,000 individuals without insurance living in LCHC's service area. With recent Medicaid redetermination reinstated after the COVID-19 public health crisis, patients have faced difficulty enrolling in insurance, causing a significant lack of reimbursement for LCHC's services even for patients otherwise eligible for Medicaid coverage. LCHC provides healthcare to patients regardless of their insurance status or ability to pay. Health access challenges persist with older adults living in the community, as there are more than 9,000 seniors living in Lawndale and Garfield Park, but few, if any, in home service providers, adult day providers, and assisted living facilities that allow those with lower incomes to receive care they need.

Alongside these adverse social determinants of health, community members have experienced high levels of chronic disease and poor health outcomes, especially compared to other Chicago neighborhoods and national averages. Many institutions, including major hospital partners like Rush University Medical Center, have noted the gap in life expectancy between North Lawndale and Garfield Park compared to neighbors in the Loop just a few miles to the east. As a specific example, opioid overdose mortality rates are over three times the Chicago average and over six times the Illinois average. Compounding this issue is the fact the West Side does not have sufficient health professional coverage for the number of individuals in need of accessible, affordable care. This shortage is driven by ongoing challenges with patient access to care, limited numbers of health care providers, and high levels of poverty leading to decreases in the use of preventive and primary care and poor health outcomes.

LCHC offers a wide range of health services including primary, dental, behavioral, pharmaceutical, immediate, maternal, pediatric, and optometry care in seven clinic locations throughout its target neighborhoods and at nineteen homeless shelter partners. These clinic locations are easily accessible by public transportation and are connected to other community organizations, described in detail below. LCHC's care is made accessible and affordable through use of a deeply discounted sliding scale system, as well as by providing care free of charge for patients experiencing homelessness or those living with HIV/AIDS. LCHC's majority bilingual staff provides a high level of service to the 22% of active patients who are uninsured and the 67% of whom are on Medicaid or Medicare. LCHC patients complete a Health Risk Assessment to screen for a variety of adverse social determinants of health, and if assessed to be at-risk can be enrolled in its Care Management program. Care Managers provide referrals and access to additional supports, including healthcare, food, housing resources, and transportation, that work together to promote health and wellness. Through regular calls and culturally appropriate communication Care Managers are able to remind patients of upcoming appointments and support Medicaid re-enrollment and insurance enrollment for eligible patients, and call patients regularly to check in. LCHC uses innovative programs to address patient's health adjacent needs and wellness such as its VeggieRx and FitnessRx initiatives, providing fresh produce and access to an exercise facility at no cost to eligible patients.

2. Describe specifically the strategies you have used to gather input from high risk, underserved and/or disadvantaged population and their leaders as a basis for program or service development.

LCHC centers its core mission on addressing community health needs and a primary way LCHC commits to this endeavor is by employing members of the community. 77% of LCHC staff reside directly within LCHC's service community, reflecting the demographics of LCHC's patients, and in tune with the needs of their communities. LCHC's Board of Directors is required through its bylaws to live or work in its service communities and 90% of current board members are people of color with significant experience guiding community-based organizations and understanding the needs within their own communities.

LCHC also uses consumer engagement tactics in order to address patients' specific needs and adjust care accordingly. Confidential surveys collected on an ongoing basis use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) model developed by the Department of Health and Human Service's Agency for Healthcare Research and Quality. The results of this survey are reviewed annually by the Clinical Quality Management Teams, and patient feedback identifying opportunities for improvement and are incorporated into the for the following year.

Many goals in LCHC's 2024-2026 Strategic Plan seek to further engage the community at both the staff and organization level. To achieve some of the goals outlined in the Strategic Plan, LCHC has created a community survey to gauge community and patient perception, and measure progress towards stated goals. Members of the community have access to this survey to voice their opinions and make suggestions on LCHC's services, responsiveness to community needs, and accessibility.

3. Describe specific partnerships with other providers and community-based organizations to promote continuity of health care for high risk/underserved and/or disadvantaged populations.

LCHC partners with many community organizations, including area churches, other nonprofit organizations, state and local government, and community leaders. Nearly all LCHC's clinics outside of its Ogden Avenue campus are co-located with partners deeply ingrained in neighborhood life. These include LCHC's school-based health center in Farragut Career Academy, its second largest clinic in the Homan Square Community Center, its clinic in the Breakthrough FamilyPlex in East Garfield Park, and its four exam room clinic in the Primo Center Interim Housing Program in Austin. A recent partnership is LCHC's joint mental health expansion grant from the City of Chicago, which has supported its behavioral health team and the work of I AM ABLE Center for Family Development, a North Lawndale based community mental health organization. To address community health and patient's health adjacent needs, LCHC partners with the Chicago Botanic Garden at the Farm on Ogden to run a prescription produce program for LCHC patients called VeggieRx. Providers can prescribe a fresh box of produce grown directly at the Farm or sourced locally to patients at high risk for food insecurity and low access to fruits and vegetables.

Sinai Chicago (Mt. Sinai Hospital) and Saint Anthony Hospital (SAH) are LCHC's primary partner hospitals. Sinai and SAH are safety-net hospitals, community partners with LCHC for over 35 years, and located a mere one mile from its primary clinic. Both hospitals share in LCHC's mission to serve underinvested communities and lower health disparities on the west side. All LCHC faculty have hospital privileges at Sinai and LCHC providers manage the Medical Stabilization Unit (MSU) at St. Anthony Hospital (SAH) to provide needed stabilization services to individuals struggling with substance use disorders. Ultimately, working with SAH and Sinai allows LCHC to provide complete continuity of care to all patients throughout health transitions through warm handoffs and internal or external referrals.

In continued collaboration with the Chicago Department of Public Health (CDPH), LCHC provides primary care and infection control oversight for all west side homeless shelters through CDPH's Shelter Based Service Teams opportunity. LCHC has longstanding partnerships with 12 homeless shelters throughout the city of Chicago, where its Mobile Health Team regularly serves the residents. To address the recent arrival of migrants seeking asylum, LCHC again coordinated with the city to provide health care to this population in seven temporary clinic locations, including acute care, covid and routine vaccinations, medication, and connection to a patient centered medical home.

In 2010, LCHC founded the Illinois Safety-Net Learning Collaborative group. LCHC hosts bi-monthly training sessions for this group of Chicago based safety net healthcare organizations providing care to the underserved to facilitate shared learning and program improvement. These strategic partnerships have furthered LCHC's ability to provide accessible, continuous and holistic health care to patients.

4. Provide two examples of how you have used the community-oriented approach to program development specified in the attached principles to develop a program of service

for high risk/underserved and/or disadvantaged populations specified in the guidelines. Include in each description components of the current program and the following quantitative information for the most recent year available:

LCHC seeks to address community needs by listening and learning from community members. One example is LCHC's HIV program: serving patients free of charge in a community-based model of care. LCHC's HIV program employs a consumer directly, who has been vital in reviewing overall program performance, identifying improvement opportunities, and generally ensuring a high standard of care for all patients with HIV. Additionally, LCHC created and launched a Consumer Advisory Board (CAB) as a strategy for engaging patients in HIV care. Through in-person meetings, patients had the opportunity to express their health and health adjacent needs, citing ways the health center has served them effectively and could improve their care, both anonymously and directly to Clinical Quality team members and physicians and nurses serving John Ryan patients. Virtual options for reviewing the care they receive are available to all patients in the form of a CAHPS survey (Consumer Assessment of Healthcare Providers and Systems). This model, designed by the Department of Health and Human Services' Agency for Healthcare Research and Quality, is also confidential and informs the Clinical Quality Team's Work Plan for modifying and improving aspects of HIV care. Not only does LCHC seek improvement from those involved in HIV care, but it also hosts a Clinical Quality committee including numerous Board members, also patients at LCHC, to evaluate the progress made towards HIV quality goals. These goals are delineated in Clinical Quality projects guided by LCHC's Chief Clinical Officer – Clinical Quality, Clinical Quality Director, and HIV staff team. For instance, LCHC's primary project for its HIV program this year has been its work to improve up to date lab work for all patients. This project was vital to ensuring LCHC's providers and patients have an updated picture of each patient's adherence with treatment and understand their current viral load to take appropriate precautions.

In a second example, LCHC has long operated a Mobile Health program to serve patients experiencing homelessness (PEH) in twelve long-term partner shelters, and seven temporary shelters run by the city of Chicago. The Mobile Health Team (MHT) mitigates the challenges facing PEH by providing medical, mental health, and substance use disorder services directly within its partner shelters, alongside referrals to dental and vision services to one of its seven clinic locations. Partnering closely with the shelters housing these patients, LCHC also seeks to ease health adjacent burdens such as unstable housing, unemployment, and lack of insurance.

LCHC has used this team to understand and adapt to the community's needs by observing and responding to patient needs directly in partner shelters, all without charging patients going through a period of homelessness. During COVID-19, LCHC prioritized finding safe locations for PEH to shelter and isolate and getting vaccines to shelters. To better serve migrants in Chicago following the growth in asylum seekers, LCHC has increased the number of its bilingual and Spanish speaking staff attending to temporary shelters in order to provide culturally appropriate care. From experience serving this population for decades and community health reports confirming high cases of substance use disorder among the population experiencing homelessness, MHT members have worked with LCHC's substance use disorder to increase its services and accessibility for PEH. LCHC has increased Medication Assisted Treatment storage in shelters and Medical Assistants pick up medications from LCHC's pharmacy for PEH. LCHC's intensive outpatient program, Recovery Community, is accessible for patients living in

shelters, and the SUD clinic is open every morning for walk-in appointments. LCHC continuously improves shelter and SUD clinic workflows to serve patients in recovery with efficiency and quality.

5. Number of clients served: 69,141
6. Total amount budgeted by your organization for the program: 73,853,485
7. Percent that program budget is of total agency budget: 100%
8. Percent of program budget that is directly reimbursed by third party payers: 67%
9. Percent of program budget that is covered by public/private grants: 29%