Healthcare Transformation Collaboratives Cover Sheet

1. Collaboration Name:
EQUITY FOR AI/AN ILLINOISANS

2. Name of Lead Entity:
AMERICAN INDIAN HEALTH SERVICES OF CHICAGO

3. List All Collaboration Members:

AIHSC

ALL NATIONS HEALTH

MENSAH RESEARCH INSTITUTE

4. Proposed Coverage Area:
COOK, WILL, LAKE, DUPAGE COUNTY

5. Area of Focus:
AMERICAN INDIAN & ALASKA NATIVES

6. Total Budget Requested:
$8,243,535.00

It is with great pleasure that the American Indian Health Service of Chicago offers its application for consideration of the Illinois Department of Healthcare and Family Services (HFS) Healthcare Transformation Collaboratives (Transformation) Funding. We are an ethnically underserved population that has suffered a multitude of historical traumas which have been left untreated. As such, our community suffers from a multitude of socioeconomical, systemic barriers, political nullification, and substandard acknowledgement of existence.

AIHSC was founded in December 1974 and has been successfully contracting with the Indian Health Service for over 40 years. AIHSC has a recently relocated to the Old Irving Park neighborhood from the Uptown neighborhood to follow the American Indian and Alaska Native population who have been transitioning away from Uptown due to regentrification of the Uptown area. Currently our UDS data shows that our two predominant zip codes are our old Uptown zip code and our new Old Irving Park neighborhood zip code.

AIHSC has been located at 4326 W. Montrose Avenue for over 2 years and has under 5 years remaining on its current lease. We currently have 3 clinic exam rooms and 3 behavioral health counseling rooms. We will have one full-time Medical Director, Dr. Albert Mensah (32 hours per week), one part-time physician, Dr. Judith Bowman (10 hours per week), and one full-time Nurse Practitioner, Vanessa Alvarez. To expand our services, we have added a full-time pharmacist, Cynthia Gourneau, Pharm. D. who is also a certified diabetes educator. We have a licensed Public Health Nurse, Jessie Yanson, BSN, RN who is also certified in infection control. We will be adding a Clinical Lead RN to ensure that the clinic runs smoothly and provide coverage or answer questions beyond the scope of our Certified Medical Assistants or MA/phlebotomist.

AIHSC's behavioral health staff consist of Renee Van Doren, LCSW, Kaitlynn Johnson, LPC and Shandiin Begay, MSW, Psychologist & Certified Alcohol and Drug Counselor, Dr. Don Feeney, Jr., Sarina DiMaso, Recovery and Relapse counselor. Ms. DiMaso is a Native American community member certified in Recovery and Relapse, White Bison and Red Road to Wellbriety. We also have a Quality Assurance Inspector/Referral Coordinator to ensure that all grant requirements for measures, reporting and performance are being met and maintained by all staff. Sharon Holt, QAI, is also certified in billing and coding, as well as experienced in Credentialing and Privileging.

American Indian Health Service of Chicago is committed to advancing health equity for the American Indian and Alaska Native population within the greater Chicagoland area. We hope to attain the highest level of health possible for our AI/AN patient population which includes people of all ages and backgrounds within the greater Chicagoland area.

If AIHSC is awarded this grant, we will be able to fulfill the premise of our project: local access to specialty care as well as the need for increased capacity for specialty care services for our American Indian and Alaska Native community with a focus on cultural sensitivity which is lacking at other facilities. The lack of care is causing health disparities in the American Indian and Alaska Native population which is exacerbated by additional social issues such as lack of transportation, housing and food insecurity, high school dropout rates higher than any other demographic, unemployment, and violence in the communities, i.e., social determinants of health that negatively impact health outcomes. Provision of this needed care will result in the improvement of health

outcomes in the American Indian and Alaska Native community, as well as lessen health disparities in the most vulnerable segments of our specific populations (alcohol and drug abuse, pre-natal, elders and youth). Over the past several decades, the lack of specialty care in the vulnerable AI/AN community has led to increased health disparities. The availability of specialists in the socially vulnerable AI/AN community is significantly lower than any other minority community within Cook County. Specialists are unwilling to practice or even see our AI/AN patients due to the percentage of patients who are uninsured or covered by Medicaid, as such it leads to lower revenues for the specialists, which creates a significant void between the reimbursement for physician services and the salaries being paid specialty physicians. Though it is rare to find quality specialty physicians willing to serve our AI/AN community, if we are fortunate enough to receive funding through this grant, AIHSC would be able to contract two part-time specialists as well as another full-time provider to assist in providing basic services to our underserved patient population.

A health-related project of this magnitude has not been addressed since incorporation of AIHSC in 1974 and requires a significant commitment of resources. The project will increase specialty care to meet an unmet need in the AI/AN community to improve health outcomes and make the healthier training/education for our patients. If we are awarded the Illinois Department of Healthcare and Family Services (HFS) Healthcare Transformation Collaboratives (Transformation) Funding 5 though increased health services as well as increased capacity for the social determinants of health in the community that will also improve health outcomes. In addition to the two-specialty care physicians we intend to hire, another full-time provider who will be added to this program as the demand for services increase and or additional specialty services are needed.

Our data shows that one of the significant barriers to care is the capacity and availability of appointments for specialty care. It is not uncommon in our AI/AN community, Chicago, and nationally for some specialties to have a six-month wait for a patient to receive an appointment, resulting in a delay in any possible clinical intervention that could improve quality of life, reduce the risk of disease progression, and assist in overall patient and family wellbeing. There are simply not enough specialty providers in the AI/AN community to serve and treat the general population, much less our AI/AN Medicaid population. Swedish Hospital, for example, is the only provider in the area that offers dermatology services, and as such, our patients cannot be seen for up to a year if they have insurance and the hunt to find rheumatologists who will see AI/AN patients who may be uninsured leaves them with waiting to be seen at Stroger Hospital. Each day our patients must defer care from specialists increases their risk for further complications, potential for amputation, loss of kidney function and even death. Death may seem an overly dramatized statement, but this did happen to a patient within the last year who was waiting to get an appointment with an appointment with an hepatologist or even an internal medicine specialist. The AI/AN young (28-year-old) mother left 4 young children. This is a mortality that did not have to happen. Increasingly many of these individuals resort to using the Emergency Department as their only resource for treatment, however, AI/AN patients are wary of using the ER due to not wanting a bill collector calling them for unpaid hospital bills as they do not have the income to afford paying these bills.

With this application, AIHSC proposes to reduce health disparities within the severely underserved AI/AN community by bringing specialty healthcare services directly to AIHSC which will expand access directly to our community.

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Urban Indian Health Programs

With 7 out of 10 Natives living in urban areas, the Indian Health Service (DHHS Agency) has contracted with 33 urban Indian health clinics to provide basic care for AI/ANs who live in urban areas, which includes Chicago. AIHSC serves the needs of urban Indians (AI/AN) living within the Greater Chicagoland area, AIHSC is one of 33 federally contracted health care centers partially funded to provide direct health care (medical and behavioral) to our American Indian and Alaska Native patient population. Since its inception in 1974, AIHSC has had to decrease services offered to our AI/AN patient population due to the limited funding available to the Indian Health Service Urban Indian Health programs. In the recent several years, IHS has been incorporating the use of culturally grounded and encouraging a focus on providing holistic care to its IHS managed facilities, tribally managed facilities and Urban Indian Health programs. This change has encouraged patients to transition away from use of opioid medications and focus on holistic traditional values and healings. UIHPs provide traditional health care services, cultural activities, and a culturally appropriate place for urban Natives to receive health care.

The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.

Heart Disease is a primary issue within the AI/AN Chicagoland community, including malignant neoplasm, unintentional injuries, and diabetes are leading causes of American Indian and Alaska Native deaths (2009-2011). American Indians and Alaska Natives born today have a life expectancy that is 5.5 years less than the U.S. all races population (73.0 years to 78.5 years, respectively). American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.

Given the higher health status enjoyed by most Americans, the lingering health disparities of American Indians and Alaska Natives are troubling. In trying to account for the disparities, health care experts, policymakers, and tribal leaders are looking at many factors that impact upon the health of Indian people, including the adequacy of funding for the Indian health care delivery system. AIHSC is hopeful that if we are successful in receiving grant funding from Illinois Department of Healthcare and Family Services (HFS) Healthcare Transformation Collaboratives (Transformation) Funding we will be able to add a couple of specialists and permanent full-time provider to assist with the health disparities experienced by AI/AN within the Chicagoland area.

Health disparities as mentioned before are differences associated with social and economic disadvantages in relation to race, gender, and more. Below are a few factors that can contribute to health disparities

- Poverty
- Low Educational attainment/ low literacy
- Unemployed
- Language barriers

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- Unequal access to health care
- Limited access to transportation
- Limited access to healthy food
- Limited housing options
- Environmental conditions

These health disparities are known to affect socially disadvantaged groups such as but not limited to:

- Racial and ethnic minorities (American Indian & Alaska Native, LatinX, African Americans)
- Children
- Elderly
- Poor
- Less educated
- No health insurance
- Lesbian, Gay, Bisexual, Transgender, and Queer (and/or questioning) individuals/identities

Understand the Underlying Causes of Health Inequity

Health Inequity: Disparities in health that are a result of systemic, avoidable and unjust social and economic policies and practices that creates barriers to opportunity (Virginia Department of Health, 2013).

American Indians have a history of health inequity according to the United States Census Bureau (2015) 28.3% of American Indians live in poverty, this is the highest rate among any other race. In addition to having the highest rate of poverty “American Indians and Alaska Natives born today have a life expectancy that is 4.4 years less than the U.S. races population, 73.7 years to 78.1 years, respectively” (IHS, 2016). There may be a possible link between poverty and the reduced life expectancy that American Indians (AI) face. Furthermore, in a recent study by the Indian Health Service (2016) AI have higher rate of easily avoidable diseases such as diabetes, liver disease and more. In the table below, you will see mortality rates for American Indians compared to All other races in 2007-2009 as well as the ratio.

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MORTALITY DISPARITY RATES

American Indians and Alaska Natives (AI/AN) in the IHS Service Area
2009-2011 and U.S. All Races 2010
(Age-adjusted mortality rates per 100,000 population)

	AI/AN Rate 2009-2011	U.S. All Races Rate - 2010	Ratio: AI/AN to U.S. All Races
ALL CAUSES	999.1	747.0	1.3
Heart Disease	194.7	179.1	1.1
Malignant neoplasm	178.4	172.8	1.0
Accidents	93.7	38.0	2.5
Diabetes mellitus	66.0	20.8	3.2
Alcohol-induced	50.0	7.6	6.6
Chronic lower respiratory diseases	46.6	42.2	1.1
Stroke	43.6	39.1	1.1
Chronic liver disease and cirrhosis	42.9	9.4	4.6
Influenza and pneumonia	26.6	15.1	1.8
Drug-induced	23.4	15.3	1.5
Nephritis, nephrotic syndrome (kidney)	22.4	15.3	1.5
Intentional self-harm	20.4	12.1	1.7
Assault (homicide)	11.4	5.4	2.1
Hypertension	9.0	8.0	1.1

* Unintentional injuries include motor vehicle crashes.

NOTE: Rates are adjusted to compensate for misreporting of American Indian and Alaska Native race on state death certificates. American Indian and Alaska Native age-adjusted death rate columns present data for the 3-year period specified. U.S. All Races columns present data for a one-year period. Rates are based on American Indian and Alaska Native alone; 2010 census with bridged-race categories.

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State of Illinois

October 2019

AI/AN, alone	AI/AN in combination	White, alone	African American
13,278 (0.3%)	36,142 (0.7%)	5,227,827 = 56.9%	1,265,134 = 24.2%

In Cook County, the percent of unemployed AI/ANs aged 16 and older was 1.7 times higher than NHWs (13% vs. 7.5%; Figure 4). These estimates do not include individuals in the military or individuals who are institutionalized. In Cook County, more than one in five AI/AN individuals lived in poverty (21.0%; Figure 5), compared to less than one tenth of NHWs (8.2%). AI/AN children experienced more poverty than NHWs. Likewise, over one in five AI/AN children aged 17 and under (22.8%) lived in households with an income below the federal poverty level, which is 2.8 times higher than NHW children (8.2%). In addition, over one in five AI/AN families (21.4%) lived in households with an income below the federal poverty level. This is 4.4 times the proportion among NHWs (4.9%). Finally, among those families in households headed by single mothers, 24.0% of families lived in poverty, which is 2.2 times the proportion of poverty among NHW single mother families (10.9%).

In Cook County, a higher percentage of AI/ANs aged 25 and older had not completed high school or passed the General Educational Development (GED) exam (22.9%; Figure 6) compared with the NHW population (6.5%). A lower percentage of AI/ANs (20.3%) reported an undergraduate or graduate degree as their highest level of education compared with the NHW population (47.6%)

In Cook County, 19.3% of AI/ANs under age 65 reported having no health insurance, a proportion 2.1 times higher than that of NHWs (9.0%; Figure 7). The proportion of uninsured AI/AN children under the age of 18 was 73.3% lower than the proportion of NHW children (0.8% vs. 3.0%; Figure 8) Figure 8. Population Under 18 with No Health Insurance Coverage, Chicago Service Area, 2010-2014 0.8 3.0 0 1 2 3 4 5 AI/AN Non-Hispanic White Percent Figure 7. Population Under 65 with No Health Insurance Coverage, Chicago Service Area, 2010-2014 Source: American Community Survey, 2010-2014 Source: American Community Survey, 2010-2014

Homicides rates were 2.4 times higher for the AI/AN population compared to the NHW population. AI/ANs experienced homicide at a rate of 4.1 per 100,000, compared to the homicide rate of 1.7 per 100,000 for NHWs

Overall Top Causes of Mortality, Chicago Service Area, 2010-2014

	American Indian/Alaska Native, All	NHW	
1	Vascular disease	Vascular disease	Source: US Center for Health Statistics. Death Certificates 2010-2014
2	Cancer	Cancer	
3	Diabetes	Chronic lower respiratory disease	
4	Chronic lower respiratory disease	Diabetes	
5	Assault	Flu and pneumonia	

Table 2. Top Male Causes of Mortality, Chicago Service Area, 2010-2014 AI/AN Males NHW Males Rank Cause Rate (per 100,000) Rank Cause Rate (per 100,000)

AI/AN Male	NHW Male	Source: US Center for Health Statistics Death Certificates 2010-2014
Vascular disease	Vascular disease	
Cancer	Cancer	
Flu and pneumonia	Chronic lower respiratory disease	
Diabetes	Flu and pneumonia	
Assault	Diabetes	

Table 3. Top Female Causes of Mortality, Chicago Service Area, 2010-2014

	AI/AN Female	NHW Female
1	Vascular disease	Vascular disease
2	Cancer	Cancer
3	Chronic lower respiratory disease	Chronic lower respiratory disease
4	Nephritis	Alzheimer's
5	Chronic liver disease/Cirrhosis	Flu and pneumonia

Source: US Center for Health Statistics, Death Certificates, 2010-2014 Table 3 summarizes the top causes of mortality for both AI/AN and NHW women.

Cancer Mortality Table 4. Top Overall Causes of Cancer Mortality, Chicago Service Area, 2010-2014

1	Colon cancer	Tracheal/Bronchitis/Lung Cancer
2	Tracheal/Bronchitis/Lung Cancer	Colon cancer
3	Bladder cancer	Breast cancer
4	Pancreatic cancer	Pancreatic cancer
5	Leukemia	Bladder cancer

In this next segment, we will focus on MATERNAL AND CHILD HEALTH as a need among AI/AN women and children. The first aspect we will provide data on is age. In general, AI/AN women tend to give birth at younger ages than their NHW counterparts. In Cook County, 6.7% of births among AI/AN women were to teenage women (19 years old or less) compared to 2.0% of NHW births. Births were 3.4 times higher among AI/AN teenage woman, compared with their NHW counterparts. In addition, 49.7% of all births among AI/AN women were to women in their 20s, compared to 32.8% among NHWs. Conversely, NHW women had more children in their 30s compared to AI/AN women. While 59.8% of all births among NHW women were to women in their 30s, 37.9% of births among AI/AN women were to women in their 30s.

Marital Status: in Cook County, 46.4% of all births to AI/ANs were to women who were married and 53.6% were to women who were not married. This was significantly different compared to NHWs in which 84.0% of births were to married mothers. The proportion of births to unmarried women was 3.4 times higher among AI/ANs compared to NHWs.

Maternal Mortality Maternal mortality is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy or its management, but not from accidental or incidental causes. Major causes of maternal death include bacterial infection; variants of gestational hypertension, including pre-eclampsia, obstetrical hemorrhage, ectopic pregnancy; and complications of abortions. In Cook County, maternal mortality was 46.2 per 100,000 live births for AI/AN women, which was significantly higher than NHW women. The rate of maternal mortality for AI/AN women was 4.5 times higher than the rate for NHW women.

Gestational Diabetes in Cook County, 3.4% of AI/AN births were to women who were diagnosed with gestational diabetes during their pregnancy. This proportion was like the proportion of NHW women, where 2.5% were diagnosed with gestational diabetes.

Maternal Smoking in Cook County, 4.1% of AI/AN women smoked while pregnant compared to 1.6% NHW women. The proportion of maternal smoking among AI/AN women was 2.6 times higher compared to NHW women.

Prenatal Care: Prenatal care refers to the medical attention received by women before or during their pregnancy, specifically addressing the mother's well-being during her pregnancy and caring for the development of her baby. The goal of prenatal care is to detect potential problems early in the pregnancy and to prevent potential complications. Early prenatal care is a significant component in ensuring a good pregnancy outcome and it is recommended for women to begin prenatal care during the first trimester. Women who receive late or no prenatal care are at risk for having undetected complications during their pregnancy that can result in severe maternal morbidity and mortality, and serious consequences to the unborn infant including low birth weight, premature birth, morbidity, and mortality. Among pregnant women in Cook County, 35.3% of AI/AN women began prenatal care in the first trimester compared to 46.9% of NHW women, a significant difference. In addition, 51.9% of AI/AN pregnant women began prenatal care in the third trimester or did not receive any prenatal care during their pregnancy compared to 45.8% of NHW pregnant women

Infant Mortality: Infant mortality is a useful indicator for the level of health in a community. It is defined as the number of deaths of infants younger than one year of age per 1,000 live births for a given time-period. Infant mortality is related to the underlying health of the mother, public health practices, socioeconomic conditions, and the availability and use of appropriate health care for infants and pregnant women. Two thirds of infant deaths occur in the first month after birth and are primarily due to health problems of the infant or the pregnancy, such as preterm delivery or birth defects. Infant deaths occurring after the first month are influenced greatly by social or environmental factors, such as exposure to cigarette smoke or problems with access to health care. The infant mortality for AI/ANs in Cook County was significantly higher (8.4 per 1,000 live births) than the infant mortality rate for NHWs.

In order to provide better prenatal, postnatal and early interventions for high-risk pregnancies, we believe that by bringing an ob/gyn specialist into AIHSC, we will build upon the community trust that we have developed, and patients will have convenient, timely access to the high-quality specialty care they so need and deserve. It is our hope that by staffing these key specialists on-site at the patients' home clinic we will reduce additional challenges and barriers for patients, ultimately helping to decrease patients' anxiety and increase the likelihood of patients keeping their appointments. AIHSC will also be able to provide transportation for our medically fragile patients to the clinic so that they are able to keep their medical and/or behavioral health appointments.

When looking at the definition of Health Equity: attainment of the highest level of health possible for people of all ages and backgrounds, with focused attention to the needs of those at greatest risk of poor health, based on social conditions. (Braveman, 2014) Within this definition, a focus on Social Determinants of Health Living and working conditions that influence individual and population health, such as your zip code, occupation, race, ethnicity, education, income, gender, and sexual orientation must be considered. AI/AN suffer from high levels of high school dropout which leads to limited economic prosperity, teen-age pregnancy, high unemployment rates, and loss of cultural identity. Economic Prosperity within Cook County for AI/AN persons is difficult to cultivate economic prosperity for AI/AN families with concentrated financial poverty through inclusive initiatives that engage all our patient population across all our communities. Health inequities are a difference based in unjust, socially determined circumstances (for example, American Indians have higher rates of diabetes due to the disruption of their way of life and replacement of traditional foods with unhealthy commodity foods). (MDH, 2014) A particular type of health difference that is closely linked with economic, social, or environmental disadvantage for example, with less access to purchasing healthy foods, our patients are more likely to become diagnosed as Type II Diabetes or hypertensive. Health disparities unfavorably affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. (Healthy People 2020) Health in All Policies (HiAP) Exclusion of American Indians and Alaska Natives in applications or data within the City of Chicago or State of Illinois is another barrier that AI/AN face, because if we do not have an option to check a box we are not represented as we are not a large enough percentage of the overall population to track. However, we are still the original inhabitants of this state and need to be counted. A way to integrate health into all sectors of society that create policies, including but not limited to transportation, criminal justice, economics, housing, employment and wages, recreation, and education. Doing this ensures that policy, system, and environment changes have a neutral or beneficial impact on health outcomes (NACCHO, 2014). As the City of Chicago is predominantly White (Caucasian), we also must address White Privilege which is the system of advantages and benefits that white people receive as a result of whiteness. It is critical that non-Natives gain an understanding of "White skin privilege is not something that white people necessarily do, create or enjoy on purpose. White skin privilege is a transparent preference for whiteness that saturates our society. White skin privilege serves several functions." (Teaching Tolerance, project of Southern Poverty Law Center, 2015) Structural Racism

A major obstacle that new staff are trained on from the first day is to have basic understanding of how health disparities currently and historically impact AI/AN (psychologically, emotionally and physically) and an Indians 101 orientation training. New employees will participate in orientation session and learn about advancing health equity. Orientation and Ongoing participation and engage in health equity learning sessions with teams and/or supervisors. Staff will identify topics and participate in quarterly health equity learning sessions. Quarterly 2016-2018 Engage individuals, families, and community in identifying and planning culturally relevant public health strategies related to advancing health equity. Staff will identify health disparities through public involvement (i.e. community health assessment, home visits, patient contact, focus groups, and various public health agencies). Identify each individual staff member's current AI/AN knowledge and increase each individuals understanding of AI/AN. During annual employee performance evaluation, staff will identify how they engaged in advancing health equity and determine their health equity goals for the coming year. Annually we will use equity lens to identify barriers in processes which hinder advancing health equity. Use quality improvement strategies to identify public health system inequities that create barriers for clients and community and implement recommended changes to minimize barriers

Supervisors and Managers Initiate and engage in health equity learning opportunities to better understand roles of advancing health equity for themselves and department staff. Provide staff with safe and respectful space to engage in health equity learning opportunities to advance health equity. Ongoing Sups/Managers/Staff will identify topics and participate in quarterly health equity learning sessions and provide updates during quarterly meetings on GPRA measures which include health equity goals for our patients. Quarterly 2021-2022; 2022-2023; 2023-2024; 2024-2025 meetings and reports will be run to see how our interventions with Behavioral Health (address Alcohol & Substance Abuse/Misuse and Depression/Anxiety); OB/GYN services to treat prenatal, postnatal, perinatal, and neonatal; and Rheumatology to treat rheumatoid arthritis, osteoporosis, ankylosing spondylitis which is more

prevalent among AI/AN. Staff will gain a better understanding of how health equity fits within social determinants of health and health in all policies framework. New supervisors and managers will complete all required trainings within the first 6 months. Current Staff: Have read, understand and work to promote engagement within the AI/AN community to identify and plan culturally relevant strategies related to health equity work. Help staff to identify health disparities through public involvement (i.e., community health assessment, home visits, patient contact, focus groups, and various public health agencies). Yearly: Evaluate each individual staff member's current AI/AN knowledge and support everyone's increased understanding of AI/AN health equity standards and changes to reach par. (Example: reading an article about health equity as well as trainings count toward advancing health equity) During annual employee performance evaluation, supervisors will identify how each staff member engaged in advancing health equity and assist in determining their health equity goals for the coming year. Yearly-Beginning 2022

Five overarching goals with related objectives. Our goals will be to use the best available evidence for making informed public health practice decisions. The strategic plan that will be developed in beginning in January is intended to be comprehensive of all programs or functions carried out by the organization and areas in which we hope to expand within the next 5 years. Goal 1: Advance health equity – the attainment of the highest level of health possible – for all AI/AN within the

Greater Chicagoland area. Health Equity Objectives 1. Increase knowledge by at least 10% above baseline for all staff of health inequities, the effects on the public's health, and relevance to their job roles and responsibilities, by July 1, 2022. 2. Create and implement an organizational framework within the clinic to ensure a focused approach to health equity, by December 31, 2021. 3. Identify one health disparity with a concentrated AI/AN community-wide focus every two years beginning December 31, 2022. 4. Establish annually a clear policy and advocacy agenda for the clinic to advance health equity and address structural racism against AI/AN and other minority and suppressed groups, beginning July 30, 2022. 5. Identify and implement up to three clinical strategies that promote economic prosperity for AIHSC, by December 31, 2022.

Develop an AI/AN Health Equity Toolkit. The toolkit is a collection of resources made up of activities, articles, data, reports, websites, and video clips about bias, health disparities, health equity, housing, poverty, race, racism, and white privilege. The purpose of the toolkit is to expand all department staff knowledge around health equity and inequities and meet the requirements of the 2022-2027 strategic plan goal of Advancing Health Equity.

Who Should Use the Health Equity Toolkit? Managers and supervisors can search the toolkit for topic related resources based on the needs of each program/division. Staff will also find available resources to use on an individual or small group basis.

Health Equity Team members are available to assist with connecting resources to specific public health work. How Often Should Staff Use the Health Equity Toolkit? Health equity should be embedded into every aspect of health care through a Health in All Policies* approach. Health disparities and inequities are present in our everyday work. Whether it's through how safe people may be during an extreme weather event, how moms and children obtain WIC services or how the department issues grant funding to the community, equity plays a key part in how well the department lessens barriers and helps to create, maintain and sustain healthy communities. It is recommended that department managers and supervisors address health equity with staff on a quarterly basis. One way to accomplish this is to use resources from the toolkit. Sample guides with suggested learnings including the amount of time needed are available in the toolkit. A Health in All Policies (HiAP) approach is a way to integrate health into all sectors of society that create policies, including but not limited to transportation, criminal justice, economics, housing, employment and wages, recreation, and education. Doing this ensures that policy, system and environment changes have a neutral or beneficial impact on health outcomes (NACCHO, 2014)

GPRA Standards

The Government Performance and Results Act (GPRA) requires Federal agencies to demonstrate that they are using their funds effectively toward meeting their missions. The law requires agencies to have both a 5-year Strategic Plan in place and to submit Annual Performance Plans describing specifically what the agency intends to accomplish toward those goals with their annual budget request. GPRA also requires agencies to have performance measures with specific annual targets. Every year, the Indian Health Service reports results for these GPRA performance measures. GPRA measures that must be reported to IHS include clinical care performance measures, such as care for patients with diabetes, cancer screening, immunization, behavioral health screening, and other prevention measures. The agency also reports many non-clinical measures, including rates of hospital accreditation, injury prevention, and infrastructure improvements.

Quarterly GPRA Reporting Beginning in 2018, official GPRA/GPRAMA measure results will be calculated through the Integrated Data Collection System Data Mart (IDCS DM) utilizing National Data Warehouse (NDW) data. However, IHS facilities and participating tribal facilities using the Resource and Patient Management System (RPMS) will still be required to submit GPRA Developmental data twice a year from RPMS's Clinical Reporting System.

Health Equity Plan 2022

Develop public health policies and plans
Conduct a Comprehensive Planning Process Resulting in a AI/AN Community Health Improvement Plan
Conduct a process to develop community health improvement plan
Promote strategies to improve access to health care services
Access Health Care Service Capacity and Access to Health Care Services
Convene and/or participate in a collaborative process to assess the availability of health care services
Identify populations who experience barriers to health care services
Identify gaps in access to health care services
Identify and implement strategies to improve access to health care services
Lead or collaborate in culturally competent initiatives to increase access to health care services for those who may experience barriers due to cultural, language, or literacy differences
Maintain Administrative and Management Capacity
Develop and Maintain and Operational Infrastructure to Support the Performance of Public Health Functions
Maintain socially, culturally, and linguistically appropriate approaches in health department processes, programs, and interventions, relevant to the population served in its jurisdiction

Clinical Metrics

CLINICAL
YEAR 1

Measures	Rheumatology	OB/GYN	General Practice
Baseline= 2021			
Growth in Therapies	>20%		>20%
Growth in Referrals	>40%	>40	>40%
Reduction in ER visits	>20%		>20%
Growth in procedures		>30%	>30%

MILESTONES:

Project Inception

On initial start date, the following specialties will be recruited and hired as soon as possible in a part-time capacity • OB/GYN • Rheumatology

Internal Medicine or General Practitioner provider will be added on Full-time basis once recruited and hired. Increased capacity will be the result of additional recruitment or use of additional providers

In order to meet the expected increased demand for services, several physicians/support staff will need to be recruited by AIHSC and then oriented to the AI/AN community.
The assumption is that the following specialties will be available 6 months post initial start date: • Rheumatology • OB/GYN

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