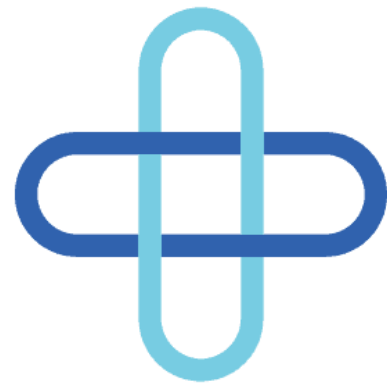


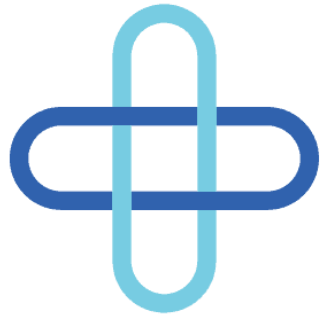


CHICAGOLAND
HEALTHCARE
WORKFORCE
COLLABORATIVE

Making the Case for Healthcare Workforce Investment

Led by Dr. Angela Jackson | September 30th, 2026

Part 1 of a two-part learning series designed to help healthcare leaders measure and communicate the impact of workforce investments



CHICAGOLAND HEALTHCARE WORKFORCE COLLABORATIVE

MISSION

The Chicagoland Healthcare Workforce Collaborative unites employers and industry partners to support an inclusive healthcare workforce, provide accessibility for unemployed and underemployed populations, and develop innovative responses to the evolving needs of the healthcare industry.

STRATEGIC PILLARS

1

Local & Targeted Hiring

Focusing recruitment efforts in areas with higher concentrations of unemployment

2

Education & Training

Bridging the gap by uniting a variety of partners across the healthcare industry

3

Retention & Career Pathways

Offering education & training opportunities to new career pathways for employees

EMPLOYER-LED SECTOR PARTNERSHIP

- 12+ employer partners
- 20+ strategic partners



MAKING THE CASE

The ROI of Healthcare Workforce Investments

Executive Roundtable



Dr. Angela Jackson

Future Forward Institute | Harvard University



COST
TODAY



INVEST
DIFFERENTLY

ROI

VALUE
CREATED

The question is not whether talent matters.

It is whether we can make the business case for investing in it.

1

What is the workforce problem costing us today?

2

What would it cost to build talent differently?

3

What measurable value would that investment create?



The goal today: move workforce strategy from a compelling story to a measurable investment case.

STEP 1

Start with the cost of the status quo

A vacancy is not just an open requisition. Turnover is not just an HR metric.

VACANCIES

Unfilled
capacity
+ time-to-fill

TURNOVER

Replacement +
onboarding

PREMIUM LABOR

Agency +
overtime
+ contract labor

PRODUCTIVITY

Ramp time +
lost output

RECRUITING

Advertising +
bonuses +
sourcing



Before asking, “What will the program cost?” ask,
“What are we already paying because the problem persists?”

A practical ROI framework



ROI is not one number first.
It is a disciplined chain of assumptions that can be tested.

STEP 4

What counts as return?

Not every return shows up in the same place on the P&L.

HARD-DOLLAR SAVINGS

- Lower agency spend
- Lower overtime
- Lower recruiting costs

AVOIDED COSTS

- Fewer vacancies
- Lower turnover
- Fewer readmissions / utilization

CAPACITY + PRODUCTIVITY

- Faster time-to-productivity
- More internal mobility
- More clinical capacity



The right measures depend on the workforce problem you are trying to solve.

TODAY'S CASES

Three ways to make the business case



Dr. Chase Palisch

Vanderbilt University Medical Center

Community
health workers

Costly utilization → targeted workforce intervention



Mamie Williams

CRAFT Education | formerly Vanderbilt

Talent pathways

Build and advance talent → retention + workforce value



Mistie Palmer

AdventHealth

Allied health talent

Buy talent → build talent → measure payback

Listen for the same five questions: **challenge • status quo cost • investment • who • return**

The Vanderbilt ROI Case for Community Health Workers

Cost model for reducing avoidable ED utilization and readmissions — based on Vanderbilt University Hospital ED population data

THE PROBLEM — STATUS QUO COST

\$4M+

avoidable annual cost from preventable ED returns & inpatient readmissions

- 6,600 inpatient bed days/year driven by a high-risk, uninsured population
- 50% ED revisit rate — more than double a healthy benchmark
- ~\$2,500 per inpatient bed day (\$5,000 for a surgical stay)

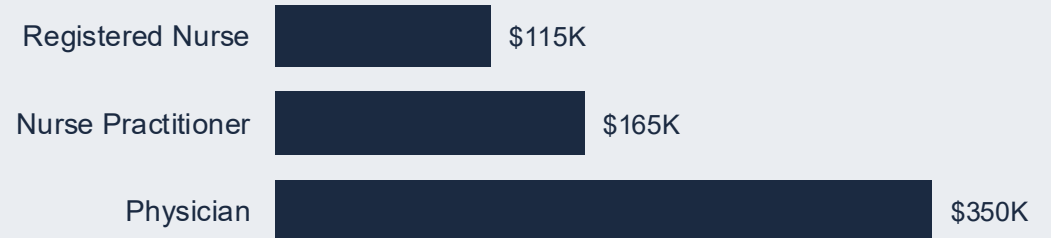
THE CHW INVESTMENT

\$310K/yr

for a team of 5 full-time Community Health Workers

- ~\$22/hr wage → ~\$62K fully-loaded cost per CHW (wages, benefits, supervision)
- Each CHW carries a caseload of ~125 high-risk patients
- Full team costs less than 2 Nurse Practitioners — while reaching far more patients

THE TRADITIONAL FIX — ADDING CLINICAL FTEs



THE PAYOFF — BREAK-EVEN & ROI

31 readmissions

avoided per year is all it takes for the CHW team to pay for itself

- At a conservative 15 avoided readmissions per CHW/year (75 total), the program avoids ~\$750K in costs
- Against a \$310K investment, that's a 2.4x return — roughly \$440K in net annual savings
- Excludes upside from improved insurance enrollment and pipeline value into licensed roles

01

THE CHALLENGE

The work that prevents readmissions had no one built to do it

The work that keeps a patient out of the hospital

**Find patients after discharge**

Shelters, camps, day centers

**Replace IDs, apply for benefits**

Insurance, SSI/SSDI (SOAR)

**Schedule follow-up, arrange rides**

Clinic, specialty, pharmacy

**Build trust over repeated contact**

Often weeks before engagement

**Wrong person, wrong work**

Navigation fell to physicians, nurses and case managers: costly, stretched thin, and not trained for street outreach. Often it didn't happen at all.

**No role existed**

No CHW job description, pay band, supervision model or field-safety protocol for this population. The closest VUMC analog was a Patient Outreach Specialist.

TRY THIS List the tasks behind the outcome you want, then ask which ones truly require a license.

02

THE COST OF THE STATUS QUO

The gap cost us bed days, return visits and margin

\$4.9M

negative contribution margin
on patients experiencing
homelessness (FY23)

6,602

inpatient bed days per year
used by this population

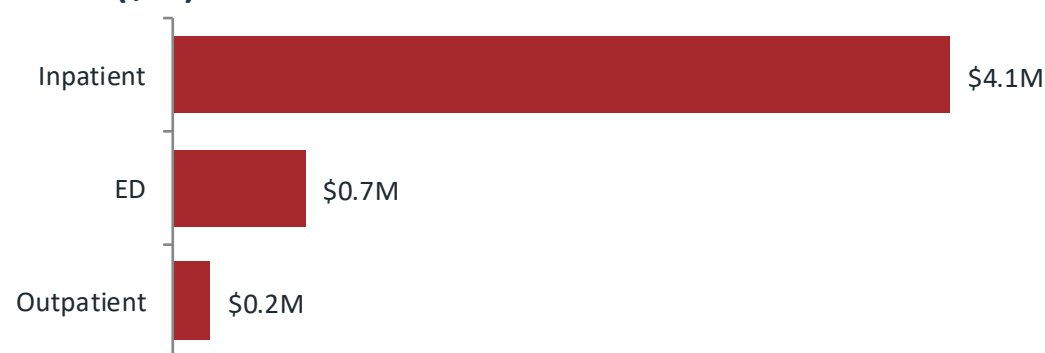
50%

return to the ED within 7
days of discharge

6%

of these patients drive 50%
of direct costs

Where the losses land: negative contribution margin by setting,
FY23 (\$M)

**One patient, three weeks**

4 ED visits, 2 admissions, **\$81,348** in costs, and discharged to
the street every time.

TRY THIS Put the problem in your CFO's units (bed days, margin, repeat visits) and find the few people driving most of it.

03

THE INTERVENTION

We built a CHW role instead of adding clinical FTEs



Identify

Epic ED screening tool and HHS registry flag patients



Engage

CHW meets the patient in the ED or on the inpatient unit



Follow

Weekly street rounds with physicians at shelters



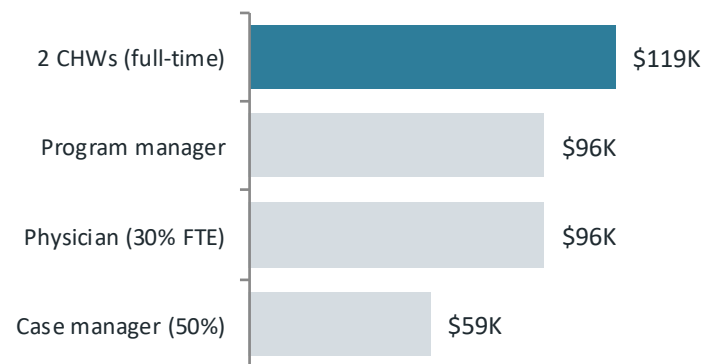
Connect

Benefits (SOAR), insurance, primary care, housing

What we built

- An HHS CHW job description, adapted from VUMC's Patient Outreach Specialist role
- An onboarding curriculum: screening and list management, social needs, SOAR, privacy, SBAR handoffs, field safety
- Clinical supervision through case management, with physicians alongside on rounds

Annual team investment (\$K)

**\$370K**

total per year. Two CHWs cost about 37% of one physician FTE.

TRY THIS Price the new role against the clinical FTE you would otherwise add; seed it with aligned partners.

A new role needed owners on both sides of the hospital walls

INSIDE VUMC

C-suite leadership

Executive sponsorship and investment decisions

Clinical operations leaders

EM, Ambulatory / PCC, case management

HR and talent acquisition

Job description, classification, hiring

Legal and Compliance

Privacy, scope of practice, field-safety guardrails

Finance and Epic / IT

Margin analysis; screening tool and registry

ED and inpatient teams

Referrals, ideally at admission



IN THE COMMUNITY

Metro Nashville government

ARP capacity grant for CHW roles

TN CHW Association

Certification and training standards

Shelters and day centers

Rescue Mission, Room In The Inn, Hospitality Hub and more

Social Security (SOAR)

Disability benefits, which bring Medicaid coverage

Philanthropy

Housing foundation and event donors

Patients

Trust, and feedback on what works

TRY THIS Bring HR, Legal and Finance in on day one. They make a new role real, safe and credible.

05

THE RETURN

Early results: the team more than covers its cost

\$5,321

net median gain in contribution margin per patient after HHS contact (96 patients, equal time before and after)

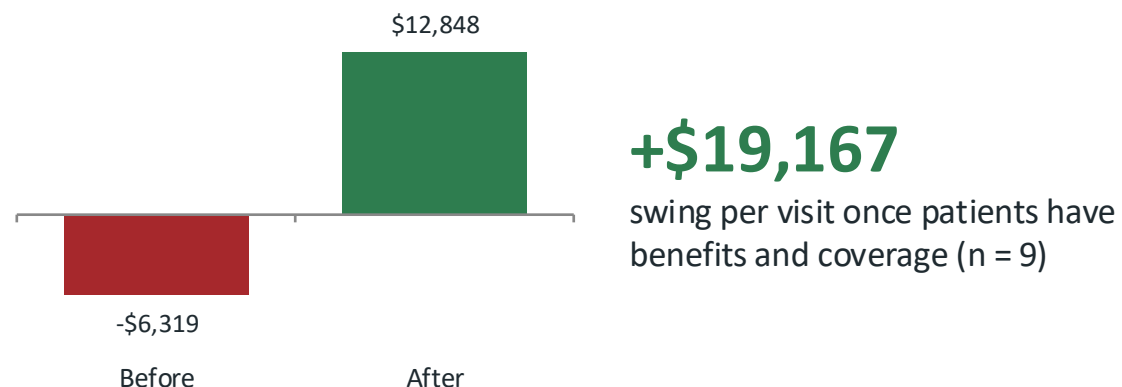
\$506K

annual return vs. \$370K team cost, from HHS patients plus SOAR approvals

\$172K

from just 9 SOAR benefit approvals, enough to fund both CHWs (\$119K)

Contribution margin per admitted visit, 12 months before vs. after SOAR approval

**What we're measuring next**

- 30-day readmission and 7-day ED revisit rates
- Bed days saved and outpatient follow-up kept
- CHW caseload, street contact rate and retention

TRY THIS Start with a simple before/after on a small group. A credible early signal beats a perfect ROI model.

What was the workforce challenge?



MA vacancy problem



The visible problem:
100+ empty MA
positions.



The hidden cost:
Backfilling and Traveler
Costs



The opportunity:
Loyalty → Clinical
Capacity

What was the cost of continuing the status quo?

01

**Vanderbilt
operating
experience:**

Traveler MA pay >
staff wages

02

**National travel-
MA benchmark :**

Traveler avg:
\$1,398/week

03

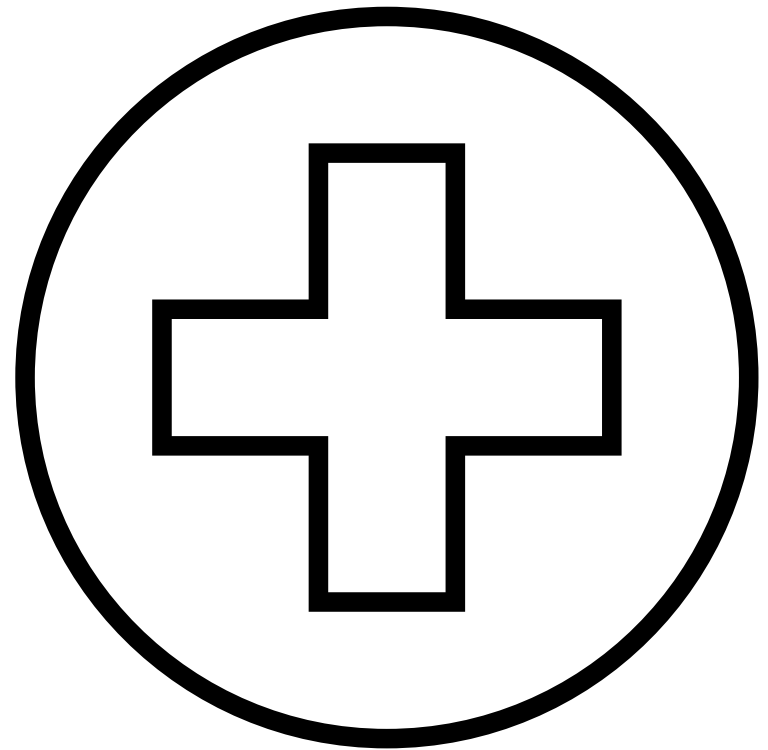
**Staff-MA wage
benchmark: Staff
median:
\$46,910/year (30–
50% gap).**

What did Vanderbilt do differently?

Earn to Learn

Incumbent Worker

Job guarantee



What were the results?

160+ positions filled

88–92% retention

100% pass rate

70+ apps common

The challenge: A market-wide Surgical Technology talent shortage



Rounded planning values used to demonstrate the framework; market identifiers omitted.

Strategic response: Build talent through an internal pathway

The impact: A \$3.3M recurring workforce cost

MODELED TURNOVER EXPOSURE

\$1.8M

Annual departures × average base salary × 0.5

THE 0.5× REPLACEMENT-COST FACTOR INCLUDES

Recruiting & hiring

Pre-employment & onboarding

Training & supervision

Ramp-up productivity

Administrative & manager time

PAID LABOR PREMIUMS

\$1.5M

incremental labor cost paid

\$1.3M

Agency labor premium

Agency hours × rate premium

\$0.2M

Overtime premium

Overtime hours × premium pay

\$1.8M modeled exposure + \$1.5M paid premiums = \$3.3M total exposure

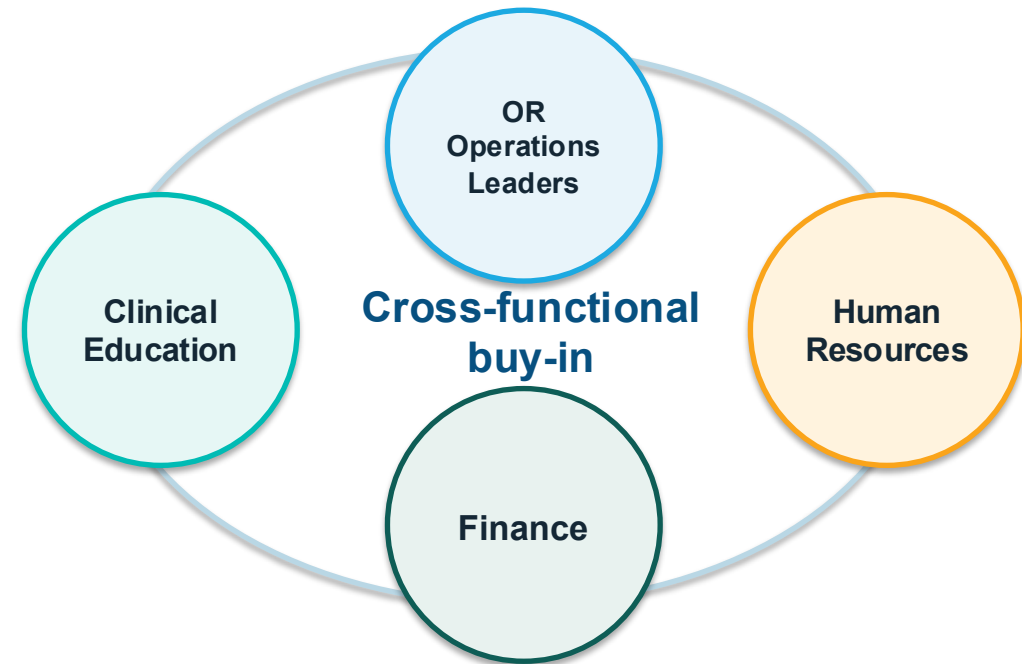
The solution: A 24-week paid pathway to build Surgical Technology talent

WHAT THE PATHWAY COMBINED

- Technical instruction
- Clinical training
- TS-C exam preparation

NCCT-authorized and focused first on internal clinical team members.

WHO HAD TO BE AT THE TABLE



24 weeks

accelerated pathway

100% paid

40 hours per week

361

internal applicants

15

cohort seats

A structured internal pathway gave AdventHealth a way to build talent from within.

The investment: \$570K to build a 15-learner cohort

Illustrative 15-learner cohort investment

PROGRAM INVESTMENT

Loaded paid training time	\$358.0K
Program and exam fees	\$76.5K
Equipment and consumables	\$30.0K
Clinical educator	\$75.0K
Program management	\$30.7K

COHORT ECONOMICS

\$570K

total program investment

15 learners

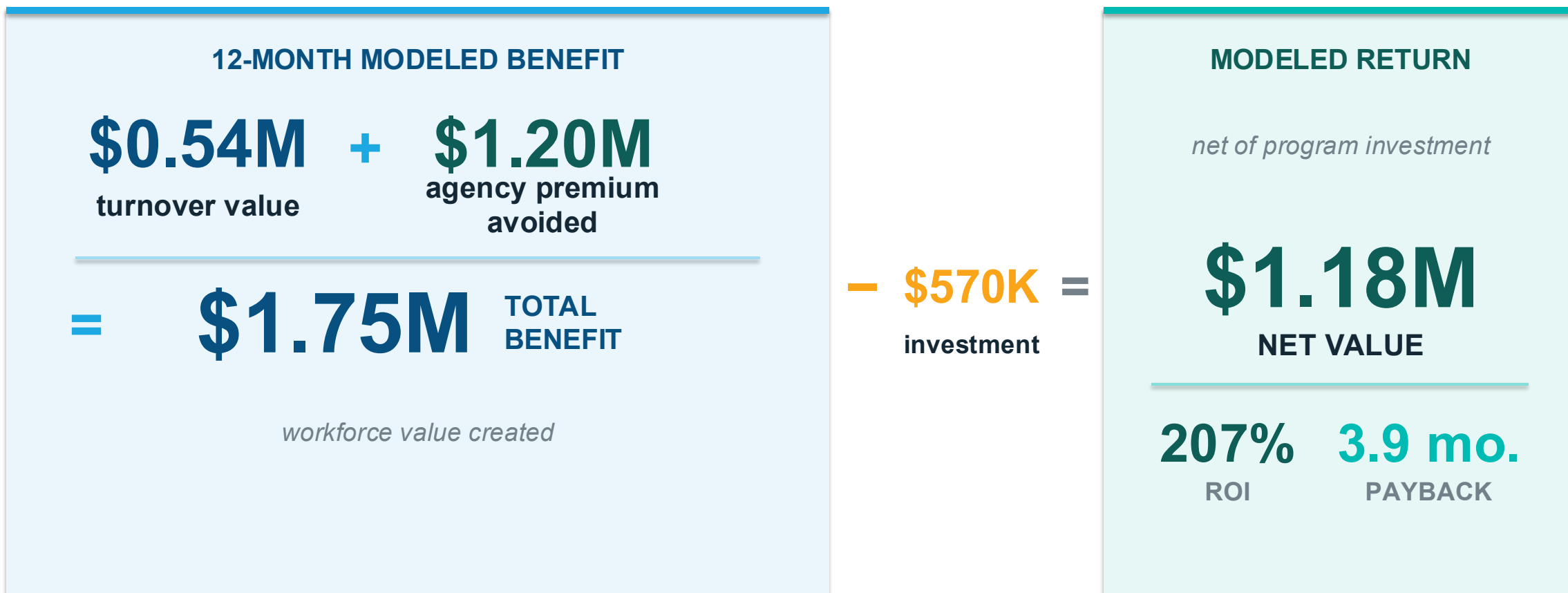
first cohort size

\$38K

average investment per learner

The cost of the pathway included paid learner time and the support capacity required to operate it.

The return: Every \$1 invested generated \$3.07 in value



A role-specific talent pathway created measurable workforce value.

NEXT: PUT THE FRAMEWORK TO WORK

Healthcare Workforce ROI Working Lab

Wednesday, October 14, 2026

Arrival & refreshments: 1:45 p.m. CT | Working Lab: 2:00–3:30 p.m. CT

Chicago Community Trust

BRING ONE REAL WORKFORCE CHALLENGE.

Leave with the beginnings of a business case.



Led by Dr. Angela Jackson

Future Forward Institute | Harvard University

WHAT YOU'LL BUILD

- 1 Cost of the status quo
- 2 Alternative investment
- 3 Expected return
- 4 Internal business case

Chicagoland Healthcare Workforce Collaborative

Appendix: What were the results?

The return was financial, operational, cultural, and strategic.

160+

positions filled

MA Trainee graduates filled roles across the system

88–92%

retention

Reported retention hovering in this range

100%

pass rate

Certification pass rate for trainees

70+

apps common

Applications per cohort are often 70+