

# Healthcare Transformation Collaboratives Cover Sheet



## 1. Collaboration Name:

Vermilion County Community Health Collaborative

## 2. Name of Lead Entity:

Carle Health

## 3. List All Collaboration Members:

1. Carle Health (which includes Carle Hoopston Regional Health Center)
2. Crosspoint Human Services
3. Bowman Street Holdings LLC, DBA Heavenly Square Grocery
4. New Life Church of Faith
5. OSF Sacred Heart Medical Center
6. Step Up
7. Danville Area Community College
8. Vermilion Advantage
9. Danville School District 118
10. CRIS Healthy Aging Center
11. Vermilion County Public Health Department
12. East Central Illinois Community Action Agency
13. City of Danville Elected Official (Mayor)

## 4. Proposed Coverage Area: Vermilion County, located in East Central Illinois

## 5. Area of Focus:

Vermilion County has high levels of racial disparities and poverty, especially in Danville, home to the County's largest Black population and the city with the highest poverty rate. There is an extraordinarily high rate of social vulnerability, if not the highest rate, in Illinois.

The Collaborative's work is to bring healthcare equity to and close the health outcome gaps within Vermilion County's most vulnerable communities. The redesigned delivery system ensures that health disparities and social determinants are addressed alongside preventive, primary, behavioral, and specialty health care services. The plan safeguards racial equity and builds in strategies to embrace County member voice.

The Collaborative takes a holistic approach to health care transformation, utilizing layered strategies – one-on-one facilitation and support; service expansion; service colocation and coordination; new initiative implementation; provider increases; and infrastructure enhancements.

Targeted social determinants of health align in four focus areas and correlate to the most significant disparities within the County. Proposed solutions include – 1) increasing income & creating economic stability; 2) creating access to fresh, nutritious & affordable food; 3) ensuring access to community-based entities that address social determinants of health; and 4) ensuring access to community and hospital-based clinical health services.

## 6. Total Budget Requested: \$28,179,824

## Eligibility Screen

*Does your collaboration include multiple, external, entities?*

Yes

*Can any of the entities in your collaboration bill Medicaid?*

Yes

### Contact Information for Collaborating Entities

*1. What is the name of the lead entity of your collaborative?*

Carle Health

*2. Please provide primary contact information, secondary contact information, and the Tax ID # of each entity in your collaborative. Please list the lead entity in the top row.*

Entity Name	Primary Contact	Position	Secondary Contact	Secondary Contact Position
Carle Health (which includes Carle Hoopeston Regional Health Center)	Dr. Timothy Meneely	Medical Director, Vermilion & & Iroquois County, Administration	Caleb Miller	Sr. VP, Specialty Services & amp; Ambulatory Care, Administration
Crosspoint Human Services	Michelle Nelson	VP of Clinical Services	Michelle Glines	CFO
Bowman Street Holdings LLC, DBA Heavenly Square Grocery	Thomas W. Miller	President/Executive Director	Marcia Keys	Store General Manager
New Life Church of Faith	Thomas W. Miller	Pastor	Dr. Eugene Barnes	Associate Minister
OSF Sacred Heart Medical Center	Jennifer Compton	VP Ancillary and Support Services	Jacob Ozier	Director Community Resource Center
Step Up	Deanna Witzel	President	Dale DeNeal	Board Member
Danville Area Community College	Dr. Stephen Nacco	President	Kerri Thurman	Vice President

Vermilion Advantage	Timothy Dudley	President/CEO	Nicole Van Hyfte	Community Development Coordinator
Danville School District 118	Dr. Alicia Geddis	Superintendent	Mrs. Kelly Truex	Director of Special Programs
CRIS Healthy Aging Center	Amy Brown	CEO	Kathy Cooksey	Associate Administrator
Vermilion County Public Health Department	Douglas Toole	Public Health Administrator	Melissa Rome	Emergency Planning and Response Coordinator / Community Liaison
East Central Illinois Community Action Agency	Odette Hyatt-Watson	Chief Executive Officer	Kea Cunningham	Community Services Manager
City of Danville Elected Official (Mayor)	Rickey Williams, Jr.	Mayor	Mona Kennet	Executive Assistant

**3. Please confirm that you have entered the required information for each entity in the table above, including secondary contact information and Tax ID #.**

I confirm

**4. Please upload the most recent IRS Form 990 (including Schedule H, if applicable) for all participants in the collaboration. (Note: These 990s will all have to be compiled into a single PDF file.)**

IRS Form 990 All

## Participating Entities

**1. Are there any primary or preventative care providers in your collaborative?**

Yes

***1A. Please enter the names of entities that provide primary or preventative care in your Collaborative.***

The primary and preventive care provider in the Collaborative is Carle Health. Hoopston Regional Health Center is an entity of Carle Health. Carle at the Riverfront will open in 2023. OSF Sacred Heart Medical Center (OSF HealthCare) also provides preventative care and Crosspoint Human Services is a provider of behavior health and substance use care.

Christie Clinic is not on the Collaborative's Steering Committee but they are a supporter. ChristieClinic is a physician-owned multi-specialty medical practice with one location in Danville, IL.

***2. Are there any specialty care providers in your collaborative?***

Yes

***2A. Please enter the names of entities that provide specialty care in your collaborative.***

Carle Health and OSF HealthCare are specialty care providers. Crosspoint Human Services is a provider of behavioral health and substance use care.

***3. Are there any hospital services providers in your collaborative?***

Yes

***3A. Please enter the name of the first entity that provides hospital services in your collaborative.***

Carle Health

***3B. Which MCO networks does this hospital participate in?***

- YouthCare
- Blue Cross Blue Shield Community Health Plan
- IlliniCare Health
- Meridian Health Plan (Former Youth in Care Only)
- Molina Healthcare

***3C. Are there any other hospital providers in your collaborative?***

Yes

***3D. Please give the name of your second hospital provider here.***

Hoopston Regional Health Center (HRHC) – A Critical Access



**3E. Which MCO networks does this hospital participate in?**

- IlliniCare Health
- Meridian Health Plan (Former Youth in Care Only)
- Molina Healthcare

**3F. Are there any other hospital providers in your collaborative?**

Yes

**3G. Please give the name of your third hospital provider here.**

OSF Sacred Heart Medical Center

**3H. Which MCO networks does this hospital participate in?**

- Blue Cross Blue Shield Community Health Plan
- Meridian Health Plan (Former Youth in Care Only)
- Molina Healthcare

**3I. Are there any other hospital providers in your collaborative?**

No

**4. Are there any mental health providers in your collaborative?**

Yes

**4A. Please enter the names of entities that provide mental health services in your collaborative.**

Steering Committee members Carle Health, Crosspoint Human Services, and OSF Healthcare are providers of mental health services.

**5. Are there any substance use disorder services providers in your collaborative?**

Yes

**5A. Please enter the names of entities that provide substance abuse disorder services in your collaborative.**

Steering Committee members Carle Health, Crosspoint Human Services, and OSF Healthcare are providers of substance abuse disorder services.

**6. Are there any social determinants of health services providers in your collaborative?**

Yes

**6A. Please enter the names of entities that provide social determinants of health services in your collaborative.**

The following entities provide social determinants of health services in the Collaborative: CRIS Healthy Aging, Crosspoint Human Services, Danville Area Community College, District 118 Danville Community Schools, Eastern Illinois Community Action Agency, Heavenly Square Grocer, STEP UP Vermilion County, and Vermilion Advantage.

They are also members of the Collaborative's Steering Committee.

**7. Are there any safety net or critical access hospitals in your collaborative?**

Yes

**7A. Please list the names of the safety net and/or critical access hospitals in your collaborative.**

Hoopston Regional Health Center (HRHC) is the Critical Access Hospital in the Collaborative.

**8. Are there any entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that are majorly controlled and managed by minorities?**

Yes

**8A. Please list the names of the entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that are majorly controlled and managed by minorities.**

Heavenly Square Grocery is a for-profit entity owned, managed, and counseled by people representing the Black community. The Collaborative's leadership will work with the owner to assist them in becoming an Illinois Business Enterprise Program (BEP).

Nonprofit Steering Committee members and Collaborative supporters either controlled or managed by minorities include –

- Dr. Alicia Geddis, Superintendent - Danville School District 118
- New Life Church of Faith in Danville, Pastor Thomas W. Miller is the church's founder.
- East Central Illinois Community Action Agency; Odette Watson is the CEO and Chief Executive Officer; Elder Tyson Parks is board chair.

**9. Please list the Medicaid-eligible billers (firms that can bill Medicaid for services) in your collaborative, and the Medicaid ID for each.**

The two collaborating providers that are Medicaid-eligible billers and would receive HTC funding through this Collaborative would be Carle Health and Crosspoint Human Services. The efforts of this Collaborative are focused in Vermilion County.

- Charlotte Ann Russell
- Cissna Park
- Danville Vermilion (CPG facility)
- Danville Fairchild
- Rossville
- Milford
- Watseka
- Carle Richland Health Center
- Carle Foundation Hospital
- Carle Physician Group
- Hoopston Physician Group
- The Medicaid ID for Crosspoint Human Services

**10. Below are high-level descriptions of project types that appeared in the Transformation funding statute. Check any that apply to your project; if none apply, please provide a brief description of what kind of entities comprise your collaboration. (This question is informational only and will not affect your eligibility).**

- Hospital plus Other Provider Partnerships in Distressed Areas to Address Health Disparities (led By Critical Area Hospitals, Safety Net Hospitals or other hospitals in distressed communities)
- Critical Access Hospital Partnerships (anchored by Critical Area Hospitals, or with Critical Area Hospitals as significant partners)
- Cross-Provider Care Partnerships Led By Minority Providers, Vendors, or Not-For-Profit Organizations
- Workforce Development and Diversity Inclusion Collaborations

## 2. PROJECT DESCRIPTION

### Brief Project Description

**1. Provide an official name for your collaboration.**

Vermilion County Community Health Collaborative

**2. Provide a one to two sentence summary of your collaboration's overall goals.**

The goals of the Vermilion County Community Health Collaborative are to reorient the County's healthcare delivery system in order to reduce disconcerting health disparities, abate reprehensible racial inequities, and enhance the languishing health and wellness of its individuals and communities. Integral to the transformation is the cultivation of a community-driven healthcare delivery system where County residents have a voice in building and maintaining the Collaborative's direction, strategies, and activities.

### Detailed Project Description

#### Introduction

Appalling, unconscionable, and risky. Vermilion County has a long and astounding history of ranking in the bottom quartile and, on occasion, last place as the Illinois County having the worst overall health outcomes among the 102 Illinois counties.

Vermilion County placed dead last in the state in 2019 for overall health outcomes in Robert Wood Johnson Foundation's *County Health Rankings and Roadmaps* national report. In 2021 Vermilion County nudged up three notches to rank 99 out of 102 counties in health outcomes and was at 100 out of 102 counties, up one rung, in health factors. As opposed to health outcomes, health factors estimate the future health of counties compared to all other counties within a state. Both have been languishing at the bottom of the rankings for years upon years. (Please refer to Attachment 1.)

Disparities abound in Vermilion County. Compared to neighboring counties with low overall rankings – Iroquois and Kankakee Counties – Vermilion County fares worse in quality-of-life indicators, health behaviors and clinical care metrics, and social and economic factors.

As a national light shines on health equity, and transparency is obligatory, there is a profound need to formally collaborate and transform the healthcare delivery system in Vermilion County. Three notches up are simply not good enough. The Vermilion County Community Health Collaborative (Collaborative) was born out of moral obligation to do more for its residents.

#### Service Area

Vermilion County is in East Central, Illinois, between Champaign County and the Indiana border. Iroquois County is to the north; Edgar County is to the south. There are 21 incorporated settlements with Danville being the largest city and the county seat.

The County takes in 898 square miles, the equivalent of 574,720 acres. As of 2017 1,029 farms occupied 471,468 acres, which means that 82% of Vermilion County is farmland. ([https://www.nass.usda.gov/Publications/AgCensus/2017/Online\\_Resources/County\\_Profiles/Illinois/cp17183.pdf](https://www.nass.usda.gov/Publications/AgCensus/2017/Online_Resources/County_Profiles/Illinois/cp17183.pdf))

Per the 2020 U.S. Census Bureau Report, the population is 74,188 people. Vermilion County's two most troubled cities are Danville and Hoopeston. The U.S. 2020 Census Bureau Report cites Danville's population as 29,657 people and Hoopeston's as 4,861 people. (Please refer to Attachment 2.)

Vermilion County's most vulnerable residents crowd together in seven of the County's 122 census tracts. They are 17183000100, 17183000200, 17183000300, 17183000400, 17183000600, 17183011200 (all in Danville, where the majority of the County's African American population resides); and 17183010200 (which is in Hoopeston, where the highest number of the County's Hispanic population lives). The Collaborative concentrates its efforts on making a significant impact in these two highly distressed cities – Danville and Hoopeston.

Vermilion County has high levels of racial disparities and poverty, especially in Danville, home to the County's largest Black population and the city with the highest poverty rate. (*U.S. Census Bureau's American Community Survey, Age by Ratio of Income to Poverty Level in the Past 12 Months [Universe: Population for whom poverty status is determined] 2014 to 2019 1-Year Estimates, Table C17024*)

The racial makeup of the County is 82.5% white, **13.0% Black**, 0.7% Asian, 0.2% American Indian, 1.5% from other races, and 2.2% from two or more races. Those of Hispanic origin comprise 4.2% of the population. (<https://datausa.io>)

Danville residents, in comparison, are 62.08% White, **32.71% Black** (60% greater than in Vermilion County), and 7.07% Hispanic. In the seven census tracts with extreme health inequities, the racial and ethnic composition shifts again and are as high as **68% Black** and as low as 25% White.

The demographic profile of Hoopeston is 88.23% White, 1.96% Black, and 11.9% Hispanic. In census tract 17183010200 the ratios shift to 82% White; 2.0% Black; and 12% Hispanic origin.

Poverty is a massive destabilizer. 2019 Illinois poverty rates came in at about 11.5% (13.2% in its rural areas). Vermilion County was at 18.9% (an increase of 3.44% in one year). Danville's poverty rate was 29.4%, the highest in the County; it reflected a 3.47% one-year increase. Danville's poverty rate was twice that of Illinois and 10.5 percentage points greater than Vermilion County's. Hoopeston's poverty rate was lower than Danville's but still almost double that of Illinois. It came in at 22.1%.

Poverty and rurality are major disrupters in Vermilion County. Whites who live in extreme poverty in many instances are just as deprived as their minority counterparts. In Illinois, 44.2% of Whites live in poverty; in **Vermilion County it is an abysmal 60.8%**; in Danville it is 42.4% - equal to that of Illinois; and **Hoopeston is a problematic 82.8%** - nearly twice that of Illinois and

significantly higher than both Danville and Vermilion County. All residents, regardless of color, encounter barriers in seeking access to quality care.

Giving consideration to child poverty rates (that is, the percent of children living below 200 percent of the poverty level), Illinois's 2019 child poverty rate was 16%. Vermilion County, in comparison, was at an astounding 56.5%, qualifying it as having the **highest child poverty rate** of any Illinois county. (Please refer to Attachment 3.)

### **Healthcare Challenges**

It was published that the Healthcare Transformation Collaboratives (HTC) funding stream intends to direct grant awards into regions with high rates of social vulnerability. (<https://www.illinois.gov/news/press-release.23517.html>) Vermilion County, without a doubt, has a high rate of social vulnerability, if not the highest rate, in Illinois.

HTC's launch centered on the regions identified as being the most susceptible to health disparities. The definition of "most vulnerable areas" was based on the U.S. Centers for Disease Control and Prevention's Social Vulnerability Index (SVI) for Illinois and areas disproportionately impacted by COVID-19.

Danville is among the Illinois Metropolitan Statistical Areas with the highest need. In fact, according to the chart in Attachment 4, it has the most need when compared to other Illinois areas. Danville had a score of 98.0%, with 100 being the most socially vulnerable, while the areas in the UIC Study scored between 87.6% (Chicago-South Catchment) and 56.6% (Southern Cook County Catchment).

The Collaborative's work is to bring healthcare equity to and close the outcome gaps in Vermilion County's most vulnerable communities – those that are high on the Centers for Disease Control and Prevention's social vulnerability index and align with the intent of the HTC funding.

The disparities permeating Vermilion County originate from multiple root causes. As a population group, Rural Americans experience significant health disparities that often mirror those of the poorest metropolitan communities. This occurs irrespective of race and ethnicity. Thus, while the most significant health disparities in the County are among the Black population, there are gaps within all racial and ethnic groups compared to Illinois aggregated values.

New data suggests rurality and social determinants of health are "intrinsically linked," prompting a new look at health care access. In 2020 Mayo Clinic published a study in JAMA Network Open suggesting patients living in rural communities' experience disparities in social determinants of health at a higher rate, which could in turn impact cancer screening and preventive care rates.

In terms of healthcare challenges that correlate to disease categories, the leading causes of death in Vermilion County are diseases of the heart, cancer, stroke, chronic lower respiratory disease, and accidents.

## Goals in Addressing Challenges

The Vermilion County Community Health Collaborative uses a stratified yet integrated approach to activate and buoy the healthcare transformation process. (Please refer to Attachment #5.) The undertaking is consequently strengthened and defined by layered and intersecting goals. This approach represents a cohesive and planful strategy.

The Collaborative's **goal statement** is to reorient Vermilion County's healthcare delivery system in order to reduce disconcerting health disparities, abate reprehensible racial inequities, and enhance the languishing health and wellness of its individuals and communities. Integral to the transformation is the cultivation of a community-driven healthcare delivery system where County residents have a voice in building and maintaining the Collaborative's direction, strategies, and activities.

From a macro perspective, the initiative's **design goals** are for the Collaborative to be holistic, innovative, and grounded in racial equity. It will be a multi-sector and multi-stakeholder undertaking and one that can attract and retain a diverse and involved workforce due to its impact and innovative approach.

The Collaborative's **goals relative to health disparities** come together under six groupings— (1) maternal and child health; (2) behavioral health and substance use; (3) chronic diseases; (4) hospitalizations & emergency department visits; (5) food insecurity; and (6) broadband and internet access. Maternal and child health, and behavioral health and substance use for youth and adults, align with the Illinois Department of Healthcare and Family Services' five pillars of improvement.

At least two **clinical outcome goals** support each health disparity grouping. For example, under maternal and child health, the Collaborative aims to increase the percentage of babies born with healthy birth weights and increase the percentage of babies born at term. Under behavioral health and substance use, a sampling of goals includes improving (lower) emergency department rates for adolescent alcohol use and increasing the number of youth and adults treated for and experiencing drug addiction recovery.

A different set of proposed goals correlates to the **social determinants of health** (SDOH) the Collaborative addresses. The goals align in one of four focus areas and directly correspond to an identified need – 1) increasing income & creating economic stability; 2) creating access to fresh, nutritious & affordable food; 3) ensuring access to community-based entities that address social determinants of health; and 4) ensuring access to community and hospital-based clinical health services.

The final cluster of goals relates to the five **pillars of improvement** within the HFS Quality Framework. HFS recognizes 12 **fundamental goals** as core to its quality framework. The 12 goals fall within three classifications – Better Care, Healthy People/Healthy Communities, and Affordable Care. The Collaborative's health transformation initiative focuses on the following objectives as they correlate to these three classifications.

- Under "Better Care," the Collaborative aims to improve population health by improving chronic care outcomes and by increasing access to preventive, treatment, and specialty care services.
- Under "Healthy People/Healthy Communities," the Collaborative's objectives are to improve participation in preventive care and screenings; create a consumer-centric healthcare delivery system; identify and prioritize the most persistent and serious health disparities to equalize; and implement evidence-based interventions to reduce disparities.
- Under "Affordable Care," the Collaborative intends to deploy technology initiatives to streamline and enhance eligibility, enrollment procedures, data integration, and cross-provider communication.

### Strategy

Collaborative partners began by studying the selected health disparities alongside the most prominent social determinants of health and the County's priority needs. The plan aligns best practices that address each chosen disparity and social determinant. The design also takes sustainability into consideration along with how partner, member, and County resources could be leveraged. The goal was for the entire undertaking to incorporate evidence-based, cost-effective, and scalable strategies against those that had been proven to work in Vermilion County or a neighboring region.

The implementation model reflects major stakeholder representation – County members; health care entities and primary care and behavioral health providers; school districts and educational institutions; human and social service agencies; the Critical Access Hospital, Carle Hoopeson Regional Health Center; and payors (such as the existing Alternative Payment Model contract that Carle currently holds with Molina).

Community Health Workers (CHW) and the Healthy Beginnings team anchors the initiatives that are intended to reach County members with the most severe social determinants of health. These health extenders, who employ a home visiting model, address social determinants of health by helping County members acquire family and social supports and by establishing critical linkages and referrals to health and community resources. They tailor solutions to meet each person's unique needs.

In **Pathway 1**, "strengthening county member's ability to persevere," community health workers and the Healthy Beginnings team (nurses, social workers, and early childhood specialists) work with County members to help them acquire **family and social supports and linkages** to community and health resources they are unable to obtain on their own. These supports and linkages are essential first-line strategies to help County members address the four pervasive social determinants of health targeted in this proposal.

In **Pathway 2**, "tackling structural determinants of health," the collaborators and supporters plan to **strengthen six community systems** within Vermilion County – (1) Education and Job Training; (2) Employment; (3) Broadband and Internet Access; (4) Food Access and Security; (5) Community and Social Service Resources; and (6) Health Care Resources. Several focus areas intentionally overlap with those included to address health disparities and represent an investment in services, community resources, and assets. They become the vehicles that enable community members to



eventually overcome the three targeted social determinants of health that are core to the proposal.

The Pathway 2 methodology addresses each need by:

**Establishing or expanding service + Providing individualized  
County member education + Establishing & navigating linkage = ACCESS**

**How Strategy Addresses the Causes of these Challenges**

The above response details how each strategy that addresses social determinants of health correlates to a pressing need in Vermilion County. Articulated below are the tactical activities foreach of the four SDOH focus areas.

SDOH 1) Cause: Poverty > Overall Goals: **Increase income and create economic stability**

Corresponding Activities

- Community Health Workers and Healthy Beginnings Team
- Education and Job Training
- Employment
- Broadband and Internet Access

Corresponding budget line items are personnel; travel; supplies; consultant services; telecommunications; training and education; other/miscellaneous; and indirect costs.

SDOH 2) Cause: Food insecurity > Overall Goal: **Create access to fresh, nutritious & affordable food**

Corresponding Activities

- Community Health Workers and Healthy Beginnings Team
- Agricultural Gardens
- Retail Grocers
- Mobile Market
- Demonstration Kitchen
- Nutrition Education

Corresponding budget line items are personnel; travel; equipment; supplies; contractual; construction; occupancy; other/miscellaneous; and indirect costs.

SDOH 3) Cause: Lack of knowledge & access to community linkages > Overall Goal: **Ensure access to community-based entities that address social determinants of health**

Corresponding Activities

- Community Health Workers and Healthy Beginnings team
- Broadband and Internet Access
- Software to Connect Clinical and Social Service Providers
- Software to Screen for Social Determinants of Health

Corresponding Budget Line Items are personnel; travel; supplies; contractual services; consultant services, telecommunications; training and education; other/miscellaneous; and indirect costs.

SDOH 4) Cause: Lack of knowledge & access to community linkages > Overall Goals: **Ensure access to community and hospital-based clinical services**

#### Corresponding Activities

- Community Health Workers and Healthy Beginnings Team
- Community-based Health Screenings & Preventive Services
- Mobile Health Clinic and Mobile Addiction Recovery Unit
- Behavioral Health Services in Schools
- Primary Care & Specialty Care (in addition to the mobile units)
- Telehealth Services
- Collaboration & Data Sharing Among County Health Care Entities and Providers
- Working with MCOs to Expand and Improve Reimbursements for Value & Outcomes
- AAS in Mental Health Degree (to increase providers)
- Broadband and Internet Access

Corresponding Budget Line Items are personnel; travel; equipment; supplies; contractual services; consultant services; training and education; other/miscellaneous; and indirect costs.

#### **Timeframe**

The Vermilion County Community Health Collaborative requests funding for five years.

#### **Capital Improvements**

The Collaborative's capital purchases include two mobile units, one for the Mobile Market (\$350,000) and one for the addiction recovery mobile unit (\$200,000).

The five-year plan also includes building one brick and mortar grocery store (\$150,000) and the land preparation for two agricultural gardens (\$25,000).

Other capital purchases over \$5,000 include equipment for the demonstration kitchen (\$550,000) and the cooling unit for the Carle-operated food initiatives (\$55,000).

#### **New Interventions**

The majority of proposed activities and strategies are new to Vermilion County and represent evidence-based, successful strategies in healthcare.

One exception is that Carle currently has an alternative payment model (APM) in place with Molina Healthcare. Going forward, the Collaborative will look to expand and improve reimbursements for value and outcomes, prioritizing quality over volume and including formula enhancement. Negotiations will take place with all MCOs that have a contract with Carle. Having these arrangements extended to the Collaborative's providers who do not yet have APMs in place will also be a priority.

The Collaborative will deploy social service referral software and SDOH screening software to be used cooperatively by the Collaborative's providers. This will bring a new associated and aligned focus on data sharing & transparency among health providers. Additionally, a job-sharing program between a community-based mental health provider (Crosspoint Human Services) and Carle to increase patient load variety and decrease burnout is a relatively new concept.

Also new to Vermilion County are the home visiting services (through CHWs and Healthy Beginnings); the addiction recovery mobile unit sized to bring treatment to smaller towns incapable of hosting larger units; the Mobile Market; the two grocery stores; the two gardens; the demonstration kitchen; the Associate of Applied Science degree in mental health; stimulating work force interests and trainings beginning with middle school students; and extending broadband and internet access across Vermilion County so that telehealth services are widely available.

### **Delivery Redesign**

A redesigned delivery system ensures that health disparities and social determinants are addressed alongside preventive, primary, behavioral, and specialty health care services. The plan safeguards racial equity and builds in strategies to embrace County member voice. It follows that services are person-centric as evidenced by the newly implemented home visiting programs.

The Collaborative takes a holistic approach to health care transformation, casting a large net that involves cross-sector, interagency participation and the cultivation of new relationships. Services are provided where they are most needed – Danville, including its most vulnerable census tracts, and Hoopston, the two areas in Vermilion County where racial inequities are most pronounced. Additionally, to increase the impact the strategies reflect layered approaches that include – one-on-one facilitation and support; service expansion; service colocation and coordination; new initiative implementation; provider increases; and infrastructure enhancements.

Finally, the Collaborative will monitor outcomes and health improvements by race. Analysis of the data will drive strategy modifications. All delivery design decisions will be data-informed.

### **Who We Are**

The list of collaborators will continue to grow through intent. Initially 14 partners have come together to drive the Vermilion County health transformation collaborative. These entities and individuals are best positioned to create solutions that address the County's most daunting health needs. The vision is that in time, collective energy will mushroom and involve partners that round out the Collaborative's holistic approach, specifically taking in representatives from housing, the Vermilion County NAACP, environmental surveillance agencies, and law enforcement.

The following details speak to the 14 partners on the Steering Committee.

#### **THREE HEALTHCARE PROVIDERS**

1) Carle Health - Lead Entity (includes Carle Hoopston Regional Health Center, a Critical Access Hospital, and Carle at the Riverfront, to open 2023) is an integrated system of healthcare services that take in a five-hospital system, multi-specialty physician group practices with more than 1,000 doctors and advanced practice providers, Carle Illinois College of Medicine and the Stephens Family Clinical Research Institute. Based in Urbana, IL, Carle has been named a Great Place to

Work®. Carle Foundation Hospital also ranks as one of America's 50 Best Hospitals™ by Healthgrades®.

Carle Hoopston Regional Health Center (Critical Access Hospital) is a 24-bed Critical Access Hospital that provides access to primary care with clinics in Cissna Park, Danville, Hoopston, Mattoon, Milford, Rossville, Tuscola and Watseka. CHRHC employs more than 200 staff members, with over 50 physicians and advanced practice providers. Specialty services include emergency medicine, general surgery, cardiology, orthopedics, gynecology, mental health, and diagnostic services including nuclear medicine, digital mammography, radiology and laboratory. Carle maintains a presence in Vermilion County through two expanded primary care health clinics in Danville. Over the years leadership came to recognize and accept that it was necessary for the health system to catalyze future and further change in the County, particularly in Danville. The merger of Hoopston regional medical center was completed in 2015. Soon after, Carle at the Riverfront was conceptualized; the planning followed.

Underscoring Carle's commitment to Danville and its surrounding communities, Carle worked shoulder-to-shoulder with a land bank, the housing authority, and the City of Danville to purchase fifty-five abandoned and decaying homes in an undesirable and blighted section of the city. The purchase represented the health system's significant commitment to community revitalization; its investment was welcomed by all and continues to be covered by local news outlets.

The health system broke ground this past summer on Carle at the Riverfront. The result of their toil will be a 17-acre, 152,650 square foot site medical campus. Slated for completion in 2023, outpatient clinical services along with an ambulatory surgical center, imaging, lab, oncology, and convenient care will be available on the campus. There will also be a plaza and event space for farmers' markets, health and wellness activities, public transportation access, and one of the Collaborative's proposed grocery stores. (Please use this link to view the progress of this undertaking: <https://youtu.be/G0KEIPgiLog>)

- 2) OSF HealthCare Sacred Heart Hospital (OSF HealthCare) is an integrated health system owned and operated by The Sisters of the Third Order of St. Francis, Peoria, Illinois. OSF HealthCare employs more than 24,000 Mission Partners in 147 locations, including 15 hospitals – 10 acute care, five critical access – with 2,097 licensed beds, and two nursing colleges throughout Illinois and Michigan.
- 3) Crosspoint Human Services has three locations in Danville. Services include care coordination; crisis intervention; counseling, therapy, social and daily living skill training; psychotropic medication/prescription administration and medication counseling training; money management through representative payee services; occupational, physical, and speech therapy; housing, transportation, community education and consultation; psycho-social rehabilitation, and employment development and placement, intensive behavioral support services, suicide prevention coordination, and specialized services for children and families in crisis.

#### EIGHT ENTITIES WORKING WITH SOCIAL DETERMINANTS OF HEALTH

- 4) CRIS Healthy Aging (CRIS) is a nonprofit social services organization in Champaign and Vermilion County. Over the past 48 years they have promoted independence in older

adults through education, health, financial, social, and supportive services.

- 5) Danville Area Community College (DACC), serving the area for more than 65 years, is an accredited public two-year community college in Danville. Both degree credit and career programs are offered. It was founded as an extension of the University of Illinois and has grown into an independent college offering courses in 76 areas of study.
- 6) District 118 Danville Community Schools is comprised of eleven schools – one high school; one Alternative Learning Academy; one middle school; one upper elementary school; and seven elementary schools. The district enrolls 4,867 students. Its minority enrollment of 70% and 57.5% of students are economically disadvantaged.
- 7) East Central Illinois Community Action Agency offers a range of social and human services that help families in poverty take steps toward independence. Their major services include HeadStart; housing and energy assistance; emergency, educational talent search academic, career, and financial counseling); and community development.
- 8) Heavenly Square Grocer, new to Danville, was developed to provide food resources to over 11,000 individual and families on the east side of Danville. The project received a \$6,125 TIF grant for renovations. The mission of Heavenly Square is "to provide our customers with affordable prices, quality products, fast and friendly customer services." They also provide the unique resource of transportation assistance to and from the store.
- 9) New Life Church of Faith is a non-Denominational church in Danville Illinois. The Church was founded in 1986 by Sister and Pastor Thomas W. Miller, in their home. The ministry's sole purpose was to make a local church available to people from all walks of life; whether black, white, poor, rich, educated, or uneducated.
- 10) STEP UP Vermilion County (STEP UP) brings groups of people together to “rally, relate and resource” around the needs County members are experiencing. They are a diverse group of 300 people who come together to work toward a common cause. Their interests include people with mental health, substance abuse and or parenting and family issues.

STEP UP members, and potential future supporters, include – Aunt Martha's; Big Brothers Big Sisters; Blue Cross Blue Shield of I.L.; Boys & Girls Club; Carle; CASA Vermilion; Catlin School District; CCMSI; Celebrate Recovery at Second Church of Christ; Central East Alcoholism and Drug Council; City of Covington, Indiana; City of Danville; Classic Homes Realty; Community Action; Congresswoman Mary Miller; CRIS Senior Services; Crosspoint Human Services; Crossroads Church; Danville Area Community College; Danville Gardens; Danville Housing Authority; Danville Metal Stamping; Danville Mission; Danville Police Department; Danville Women's Care Clinic; Danville School District 118; Fellowship of Christian Athletes; FiberTeq; Gateway Family Services; Habitat for Humanity; Hall of Fame Plaques and Signs; Her House Ministry; Hope Center; Hoopston Multi Agency; Hooves of Hope; Illinois Family Resource Center; Indiana Center for Recovery; Lakeview College of Nursing; Lakewood Insurance Agency; Love Inc; McDonald's dba DND Witzel Enterprises; Neuhoff Media; New Directions Treatment Center; New Life Church; OMNI Youth Services;

OSF HealthCare; Peer Court; Project Success; Rosecrance; Safe Families; Salvation Army; Second Church of Christ; Representative Mike Marron; Representative Tom Bennett; Robinson Chiropractic; Senator Scott Bennett; Southern Illinois Healthcare Foundation; Soul Garden Recovery; Saint James United Methodist Church; Step Recovery; Sunset Funeral Homes; Survivor Resource Center; Sygma; TheDwelling Place; Trigard; United Way of Danville Area; Universal Health Services; Urban Strategies; Veterans Affairs Hospital; Vermilion Advantage; Vermilion County Board; Vermilion County Coroner; Vermilion County Health Department; Vermilion County Mental Health 708 Board; Vermilion County Sheriff's Department; Vermilion County State's Attorney; Vermilion County Probation Department; Western Indiana Community Foundation; Westville School District; White Smith Marketing; WHPO Radio Hoopston, IL.

- 11) Vermilion Advantage's provides strategic leadership on critical business issues, advocating the pursuit of opportunities to strengthen the local economy and business environment. It was founded in 2002 when the Economic Development Corporation and the Danville Chamber of Commerce merged into the organization now known as Vermilion Advantage.

#### TWO INTEGRATORS

- 12) City of Danville Elected Official (Mayor) is the city's chief administrative officer. Rickey Williams, Jr., currently serves in that capacity. His involvement is integral to ensuring the adaptation of racial equity policies and laws, lending credibility to the entire undertaking, and rallying Danville stakeholders to support the Collaborative.

- 13) Vermilion County Health Department operates under a mission to improve the quality of life for all residents of Vermilion County utilizing disease prevention, health protection and health promotion programs through enhanced community collaboration, cooperation and communication. The Department has a key role in providing and organizing county-wide health data and access to data sources, networking various entities throughout the County, and drawing the necessary participants to the health transformation Collaborative.

City of Hoopston Elected Official (Mayor) will join the Steering Committee in Year 2.

#### FIVE SUPPORTERS & MEMBERS (listed in alphabetical order)

Aunt Martha's Health Center is a federally qualified health center with two community health centers in Danville, one of which is a collaboration with OSF HealthCare. They provide primary care services, behavioral health (psychiatry and therapy, telepsychiatry, family planning, parent coaching, support for pregnant women, care coordination, and COVID-19 related services.

Christie Clinic (healthcare provider) is a large physician-owned multi-specialty medical practice in Danville.

Danville Rotary Club recently celebrated its 100-year anniversary. Like other clubs, the 84-member Danville Rotary has seen changes over the years. But its core value – service above self – has stayed the same.

Kiwanis Club of Danville is a community service club that was founded in 1943. Members stage service projects, devote voluntary hours of services, and raise funds for Danville charities and residents.

Project Success of Vermilion County is an umbrella children and family services organization based. They operate 18 sites and one community center in Vermilion County, where they serve over 1,000 area children and families. Critical services are provided to local children, including homework assistance, tutoring, credit recovery, and many project-based academic enrichment programs.

*[Optional] Please upload any documentation you wish to submit in support of your response.*

Section 2 Attachment\_Project Description

### 3. GOVERNANCE

#### Structure and Processes

- 1. Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated and priorities set.*

[Governance Structure] The Vermilion County Community Health Collaborative (Collaborative) represents the coming together of civic, nonprofit, educational, and religious entities to collectively pursue the mitigation of health disparities and racial inequities in the County's most disadvantaged and vulnerable neighborhoods/communities.

The Collaborative's governance model is multi-layered to meet the needs and interests of many. (Please refer to Attachment 6.) Timothy Meneely, D.O., Medical Director, Vermilion and Iroquois Counties, Carle has led the Collaborative's efforts thus far and will continue to act in this capacity going forward. In addition, Carle will be the Collaborative's fiscal agent.

The governance structure of the Collaborative includes the **steering committee**, which is comprised of Vermilion County entities that are hands-on and core to the initiative's work. This group is frequently and interchangeably referred to as the **collaborators or partners** in this proposal.

Many County members participated in the discussions leading up to the submission of this proposal. However, they do not represent entities directly engaged in the Collaborative's work but rather have a social investment and interest in the County, and consequently in this initiative. This group is referred to as the Collaborative's **supporters and members**.

Collaborators and members alike will be asked to bring forward the names of community residents to serve on the **Community Advisory Council** (Council). The Council will be created in the initial months following a grant award so that its members have an opportunity to

comment on, shape, and be involved in decision-making. (The rollout of strategies is over five years, so there remains a considerable amount of work for the Community Advisory Council.) Among the responsibilities of the Community Advisory Council are informing the steering committee about the Collaborative from their perspective and advising them on how implementation would work best. They will be a liaison to the public and have a voice in decision making to ensure engagement and empowerment of those who need the services most. The intent is for the Collaborative to be community and equity driven.

The steering committee, headed by Dr. Meneely, will lead the Collaborative's initiatives. Committee members will meet quarterly to review and discuss how to resolve barriers and obstacles, and to support and encourage continued progress. Essential responsibilities of the committee include – approving the Collaborative's policies; overseeing the Collaborative's budget and approving any budget modifications before their submission to HFS; identifying and implementing new metrics, as needed; reviewing impact via all reported data and activities of the various components; ensuring the Illinois Department of Healthcare and Family Services (HFS) reports are developed and submitted in a timely manner; and bringing forward recommendations for operational improvements and growth.

A transformation grant manager will liaise with the steering committee, supporters and members, and the Collaborative's employees and teams. This individual will assist with the planning and implementation of the health transformation initiative under the direction of the steering committee. S/he will monitor service metrics and engage with staff to ensure the highest level of service; provide thoughtful and actionable suggestions to improve quality and value to the HFS, the Collaborators, and the stakeholders; and participate in the development and implementation of new policies. S/he will be a non-voting member of the steering committee.

An agenda will be developed for each meeting; meeting minutes and action items will be summarized by the appointed secretary. The Council will meet monthly for 90 minutes for the first six months of implementation, then quarterly for the remainder of the initiative's life. Each partner organization will assign a coordinator to ensure their organization's activities for the initiative are completed and their milestones achieved.

Decisions will be made by a majority vote of the Collaborators, either in person or electronically in real-time or asynchronously, and each will have an equal vote. The election of officers, approvals of policies, approval of minutes, and alterations in the program will be by a simple majority vote under parliamentary rules. At no time will a motion be entertained that breaks the underlying construct of a grant award or shifts the payments materially.

Carle will hold the Collaborative's finances and distribute funds based on letters of agreement and the steering committee's approval/review. A budget will be created and accounting maintained by Carle through the transformation grant manager's office. When Collaborative funds are to be used, sub-award letters of agreement will be generated, including articulating metrics to be reported, accounting of funds used, and invoicing arrangements. All payments and expenditures will be authorized under the approved budget.



## STEERING COMMITTEE MEMBERS

### Healthcare Providers

Carle Health (includes Carle Hoopston Regional Health Center, a Critical Access Hospital, and Carle at the Riverfront, to open 2023)

OSF HealthCare Sacred Heart Medical Center

Crosspoint Human Services

### Entities Providing Services Relating to Social Determinants of Health

CRIS Healthy Aging

Danville Area Community College

District 118 Danville Community Schools

East Central Illinois Community Action Agency

Heavenly Square Grocer

New Life Church of Faith

STEP UP Vermilion County

Vermilion Advantage

### Integrators

City of Danville Elected Official (Mayor)

Vermilion County Department of Public Health

Hoopston's Mayor – In Year 2

### Ex Officio Members

Senior VP Carle Health – Caleb Miller

Associate CMO Carle Health – Sally Salmons, MD

## SUPPORTERS & MEMBERS (listed in alphabetical order)

Aunt Martha's Health Center (FQHC)

Christie Clinic (healthcare provider)

Danville Rotary Club

Kiwanis Club of Danville

Project Success of Vermilion County

[Formulating Policies] Policy development initially will be proactive to ensure a smooth start-up phase of the Collaborative. The intent of these policies, which will be approved by the steering committee with input from the Community Advisory Council (as appropriate) and the transformation grant manager, is to anticipate and avoid potential conflict situations and provide solid guidelines for the new employees and committees.

Both staff and leadership will be involved in policy formulation throughout the life of the Collaborative. Policy recommendations often originate with frontline employees and their immediate supervisors; approval of the recommendations then work their way up the chain of command until they reach the steering committee, the body that has final approval of all major administrative policies. (The steering committee does not get involved in detailed staff processes and procedures.)

The Collaborative affirms that staff involvement in policy formulation is important, as staff frequently implement policies. The Community Advisory Council's voice is likewise key as they are frequently in the best position to evaluate what is working and what could work better.

***[1. Optional] Please upload any documentation you wish to submit in support of your response.***

Section 3 Attachment A\_Governance

### **Accountability**

- 2. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally, and with extensive participation from each participating entity? What methods will be used to enforce policy and procedure adherence?***

Leaders of the collaborating entities will be on the steering committee. Each entity was asked to sign a memorandum of understanding which details their responsibilities on multiple levels. (Please refer to Attachment 7.) Stated in the letter is a clause that committee members may be excused at their request or new ones added by committee vote. Should their participation fall off or they demonstrate a conflict of interest, the member may be removed by a majority vote of the steering committee. Participants in the Collaborative's projects are expected to exhibit honest dealing, prudent and ethical actions, and the highest level of community stewardship over the resources of the Collaborative.

Another section in the memorandum of understanding states that all members of the Collaborative confirm they have policies regarding - nondiscrimination; sexual harassment; diversity; ethics; and training in the above regularly for employees.

***[2. Optional] Please upload any documentation or visuals you wish to submit in support of your response.***

Section 3 Attachment B\_Governance

### **New Legal Entity**

- 3. Will a new umbrella legal entity be created as a result of your collaboration***

No

- 4. How will you ensure direct payments to providers within your collaboration are utilized for your proposal programs intended purposes? If the plan is to use a fiscal intermediary, please specify.***

Carle will hold the Collaborative's finances and distribute funds based on letters of agreement and the steering committee's approval/review. A budget will be created and accounting maintained by Carle through the transformation grant manager's office.

When Collaborative funds are to be used, sub-award letters of agreement will be generated, including articulating metrics to be reported, accounting of funds used, and invoicing arrangements. All payments and expenditures will be authorized under the approved budget.

## 4. RACIAL EQUITY

### Racial Equity Impact Assessment Questions

**1. *Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal/policy?***

The Vermilion County Community Health Collaborative's strategies are applicable to most Vermilion County members, irrespective of race. However, because the Collaborative intends to focus on boosting services within Danville and Hoopeston, the racial/ethnic groups to be affected most by and concerned with the issues related to this proposal are the Black and Hispanic populations.

The Collaborative's decision to focus on Danville and Hoopeston was based on the needs expressed by County residents. (Please refer to Section V - Community Input.) The priority needs were then cross-referenced with what published data identified as the most significant socioeconomic disparities in Vermilion County, Danville, and Hoopeston, and the most glaring health care disparities among the Black and Hispanic populations.

**2. *Have stakeholders from different racial/ethnic groups especially those most adversely affected or from vulnerable communities – been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged?***

[Involvement] The **Collaborative** is young, and the existing collaborators intend to cultivate relationships and significantly involve people of color in the ongoing development and operation of Vermilion County's healthcare transformation initiative.

Four Steering Committee members (equivalent to 31%) are representative of the African American community. One was born and raised in Vermilion County; a second member is long-time resident.

[Who's Missing?] The Collaborative seeks to employ a holistic approach in its healthcare transformation initiative. While the majority of Collaborators are linked to health service delivery and social/human/educational entities, the goal is to involve residents, environmental agency representatives, and an additional number of elected officials to participate as either collaborators, partner, or members of the Community Advisory Council.

The Vermilion County Community Health Collaborative also has committed to hiring and contracting with as many County members and/or minority individuals as possible. Targets were set at 10% in Year I; 20% by Year II; and 30% by Year IV.

Because this is a place-based initiative and the targeted population's employability skills are limited, the Collaborative will be challenged to retain a significant number of qualified job applicants within Vermilion County.

3. *Which racial/ethnic groups are current most advantaged and most disadvantaged the issues this proposal seeds to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?*

[Who's Most Advantaged/Disadvantaged] A substantial percentage of its residents will benefit from the implemented strategies because most of Vermilion County is considered rural, and nearly all County members suffer from health inequities. However, as health disparities in Vermilion County are alarmingly higher among Blacks and Hispanics, these population groups stand to gain the most from the proposed initiative. It is important to note that **Danville and Hoopeston are the most racially diverse cities in the County**, and as such, 80% of the initiative's activities target these two areas.

Health disparities among the Hispanic population, while notable, are generally not as pronounced as those in Blacks but are greater than those among non-Hispanic whites.

[How Racial Groups are Affected] Rural communities often exhibit worse health outcomes, have less access to health care resources, and are less diverse than urban communities. This is irrespective of race and ethnicity. Thus, while persistent poverty impacts all races and ethnicities, the health disparities presented in this proposal clearly illustrate that the Black population in Vermilion County fares far worse than its Hispanic and white counterparts.

[Quantitative & Qualitative Evidence of Inequality] Considerable quantitative and qualitative evidence of inequality exists, but perhaps none as disturbing as the citation that follows.

In June 2020, 247WallSt.com published a special report, "The Worst Cities for Black Americans." (<https://247wallst.com/special-report/2020/06/02/the-worst-cities-for-black-americans-6/2/>) To determine the 15 worst cities for black Americans, 24/7 Wall Street evaluated income, education, health, incarceration, and other socioeconomic inequalities using data from the U.S. Census Bureau, the Centers for Disease Control and Prevention, and the Bureau of Justice Statistics. They then ranked the nation's metropolitan areas based on racial disparities. Danville, where most Blacks in Vermilion County live, was among the 15 cities cited. In fact, it came in at a very alarming fifth place. Highlights of the reasons are:

- Black population: 13.0% in Vermilion County; 32.71% in Danville
- Black median income: \$23,963 (49.2% of white income)
- Unemployment: 18.8% (black); 6.9% (white)
- Homeownership rate: 31.7% (black); 75.8% (white)

The authors went on to say,

*“Just 5.3% of black adults in Danville have a bachelor's degree. This is the fourth-lowest share of all metro areas nationwide and nearly one-third of the 15.4% college attainment rate for white adults in the metro area — itself one of the lowest shares in the nation. Racial disparities in educational attainment in the United States are tied to other forms of inequality, including the concentration of poverty in nonwhite communities. Those without a college education are far more likely to live below the poverty line than those with a college education, and in Danville, 48.3% of black residents live in poverty — the ninth highest poverty rate nationwide and far more than the 15.2% white poverty rate in the metro area.*

*Poverty status is one of the clearest determinants of health and life expectancy, and in Danville, health outcomes are far worse for the black population than the white population. For every 100,000 black residents in Danville, 1,208 die each year, **the third-highest black mortality rate nationwide among metro areas**. The white mortality rate in the area is considerably lower, at 923 deaths per 100,000 white residents.”*

In 247WallSt.com’s 2018 report, Danville ranked #13 on the list of worst cities for Blacks. The situation of Danville’s Black population worsened over the past two years.

There are multiple root causes of inequality in Vermillion County. Significant is that compared to neighboring counties that share low overall rankings – Iroquois and Kankakee Counties – Vermillion County fares worst in terms of quality-of-life indicators, health behaviors, clinical care metrics, and social and economic factors.

A sampling of health disparities included in Section 7, Healthy Equities and Outcomes, appears below. It highlights some of the significant variances by race/ethnicity to the high degree of health inequality among Vermillion County residents.

- Adult E.D. Mood Disorder Hospital Visits: Illinois is at 30.37 people per 100,000. Vermillion County comes in at 65.59 people per 100,000 (more than double Illinois’ outcome). But looking at outcomes by race reveals a disturbing picture. The outcomes of Blacks are at 80.85 – 19% higher than in Vermillion County and 30% higher than Illinois aggregation.
- Adult E.D. Anxiety-Related Disorder Visits: Illinois aggregated outcome is 36.73 people per 10,000 people; Vermillion County is at 75.41, again double that of Illinois. But in this indicator, all three racial and ethnic groups greatly exceed that in Illinois and Vermillion County. The outcome of whites is 70.20 compared to 34.48 of whites statewide; Blacks are at 85.08 compared to 50.88 Blacks statewide; and Hispanics are at an astounding 145.22 compared to 31.62 Hispanics statewide.

- Uncontrolled Diabetes (observed): Illinois is at 46.31 people per 100,000 people. Vermilion County is at 73.23 which is 36.7% higher than that of Illinois' combined total. Blacks are at a very high 140.63 compared to 116.18 for Blacks statewide, and whites are at 62.84 over 33.96 for whites statewide.

Years of potential life lost for both the County and the racial and ethnic groups cited are considerably below Illinois. [Years of Potential Life Lost] Years of Potential Life Lost rate for Vermilion County is 10,600 per 100,000 people. (<https://www.countyhealthrankings.org/app/illinois/2021/rankings/vermilion/county/outcomes/overall/snapshot>) Comparing Blacks to whites, the value of the former is 18,100 per 100,000 people. White's level is 9,300, less than the aggregated outcome for the County and nearly half of the rate for Blacks. Illinois is at 6,600.

Vermilion County's jail admissions also demonstrates racial inequality. In 2015 (the most recent data available), Blacks comprised 13.0% of County membership, but 49% of people in jail and 56% of people in prison.

Similarly, although black youth comprised 18% of the youth population (ages 10-17) in 2015, they accounted for 59% of juvenile arrests, 59% of juvenile detention admissions, and 65% of corrections admissions for new sentences.

[What's Missing or Needed] Unfortunately, few studies examine racial and ethnic disparities within rural communities. The authors of this proposal were challenged to obtain information on health disparities and health outcomes by age for Vermilion County's Black and Latinx populations and were similarly limited in finding researched and published health disparities data that had been analyzed by race and ethnicity.

Also needed is a breakdown and analysis of disparities by age, and a more substantial number of health disparities need to be assessed by race and ethnicity.

Quoting a 2016 research report, "Intersection of Living in a Rural Versus Urban Area and Race/Ethnicity in Explaining Access to Health Care in the United States": "It is well documented that people in rural areas have worse access to health care than those in urban areas, but **little is known about the interaction of race/ethnicity and rural residence.**" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4940644/>)

**4. *What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?***

This section examines the factors associated with racial inequity in Vermilion County, Danville, and Hoopston. The latter city was included as the largest percentage of Hispanics in Vermilion County live in Hoopston.

[Factors - Poverty] Poverty aligns with racism. In the 2013 Durbin Declaration presented to the U.N. General Assembly, a U.N. rights expert underscored that "poverty is closely associated with racism and contributes to the persistence of racist attitudes and practices which in turn generate more poverty." (<https://www.socialwatch.org/node/16324>)

Vermilion County has high levels of poverty and racism, as does Danville, home to the County's largest Black population and city with the highest poverty rate.

2019 Illinois **poverty rates** came in at about 11.5% (13.2% in its rural areas). Vermilion County was at 18.9% (an increase of 3.44% in one year). Danville's poverty rate was at 29.4%, the highest in the County, and reflected a 3.47% one-year increase. Danville's poverty rate was higher than twice that of Illinois and 10.5 percentage points more than Vermilion County's. Hoopston's poverty rate was lower than Danville's but still higher than that for Illinois. It came in at 18.1%.

Examining the **percent of residents living in poverty by race**, as of 2019, 44.2% of whites in Illinois were living in poverty. In Vermilion County it was 60.8%; in Danville it was 42.4%, equal to that of Illinois; and in Hoopston it was 82.8%, nearly double that of Illinois and significantly higher than both Danville and Vermilion County. (<https://datausa.io>)

A look at the percent of Blacks who lived in poverty showed a greater level of disparity. In Illinois 23.8% of Blacks lived in poverty. The percent was similar, though slightly higher in Vermilion County, which came in at 20.8%. Danville was at 48.8%, twice that of Illinois. Hoopston, where few Blacks live, was at 2.98%.

Considering **child poverty rates** (the percent of children living below 200 percent of the poverty level), the 2019 child poverty rate in Illinois was 16%. Vermilion County, in comparison, was at an astounding 56.5%, qualifying it as having the highest child poverty rate of any Illinois county. (*U.S. Census Bureau's American Community Survey, Age by Ratio of Income to Poverty Level in the Past 12 Months (Universe: Population for whom poverty status is determined), 2014 to 2019 1-Year Estimates, Table C17024*)

[Factors - Segregation & Lack of Diversity] Racial segregation is a problem across Illinois, not just in Chicago, according to a new study, "Segregated in the Heartland," published in *Governing* magazine. According to rankings on a black-white dissimilarity index, Chicago came in third behind New York City and Milwaukee. Danville placed 12th in the nation, just behind the St. Louis metropolitan area.

Affirming that segregation exists in Vermilion County, there are racial and ethnic minorities in a mere seven of Vermilion County's 122 census tracts. The census tracts are – 17183000100, 17183000200, 17183000300, 17183000400, 17183000600, 17183011200 (all in Danville, where most of the County's African American population resides); and 17183010200 (Hoopston, where most people who are Hispanic live).

[Factors - Rural Implications] It is well-established that the rural poor fare worse than their racial and ethnic counterparts living in urban or suburban areas. Lack of funds to clean the

environment and invest in the poorest sections of the County – and people – are not available. When they do exist, they tend to be allocated to more desirable parts of the region. Historically, rural communities of color that struggle with poverty receive less help – from fewer grocery stores and medical services to housing. (Case in point, Vermilion County does not have a rural flood control infrastructure.) Economic distress compounds and makes it even more difficult for someone to dig themselves out of their depressed socioeconomic situation. These racial inequalities lead to extremely low health outcomes and mental health issues, and with poor health, it is nearly impossible to excel in school or on the job. This is a vicious cycle that the Collaborative pledges to address and improve.

[How the Inequities Arose] The City of Danville is located along the Vermilion River in East Central Illinois, bordering Indiana to the east. It was founded in 1827 when the first grist mill (cereal grain) was built along the North Fork of the Vermilion River, where Ellsworth Park is now located. Additional mills and some sawmills followed. The 1850s saw the construction of the first railroad and the start of coal mining in the area. It was coal that made Danville a railroad hub.

In the 1950s, following a period of decline, financial affluence returned. Several large industries moved into Danville. However, while Danville expanded outward, the downtown was experiencing disinvestment. The connection with the Vermilion River was being lost. Urban renewal initiatives attempted to restore the vitality of downtown but failed to attract enough interest in the inner city.

[Are Racial Inequities Expanding or Narrowing?] It appears that racial inequities in Vermilion County are expanding. There has been a gradual population decline which was most pronounced in the 2020 U.S. Census Report. In fact, in June 2020, **Danville had the largest net population outflow among all Illinois cities**, equal to 1.26 percent. ([https://www.thecentersquare.com/illinois/danville-has-largest-net-population-outflow-among-illinois-cities/article\\_2e164168-a5d0-11ea-ba21-9757c840324c.html](https://www.thecentersquare.com/illinois/danville-has-largest-net-population-outflow-among-illinois-cities/article_2e164168-a5d0-11ea-ba21-9757c840324c.html)) Nationally, only three communities saw a bigger percentage decline. It also marked Danville's largest decrease in population in recent years. Over the past two years, Danville School District 118 dropped by 526 students, a loss equal to about one-and-a-half elementary schools. (<https://vermilioncountyfirst.com/2019/04/18/new-census-data-shows-were-shrinking/>)

White Flight, a companion of migration, is visible. A look at Vermilion County's population between 2010 and 2019 shows that the white population declined by 6,641 County members (a 9.86% loss), against a reported 9.1% decrease for the entire County. This further compares to a gain among Blacks of 229 members. The median household income also decreased between 2010 (\$49,429) and 2019 (\$46,515).

[Root Causes of Racial Inequities] The predominant root cause of racial inequity in Vermilion County has been attributed to poverty and geography. Poverty, in turn, led to segregation (the poor are unable to afford housing anywhere but in the depressed areas of the County). Once a person of color lives in a County's poorest city they can be easily overlooked and given few opportunities to advance beyond their current circumstances.



The Vermilion County Community Health Collaborative's plan addresses poverty and racial segregation. Its core aims are to increase income and create economic stability for County members; create access to fresh, nutritious, and affordable food; ensure access to community-based entities that address social determinants of health; and ensure access to community and hospital-based clinical services.

In response the Collaborative further takes a holistic approach to health care transformation, providing services to where they are most needed and focusing on involving Danville and Hoopston County members where racial inequities are most pronounced.

**5. *What does the proposal seek to accomplish? Will it reduce disparities or discrimination?***

[What the Collaborative Seeks to Accomplish?] The Vermilion County Community Health Collaborative seeks to cultivate a county-wide network of stakeholders and innovators who together, with commitment and toil, establish a multi-sector, holistic, and unprecedented undertaking. The proposed initiative sets out to minimize health disparities, obstruct their closely aligned racial inequities, and diminish the impact of the County's most pressing social determinants of health. Eighty percent of Collaborative's activities will take place in Danville and Hoopston.

After all, the County ranks in just about last place in the 2021 Illinois County Health Rankings published by the University of Wisconsin Population Health Institute. There's no other acceptable path but upward, and that's where the Collaborative intends to lead the County.

The Collaborative is implementing a place-based initiative and making a long-term commitment to health care transformation.

[Will Disparities or Discrimination be Reduced?] YES. Evidence-based strategies and best practices are being employed. Approaches are tailored to reach deep into the target communities. New employees, to every extent possible, will reflect the populations served. The approach is holistic and broad and will be guided by a Community Advisory Board.

A sampling of the disparities and racial inequities to be reduced are infant mortality, chronic diseases and chronic disease morbidity, addiction and other behavioral health disorders, drug overdose mortality rates, food insecurity, social services and health care lack of access, poverty, and roadblocks to career pathways, educational opportunities, and jobs.

**6. *What are negative unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts to be prevented/minimized and equitable opportunities be maximized?***

[Unintended Consequences] The Collaborative does not anticipate adverse impacts occurring within the County. That is because mostly all residents and businesses stand to benefit.

Attainment of the established milestones could be hampered, however, if external factors slow hiring. The two most likely to delay hiring and cause the Collaborate to veer off its mark are:

1. The nationwide job shortage means there could be a limited pool of interested applicants; and
2. A qualified workforce might not exist in Vermilion County despite the Collaborative's desire to hire as many County members as possible to fill vacant positions.

[Negatively Affected Racial/Ethnic Groups] All racial and ethnic groups are represented in Vermilion County and nearly everyone can benefit from the services provided. No one is excluded based on race and ethnicity – Blacks, Hispanics, and Whites are all in need of these services that will be provided.

[Minimizing Adverse Impacts] Adverse impacts can be prevented and minimized by assuring County members (residents and businesses) feel a sense of ownership. The Collaborative's messaging will position the Collaborative as an opportunity for Vermilion County members, one where everyone stands to gain. Achieving continuous and authentic two-way communication must be practiced by the Collaborators and supporters. The Community Advisory Council is also tasked with averting any adverse impacts before they become significant.

**7. *Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?***

[Ensuring Positive Impacts] The Vermilion County Community Health Collaborative spent many months developing its healthcare transformation model. However, the plan is fluid – and needs to remain such – to optimally address the effective reduction of health disparities and ensure continued progress toward reaching health equity. The experience has been that at each Collaborator's meeting, additional strategies emerge. Additionally, each quarterly evaluation will inform future implementation, allowing the Collaborative to ensure positive impacts on racial equity and inclusion.

The Collaborative will seek additional strategies to create a more holistic model to improve health outcomes as the months' progress. This includes broadening the stakeholder base. For example, the vision is for the Vermilion County Housing Authority representatives, the Danville Department of Engineering & Urban Services, and the Sheriff to become partners. The collaborators also look forward to the full support of elected and appointed officials to ensure movement in adapting racial equity policies and laws. Engagement with the Vermilion

County NAACP Chapter can also serve to strengthen the Collaborative's efforts. Finally, the Collaborative is eager to engage the Community Advisory Council.

[Changes to Ensure Positive Impact] The Collaborative could adopt, promote and advocate for a "Health in all Policies" approach as promoted by the CDC. They intend to integrate health consideration into social, economic, and health policies across all sectors. Taking this approach could certainly boost the Collaborative's efforts to improve health for all communities and people.

**8. *Is the proposal realistic adequately funded, with mechanics to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting stakeholder participation and public accountability?***

[Why the Plan is Realistic and Doable] Evidence-based strategies ground the Vermilion County Community Health Collaborative. They were decided upon by Vermilion County professionals in health care, social services, and education. All were in agreement with the proposed plan. Additionally, having Carle as the lead entity and fiscal agent strengthens the plan's viability due to their stature and commitment to Vermilion County and their expertise and willingness to leverage their internal resources.

When the Collaborative members decided what strategies to include in the health transformation initiative, a critical criterion was that proposed activities had to have a likely, identified, and alternative source of funding that could partially or fully sustain that activity's continued implementation beyond the end of the grant period.

The health transformation collaborative is modestly funded and the Steering Committee approved the budget. There will be a gradual rollout of activities, ongoing evaluation (including monthly financial statements), and a reliance on multiple revenue sources. If necessary, contingency will be put in place by the Steering Committee to ensure the Collaborative is implemented with success and for the long term.

The presence of Carle at the Riverfront will also serve as a cornerstone of opportunity by promoting an abundance of health care services, jobs, resources, and community beautification.

[Ensuring Data Collection, Public Reporting, Stakeholder Participation, & Public Accountability] The Vermilion County Community Health Collaborative represents the coming together of civic, nonprofit, educational, and religious entities to collectively pursue the mitigation of health disparities and racial inequities in the County's most disadvantaged and vulnerable neighborhoods/communities. The Collaborative is committed to data collection as detailed throughout the proposal, public reporting, stakeholder participation, and public accountability. The Collaborative's governance model safeguards against any actions to the contrary.

**9. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?**

[Success Indicators & Progress Benchmarks] It is the Vermilion County Community Health Collaborative's intent to report data on performance, outcomes, and targets in aggregation and by race and ethnicity. Collaborators are eager to work with HFS on setting baselines and finalizing success indicators and progress benchmarks.

The Collaborative will focus on a set of metrics that relate to the racial inequalities discussed in this section. In addition to its measurement of healthcare disparities and outcomes, these measurements correlate with the goals stated earlier in the Racial Equity Impact Assessment Form under "Clarifying the Purpose" Question 5.

There will be a set of **process objectives** metrics that tie back to the question, "did the Collaborative do what they said they would do." For example, will 80% of project activities actually be in Danville and Hoopston? How many food security initiatives were launched and where were they located? How many people benefitted? Similarly, the Collaborative will look to confirm that an increased number of youth and adults were screened for depression. How many open positions were filled by minorities? Were additional people of color brought onto the Collaborative as either collaborator, partner, or member?

Racial improvements in **health outcomes** will be tracked, as well. By collecting and analyzing data for each cited health disparity by race, decreases among all racial groups can be noted. Similarly, will the number of emergency room visits decline by race and ethnicity so that Vermilion County is more in line with the aggregated number in Illinois? Finally, there will be reviews of Robert Wood Johnson's Community Health Rankings to affirm that Vermilion County is no longer at the bottom of Illinois Health Outcome and Health Factor ratings.

Another set of metrics, although they represent **long-term goals**, tie to externally measured indicators and most often relate to the systemic inequalities mentioned earlier. These will include reviewing annually published reports on Black/African American and Hispanic median income and how that (changed) number correlates to the median income of the white population in Vermilion County. The Collaborative is also interested in monitoring Black and Hispanic unemployment rates and how that (changed) percentage correlates to the unemployment rates of whites. Like reviews will be made for all the social determinants of health metrics targeted in the Collaborative's proposal.

In addition to the named measurement categories, the Collaborative will count and assess participant engagement in all activities by race/ethnicity to assure equality, and all studies will look for baseline improvements. The number of people of color who become collaborators will also be a success indicator.

The above detailing is not inclusive; rather, it is an example of the success indicators and progress benchmarks that comprise the Collaborative's collection and study of metrics.

[Documenting & Evaluating Impacts] The transformation grant manager is responsible for collecting, evaluating, and documenting the data and findings for the initiatives addressing economic stability, food security, and access to care. The team members heading the community health worker's program and Healthy Beginnings, two initiatives that focus on building County members' resilience, are responsible for collecting, evaluating, and documenting their impacts and submitting those results to the project manager.

Most impacts will be measured quarterly and presented at the corresponding quarterly meeting of the Collaborative for review and evaluation. Carle's Business Intelligence (CBI) office will provide in-kind services for data extrapolation and reporting.

[Assessment of Engagement] The Collaborative will use membership rosters, meeting participation, collaborator satisfaction surveys, partner satisfaction surveys, and Community Advisory Council satisfaction surveys to assess the level and diversity of stakeholder engagement.

To measure the ongoing quality of stakeholder engagement, the Collaborative will evaluate individual stakeholder feedback, as well as their tangible involvement. Did stakeholders bring additional County leaders and residents to the table? Did they help to form the Community Advisory Council? Did they negotiate partnerships with public leaders, business owners, government entities, and funders on behalf of the collaborative?

The transformation project manager will complete these assessments.

## 5. COMMUNITY INPUT

### Service Area of the Proposed Intervention

**1. *Identify your service area in general terms.***

The service area is Vermilion County in East Central Illinois. It is between Champaign County to the west and the Indiana border to the east.

**2. *Select all Illinois counties that are in your service area.***

Vermilion County

**3. *List all zip codes in the service area separated by commas.***

There are 24 zip codes in Vermilion County:  
61832 – Danville (racially diverse section) and 61834 – Danville; 60942 – Hoopston, 61846, 61883, 61858, 61817, 61833, 60963, 61841, 61870, 61865, 61814, 61844, 60960, 61876, 61811, 61850, 61812, 61810, 61848, 61857, 61831, 60932

## Community Input

### *1. Describe the process you have followed to seek input from your community and what community needs it highlighted*

[Process] Carle Foundation Hospital's (Carle) executive team, led by Caleb Miller, Senior Vice President Carle Specialty and Ambulatory Care and Timothy Meneely, D.O., Medical Director, Vermilion and Iroquois Counties, were eager to begin dialoguing about a transformation collaborative. Carle had just completed its strategic plan and community health needs assessment, and an upcoming groundbreaking for Carle at the Riverfront in Danville was approaching. The team was highly motivated by the opportunity to reduce healthcare disparities, address racial inequity, and bring a coordinated platform of resources to the residents of Vermilion County.

Dr. Meneely has been meeting individually and engaged in telephone conversations with community stakeholders since July 2021 to generate interest and garner a network of supporters who were interested in collectively developing the Vermilion County Community Health Collaborative. There were hundreds of telephone calls, emails, and one-on-one meetings. Contact was made with businesses, organizations, and elected officials. The entities, in turn, brought forward the needs of the County residents. Most have consumer councils and a means to obtain County resident feedback. For example, Pastor Miller of New Life Church of Faith was able to speak on behalf of his parishioners. The East Central Illinois Community Action Agency supplied a summary of community needs based on the telephone calls for assistance. Heavenly Square Grocery, newly started by a community member, was well versed in food security. Because they continuously develop classes to meet the expressed needs of their students, Danville Area Community College was in a position to bring information forward. Similarly, the superintendent of Danville's School District 118 spoke on behalf of her students. All of these entities directly serve County members day in and day out.

The first Zoom group meeting was held in August for those interested in either finding out more about or joining the Collaborative. Subsequent meetings continue to be held approximately every two weeks. Throughout, community stakeholders have been eager to participate in the Collaborative and make it happen for Vermilion County residents.

Also in August, leadership utilized the direct input received from over 1,100 County residents via a community health survey administered between August and November 2019. (Please refer to Attachment 9.) The results were included in the 2021-2023 Vermilion County Community Health Plan which incorporated the community health needs assessment for the County. The Collaborative partners agreed that the community's priority needs were income stability, food security, and access/linkages to human, social, and health and behavioral health services. (Please refer to Attachment 10.)

The next step was to develop strategies to address the County resident's needs. The resulting plan includes either expanding or establishing preventive, primary care, and specialty health care services; behavioral health access; grocers; agricultural gardens; mobile food purchasing; nutrition education; coaching and mentoring programs for youth, jobs and job training programs; and career pathways.

As mentioned in the previous section on governance, the Vermilion County Community Health Collaborative will establish a Community Advisory Council. The Council will be developed during the initial planning stages after an award is made so that its members have an opportunity to comment on, shape, and be involved in decision-making. Community members themselves are best positioned to inform the Collaborative partners and members as to their most pressing needs. The vision is that operationally all governance entities will function as one cohesive unit.

Among the responsibilities of the Community Advisory Council are informing the steering committee about County member needs from their perspective and advising on how implementation would work best. They will liaise with the public and have a voice in decision-making to embed engagement and empowerment.

Collaborative partners will bring forward the names of residents to sit on the Council.

[Elected Officials] The Collaborators have consulted with Mike Marron, State Representative 104<sup>th</sup> District; Scott Bennett, State Senator, Illinois 52<sup>nd</sup> Senate District; and Rickey Williams, Jr., Mayor, City of Danville. Mayor Williams has been attending the Collaborative meetings. Letters of support have been submitted by all three elected officials.

**2. *Please upload any documentation of your community input process or findings here.***

See Section 5 Attachment A\_Community Input

**Input from Elected Officials**

**1. *Did your collaborative consult elected officials as you developed your proposal?***

Yes

**1A. *If you consulted Illinois federal or state legislators, please select all legislators whom you consulted.***

Bennett, S. – Ill. Senator – 52<sup>nd</sup> State Senate District, Marron M. – Ill. Representative – 104<sup>th</sup> State Representative District

**1B. *If you consulted local officials, please list their names and titles here.***

Rickey Williams, Jr., Mayor, City of Danville. Mayor Williams has been attending the Collaborative meetings.

*[Input from Elected Officials – Optional] Please upload any documentation of support from or consultation with elected officials.*

See Section 5 Attachment B\_Community Input

## **6. DATA SUPPORT**

### ***1. Describe the data used to design your proposal and the methodology of collection.***

The data used to design the Collaborative originated with the Vermilion County Community Health Needs Assessment (CHNA), completed in December 2020. The CHNA was designed under the guidance and structure of the Illinois Project for Local Assessment of Needs (IPLAN) and was the result of a comprehensive, community-based public health needs assessment. The CHNA “used aggregated data accessed from CountyHealthRankings.org, Center for Disease Control and Prevention, U.S. Census Bureau, Illinois Department of Public Health, Illinois State Police Crime Reports, Illinois Department of Healthcare and Family Services, and local city and county agencies.”

Following the CHNA, the “Vermilion County Community Health Plan, 2021-2023” was published. This subsequent document represents the joint work of the Vermilion County Health Department, OSF HealthCare, United Way of Danville Area, and Carle.

Work on the Needs Assessment and Plan informed the development of Carle’s strategic plan. The two documents, each representing a large body of work, were pivotal to Carle’s decision to initiate a healthcare transformation in the County.

When it came time to develop the foundation of the Collaborative, participants began with the CHNA followed by the 2021 Robert Wood Johnson’s County Health Rankings. (This was a comprehensive source of data in that a considerable amount of (but not all) information was available by race. That led the team to use the Illinois Public Health Community Map, published by the Illinois Department of Public Health, another excellent resource (<http://healthcarereportcard.illinois.gov/maps>), Conduent Healthy Communities data (<https://carle.org/about-us/community-report-card>), and in-house data including one additional document, the Carle Hoopeson Regional Health Center Plan (in northern Vermilion County), 2021-2023. Excel spreadsheets were used to analyze the data.

### ***2. Attach the results of the data analyses used to design the project and any other relevant documentation.***

See Section 6 Attachment\_Data Support

## **7. HEALTH EQUITY AND OUTCOMES**

### ***1. Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes***



[Targeted Healthcare Disparities] The Collaborative intends to reduce the health disparities that contribute to health inequity and to conversely improve the health outcomes for all who live and work in Vermilion County. Clinical interventions are recognized as being half the battle to attaining the goal. The other half addresses racial equity and its co-occurring social determinants of health.

The specific health disparities targeted are organized into six sets. They show significant outcome gaps by race and by region, making it clear why Vermilion County continues to be among the least healthy counties in Illinois. The disparity groupings are – Maternal and Child Health (also a 29 Pillar); Behavioral Health and Substance Use (also a Pillar); Chronic Diseases; Hospitalizations and Emergency Room Visits; Food Insecurity; and Broadband and Internet Access. Line-by-line details follow.

### **MATERNAL AND CHILD HEALTH** – PILLAR

1. LIVE BIRTHS WITH LOW BIRTHWEIGHT  
**Vermilion County = 11%** (highest rate among all Illinois counties); Illinois = 8%  
Disparity by Race/Ethnicity: White = 9%; **Black = 17%**; Hispanic = 6%
2. INFANT MORTALITY (per 1,000 live births)  
**Vermilion County = 11** (highest rate among all Illinois counties); Illinois = 6  
Disparity by Race/Ethnicity: White = 8; **Black = 74**; Hispanic = Data not available
3. PRETERM BIRTH RATE  
**Vermilion County = 15.40%** (fifth highest rate among all Illinois counties);  
Illinois = 10.7%  
Disparity by Race/Ethnicity: White = 14.59%; **Black = 18.73%**; Hispanic = 7.96%

### **BEHAVIORAL HEALTH & SUBSTANCE USE** (youth & adults) – PILLARS

1. ADULT EMERGENCY DEPARTMENT MOOD DISORDER VISITS (per 10,000)  
**Vermilion County = 65.59**; Illinois 30.37  
Disparity by Race/Ethnicity: White = 63.89 (27.78 statewide); **Black 80.85** (56.34 statewide);  
Hispanic = 50.18 (16 statewide)
2. ADULT EMERGENCY DEPARTMENT ANXIETY DISORDER VISITS (per 10,000)  
**Vermilion County = 75.41**; Illinois = 36.73  
Disparity by Race/Ethnicity: White = 70.29 (34.48 statewide); Black = 85.08 (50.88 statewide);  
**Hispanic = 145.22** (31.62 statewide)
3. DRUG OVERDOSE MORTALITY (per 100,000) Please Note: Nonfatal deaths are higher but data is not available by race and ethnicity  
**Vermilion County = 28**; Illinois = 22  
Disparity by Race/Ethnicity: White = 24; **Black = 53**

4. AGE ADJUSTED ER RATE DUE TO ADOLESCENT ALCOHOL USE (per 10,000, ages 10- 17 years)  
**Vermilion County = 11.2**; Illinois = 10.9  
 Disparity by Race/Ethnicity: No racial/ethnic data available for this indicator by County. However, by looking at the Danville zip code where the largest Black population in the County resides (61832), there are **14.7 emergency room visits** for alcohol use per 10,000 compared to the 11.2 value for Vermilion County. This is the highest value in the County. The information is not available for 61834 (also Danville) or 60942 (Hoopeston).

## **CHRONIC DISEASES**

1. ADULT OBESITY (Percentage of the adult population, 18 years and older)  
**Vermilion County = 43%** (highest rate among all Illinois counties); Illinois = 30%  
 Disparity by Race/Ethnicity: No racial/ethnic data is available for this indicator by County. However, looking at the eight census tracts where Vermilion County's most vulnerable populations live, it was possible to document obesity by race. The rates for these census tracts are – 17183000100 = 49%; 17183000200 = 49.2%; 1718300300 = 45.4%; 17183000400 = 49.2%; 17183000600 = 47.3%; 17183011200 = 46.1%. In Hoopeston's census tract 17183010200 the obesity rate is 37.5%. All are much higher than that of Illinois.
2. UNCONTROLLED DIABETES - observed (per 100,000)  
**Vermilion County = 73.34**; Illinois = 46.31  
 Disparity by Race/Ethnicity: White = 62.84 (compared to 33.96 statewide); **Black = 104.63** (compared to 116.18 statewide); Hispanic = Data not available
3. HIGH BLOOD PRESSURE PREVALENCE (BRFSS)  
**Vermilion County = 39.9%**; Illinois = 32.2%  
 Disparity by Race/Ethnicity: No racial/ethnic data available for this indicator by County. However, in Danville, home to Vermilion County's largest Black population, the rate is 40.2%. In Hoopeston, home to the County's largest Hispanic population, the rate is 39.5%. There was only one area with a rate worse than Danville's and Hoopeston's. It was in Tilton that had a rate of 41.5%. Tilton is to the south of Danville in Vermilion County. 95% of their population is white.
4. AGE-ADJUSTED ER RATE DUE TO HEART FAILURE (per 10,000)  
**Vermilion County = 29.6**; Illinois = 30.9  
 Disparity by Race/Ethnicity: No racial/ethnic data is available for this indicator by County. However, by looking at Hoopeston zip code 60942, home to the largest Hispanic population in the County, the value is **45.9**, the second-worst value in all of Vermilion County. (The worst value in the County is in 60963, Rossville, which borders Hoopeston to the south.) Danville's value is equal to that of Vermilion County.

**HOSPITALIZATIONS & EMERGENCY ROOM VISITS** (rate of hospital stays for ambulatory-care sensitive conditions)

1. PREVENTABLE HOSPITAL STAYS FOR SENIORS (per 100,000 Medicare enrollees)  
**Vermilion County = 6,683**; Illinois = 4,913  
Disparity by Race/Ethnicity: White 6,381; **Black == 10,695**; Hispanic = 3,843; **Asian = 8,715**
2. ADULT ER HYPERTENSION VISITS (per 10,000)  
**Vermilion County = 81.13**; Illinois = 43.39  
Disparity by Race/Ethnicity: White = 66.09 (30.46 statewide); **Black = 192.73** (130.42 statewide); Hispanic = 55.32 (20.59 statewide)

**FOOD INSECURITY**

1. NUMBER OF GROCERY STORES (per 10,000)  
**Vermilion County = 1.97**; Illinois = 2.24  
No racial/ethnic data available for the indicator.
2. LOW ACCESS TO FOOD AND LOW INCOME  
**Vermilion County = 25.7%**; Illinois = 17%  
No racial/ethnic data available for the indicator.
3. LOW ACCESS TO FOOD  
**Vermilion County 66%**; Illinois 59%  
No racial/ethnic data available for the indicator.

**BROADBAND & INTERNET ACCESS**

1. HOUSEHOLDS WITH A COMPUTER  
**Vermilion County = 83.6%**; Illinois = 89.9%  
No racial/ethnic data available for the indicator.
2. HOUSEHOLDS WITH BROADBAND INTERNET CONNECTION (100 mbps or faster)  
**Vermilion County = 81.8%**; Illinois = 93.7%  
Additionally, 0.00% have access to 1 gigabit broadband in Vermilion County compared to 29.7% in Illinois. (<https://broadbandnow.com/Illinois>)

“For households in the Danville schools, the internet subscription is even lower.”(<https://storymaps.arcgis.com/stories/029ce0b7234842d4aa659086596bc37e>) No racial/ethnic data is available for this indicator.

[Causes of the Disparities] The disparities permeating Vermilion County originate from multiple root causes.

As a population group, Rural Americans experience significant health disparities that often mirror those of the poorest metropolitan communities. This occurs irrespective of race and ethnicity. Compounding the hardship, a recent report released by the University of Illinois Chicago School of Public Health found that the COVID-19 pandemic has negatively impacted preexisting health disparities in rural Illinois. (*Southern Illinois University (SIU) Medicine Department of Population Science and Policy, SIU Paul Simon Public Policy Institute and the SIU Medicine Center for Rural Health and Social Service Development*)

This University of Illinois report includes several insightful yet disturbing findings. They note rural residents experience the 5 Ds. "The communities start at a DISADVANTAGE as they are food, healthcare, social service, and data DESERTS. They are further impacted by organizational and technological DISCONNECTIONS. And rural regions experience DISPARITIES similar to those found in low-income urban areas, but experience even fewer DEVELOPMENT opportunities than urban counterparts."

[Reason for Inclusion] There was a significant variance between health outcomes in Vermilion County and the state aggregated values for Illinois and the nation. The disparities noted were selected as they are among the top causes of death in Vermilion County (heart diseases, cerebrovascular diseases, and diabetes mellitus); they lead to multiple emergency department visits and inpatient stays, resulting in high hospital utilization and costs. They are also tied to diminished quality of life factors.

Maternal and child health was chosen because of its importance in determining the population's health and the health of future generations. Rural maternal and child health outcomes are particularly daunting in Vermilion County and Danville, complicating the factors their women need to overcome. A lack of access to health education and prenatal services can result in many negative maternal health outcomes including premature birth, low-birth weight, maternal mortality, severe maternal morbidity, and increased risk of postpartum depression.

Please Note: A frustrating barrier was encountered when obtaining the data as many health disparity indicators were not detailed by race and ethnicity. This further limited the pool of what could be highlighted in this proposal.

**2. *What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable impacts of these activities that will show progress against the obstacles or barriers you are targeting?***

The transformational health delivery system leverages the existing assets and resources of the entities represented by the steering committee participants and the Collaborative's supporters. Many of the initiatives address and align with the disparities noted in the health disparities delineation; others specifically address social determinants of health, and some, such as food insecurity, do both.

Activities included in response to the listing of selected health disparities efficiently fall into one of the six groupings identified – maternal and child health; behavioral health and substance use; chronic diseases; hospitalizations and emergency room visits; food security;

and broadband and internet access.

### *Maternal and Child Health*

The Collaborative will initiate Healthy Beginnings home visiting services in Vermilion County. Healthy Beginnings is a long-term home visiting service, providing weekly home visits to low-income, expectant mothers and their families, pregnancy and until the child associated with the pregnancy turns two years of age (up to five years if a child is born with opioids in their system). The team uses the evidence-based Nurse-Family Partnership Model and works with families to connect with its broad community network and the best healthcare resources available. Direct service team members include registered nurses, social workers/counselors, early childhood educators, and community health workers. The team focuses on family health (pregnancy, postpartum, early childhood wellness, chronic condition identification and management), early childhood development, family dynamics, violence reduction, adult educational advancement and employment, social determinants of health, and truly anything a family may need. This model is quite successful in Champaign County, and its implementation in the most challenged census tracts of Vermilion County represents an expansion of services. Healthy Beginnings is an extension of Carle.

The immediate, measurable impact will be the number of County mothers receiving Healthy Beginnings services six months after initiation, along with a 40%+ minority representation (also at six months).

### *Behavioral Health & Substance Use (youth & adults)*

The plan is to retain 1.5 FTE mental health advanced practice providers and 4-5 licensed clinical professional counselors. Crosspoint and Carle will co-hire these employees and share supervisory duties. The providers will work at both entities, delivering expanded services in rural schools and at Carle. These dual appointments are considered to be an innovative way of improving job retention. One full-time equivalent licensed clinical social worker will be retained as an employee of Crosspoint to provide social work services at CRIS Aging Center.

Additionally, the Collaborative will purchase a small mobile unit. The initial focus will be on delivering addiction recovery services and staffed by Carle's Addiction Recovery Center with regional grant funding. These services are also provided on Carle's existing mobile health clinic (described more fully under Chronic Diseases), along with health screenings and care services.

The anticipated impacts are tied to the number of youth and adults who register to receive behavioral health services. Although metrics are not yet defined, success will be measured by analyzing the number of appointments kept and the number of closed-loop referrals. A 20% minority representation at six months and a 40% representation at one year will be viewed as a positive impact.

### *Chronic Diseases*

Mobile health units can play an important role in reducing health disparities by traveling and providing preventive, primary, and specialty health care services to rural areas in the County. Carle's mobile health clinic will bring affordable, non-urgent medical services to Vermilion County communities. This represents an expansion of services as the mobile unit currently provides care and services to over 2,000 people a year in Champaign, McLean, and Vermilion Counties.

Full-service and accessible medical care will be available to infants, children, adults and seniors on the wheelchair accessible Mobile Health Clinic. The mobile unit is staffed with practitioners in pediatrics, family medicine, women's health and pregnancy, and addiction recovery. The clinic's primary care providers are multilingual; translator support is available as needed.

The immediate, measurable impact will be the number of County members receiving preventive, screening, primary, or specialty health services six months after the Carle mobile health clinic launches in Vermilion County, along with a 20% minority representation (also at six months). At the end of one year, it will be 40%.

Community Health Workers (CHW) will be employed from the census tracts most affected by racial and health inequality, and will work to increase access to care and resources within those census tracts. Tailoring solutions to meet the unique needs of County members, they will assist with health insurance enrollment, link and navigate clients to health screenings and medical appointments, function as a liaison for their client's medical provider assuring follow-through with treatment and medication recommendations, and provide health and nutrition education. In addition to helping their client obtain direct services, they will work to remove specific barriers to access that could be preventing someone from getting needed care. For example, the CHWs can help their clients with childcare, transportation, translators, clothing, or any other service that impedes health service procurement. Ample research has confirmed that CHWs appear more effective when compared with alternatives and are cost-effective for preventing, treating, and monitoring certain chronic health conditions, particularly among underserved communities. The Collaborative's community health workers will be assigned to a medical team through which they will receive guidance and to whom they will provide feedback after visiting their assigned clients.

### *Hospitalizations & Emergency Department Visits*

Hospitalization and emergency department visits are expected to decline over time due to the involvement of community health workers, the Healthy Beginnings team, the mobile health clinic, telehealth expansion, additional behavioral health services, and nearly every strategy employed through this initiative. There are no specific activities linked to this grouping.

### *Food Security*

The Collaborative sets forth a robust agenda to ensure all County members have access to fresh, nutritious, and affordable foods. The planned initiatives incorporate ample opportunities to obtain food for a reasonable cost and at multiple locations.

Community health workers and the Healthy Beginnings team will conduct food security screenings with the County members under their charge. Screenings will also be completed at all Carle clinical sites, recorded in Epic, and facilitated by using the new community referral software platform.

Community health workers and the Healthy Beginnings team will conduct food security screenings with the County members under their charge. The screenings will also be completed at Carle's clinical sites and recorded in Epic, facilitated by using the new community referral software platform.

Other undertakings include the design, buildout, and maintenance of two community gardens, one on the east side of the Danville and one on the west side. A mobile unit will be purchased (MobileMarket), which will allow for an increased number of fresh fruits and vegetables to be available throughout the County. Two local grocers will become access points – one a new establishment on the East Side and a smaller convenience-type store on the West Side. The build out of a demonstration kitchen will allow county members to learn about healthy food selection and preparation, portion control, and how to establish/modify eating routines and behaviors. This approach will be particularly important for County residents with chronic diseases. The mobile health clinic, community health workers, and Healthy Beginnings team will align with Carle clinical sites to provide health and nutrition education components.

The immediate, measurable impact will be assessed by counting the number of County members shopping at the new stores, the mobile market, and the gardens. The community health workers and Healthy Beginnings team will also obtain feedback from the County members with whom they work to determine if, from their client's point of view, they have improved and consistent access to healthy, higher quality food. The results will be recorded in Epic as a follow-up to their initial food insecurity survey.

#### *Broadband and Internet Access*

A Rural Broadband Cooperative will be formed. The plan is to retain a consultant to assess the County's needs, design a solution, work with the State of Illinois to obtain financial support plus explore other broadband expansion options, and initiate services. Instruction to ensure County residents have digital literacy goes hand-in-hand with this strategy, as will expanding telehealth services throughout the County. The latter is particularly important for increased access to employment, education, and primary, specialty, and behavioral health services.

The Rural Broadband Cooperative is a long-term goal. It will be deemed successful when an increased number of County members have internet access, and the Collaborative's telehealth programs can grow accordingly.

### **3. *Why will the activities you propose lead to the impact you intend to have?***

The Collaborative partners studied the selected health disparities alongside the County resident's priority needs and the corresponding best practices to address the noted health disparities. The final list of strategies and activities also considered sustainability, along with how partners, members, and County resources could be leveraged. The goal was for the entire undertaking to incorporate evidence-based, cost-effective, and scalable strategies alongside those proven to work in Vermilion County or a neighboring region.

The implementation model reflects major stakeholder representation – County members; healthcare entities and primary care and behavioral health providers; school districts and educational institutions; human and social service agencies; the critical access hospital, Carle Hoopston Regional Health Center; and payors (that is, through existing pay for performance contracts that Carle currently holds with Molina).

Each step of the Vermilion County Community Health Collaborative builds upon the one that precedes it producing an end product designed to meet the initiative's goals. For this reason, there is overlap in that Healthy Beginnings, food security, and broadband and internet access are also strategies to curtail social determinants of health and discussed again later in this proposal. This layered approach represents a cohesive and planful strategy.

## **8. ACCESS TO CARE**

### **1. *Name the specific obstacles or barriers to healthcare access you are targeting in your service area. Describe the causes of these obstacles that your project specifically seeks to address and explain why you have chosen to address these causes.***

[Specific Barriers to Access & Why Selected] The obstacles to healthcare access have long been in place. This is supported by observing the number of years Vermilion County ranked among the least healthy counties in Illinois per the Robert Wood Johnson County Health Rankings. For the past ten years, which is as many years as could be extrapolated, Vermilion County received a health outcomes score that placed them at the bottom among Illinois' 102 counties. In 2020 Vermilion County ranked 101 of 102; in 2019 it was 102 of 102 (dead last); 2018 = 99/102; 2017 = 97/102; 2016 = 91/102; 2015 = 92/102; 2014 = 95/102; 2013 = 96/102; 2012 = 95/102; 2011 = 98/102.

The County Health Rankings utilize two types of overall rankings. There are overall rankings in Health Outcomes, which represent the health of counties within the state (by looking at how long people live and how healthy people feel while alive), and overall factors in Health Factors, which represent what influences the health of a county. The latter estimates a county's future health compared to the other counties within a state. Health behaviors, clinical care, social and economic, and physical environment factors determine the rankings.

In 2021, Vermilion County ranked 99 out of 102 counties on the County Health Rankings – Health Outcomes (the higher the number the worse the ranking), and 100 out of 102 on Health Factors rankings. Vermilion County ranked at the very bottom, 102 out of the 102 counties



within the subcategory of Health Behaviors (which includes obesity, the food environment, and heavy drinking).

Similarly, **poverty** has been intergenerational and engrained, as has **segregation**. These are among the most significant barriers to healthcare access. County residents stated that health care access was hindered due to: cost of treatment; not having health insurance; not knowing where to go; long waiting periods to get an appointment; unpaid balances; lack of transportation; and unavailable needed services.

[Causes of the Obstacles] The Vermilion County Community Health Collaborative's plan addresses poverty and racial segregation as research cites them among the most significant causes of barriers to healthcare access.

Additionally, in rural communities many factors come together to create barriers to care. Contributors to these challenges are limited access to health promotion and disease prevention programs. The Rural Health Information Hub cites the following as potential barriers to health care access.

- Cultural and social norms surrounding health behaviors
- Low health literacy levels and incomplete perceptions of health
- Linguistic and educational disparities
- Limited affordable, reliable, or public transportation options

**2. *What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?***

Please Note: The first part of this question was answered in Section 7, Health Equities and Outcomes, question 2 and again in Section 9, Social Determinants of Health, question 2. It appears the same question was asked three times.

The Collaborative's activities relative to health disparities come together under six groupings – 1) maternal and child health; 2) behavioral health and substance use; (3) chronic diseases; (4) hospitalizations & emergency department visits; (5) food insecurity; and (6) broadband and internet access. With intent, the majority of activities undertaken to address health disparities also address social determinants.

The Collaborative further takes a holistic approach to health care transformation. Services are provided where they are most needed – Danville, including its most vulnerable census tracts, and Hoopston. Racial inequities are most pronounced in these two Vermilion County cities

**3. *Why will the activities proposed will lead to the intended impact***

The proposed activities will lead to the intended impact as the solutions are evidence-based, represent best practices, and will be sustainable (following an investment by the Illinois

Department of Healthcare and Family Services).

Additional reasons the Collaborative is confident that the proposed activities will lead to the intended impact are –

- Traditionally siloed institutions of the past did not attempt to simultaneously challenge health disparities and social determinants of health while improving clinical outcomes. The Collaborative simultaneously tackles health disparities and social determinants of health to improve outcomes and quality of life.
- Prior county-wide endeavors lacked an integrated focus on racial equity. The Collaborative emphasizes racial equity, including helping County members create economic stability and food security
- While most entities providing direct services utilize a patient satisfaction survey or suggestion box to garner client or patient input, none incorporated the resident's viewpoints to the magnitude of the Collaborative's plan. The Collaborative considered residents' needs in the model's design and will have a Community Advisory Council to ensure residents have a voice. The model is County member-focused.
- Very few providers and entities employed a holistic approach, and if they did, it was minimal. The Collaborative casts a large net and embraces participants that range from Vermilion County residents to civic partners to Danville Education District 118 to Danville Area Community College to social and human service providers to two health systems to the Vermilion County Department of Public Health. The Collaborative plans to have future representation from housing, environmental surveillance agencies, and law enforcement agencies.
- Integrating community health workers and Healthy Beginnings to work with the most at-risk populations was not core to any previous project design. Consequently, the focus of past efforts had not been on – (1) building County resident's ability to persevere in the face of social determinants that hinder their quality of life; (2) providing linkages to social, human, and health and behavioral health services; and (3) having teams of in-home health educators and navigators provide one-on-one services as a primary means to achieve equitable health outcomes. The Collaborative joins together all of these elements.

## **9. Social Determinants of Health**

- 1. Name the specific social determinants of health you are targeting in your service area. Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes.***

[Targeted SDOH] The Vermilion County Community Health Collaborative understands and recognizes the importance of identifying – and to every extent possible, addressing – the prominent social determinants of health in Vermilion County. The Collaborators fully

acknowledge that to improve health and achieve health equity, the health care delivery system must employ broad approaches that address the social, economic, and environmental factors influencing wellbeing

Four socioeconomic determinants of health are core to the Collaborative's approach to transform the health care system. They are –

- Poverty;
- Food insecurity;
- Lack of access to community-based entities that address social determinants of health; and
- Lack of access to community and hospital-based clinical health services (includes preventative care, primary care, specialty care, hospital services, mental health and substance abuse services).

The fundamental premise is that when faced with health challenges, people whose basic needs are met are better able to focus on improving their health and take steps to avoid future problems. Income supports, food assistance, job training, and other services are important components that can lead low-income rural residents to self-sufficiency.

This is the Collaborative's starting point.

[Reason for Selection] Tom Frieden, MD, MPH, and director of the Centers for Disease Control and Prevention between 2009 to 2017, introduced a five-tiered pyramid as a framework for improving health on a population level. The pyramid base shows that interventions that focus on socioeconomic determinants of health have the greatest potential impact. (Please refer to Attachment #13.) Strategies and activities that align with socioeconomic determinants of health are precisely where the Collaborative has chosen to place its emphasis.

It has been well established that socioeconomic, behavioral, and physical environmental factors account for 50 to 60 percent of a population's health outcomes. The Collaborative intends to address these factors by introducing and linking Vermilion County residents to a broad range of supports and services, and by creating partnerships between health organizations and social and human service entities that address social determinants of health. Until this point, these greatly needed services have been siloed and to a larger extent, unavailable. The Collaborative will bring together the necessary resources to fill gaps and voids, then assure their access to County residents.

Rurality influences social determinants of health, as well. Rural communities are more likely to experience socioeconomic factors that impact health, such as poverty, low educational attainment, housing inadequacies, and inequality across most spectrums. The research bears this out, as does the feedback from Vermilion County collaborators and supporters.

**2. *What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?***

Please Note: The first part of this question was answered in Section 7, Health Equities and Outcomes, question 2 and again in Section 8, Access to Care, question 2. As this section addresses social determinants of health, a decision was made to amend the question to, “What activities will your collaborative undertake to address the social determinants of health mentioned?”

[Activities to Address Social Determinants of Health] The Collaborator's assert that social and human service providers have a significant role in ensuring rural residents and families have resources to maintain or improve their health. This is why many of the proposed strategies involve providing referrals, coordinating services, and even co-locating services with schools and human and social service organizations.

The Vermilion County Community Health Collaborative addresses social determinants along two pathways – (1) Approaches to strengthen County members' ability to persevere in the face of daunting social determinants of health; and (2) Initiatives to bolster structural determinants of health and enhance community resilience.

In Pathway 1, “strengthening county member’s ability to persevere,” trained community health workers and the Healthy Beginnings team (nurses, social workers, and early childhood specialists) work with community members to help them acquire family and social supports and the **linkages to community resources** they are unable to obtain on their own. Assessment, planning, guidance, referral, navigation, and follow-up are but a few of the core focus areas each team member employs in their work.

Bottom line, both family and social supports and linkages to community resources are essential first-line strategies that will help County members mitigate the four targeted and pervasive social determinants of health targeted in this proposal – poverty; food insecurity; lack of access to community-based entities that address social determinants of health; and lack of access to community and hospital-based clinical health services.

In Pathway 2, “tackling structural determinants of health”, the collaborators and partners plan to strengthen the five community systems within Vermilion County. The activities align with – (1) Education and Job Training; (2) Employment; (3) Broadband and Internet; (4) Food Access and Security; (5) Community and Social Service Resources; and (6) Health Care Resources. (Several of these focus areas intentionally overlap with the strategies detailed in Section 7, Health Equity and Outcomes, and with the SDOH focus areas.)

The detailed solutions below represent an investment in services, community resources, and assets. When implemented, they become the vehicles that County members must have to overcome the social determinants of health that are core to our proposal. Underpinning all linkages to the planned solutions are the community health workers and Healthy Beginnings

team, both of which represent expansion activities.

1. Cause: Poverty & Lack of Income > Solution: **Increase income & creating economic stability**

Corresponding Community Systems to be Strengthened

- (Education and Job Training) - Mentoring middle and high school students and holding an annual health fair at Danville High School to cultivate an interest in STEM classes and health care as a career; Offering certain DACC-sponsored college preparatory classes for high school seniors; Covering the cost of Community Health Worker's required certification coursework; Launching DACC's AAS degree in mental health program; Taking part in DACC's Farm-to-Fork agriculture program
- (Employment) - Hiring a high school student as a community health worker; Matriculating students from DACC's AAS degree in mental health program; Experimenting with job sharing to improve retention; Utilizing 85 workers in the Collaborative
- (Broadband and Internet Access) - Developing a Rural Broadband Cooperative to expand the number of training and employment opportunities available to County members

2. Cause: Food Insecurity > Solution: **Create access to fresh, nutritious & affordable food**

Corresponding Activities to Strengthen Community Systems

- Agricultural Gardens
- Retail Grocers
- Mobile Market
- Demonstration Kitchen
- Nutrition Education

3. Cause: Lack of access to community-based entities that address social determinants of health > Solution: **Establish service + County member education + establish & navigate linkage +=Access**

Corresponding Activities to Strengthen Community Systems

- Community Health Workers and Healthy Beginnings team
- Broadband and Internet Access
- Software to Connect Clinical and Social Service Providers
- Software to Screen for Social Determinants of Health

4. Cause: Lack of access to community and hospital-based clinical health services > Solution: **Establish service + County member education + establish & navigate linkage +=Access**

All of the following are considered activities to strengthen the health system:

- Community Health Workers & Healthy Beginnings
- Community-based Health Screenings & Preventive Services
- Mobile Health Clinic and Mobile Addiction Recovery Unit
- Behavioral Health Services in the Schools
- Primary Care & Specialty Care (in addition to the two mobile units)
- Telehealth Services
- Collaboration & Data Sharing Among County Health Care Entities and Providers
- Broadband and Internet Access
- Working with MCOs to Expand and Improve Reimbursements for Value & Outcomes
- AAS in Mental Health Degree (to increase providers)

[Immediate, Measurable Impacts] Focusing on the four socio-economic determinants of health that are the Collaborative's priorities, the following immediate, measurable impacts will show progress against the targeted obstacles.

Poverty/Income > **Increasing Income & Creating Economic Stability**

The immediate, measurable impact to indicate progress will be the number of County members newly receiving income supports (SNAP or WIC) within the initial six months of the community health worker and Healthy Beginnings launch. Also included will be a count of the number of people who decided to obtain their Graduate Education Degree (GED), join a job training program, or gain employment.

Food Insecurity > **Creating Access to Fresh, Nutritious & Affordable Food** (These impacts also appeared in Section 7, Health Equity and Outcomes.)

The immediate, measurable impact will be assessed by counting the number of County members shopping at the new stores, the mobile market, or the gardens. The community health workers and Healthy Beginnings team will also obtain feedback from the County members under their charge to find out if they feel reduced hunger.

Lack of community-based entities that address social determinants of health > **Access to Care**

The immediate, measurable impact will be judged by the number of closed-loop referrals (completed appointments) for social, human and health care services by the community health workers or the Healthy Beginnings team. The volume of partner visits (for example, at Crosspoint and East Central Illinois Community Action Agency), will be counted as will the number of referrals made by the mobile health clinic team.

Lack of community and hospital-based clinical health services > **Access to Care**

Similar to community-based social and human service entities, the immediate and measurable impact will be judged by the number of closed-loop referrals (completed appointments) as reported by the community health workers and Healthy Beginnings team. Epic will also be able to capture increased patient volume and service utilization, two additional metrics that will be used to evaluate short-term impact.

***[2. Optional] Please upload any documentation or visuals you wish to submit in support of your response.***

See Section 9 Attachment\_Social Determinants of Health

***3. Why will the activities you propose lead to the desired impact you intend to have?***

The proposed strategies and activities address social determinants of health are varied, multimodal, and included because they are evidence-based approaches representing best practices. They are further conducted in consort with partners and implementation via a network of linkages.

Finally, the collaborators and supporters have a demonstrated ability to foster trusting relationships, bring initiatives to greater scale with community partners, and improve outcomes of people served by the mobile health clinic and Healthy Beginnings teams in other counties. The Collaborative will be building on this momentum and success.

## **10. CARE INTEGRATION & COORDINATION**

***1. Describe how your proposal improves the integration, efficiency, and coordination of care across provider types and levels of care.***

Care integration and coordination are well recognized for their ability to influence positive patient outcomes and experiences while also reducing healthcare costs.

Some professionals and researchers define care coordination as connecting the dots across multiple providers and settings, and care integration as the bringing together of multiple providers and setting together to create a more seamless patient experience. The Vermilion County Community Health Collaborative builds upon both approaches – in fact, these concepts meld to form the foundation of this initiative. Several of the strategies presented represent an expansion and enhancement of current practices; others are new endeavors.

To start, Carle employs a team-based model that has been awarded NCQA Medical Home recognition since 2018. They have also enhanced their integrated care delivery practices by participating in an Accountable Care Organization (ACO) for the past three

years.

The Vermilion County Community Health Collaborative employs six strategies to improve the integration, efficiency, effectiveness, and coordination of care. They are (1) medical team extenders; (2) co-location of services with onsite collaboration; (3) cross-sector partnerships; (4) cross-location of non-medical services; (5) technology; and (6) oversight & accountability.

**Medical Team Extenders** (Expansion with new implementation practices/enhancements) – Community Health Workers are members of the medical teams who liaise between the target population and a variety of health, human, and social services organizations who participate in the Collaborative. The CHWs allow medical provider teams insight into the very homes of their patients. Conversely, the CHWs bring back important health-related guidance to the County residents with whom they work. This strategy is particularly effective with people with chronic conditions and with socioeconomic challenges and other social determinants of health that put them at risk for poor health outcomes.

Ten community health workers, representing a new cadre, will be trained and function as extenders of the primary care team. They will work with other provider entities in the Collaborative and eventually at Hoopston Regional Health Center when the project extends into north Vermilion County.

**Co-location with Onsite Collaboration** (Enhancements) – Several organizations and entities will welcome in-house behavioral health providers and social service staff whom Carle's behavioral health physicians will supervise. These individuals will team with their internal staff to deliver coordinated care. They include Crosspoint Human Services, CRIS Healthy Aging Center, and School District 118. The goal is to achieve seamless and continuous care while supporting improved outcomes and experiences for Vermilion County members.

**Cross-sector Partnerships** (New with enhancements) – Many organizations in Vermilion County are committed to the purpose and goals of the Vermilion County Community Health Collaborative. Representing enhanced relationships, many have a hands-on role; others have a supportive role; some have both.

- The following health care organizations are participating in the transformation initiative – Carle Health; OSF HealthCare; Crosspoint Human Services; Christie Clinic; and the Vermilion County Department of Public Health.
- The educational entities that joined the initiative and have significant roles across several platforms are Danville School District 118 and Danville Area Community College.
- The faith-based community will bolster the Collaborative's outreach efforts, targeting



members who could benefit from the services being offered and who conversely will support the services being offered themselves. The primary entity involved with the Collaborative is Pastor Thomas Miller of New Life Church of Faith in Danville.

- Several for-profits and nonprofit entities have joined in the effort to transform health care delivery. These are the entities that address social determinants of health. Among them are – CRIS Healthy Aging; East Central Illinois Community Action Agency; Heavenly Square Grocery; STEPUP Vermilion County; and Vermilion Advantage.

Cross-location of Services (New) – The Vermilion County Community Health Collaborative ensures that in Vermilion County, a selection of (a) health support services are provided at human/social service organizations and schools, and (b) human/social services are provided at medical facilities. Two examples are locating a financially affordable grocer in Carle at the Riverfront and engaging in Broadband and Internet Access expansion to offer telehealth services.

Technology (Enhancement) – The Vermilion County Community Health Collaborative will invest in a community referral platform that is compatible with the Epic App Orchard. Intended to bridge the gap between health and social care providers, the platforms allow cooperating physicians, provider practices, and the Collaborative's community health workers to locate and connect patients to community resources and social services. (The platforms additionally screen for social determinants of health.)

The platform selected will emphasize community collaboration and a patient-focused model rather than a health-care centric approach. Fortunately, four of the Collaborating providers currently use Epic, allowing for future cross-institution data sharing and communication on referrals to services. The new features of Epic's referral platform will improve efficiencies and care coordination.

Additional technology-based initiatives include the provision of expanded telehealth services and broadband connectivity throughout the County.

Oversite & Accountability (New) – The transformation grant manager is responsible and accountable for successful implementation of the Collaborative's care integration and coordination strategies. Supervision, evaluation, communication, and policy development are among this individual's key responsibilities. They are also charged with ensuring the Collaborative's planned tactics are effectively operationalized.

**2. *Do you plan to hire community health workers or care coordinators as part of your intervention?***

Yes.

**2A. Please submit care coordination caseload numbers and cost per caseload.**

The Collaborative will be hiring ten community health workers and one community health worker supervisor.

Key to addressing social determinants of health is the deployment of community health workers. These advocates and community liaisons will connect community members with accessible preventive, primary, or specialty health care services. They also have a key role in referring community members to social services, promoting family health and wellness, helping with health system navigation, providing education and support, and functioning as an extension of the primary care team.

Some may work in homes, others at partner locations or community hubs. Decisions as to placement will be informed by a combination of best practices, CDC census tract data, and input from Collaborative partners. One of the CHWs will be a high school student to ensure teens' potential for healthy outcomes is bolstered, similar to their adult counterparts. The intent is that all CHWs are residents of Vermilion County.

**3. Are there any managed care organizations in your collaborative?**

No.

**3A. If no, do you plan to integrate and work with managed care organizations?**

Yes.

**3B. Please describe your collaboratives' plans to work with managed care organizations.**

While Carle and OSF Healthcare work with several managed care organizations (MCOs), none are currently Collaborative partners. Involvement with MCOs will be front and center further into the implementation phase of the Collaborative, especially when Carle on the Riverfront opens in 2023. YouthCare, Blue Cross Blue Shield Community Health Plan, CountyCare Health Plan in Cook County only, IlliniCare Health, Meridian Health Plan, formerly Youth in Care Only), and Molina Healthcare are the managed care organization that Carle works with currently.

## 11. Minority Participation

1. ***Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise Program (BEP) and/or nonprofit entities majorly controlled and managed by minorities that will be used on the project as subcontractors or equity partners.***

[BEP-Certified Vendors & Nonprofit Minority-Run Entities]

Heavenly Square Grocery is a for-profit entity owned, managed, and counseled by people representing the Black community. The Collaborative's leadership will work with the owner to assist them in becoming an Illinois Business Enterprise Program (BEP).

Nonprofit Steering Committee members and Collaborative supporters either controlled or managed by minorities include –

- Dr. Alicia Geddis, Superintendent - Danville School District 118
- New Life Church of Faith in Danville, Pastor Thomas W. Miller is the church's founder.
- East Central Illinois Community Action Agency; Odette Watson is the CEO and Chief Executive Officer; Elder Tyson Parks is board chair.

2. ***The respective role of each of the entities listed above and specify whether they will have a role only during the implementation of your proposal or if they will have a role in the ongoing operation of your transformed delivery system***

[Role of Minority Entities] The responsibilities of the following entities span from project development to implementation to the ongoing operations of the Collaborative.

- Dr. Alicia Geddis, a member of the Steering Committee and the Superintendent at School District 118, will open her doors to test case having a Danville high school student as a community health worker. Dr. Geddis is agreeable to initiating additional behavioral health services at the schools and promoting the classes that will be offered to high school seniors at DACC. She will also be integral to implementing the annual Health Career Fair that will be held in Danville's high school. (School District 118 has a long-term role that began during the planning phase of the Collaborative.)
- Marcia Keys is a member of the Steering Committee and the General Manager of Heavenly Square Grocery. In this capacity she will also be responsible for managing the agricultural garden on the east side of Danville. Ms. Keys is a retired food-service administrator with the Illinois Department of Corrections and organizer of Over the Rainbow, a religious organization dedicated to helping people throughout the County. (Heavenly Square Grocer has a long-term role that began during the planning phase of the Collaborative.)

- Pastor Miller, born and raised in Danville, has been working with the Collaborative since the beginning and is particularly invested in food security initiatives. He paved the way for Heavenly Grocery to be a part of the Collaborative and is a proponent of the agricultural garden on the east side of Danville. The Collaborative's demonstration kitchen will be located in New Life Church of Faith. (New Life Church of Faith has a long-term role that began during the planning phase of the Collaborative.)
- Odette Watson, CEO of East Central Illinois Community Action Agency, is a long-time resident of Danville. The organization offers a continuum of social and human services to help families in poverty take steps toward independence. They will have a critical role as providers of services that address social determinants of health and a convener of like service providers in Vermilion County. (East Central Illinois Community Action Agency has a long-term role that began during the planning phase of the Collaborative.)

Each of the above Steering Committee members represents the African American community. The Collaborative looks forward to increasing minority and local representation throughout all aspects of the initiative, from its steering committee to its employees, contractors, and volunteers.

In addition to seeking minority candidates for all new hires there are several opportunities to retain Black or minority owned businesses and contractors. If the businesses are not BEP certified, the Collaborative will look for DEI committed entities. These opportunities will open up as the Collaborative begins purchasing, hiring and contracting. They include:

- Community Health Worker (CHW) training – All community health workers will receive CHW certification training. Both DACC and UIUC will have certification training programs, and both have strong Diversity, Equity, and Inclusion (DEI) commitments and departments, with a diverse staff.
- Construction of the retail grocery store for healthy foods – The only BEP registered business in Vermilion County is a construction firm per a recent search of the Illinois Department of Central Management services. The Collaborative will entertain a bid preferentially from this firm to buildout the retail space. The bid will need to be competitive on price and quality.
- Two agricultural gardens and markets – DACC will provide consult on the development and buildout of the two agricultural gardens. Danville Rotary Club, Kiwanis Club of Danville and Project Success will have supporting roles. DACC is a strong DEI committed entity.

The Vermilion County Community Health Collaborative also has committed to hire with as many County members or minority individuals as is possible. Targets were set at 10% in Year I; 20% by Year II; and 30% by Year IV. This preference extends to the garden volunteers and broadband consultant.

Please Note: Carle Health, the lead entity, supports and is actively engaged in efforts focused on diversity, equity, and inclusion. The health system has pledged to create an environment of inclusion, free from racism in the care and service they deliver, the communities they serve, and for team members. Carle has defined actionable steps to ensure their DEI goals are achieved and has committed to transparency and sharing the institution's progress with the public.

## 12. JOBS

### Existing Employees

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

[Data] No current positions will be eliminated as a result of the Collaborative. To the contrary, ten current employees will have expanded job responsibilities as a result of the Collaborative's work and several others will actually work in the Collaborative. (Please refer to Attachment 14.)

[Benchmarks] The determination of compensation ranges at Carle is based on regional and industry salary benchmarks. Periodic wage studies and adjustments are performed to ensure wages are within standards. Many positions are part of job ladders that provide a defined path for career advancement. In September 2021, Carle announced the adoption of a \$15 minimum wage. With this announcement Carle also committed to reviewing all positions earning less than \$20 per hour.

The intent is for all newly developed positions within the Collaborative to follow these guidelines set as industry standards.

All employees within the organizations or businesses represented by the Collaborative's partners and supporters will be notified of the initiative's newly created positions and welcome to apply to promote advancement. Similarly, any staff members that the Collaborative hires will have access to job vacancy postings and will be eligible to apply for open positions within an associated participant's organizations or business.

Career pathways were built into this proposal as they were deemed essential. The trained community health workers will have several opportunities to advance, for example their next likely move would be as case or care coordinators for any of the Collaborative's clinical entities. The Collaborative is looking to establish a job mentoring program and conduct an annual jobs fair for high school students. The students will also have the option to participate in career training as early as their senior year at Danville Area Community College (a collaborating partner) and enroll in DACC's new applied science program in mental health to earn an AAS degree in Mental Health. (This matriculating program prepares students for

career opportunities which include – social work technician, social work assistant, casework specialist, casework assistant, human service specialist, human service specialist, mental health technician, psychiatric aid, outreach specialist, substance abuse technician, adoption counselor assistant, child and youth care worker, youth specialist, foster care specialist, and family protection specialist.)

Health care providers in the area are committed to (and excited by the prospect of) hiring these individuals following their participation in a training program.

Additionally, one of the ten community health workers will be a high school student in hopes that students develop healthy behaviors and routines, and that the community health worker discovers a career they want to pursue. And high school students will be encouraged to volunteer in either of the two gardens to cultivate an interest in either agriculture or the food industry. They would do this as part of the DACC culinary "farm to fork" agriculture program.

***[1. Optional] Please upload any documentation or visuals you wish to submit in support of your response.***

See Section 12 Attachment 14\_Jobs

### **New Employment Opportunities**

***2. Please estimate the number of new employees that will be hired over the duration of your proposal.***

62.

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

The Collaborative will hire over 62 new employees and increase the responsibilities of 10 current Carle employees throughout the initiative's five-year funding cycle. An additional 13 independent contractors will be retained. That comes to 85 workers, in all.

These are detailed in the budget and the Hiring Chart. (Please refer to Attachment 15.)

[New Employment Opportunities] While the Collaborative requests support over a five-year funding cycle, new employees will be hired throughout years one to four. The position classifications range from professionals to service workers.

It is anticipated that unbudgeted positions will be added over the duration of the initiative. Organic growth could give rise to new funding opportunities that will permit the hiring of unbudgeted staff members. The expansion of community health workers provides an excellent example. It is the hope that many who are newly trained will work their way up the career ladder. As they move on (hopefully within the Collaborative),

new employment opportunities will open up for County residents qualified to be hired for entry-level positions.

[Reflecting Target Population] As with all hiring opportunities, the Collaborative has made a commitment to hire or contract with as many County members or minority groups as possible. Targets are set at 10% in Year 1; 20% by Year2; and 30% by Year 4.

***[3. Optional] Please upload any documentation***

See Section 12 Attachment 15\_Jobs

***4. Please describe any planned activities for workforce development in the project.***

[Workforce Development] Initial training will be provided to all new employees, but particularly for the community health workers as they will be on a track to attain state certification as a CHW. They will receive training from an accredited Illinois program in alignment with recent state legislation. This will be supplemented with on-the-job training on how to use Epic to conduct and record the results of the food security status and social determinants of health screenings they administer. This skill training will be of utmost value as any of the CHWs consider career advancement.

In addition, skill development, continuing education and training will be incorporated into all of the Collaborative's positions. Career development is essential to assuring retention as well as recruitment of the most talented individuals.

This meticulous planning and modus operandi will ground the Collaborative's undertakings.

## **13. QUALITY METRICS**

### **Alignment with HFS Quality Pillars**

***1. Tell us how your proposal aligns with the pillars and the overall vision for improvement in the Department's Quality Strategy.***

[Alignment with the Pillars] The Vermilion County Community Health Collaborative aligns with HFS Quality Framework on multiple fronts. In terms of mirroring the Quality Strategy's intent, the Collaborative's proposal sets forth strategies to ensure implementation is of the highest quality, is equity-focused, and promotes solutions reflecting the most cost-effective approaches and methodologies. The continuous identification of potential opportunities for healthcare coordination and improvement is central to the proposed plan.

Equity is a key consideration throughout every facet of the Collaborative; metrics and data analysis will inform all decisions regarding implementation strategies. Evaluations will

consider quantitative and qualitative gains in health outcome indicators and each will be filtered by race and ethnicity.

Carle's Business Intelligence (CBI) office will provide in-kind services for data extrapolation and reporting. The transformation grant manager will build quarterly reports for the steering committee based on the data streams provided by the CBI.

The transformation grant manager will be responsible for analyzing data streams; the steering committee will review and decide if an additional committee (a quality improvement committee) is needed to act on the information. A Plan-Do-Study-Act (PDSA) methodology will be used to address outcomes that are not met or if declining trends are observed for any indicator.

The HFS Quality Framework includes five pillars of improvement. The Vermilion County Community Health Collaborative is focusing on three of the five pillars:

1. Maternal and Child Health
2. Adult Behavioral Health
3. Child Behavioral Health

These are detailed in Section #7 Health Equities and Outcomes.

In addition to the pillars, HFS recognizes 12 goals as fundamental to its quality framework. The 12 goals fall within three categories – Better Care, Healthy People/Healthy Communities, and Affordable Care. The Collaborative's plan focuses on the following baseline measures that correlate with the three categories.

Under "Better Care" the Collaborative aims to advance population health by improving chronic care outcomes and increasing access to preventive, treatment, and specialty care services.

Under "Healthy People/Healthy Communities" the Collaborative's goals are to improve participation in preventive care and screenings; create a consumer-centric healthcare delivery system; identify and prioritize to reduce health disparities; and implement evidence-based interventions to reduce disparities.

Under "Affordable Care," the Collaborative intends to deploy technology initiatives to streamline and enhance eligibility, enrollment procedures, and data integration.

[Vision for Improvement] The Collaborative's aggregated health indicators contribute to its overall HTC goals – to reorient Vermilion County's healthcare delivery system to reduce health disparities, abate racial inequities, and enhance the health and wellness of its individuals and communities. In that vein, an overarching approach of the plan is to embrace the voice and



needs of the community, support opportunities for ongoing training and partnership, and incorporate resources that ensure engagement in quality improvement activities.

Reimagining health in Vermilion County, the Collaborative envisions that the County will become a place where an increased number of pregnancies come to term and a greater percentage of newborns are of average birth weight.

Health disparities will be minimal and Blacks will no longer have the worst health outcomes within Illinois. Hospital utilization, including stays in neonatal intensive care units, will decrease for both mother and child. And Vermilion County will no longer have the lowest health rankings in the state on maternal and child health factors.

Vermilion County will also become a place with fewer behavioral health disorders, substance use and overdoses, and suicides. Behavioral health services will be more abundant and all County members, from children through seniors, will have access to these services. Emergency department visits and inpatient hospitalizations for youth and adults will decrease, especially among people with bipolar, depressive, and substance use disorders. Health disparities will improve and Blacks and Hispanics will no longer be ranked as having the worst health outcomes in Vermilion County or in Illinois.

**2. Does your proposal align with the following Pillar of Improvement?**

**2A. Maternal and Child Health?**

Yes

**Maternal and Child Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.**

The Collaborative proposes being accountable for improving “Well-Child Visits in the First 30 Months of Life.”

**2B. Adult Behavioral Health?**

Yes

**Adult Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.**

The Collaborative proposes being accountable for improving “Pharmacotherapy for Opioid Use Disorder.”

**2C. Child Behavioral Health?**

Yes

**Child Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.**

The Collaborative proposes being accountable for improving “Visits to the Emergency Department for Behavioral Health Services That Result in Hospitalization.”

**2D. Equity?**

No

**2E. Community Based Services and Support?**

No

**3. Will you be using any metrics not found in the quality strategy?**

No

**14. MILESTONES**

***For all activities described in your proposal, please provide a calendar of milestones to show progress (e.g., when IT will be purchased, when IT will be operative, when construction projects will begin and end, when people will be hired, etc.) The timeline should be in months from award.***

A detailed chart has been uploaded pin pointing the year on month of activity initiation and conclusion. A month-by-month presentation across the five-year grant cycle is provided. [Please refer to Attachment 16.] A summary of the Collaborative’s detailed calendar of milestones follows.

Year 1

*List of Activities Launched & Completed* – Develop and initiate the Community Advisory Council; Hire the Transformation Grant Manager; Launch Healthy Beginnings; Launch the Mobile Health Clinic; Begin the mentorship program for middle and high school students; Hold the first student fair to spark interest in health care as a profession; Launch Heavenly Square Grocer; Launch the Mobile Market; Begin the west side’s agricultural garden; Hire the nutrition educator; Lease the software to connect clinical and social service providers and screen for social determinants of health.

*List of Activities Launched, but Completion will be in Subsequent Years* – Hire the initial group of community health workers; Hire the initial group of behavioral health providers

shared by that Crosspoint Human Services and Carle; Order the mobile unit for addiction recovery services; Begin enrolling CHWs for classwork to earn their certification; Begin preparation for DACC's AAS curriculum and course offerings; Retain a consultant to bring broadband and internet access to Vermilion County.

### Year 2

*List of Activities Launched in Year 2 & Completed in Year 2* – Expand telehealth primary care services; Expand community-based health screenings; Hire a social worker who will be at CRISHealthy Aging Center; Begin the east side's agricultural garden; Hire the demonstration kitchen assistant; Equip and open the demonstration kitchen.

*List of Activities Launched in Year 2, but Completion will be in Subsequent Years* – Begin preparations for the grocer at Carle at the Riverfront.

*List of Activities Launched in Year 1 & Completed in Year 2* – Begin preparations for the addiction recovery mobile unit.

### Year 3

*List of Activities Launched in Year 1 & Completed in Year 3* – Full launch of the community health workers program; Full launch of the behavioral health providers co-hired by Crosspoint Human Services and Carle; Full launch of the matriculating AAS degree in mental health at DACC.

*List of Activities Launched in Year 2 & Completed in Year 3* – Opening of the grocer at Carle at the Riverfront.

### Year 4

*List of Activities Launched in Year 1 & Completed in Year 4* – Attainment of certification for the community health workers; Completion of the Rural Broadband Cooperative.

### Year 5

There is no activity initiation in Year 5 but there is a need for continued support for the launched initiatives. By the end of the five-year funding cycle all activities will be self-sustaining.

***[Optional] Please upload any documentation or visuals you wish to submit in support of your response.***

See Section 14 Attachment\_Milestones

## 15. BUDGET

### 2. *Number of Individuals Served*

**Please project the number of individuals that will be served in each year of funding.**

#### **Year 1 Individuals Served**

74630

#### **Year 2 Individual Served**

75860

#### **Year 3 Individuals Served**

77140

#### **Year 4 Individuals Served**

78270

#### **Year 5 Individuals Served**

79450

#### **Year 6 Individuals Served**

80630

## 16. SUSTAINABILITY

*Include a narrative that describes how your budget will decrease reliance on Transformation funding over time and how reimbursements for services and other funding sources will increase and establish sustainability over time.*

[Road to Sustainability] The Vermilion County Health Care Collaborative will be sustainable within five years. When its members decided what strategies to include in the healthcare transformation initiative, a critical criterion was that for the proposed activities, there had to be an identified and alternative source of funding that could either partially or fully sustain that activity's continued implementation beyond the grant period. The sustainability plan for the major strategies is detailed below.

1) **Community Health Workers:** Future payment will be covered, in part, by Medicaid per the Illinois Health Care and Human Services Reform Act contained in House Bill 158. This is the result of new legislation. Beyond Year 5, the balance of the salary package will be the

responsibility of the hiring entity.

**2) Healthy Beginnings:** Future payment for home visiting also will be covered, in part, by Medicaid per the Illinois Health Care and Human Services Reform Act. In addition, funding will be braided with the support received from Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and Illinois State Board of Education (ISBE) funding opportunities, and the philanthropic community.

**3) Mobile Health Clinic:** Services provided on the mobile health clinic will be sustained beyond the funding cycle through revenues generated from Medicaid and Medicare. Any revenue gaps will be offset by Carle. Vehicle maintenance will be covered through philanthropic giving activities at Carle. (Please Note: The vast majority of people currently served on the mobile unit receive charitable support from Carle's Financial Assistance Program.)

**4) Behavior Health and Substance Use Initiatives** (including LCSWs): These services will continue beyond the HTC funding cycle through diversification of braided grant funds including Medicaid and Medicare reimbursements. The health care entities hosting the Collaborative's behavioral health and substance use services will be responsible for supporting the un-reimbursed balance of the employee's salary package. In Year 3, the leadership team representing the Collaborative's health care providers will work with their managed care organization to pursue alternative and enhanced payment methods and structures.

Vehicle maintenance will be covered through philanthropic giving activities at Carle.

**5) Food Security Initiatives:**

- Grocer (Heavenly Square Grocer) – The Heavenly Square Grocer will be self-sustaining through in-store sales by Year 5.
- Grocer (Carle at the Riverfront) – The grocery store at Carle at the Riverfront will be leased to a local entrepreneur at favorable rental terms. The expectation is that Carle's grocer will be self-sustaining through sales within five years.
- Agricultural Gardens – Both gardens will be under the direction of the Danville Area Community College who will build and manage a community garden on the Carle at the Riverfront Campus and adjacent to Heavenly Square Grocer. The College will hire a project planner for the gardens, covered by HTC funds, to develop a design and oversee construction of the garden. Project Success of Vermilion County students and DACC students will provide the majority of the hands-on farm work to fulfill their community service commitment.

The agricultural garden's chief partners are Danville Rotary Club, Kiwanis Club of Danville, and Project Success of Vermilion County. DACC is providing free use of the Campus greenhouse for the growth and cultivation of the plants designated for the garden. Danville Rotary and Kiwanis Club offered to help raise funds to sustain the garden with annual purchases of supplies and seeds.

Beginning in Year 2, DACC will again direct the building and manage the second garden adjacent to Heavenly Square Grocer. Project Success of Vermilion County student volunteers and DACC students will provide the majority of the hands-on farm work to fulfill their community service commitment. Danville Rotary and Kiwanis Club will assist with raising funds to sustain the garden with annual purchases of supplies and seeds.

- Mobile Market – Under Carle’s purview, long-term expenses for the Mobile Market will be sustained by a combination of product sales (which are intended to equal the food costs), grant funds and other philanthropic support (to cover salaries and operational expenses including maintenance). Support also will be sought solicited from the US Dept of Agriculture's Dairy Donation Program and the surplus food contribution program.
- Demonstration Kitchen – Operating support to sustain the demonstration kitchen will be from braided funding sources, including commercial sponsorships with local restaurants, food retailers, and possibly Vermilion County's large local food products company. Space rentals for church events and leasing arrangements with local nonprofits, such as schools, food banks, and educational institutions, are also expected to make the kitchen self-sustaining.
- Nutrition Education – Carle will sustain the salary package of the nutrition educator.

**6) Education:**

- Annual Career Fair – Carle will sustain the costs associated with the annual career fair.
- Mentorship – Carle will sustain the costs associated with the mentorship program. It will primarily be a volunteer-driven initiative.
- Associate of Applied Science (AAS) in Mental Health – The Collaborative's investment will be hiring the program specialist to develop the 60-credit program of study in mental health, so no long-term costs are involved. Student tuition will cover the ongoing costs associated with offering the new degree program, allowing it to become self-sustaining.

**7) Telehealth Expansion** (of current primary care and specialty health services): Carle will sustain the costs associated with the telehealth expansion.

**8) Software Applications** for the County Member Referral Program / Food Insecurity Screenings/SDOH Screenings: The software applications will be purchased or leased with HTC funds and sustained by Carle.

**9) Broadband & Internet Access:** The costs of retaining a consultant to assess, design, and secure seed funding for the Rural Broadband Cooperative are short-term.

As this initiative is intended to be a cooperative, the ongoing costs of providing enhanced broadband in Vermilion County will be shared through subscriptions by entities using it (Carle, OSF Healthcare, Christie Clinic, and Crosspoint).

**10) Jobs/Other New Employees:** It is difficult to predict if the transformation grant manager's position will need to become self-sustaining. If it does, the Collaborative will seek philanthropic support, including grant funding, to assure it becomes a long-term position. Another option will be to have each steering member make an annual contribution to support this individual's salary package.

[Addressing Social Determinants of Health] All of the services listed in response to question 16.i dually address social determinants of health. Their sustainability plans were detailed in response to section 16.i.

The Collaborative components include:

1. Community Health Worker
2. Healthy Beginnings
3. Behavior Health and Substance Use Initiatives
4. Food Security Initiatives
5. Education
6. Jobs
7. Telehealth
8. Software Applications
9. Broadband & Internet Access

[Highlights of Key Assumptions]

Key assumption #1: It will be possible to bill Medicaid for the services of the community health workers and home visiting services (under Healthy Beginning) by 2025.

Key assumption #2: When launched, the Collaborative will look to have its health provider's current Alternative Payment Models (APM) with managed care organizations (MCO) extended to all of the providers, and when possible, the current arrangements will be enhanced. Going forward the Collaborative will look to expand and improve reimbursements for value and outcomes, prioritizing quality over volume and including formula enhancement.

Key assumption #3: When its members decided what strategies to include in the healthcare transformation initiative, a critical criterion was that for the proposed activities, there had to be a likely, identified, and alternative source of funding that could either partially or fully sustain that activity's continued implementation beyond the end of the grant period.

Key assumption #4: All collaborating partners with staff hired with HTC funding will assume responsibility for supporting the individual's employment and salary beyond the funding cycle. For example, if the Medicaid reimbursements for the behavioral health staff placed at Crosspoint do not cover their salaries, Crosspoint will assume responsibility for contributing funds to cover the balance of their salary.

# Vermilion County Community Health Collaborative

## Letters of Support



11/05/2021

Ms. Theresa Eagleson, Director  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Gran Avenue, East  
Springfield, Illinois 62763

Re: Agreement to collaborate as a partner in the Vermillion County Community Health Collaborative

Dear Director Eagleson,

I am writing this letter to commit the support of Crosspoint Human Services to the Vermillion County Community Health Collaborative being proposed, should it be funded by the Illinois Department of Healthcare and Family Services under the Healthcare Transformation Collaborative Initiative.

Crosspoint Human Services is a 5013c provider of mental and behavioral health care in Vermillion County with longstanding relationships to CRIS Healthy Aging Center and school districts in the area. Providing care to patients at several sites including medical and counseling behavioral services, Crosspoint will be involved in the Collaborative as the main partner for growth and community impact in behavioral health.

The Vermillion County Community Health Collaborative aims to among other areas, improve access to behavioral health by increasing the number of mental health professionals available in the county, including sharing of mental health providers between entities. The collaborative also aims to add counseling to the Medicare beneficiaries and the more isolated, rural school districts.

At Crosspoint, we believe that all people should have every opportunity to realize their highest possible level for a productive and healthy life in their community. This is why we believe in this collaborative and are pleased to be a partner by providing our mental and behavioral health expertise and resources and committing to being dutiful stewards of the resources obtained through this funding opportunity as outlined in the budget section of this proposal.

As a partner we will focus on the following three areas:

1. Increase in counseling availability to rural school districts through contracted tele-counseling and evaluation services.
2. Increase in appointment availability for patients by the co-hiring of Mental Health prepared Nurse Practitioners with Carle Health (initially will use telehealth engagement until hiring is accomplished).
3. Providing LCSW services by hiring for a contract with CRIS Healthy Aging.

As the Director of Crosspoint, I will serve as a member of the collaborative's steering committee executing duties as outlined in the Governance document of this collaborative. I commit to acting on behalf of the best interest of the community we aim to serve with these efforts.

Last, I highly recommend your funding support of this collaborative as it will help us extend much needed mental and behavioral health services to those most disadvantaged in our community.

Sincerely,

 \_\_\_\_\_  
Lisa R. ... CEO



## HEAVENLY SQUARE GROCERY

1403 North Bowman Avenue, Unit C., Danville, Illinois 61832  
www.heavenlysquaregroceries.com  
(217) 597-2346

Ms. Theresa Eagleson, Director  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Gran Avenue, East  
Springfield, Illinois 62763

### **Re: Agreement to collaborate as a partner in the Vermillion County Community Health Collaborative**

Dear Director Eagleson,

This letter is to commit the support of Bowman Holdings LLC, DBA Heavenly Square Grocery to the Vermillion County Community Health Collaborative being proposed, should it be funded by the Illinois Department of Healthcare and Family Services under the Healthcare Transformation Collaborative Initiative.

Bowman Street Holdings LLC, DBA Heavenly Square Grocery, is a new business that will be located at 1403 North Bowman Avenue, Danville, Illinois. The discount grocery Save-A-Lot was the previous occupant of the 1403 North Bowman Avenue retail site. The grocery store occupies a 7,000 square foot retail space and serve as a discount grocery offering brand-name and private-label grocery items, fresh meat, and fresh produce. Heavenly Square Grocery will employ 29 low-income personnel from the local community. The surrounding community of nearly 12,000 low-income residents (1/3rd the population of Danville, Illinois) within the two-mile radius of Heavenly Square Grocery meets the definition of a Food Desert according to the United States Department of Agriculture (USDA) standards.

The main mission of Heavenly Square Groceries is to provide the community with affordable, quality foods, healthy eating resources, and excellent customer service.

Our mission and commitment to the community makes us an ideal partner to The Vermillion County Community Health Collaborative which aims to among other areas, address food insecurity by building community gardens, providing healthy eating, and cooking education and partnering with organization like ours to improve community access to healthy and sustainable foods.

As a partner, we will focus on the following two areas:

1. Opening and operating a community grocery store
2. Assisting with healthy eating and cooking demonstrations through the demonstration kitchen included in this collaborative.

As President and Executive Director of Bowman Holdings, DBA LLC Heavenly Square Grocery and a member of this alliance, I pledge to execute the activities as outlined in this collaborative and to act on behalf of the best interest of the community we aim to serve with these efforts.

I highly recommend your funding support of this collaborative. The Carle-led alliance will help our community access important resources to address key social determinants of health and improve the overall wellbeing of our community members.

Sincerely,

A handwritten signature in blue ink that reads "Thomas W. Miller". The signature is fluid and cursive, with the first name "Thomas" being more prominent and the last name "Miller" following in a similar style.

Thomas W. Miller  
President and Executive Director  
Bowman Street Holdings, LLC  
DBA: Heavenly Square Grocery

November 2, 2021

Ms. Theresa Eagleson, Director  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Gran Avenue, East  
Springfield, Illinois 62763

**Re: Agreement to Join the Vermillion County Community Health Collaborative**

Dear Director Eagleson:

This is to commit the support of Danville Area Community College (DACC) to the Vermillion County Community Health Collaborative as proposed, should it be funded by the Illinois Department of Healthcare and Family Services under the Healthcare Transformation Collaborative Initiative.

Accredited by the Higher Learning Commission, DACC is a comprehensive community college that offers more than 50 career, technical, and transfer programs to address the educational needs of the 70,000 residents in Vermillion County, Illinois, as well as parts of Champaign, Ford, Iroquois, and Edgar counties. Along with traditional college services, DACC provides a wide range of support services for underrepresented communities, including veterans, disabled people, and the district's neediest residents. The College oversees the regional one-stop American Job Center to support job placement and training throughout the east-central Illinois region. DACC also supports more than 75 regional manufacturing, healthcare, transportation and logistics, and retail businesses by producing skilled workers and customized business training. DACC manages an on-campus Child Development Center to provide daycare for students with children as young as fifteen months. Further, in the finest tradition of a comprehensive community college, DACC also has a Community Education Department dedicated to enhancing and improving the lives of community members by offering courses, workshops, seminars, tours, conferences and other activities.

Healthcare is a major industry sector that relies on DACC for support. The College's nursing program is accredited by the Accreditation Commission for Education in Nursing and graduates nearly 100 nurses with associate degrees annually. More than 80 percent of the pass NCLEX licensing examination to become registered nurses. Almost 95 percent of these RNs find employment in the healthcare profession within six months. DACC's radiologic program and the health information technology program have also maintained national accreditation over the past five years.

The Vermilion County Community Health Collaborative closely aligns to the mission of a comprehensive community college, which is to be responsive to community need. DACC quickly adapts instructional offerings to address worker shortages as well as a deficiency in service coverage, such as the critical shortage of trained behavioral-health specialists.

Our expertise and resources makes us an ideal partner to The Vermilion County Community Health Collaborative which aims to among other areas, train and employ community health workers (CHWs) in order to increase the community's access to care and resources. The CHWs will provide health education to the community and help clients in accessing resources such as healthcare, foods, clothing, childcare, health insurance, transportation. The collaborative will also build community gardens to address food insecurity and increase community access to healthy and sustainable foods.

As a partner we will focus on the following two areas:

1. Development and implementation of a Community Health Worker training certification and a new degree allowing Community Health Workers and others to participate more fully in academic and job opportunities. The Associate of Applied Science Degree in Mental Health/Social Work is designed to prepare students for transfer into partnering university programs and entry level employment in a range of social service careers.
2. Provide consult on the development and build out of two community gardens in a partnership with a number of civic groups and with the planning and developmental support of DACC's Horticulture and Agriculture departments.

As the President of DACC, I will serve as a member of the Collaborative's steering committee and execute duties as outlined in the Governance document of this alliance. I pledge to act on behalf of the best interest of the community we aim to serve with these efforts.

By virtue of DACC's commitment to this initiative, I highly recommend your funding collaborative. The Carle-led alliance will help our community access important resources to address key social determinants of health and improve the overall wellbeing of our community members.

Sincerely,



Dr. Stephen Nacco  
President  
Danville Area Community College  
2000 East Main Street  
Danville, IL 61832

Ms. Theresa Eagleson, Director  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Gran Avenue, East  
Springfield, Illinois 62763

**Re: Agreement to collaborate as a partner in the Vermillion County Community Health Collaborative**

Dear Director Eagleson,

It is my pleasure to write this letter to commit the support of CRIS Healthy Aging Center to the Vermillion County Community Health Collaborative being proposed, should it be funded by the Illinois Department of Healthcare and Family Services under the Healthcare Transformation Collaborative Initiative.

CRIS Healthy Aging Center has the privilege of being the Coordinated Point of Entry for both Vermilion and Champaign Counties. It is through this important role that we see firsthand the difference in economic need, diversity, environment, resources, and other social determinants of health. CRIS' long-standing presence in the Vermilion County Community has allowed us insight into the needs of the older adult community and their families.

As a trusted partner and through collaborative efforts CRIS has been able to respond rapidly in this most unprecedented time. We became an expert source in pandemic related matters and started surveying community members to better meet their needs. In response CRIS created an emergency response team mobilized to provide researched, accurate information, and emergency wellness packages. Through our Caregiver Advisory program we identified caregivers and aided in arranging pick-up for older adults unable to reach the pick-up location. Additionally, once these Caregivers were identified they were contacted by CRIS' Memory Care program, with many participating in service. As our Senior Information Services caseworkers followed up, we were able to recognize others who needed services such as Money Management and other related services.

We have been involved in the development of this collaborative and planning of projects and will be serving on the steering committee should funding be awarded.

Vermilion County has languished at the bottom of the County Health Outcomes rankings for years. Many Vermilion County residents struggle with various preventable chronic health conditions such as diabetes and hypertension. It is imperative that our community has adequate access to treatment, preventive care and health information in order to address the health





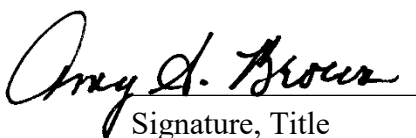
disparities associated with rural communities. Numerous organizations are currently engaged in the transformation of the county around the social determinants of health, and this project will unify those participants in a series of initiatives that produce a true wrap around care system for the most disadvantaged. Recently the County in concert with University analysis and guidance, participation of municipal governments and healthcare entities underwent its Needs Assessment, identifying areas of needed improvement. This, and the county health rankings detail, were used to create the suite of projects we are looking to participate in.

The proposed collaborative's projects will improve access to health services and information, using a participatory approach where members of the community will receive health education training as Community Health Workers, empowering them to assist community members in accessing care, social services, transport etc. With this training program, we will create permanent Community Health Worker jobs, thus contributing to job creation and the economy. Furthermore, this project will facilitate and increase access to healthy food and nutrition education by bringing these resources into the community and eliminating several barriers to access while directly addressing the chronic health diseases affecting the county. The collaborative will mentor students in health career pathways and host a yearly health careers fair to educate our youngest community members on employment options. The local health care entities are in need of these positions on a continuous basis as the population ages, and the need for care increases. Our local educational institutions stand ready to assist with training in many of these areas already established. Education, and job creation, follow this innovation. The project also aims to improve access to behavioral health by increasing the number of mental health professionals available in the county, including sharing of mental health providers between entities that have not, individually, been able to attract and retain such individuals in the past.

I believe it is the whole-person approach of this project, which will make it sustainable, greatly benefit our community and have a long-term impact in the livelihood and wellbeing of the residents of Vermilion County.

Vermilion County residents deserve the opportunity to prosper and thrive in both their health and economics. It is for these reasons that I am in support of this collaborative.

Sincerely,

 , CEO  
Signature, Title







**BOARD OF DIRECTORS & SUSTAINING MEMBERS**

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Auston Surprenant	Danville Area Board of Realtors
Mary Surprenant	United Way
Alyssa Sweeten	Walgreens Accounting Center
Jackie Vinson	Housing Authority City of Danville
John Vogt	thyssenkrupp Crankshaft Company
Mike Weese	Village of Westville
Amy Winter	The Commercial News
Jim Wood	The Cedarwood Companies
Richard Woodard	Woodard's Computing Services
Julie Zimmerman	Genpect

FOUNDING DIRECTOR Lou Mervis



S.

Theresa Eagleson, Director  
 Illinois Department of Healthcare and Family Services  
 Prescott Bloom Building  
 201 South Gran Avenue, East  
 Springfield, Illinois 62763

**Re: Agreement to collaborate as a partner in the Vermillion County Community Health Collaborative**

Dear Director Eagleson,

This letter is to commit the support of Vermilion Advantage, NFP to the Vermillion County Community Health Collaborative being proposed, should it be funded by the Illinois Department of Healthcare and Family Services under the Healthcare Transformation Collaborative Initiative.

Vermilion Advantage, through membership value, provides strategic leadership on critical business issues – leading economic & workforce development, anticipating and responding to members’ needs, addressing quality of life issues and providing a network of information & business contacts – advocating the pursuit of opportunities to strengthen the local economy and business environment. Vermilion Advantage also houses the Chamber of Commerce helping Vermillion County’s small businesses grow and succeed.

We have been involved in the development of this collaborative and planning of projects and will be serving on the steering committee should funding be awarded.

Vermilion County has languished at the bottom of the County Health Outcomes rankings for years. Many Vermillion County residents struggle with various preventable chronic health conditions such as diabetes and hypertension. It is imperative that our community has adequate access to treatment, preventive care and health information in order to address the health disparities

Vermilion Advantage, NFP  
 217-442-6201

15 North Walnut Street  
 800-373-6201

Danville, Illinois 61832  
 Fax: 217-442-6228

Email: [contact@vermilionadvantage.com](mailto:contact@vermilionadvantage.com)

Website: [www.vermilionadvantage.com](http://www.vermilionadvantage.com)

associated with rural communities. Numerous organizations are currently engaged in the transformation of the county around the social determinants of health, and this project will unify those participants in a series of initiatives that produce a true wrap around care system for the most disadvantaged. Recently the County in concert with University analysis and guidance, participation of municipal governments and healthcare entities underwent its Needs Assessment, identifying areas of needed improvement. This, and the county health rankings detail, were used to create the suite of projects we are looking to participate in.

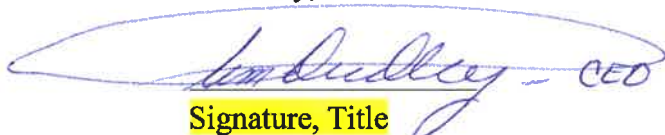
The proposed collaborative's projects will improve access to health services and information, using a participatory approach where members of the community will receive health education training as Community Health Workers, empowering them to assist community members in accessing care, social services, transport etc. With this training program, we will create permanent Community Health Worker jobs, thus contributing to job creation and the economy. Furthermore, this project will facilitate and increase access to healthy food and nutrition education by bringing these resources into the community and eliminating several barriers to access while directly addressing the chronic health diseases affecting the county. The collaborative will mentor students in health career pathways and host a yearly health careers fair to educate our youngest community members on employment options. The local health care entities are in need of these positions on a continuous basis as the population ages, and the need for care increases. Our local educational institutions stand ready to assist with training in many of these areas already established. Education, and job creation, follow this innovation.

The project also aims to improve access to behavioral health by increasing the number of mental health professionals available in the county, including sharing of mental health providers between entities that have not, individually, been able to attract and retain such individuals in the past.

I believe it is the whole-person approach of this project, which will make it sustainable, greatly benefit our community and have a long-term impact in the livelihood and wellbeing of the residents of Vermilion County.

Vermillion County residents deserve the opportunity to prosper and thrive in both their health and economics. It is for these reasons that I am in support of this collaborative.

Sincerely,

A handwritten signature in blue ink, enclosed in a blue oval. The signature is cursive and appears to read "Tom Dudley". To the right of the signature, the letters "CEO" are written in a simple, sans-serif font.

Signature, Title



# East Central Illinois Community Action Agency

*Serving Ford, Iroquois, and Vermilion Counties since 1965*



## Board of Directors

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Debbie Smith  
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Tim Nuss

## Chief Executive Officer

Odette Hyatt-Watson, CCAP

Ms. Theresa Eagleson, Director  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Gran Avenue, East  
Springfield, Illinois 62763

Re: Agreement to collaborate as a partner in the Vermilion County Community Health Collaborative

Dear Director Eagleson,

This letter is to commit the support of East Central Illinois Community Action Agency to the Vermilion County Community Health Collaborative being proposed, should it be funded by the Illinois Department of Healthcare and Family Services under the Healthcare Transformation Collaborative Initiative.

The East Central Illinois Community Action Agency is a 501(c)(3) not-for-profit multi-functional Community Action Agency. The Agency has over 55-years of experience in combating poverty, annually serving over 5,800 individuals and families with low-income and disadvantaged backgrounds through a staff of 16 dedicated family advocates. The Agency administers state and federal grants to include adult and youth education, employment readiness, energy bill assistance, emergency assistance, home ownership and homelessness prevention. Our mission is to stabilize our families in poverty; engage, empower and enrich individuals, families, and communities to become self-sufficient by providing information, training, education, and partnership services. We have been involved in the development of this collaborative and planning of projects, and will be serving on the steering committee should funding be awarded.

Vermilion County has languished at the bottom of the County Health Outcomes rankings for years. Many Vermilion County residents struggle with various preventable chronic health conditions such as diabetes and hypertension. It is imperative that our community has adequate access to treatment, preventive care and health information in order to address the health disparities associated with rural communities. Numerous organizations are currently engaged in the transformation of the county around the social determinants of health, and this project will unify those participants in a series of initiatives that produce a true wrap around care system for the most disadvantaged. Recently the County in concert with University analysis and guidance, participation of municipal governments and healthcare entities underwent its Needs Assessment,

*Member of:*



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[www.comaction.org](http://www.comaction.org)

*"Engaging and empowering families and communities to become self-sufficient"*





# East Central Illinois Community Action Agency

*Serving Ford, Iroquois, and Vermilion Counties since 1965*



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## Chief Executive Officer

Odette Hyatt-Watson, CCAP

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The proposed collaborative's projects will improve access to health services and information, using a participatory approach where members of the community will receive health education training as Community Health Workers, empowering them to assist community members in accessing care, social services, transport etc. With this training program, we will create permanent Community Health Worker jobs, thus contributing to job creation and the economy. Furthermore, this project will facilitate and increase access to healthy food and nutrition education by bringing these resources into the community and eliminating several barriers to access while directly addressing the chronic health diseases affecting the county. The collaborative will mentor students in health career pathways and host a yearly health careers fair to educate our youngest community members on employment options. The local health care entities are in need of these positions on a continuous basis as the population ages, and the need for care increases. Our local educational institutions stand ready to assist with training in many of these areas already established. Education, and job creation, follow this innovation.

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I believe it is the whole-person approach of this project, which will make it sustainable, greatly benefit our community and have a long-term impact in the livelihood and wellbeing of the residents of Vermilion County.

Vermilion County residents deserve the opportunity to prosper and thrive in both their health and economics. It is for these reasons that I am in support of this collaborative.

Sincerely,

Odette Hyatt-Watson, CCAP, NCRI  
Chief Executive Officer

*Member of:*

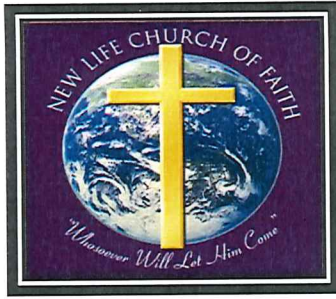


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New Life Church of Faith  
1419 North Bowman Avenue  
Danville, Illinois 61832  
[www.newlifechurchoffait.org](http://www.newlifechurchoffait.org)  
(217) 446-8214

November 12, 2021

Ms. Theresa Eagleson, Director  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building, 201 South Gran Avenue, East  
Springfield, Illinois 62763

**Re: Agreement to collaborate as a partner in the Vermillion County Community Health Collaborative**

Dear Director Eagleson,

This letter is to commit the support of New Life Church of Faith to the Vermillion County Community Health Collaborative being proposed, should it be funded by the Illinois Department of Healthcare and Family Services under the Healthcare Transformation Collaborative Initiative.

We are a non-denominational ministry that has served the Danville and Champaign communities for the past 35 years. We serve several members who would benefit greatly from this grant project.

We have been involved in the development of this collaborative and planning of projects, and will be serving on the steering committee should funding be awarded.

Vermilion County has languished at the bottom of the County Health Outcomes rankings for years. Many Vermilion County residents struggle with various preventable chronic health conditions such as diabetes and hypertension. It is imperative that our community has adequate access to treatment, preventive care and health information in order to address the health disparities associated with rural communities. Numerous organizations are currently engaged in the transformation of the county around the social determinants of health, and this project will unify those participants in a series of initiatives that produce a true wrap around care system for the most disadvantaged. Recently the County in concert with University analysis and guidance, participation of municipal governments and healthcare entities underwent its Needs Assessment, identifying areas of needed improvement. This, and the county health rankings detail, were used to create the suite of projects we are looking to participate in.



The proposed collaborative's projects will improve access to health services and information, using a participatory approach where members of the community will receive health education training as Community Health Workers, empowering them to assist community members in accessing care, social services, transport etc. With this training program, we will create permanent Community Health Worker jobs, thus contributing to job creation and the economy. Furthermore, this project will facilitate and increase access to healthy food and nutrition education by bringing these resources into the community and eliminating several barriers to access while directly addressing the chronic health diseases affecting the county. The collaborative will mentor students in health career pathways and host a yearly health careers fair to educate our youngest community members on employment options. The local health care entities are in need of these positions on a continuous basis as the population ages, and the need for care increases. Our local educational institutions stand ready to assist with training in many of these areas already established. Education, and job creation, follow this innovation. The project also aims to improve access to behavioral health by increasing the number of mental health professionals available in the county, including sharing of mental health providers between entities that have not, individually, been able to attract and retain such individuals in the past.

I believe it is the whole-person approach of this project, which will make it sustainable, greatly benefit our community and have a long-term impact in the livelihood and wellbeing of the residents of Vermillion County.

Vermillion County residents deserve the opportunity to prosper and thrive in both their health and economics. It is for these reasons that I am in support of this collaborative.

Sincerely,

A handwritten signature in blue ink, appearing to read "Thomas Miller". The signature is fluid and cursive, with a large initial "T" and "M".

Pastor Thomas Miller

# STEP UP

VERMILION COUNTY

November 12, 2021

Ms. Theresa Eagleson, Director  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Gran Avenue, East  
Springfield, Illinois 62763

**Re: Agreement to collaborate as a partner in the Vermilion County Community Health Collaborative**

Dear Director Eagleson,

This letter is a commitment of the support of Step Up to the Vermilion County Community Health Collaborative being proposed, should it be funded by the Illinois Department of Healthcare and Family Services under the Healthcare Transformation Collaborative Initiative.

Step Up is a 501c3 and began in 2017 as a collaboration between business leaders, educators, health care workers, politicians, law enforcement, health department, non-profit organizations, and local community members to Rally-Relate-Resource to address community needs throughout Vermilion County. Our mission statement is “Step Up Vermilion County exists to bring the community together, to identify and address current challenges facing the County, to empower growth and development, and to create positive outcomes in economic, educational, social and spiritual arenas.” The three areas that we focus on specifically are - Mental Health, Substance Abuse, Parenting & Families – and we are very proud of the accomplishments achieved since the beginning, yet we still have so many needs in our community. We have been involved in the development and planning of this project with Vermilion County Community Health Collaborative and will be serving on the steering committee should funding be awarded. We look forward to making an even greater impact on our communities in the future!

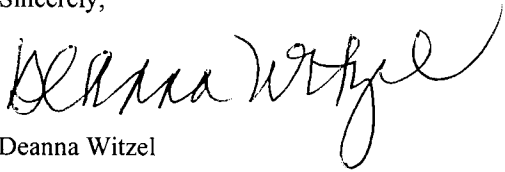
Vermilion County has long ranked at the bottom of the County Health Outcomes throughout the State of Illinois. Many residents suffer from chronic health issues such as diabetes and hypertension that are manageable with the proper treatment and access to affordable health care. It is important that our county can provide preventative care that is easily available to our residents. Numerous organizations are currently engaged in providing options for our residents and this project would be able to unify these organizations and provide for our most disadvantaged. Recently the County partnered with University Analysis and Guidance, and municipal government and healthcare entities under its Needs Assessment which identified the areas which need improvement. With this, and the current county health ranking, details were used to create the projects we are looking to participate in.

The proposed collaborative's projects will improve access to health services and information, using an approach where members of the community will receive health education training as Community Health Workers, empowering them to assist community members in accessing care, social services, transport etc. With this training program, we will create permanent Community Health Worker jobs, thus contributing to job creation and the economy. Furthermore, this project will facilitate and increase access to healthy food and nutrition education by bringing these resources into the community and eliminating several barriers to access while directly addressing the chronic health diseases affecting the county. The collaborative will mentor students in health career pathways and host a yearly health careers fair to educate our youngest community members on employment options. The local health care entities need these positions on a continuous basis as the population ages, and the need for care increases. Our local educational institutions stand ready to assist with training in many of these areas already established. Education and job creation follow this innovation.

The project also aims to improve access to behavioral health by increasing the number of mental health professionals available in the county, including sharing of mental health providers between entities that have not, individually, been able to attract and retain such individuals in the past.

I believe that the whole-person approach of this project is what makes it unique and sustainable. It will greatly benefit our community and have a long-term impact on the wellbeing of the residents of Vermilion County. Our residents deserve the opportunity to thrive and prosper in both their health and economics. This initiative will provide both and that is why I wholeheartedly support the Vermilion County Community Health Collaborative being proposed.

Sincerely,

A handwritten signature in black ink, appearing to read "Deanna Witzel". The signature is fluid and cursive, with a large, sweeping flourish at the end.

Deanna Witzel  
McDonald's Owner/Operator  
Step Up Founder & President



Vermilion County Community Health Collaborative

## **Exhibits**

# Vermilion County Community Health Collaborative

## Section 2. Project Description

### Attachment 1. County Health Rankings for the 102 Ranked Counties in Illinois, 2021

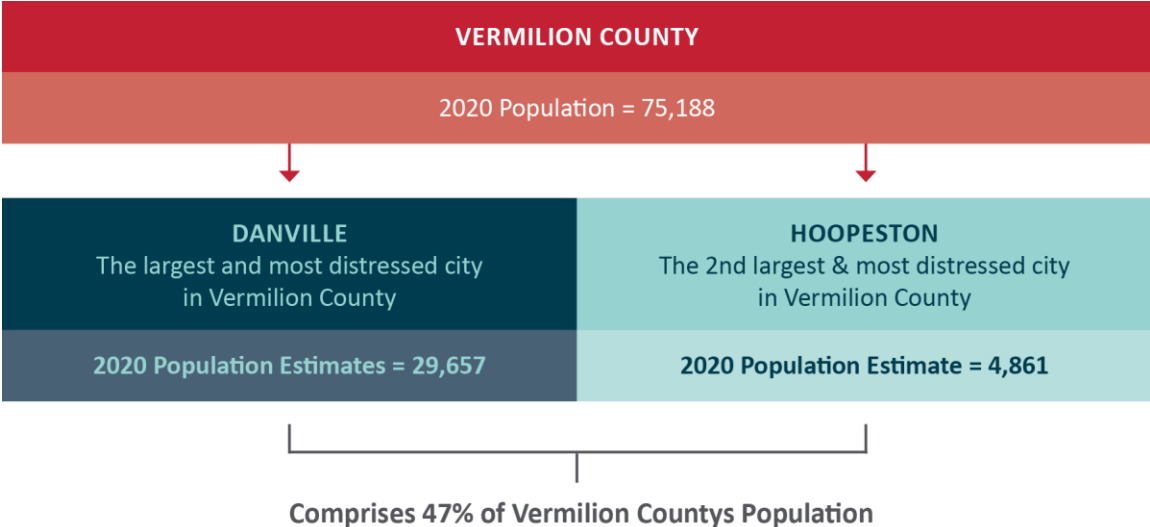
County	HEALTH OUTCOMES	HEALTH FACTORS	County	HEALTH OUTCOMES	HEALTH FACTORS	County	HEALTH OUTCOMES	HEALTH FACTORS	County	HEALTH OUTCOMES	HEALTH FACTORS	County	HEALTH OUTCOMES	HEALTH FACTORS
Adams	46	24	DuPage	1	1	Jo Daviess	17	16	McLean	13	6	Scott	56	27
Alexander	101	102	Edgar	67	76	Johnson	40	89	Menard	29	17	Shelby	37	37
Bond	57	23	Edwards	71	19	Kane	7	21	Mercer	36	34	St. Clair	94	80
Boone	21	65	Effingham	27	10	Kankakee	87	84	Monroe	3	2	Stark	84	56
Brown	18	13	Fayette	54	94	Kendall	2	4	Montgomery	75	86	Stephenson	50	68
Bureau	22	54	Ford	48	46	Knox	60	83	Morgan	78	71	Tazewell	16	14
Calhoun	41	57	Franklin	93	97	Lake	5	8	Moultrie	19	31	Union	81	88
Carroll	11	41	Fulton	74	81	LaSalle	59	74	Ogle	30	49	Vermilion	99	100
Cass	82	82	Gallatin	97	95	Lawrence	92	93	Peoria	79	48	Wabash	32	29
Champaign	28	15	Greene	80	78	Lee	24	50	Perry	53	90	Warren	45	52
Christian	58	77	Grundy	15	18	Livingston	66	38	Piatt	8	5	Washington	14	9
Clark	49	69	Hamilton	23	33	Logan	52	43	Pike	76	79	Wayne	70	64
Clay	33	60	Hancock	34	26	Macon	89	73	Pope	77	96	White	85	63
Clinton	12	11	Hardin	100	101	Macoupin	73	42	Pulaski	102	98	Whiteside	25	45
Coles	47	58	Henderson	88	62	Madison	72	59	Putnam	35	40	Will	9	12
Cook	44	53	Henry	26	39	Marion	96	87	Randolph	68	72	Williamson	62	55
Crawford	38	44	Iroquois	86	67	Marshall	64	30	Richland	51	25	Winnebago	90	91
Cumberland	31	35	Jackson	83	66	Mason	69	75	Rock Island	43	70	Woodford	6	3
De Witt	55	28	Jasper	10	36	Massac	95	92	Saline	98	99			
DeKalb	20	22	Jefferson	91	85	McDonough	42	61	Sangamon	65	20			
Douglas	39	51	Jersey	61	47	McHenry	4	7	Schuyler	63	32			

Source: County Health Rankings and Roadmaps (<https://www.countyhealthrankings.org/>), a program of the University of Wisconsin Population Health Institute, and supported by the Robert Wood Johnson Foundation.

# Vermilion County Community Health Collaborative

## Section 2. Project Description

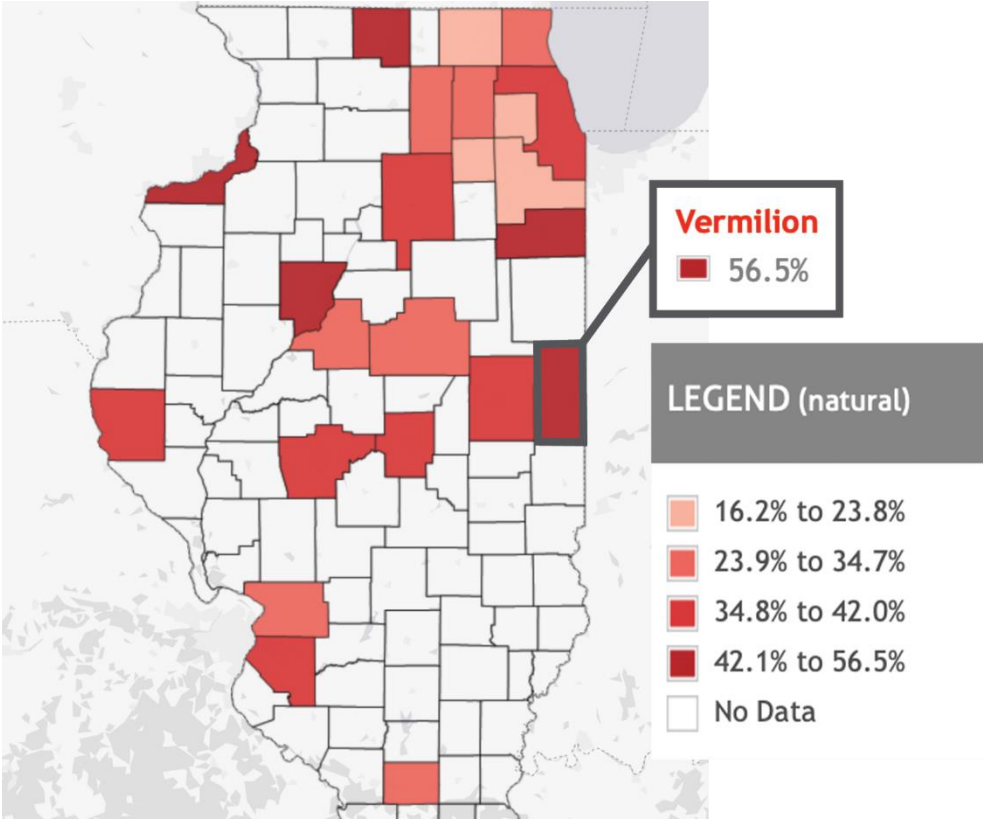
### Attachment 2. Service Area Population



# Vermilion County Community Health Collaborative

## Section 2. Project Description

### Attachment 3. Children Below 200 Percent of the Poverty Level, selected counties in Illinois, 2019



Data Source: U.S. Census Bureau's American Community Survey, Age by Ratio of Income to Poverty Level in the Past 12 Months (Universe: Population for whom poverty status is determined), 2014 to 2019 1-Year Estimates, Table C17024.

# Vermilion County Community Health Collaborative

## Section 2. Project Description

### Attachment 4. Social Vulnerability Index

Areas in Illinois above average (upper 50th percentile) in social vulnerability			
Areas with CDC Social Vulnerability Index Percentile Score 50 <sup>1</sup>	Pop. Count <sup>2</sup>	CDCSVI %-tile Score <sup>3</sup>	Sample of Zip Codes w/ SVI Score > 75 <sup>4</sup> ("most vulnerable")
<b>1. Areas from UIC Study [5]</b>			
Chicago South Catchment	1,026,829	87.6	<u>60621, 60636, 60637</u>
Chicago West Catchment	590,175	83.5	<u>60623, 60624, 60644</u>
Metro East St. Louis Catchment <sup>5</sup>	522,652	58.8	62201, 62203, 62204
West Cook County Catchment	529,407	58.0	<u>60104, 60153, 60804</u>
Southern Cook County Catchment	895,830	56.6	<u>60472, 60501, 60827</u>
<b>2. Metropolitan Statistical Areas (MSA) [8]</b>			
Danville, IL [Vermilion CTY]	75,758	98.0	<u>61832</u>
Kankakee Bradley, IL [Kankakee CTY]	109,862	91.1	60901, 60950, 60958
Rockford, IL	336,116	88.1	61101, 61102, 61103
Decatur, IL [Macon CTY]	104,009	78.2	<u>62522, 62523, 62526</u>
Moline Rock Island, IL	206,229	69.0	<u>61201, 61443</u>
Springfield, IL [Sangamon CTY]	197,661	60.4	62701, 62702, 62703
Champaign Urbana, IL [Champaign CTY]	209,448	53.5	<u>61801, 61820</u>
Peoria, IL	400,561	50.1	61602, 61603, 61605
<b>3. Marion Health Region Statistical Areas [5]</b>			
Mount Vernon, IL μSA [Jefferson CTY]			<u>62846, 62864, 62872</u>
Centralia, IL μSA [Marion CTY]			<u>62801, 62882</u>
Cape Girardeau, MO-IL MSA [CTY]			62914
Paducah, KY-IL μSA [Massac CTY] <sup>6</sup>			
Carbondale-Marion MSA			<u>62901, 62902, 62903</u>
15 Other counties in the region			62930, 62946, 62460, 62466, 62906, 62879, 62934, 62954, 62984, 62919, 62931, 62947, 62885, 62886

<sup>1</sup>CDC-SVI: <https://www.atsdr.cdc.gov/placeandhealth/svi/index.html>  
<sup>2</sup>American Community Survey 2014 2018 5 Year Estimates: <https://data.census.gov/cedsci/all?d=ACS%205-Year%20Estimates%20Detailed%20Tables>  
<sup>3</sup>From CDC based on 2018 estimates: [https://www.atsdr.cdc.gov/placeandhealth/svi/data\\_documentation\\_download.html](https://www.atsdr.cdc.gov/placeandhealth/svi/data_documentation_download.html)  
<sup>4</sup>From Covid-19 Healthcare Coalition/Mitre: <https://c19hcc.org/resource/vulnerable-population>  
<sup>5</sup>St. Clair and Madison counties  
<sup>6</sup>Highest zip code 62960, Metropolis (pop.~11,250)  
 Lastly, an underlined zip code means that is also designated as being disproportionately impacted area (DIA) due to Covid-19 by the ILDCEO <https://www2.illinois.gov/dceoSmallBizAssistance/Pages/C19DisadvantagedBusGrants-test.aspx>

Source: Illinois Department of Healthcare and Family Services, "Healthcare Transformation Proposal" (page 7)

<https://www2.illinois.gov/hfs/SiteCollectionDocuments/HFSTransformationProposalFebruary24.pdf>.

# Vermilion County Community Health Collaborative

## Section 2. Project Description

### Attachment 5. Collaborative Blueprint

<p><b>Overarching Goals</b></p>	<p><b>Service Oriented</b></p> <ul style="list-style-type: none"> <li>Expand access to community-based preventive, primary or specialty care</li> <li>Address social and structural determinants of health</li> <li>Develop solutions to meet County members’ personalized needs</li> </ul> <p><b>Design Oriented</b></p> <ul style="list-style-type: none"> <li>Create a holistic approach to health care transformation</li> <li>Ground the Collaborative in maintaining racial and health equity</li> <li>Cultivate a multi-sector innovative collaboration with community engagement</li> <li>Foster a culture that attracts, develops and retains a diverse, highly engaged workforce to advance the primary health care mission</li> <li>Ensure that all HTC investments are sustainable beyond the funding cycle.</li> <li>Create a measurable and lasting impact that improves health outcomes, health equity.</li> </ul>
<p><b>Disparities Being Targeted</b></p>	<ul style="list-style-type: none"> <li>Maternal &amp; child health - PILLAR</li> <li>Behavioral health &amp; substance use PILLAR (youth &amp; adults)</li> <li>Chronic diseases</li> <li>Hospitalizations</li> <li>Food insecurity</li> <li>Broadband access</li> </ul>
<p><b>Initiatives to Reduce Disparities</b></p>	<ul style="list-style-type: none"> <li>Create CHW program</li> <li>Expand Healthy Beginnings to Vermilion County</li> <li>Expand community-based health screening and primary care services (mobile)</li> <li>Expand community-based addiction recovery services (mobile)</li> <li>Initiate school-based behavioral health services</li> <li>Initiate counseling services for seniors</li> <li>Implement multiple food access to programs, from a Mobile Market to produce gardens to grocers</li> <li>Implement healthy cooking teaching demonstrations</li> <li>Implement healthy eating education</li> <li>Expand telehealth offerings for preventive, primary and specialty care</li> <li>Expand broadband &amp; connectivity throughout all of Vermilion County</li> </ul>
<p><b>By implementing initiatives (above) these disparities will be reduced</b></p>	<ul style="list-style-type: none"> <li>Decreased number of live births with low birth weights</li> <li>Decreased infant mortality rates</li> <li>Decreased preterm births</li> <li>Decreased ED visits for behavioral health reasons</li> <li>Decreased drug overdose mortality rates</li> <li>Decreased ED rates due to adolescent alcohol use</li> <li>Decreased obesity rates</li> <li>Decreased percentage of people with uncontrolled diabetes</li> <li>Decreased prevalence of high blood pressure</li> </ul>

# Vermilion County Community Health Collaborative

	<ul style="list-style-type: none"> <li>• Decreased ED utilization for heart failure</li> <li>• Decreased number of emergency department visits</li> <li>• Decreased number of hospitalizations</li> <li>• Decreased 30-day readmissions</li> <li>• Decreased scarcity of nutritious, affordable food</li> <li>• Decreased prevalence of hunger and food-related illnesses</li> <li>• Decreased difficulties when needing to see a doctor due to availability of telehealth services</li> <li>• Decreased number of County members without sufficient Broadband</li> </ul>
<p><b>Health Outcomes achieved by reducing disparities</b></p>	<ul style="list-style-type: none"> <li>• Increased percentage of live births with healthy birth weights</li> <li>• Increased percentage of live births</li> <li>• Increased percentage of babies born at term</li> <li>• Increased number of youth, adults, and seniors receive outpatient behavioral health services</li> <li>• Increased number of youth and adults are treated for and experience drug addiction recovery</li> <li>• Increased number of youth and adults screened for depression</li> <li>• Increased number of children and adults with healthy body weights</li> <li>• Improved control of type 2 diabetes mellitus</li> <li>• Improved control of hypertensive disease</li> <li>• Improved diagnosis, monitoring and patient compliance related to heart disease</li> <li>• Improved utilization of inpatient care for seniors and for patients with hypertensive disease (i.e., fewer visits)</li> <li>• Improved access to healthy, affordable foods</li> <li>• Increased number of County members who know how to select healthy foods</li> <li>• Increased number of County members who cook healthier meals</li> <li>• Improved healthy eating and nutrition education</li> <li>• Increased number of telehealth patient visits for primary, specialty, and behavioral health care services</li> <li>• Increased number of encounters with human and social services agencies - referrals</li> </ul>
<p><b>Social &amp; Structural Determinants of Health</b></p>	<p><b>Socioeconomic Determinants of Health Focus Areas</b></p> <ul style="list-style-type: none"> <li>• Poverty</li> <li>• Food Insecurity</li> <li>• Lack of Clinical &amp; Community Linkages</li> </ul> <p><b>Structural Determinants of Health Focus Areas</b> <i>(to alleviate the impact of the identified social determinants of health)</i></p> <ul style="list-style-type: none"> <li>• Education &amp; Job Training</li> <li>• Employment</li> <li>• Broadband &amp; Internet Access</li> <li>• Food Access and Security</li> <li>• Community and Social Service Resources</li> <li>• Health Care Resources</li> </ul>
<p><b>SDoH Strategies</b></p>	<p><b>These initiatives are either new (or innovative) to Vermilion County or ones that are expanding into the County.</b></p>

# Vermilion County Community Health Collaborative

	<ul style="list-style-type: none"> <li>• Launch a community health worker (CHW) program that includes training</li> <li>• Expand Healthy Beginnings</li> <li>• Hire and train a minimum of 70+ employees/ contractors for the Collaborative over five years</li> <li>• Cultivate workforce interests and trainings among high school students</li> <li>• Increase offerings for career and college level trainings</li> <li>• Expand food insecurity screenings</li> <li>• Design and build two community produce gardens</li> <li>• Establish two local grocers</li> <li>• Establish a commercial kitchen for nutrition and food preparation training and for health education</li> <li>• Purchase and operate a Mobile Market</li> <li>• Expand telehealth services</li> <li>• Expand Broadband Access &amp; Connectivity</li> <li>• Purchase, train, and deploy social service referral and SDOH screening platforms that are compatible with Epic and for use by all Vermilion County Collaborative providers</li> </ul>
<p><b>Innovation</b></p>	<p><b>The majority of activities and strategies are new to Vermilion County and although not innovative to healthcare, they are innovative for this region of Illinois.</b> This is with one exception –</p> <ul style="list-style-type: none"> <li>• Carle health currently has an alternative payment model in place with Molina Healthcare. Going forward the Collaborative will look to expand and improve reimbursements for value and outcomes, prioritizing quality over volume and including formula enhancement.</li> </ul> <p><b>Some of the “firsts” for Vermilion County include:</b></p> <ul style="list-style-type: none"> <li>• Utilization and deployment of social service referral software and SDOH screening software to be used cooperatively by the Collaborative’s providers, along with a focus on data sharing and transparency – NEW</li> <li>• Instituting a job sharing program between a community-based mental health provider and Carle to increase patient load variety and decrease burnout</li> <li>• Simultaneously tackling health disparities and social determinants of health to improve outcomes and quality of life - NEW</li> <li>• Strongly emphasizes racial equity including helping County members create economic stability and food security - NEW</li> <li>• Considers resident’s needs in the new delivery model and has a Community Advisory Council to ensure residents have a voice going forward. It is a person-centric model - NEW</li> <li>• Integrates both community health workers and Healthy Beginnings, both home visiting programs, to work with the most at-risk populations - NEW</li> </ul>
<p><b>Collaborators &amp; Supporters</b></p>	<p><b>Steering Committee</b></p> <ul style="list-style-type: none"> <li>• Carle Health, including Carle Hoopston Regional Health Center (a critical access hospital)</li> <li>• OSF HealthCare Sacred Heart Hospital</li> <li>• Crosspoint Human Services</li> <li>• CRIS Healthy-Aging Center</li> <li>• Danville Area Community College</li> <li>• City of Danville Elected Official (Mayor)</li> <li>• District 118 Danville Community Schools</li> <li>• Eastern Illinois Community Action Agency</li> </ul>



# Vermilion County Community Health Collaborative

- Heavenly Square Grocery (Bowman Holdings, LLC)
- New Life Church of Faith
- STEP UP – Designee
- Vermilion Advantage
- Vermilion County Dept. of Public Health

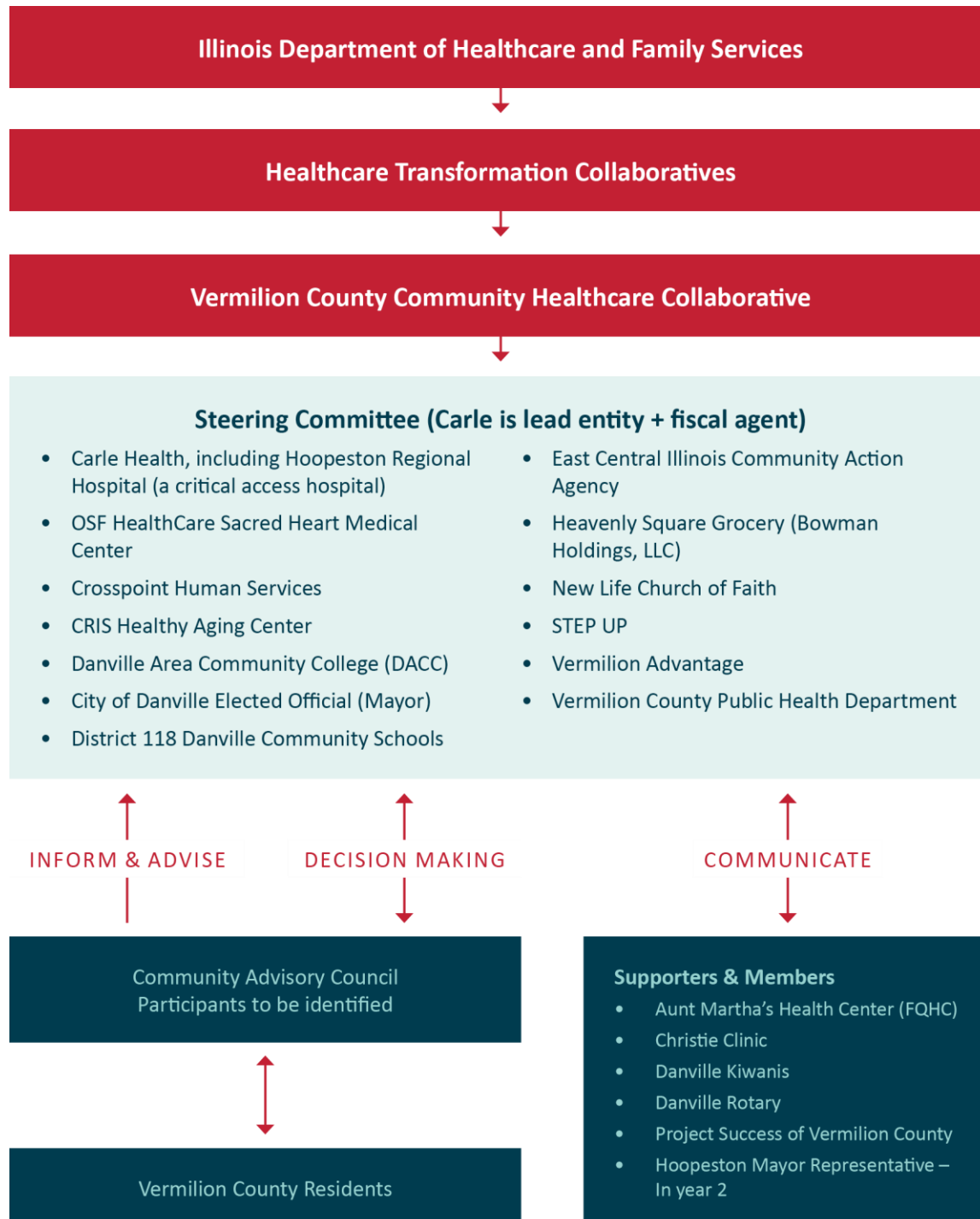
## **Supporters & Members** *(listed in alphabetical order)*

- Aunt Martha's Health Center (FQHC)
- Christie Clinic
- Danville Kiwanis
- Danville Rotary
- Project Success of Vermilion County
- Hoopeston Mayor Representative – In year 2

# Vermilion County Community Health Collaborative

## Section 3. Governance

### Attachment 6. Organization Chart



## SECTION 4. RACIAL EQUITY

### HIGH-LEVEL NARRATIVE

Vermilion County is home to a diverse population despite its low Diversity Index score of 40.3 percent (compared to Illinois at 61.4 percent). A higher percentage of veterans live in the County compared to the value for Illinois (9.3% in Vermilion County compared to 5.7% in Illinois). Among the County's 5,178 veterans, the poverty rate is 9.6% and the veteran disability rate is 33.82% (<https://worldpopulationreview.com/us-counties/il/vermilion-county-population>). Vermilion County also has a much higher percentage of civilians with disabilities (15.4%), as does Illinois (11.6%), and exceeds the United States' percentage (12.6%), as well.

As highlighted in the Racial Equity Assessment Form, Vermilion County's most vulnerable residents crowd together in seven of the County's 122 census tracts. The census tracts are – 17183000100, 17183000200, 17183000300, 17183000400, 17183000600, 17183011200 (all in Danville, where most of the County's African American population resides); and 17183010200 (which is in Hoopston, where most of the County's Hispanic population lives).

The combination of health and rural inequities is apparent throughout Vermilion County when considering COVID-19 cases and vaccination rates. The New York Times publishes COVID-19 data daily. As of November 7, 2021, Vermilion County was cited as one of Illinois' hot spots having a seven-day average of 47 cases per 100,000 people. It had the fourth-highest seven-day average for new cases out of Illinois 102 counties. This value compares to 20 cases per 100,000 people for Illinois' seven-day average. Vermilion County's total is even higher than Cook County's seven-day average at 16 cases per 100,000 and Pulaski County at 11 cases. Putting this information in perspective, Pulaski County ranked last, 102 out of 102, in the 2021 County Health Rankings (<https://www.nytimes.com/interactive/2021/us/vermilion-illinois-covid-cases.html>). This data is corroborated by the CDC's Covid Data Tracker where their seven-day metrics put Vermilion County as the most affected in Illinois. Cumulative case counts have the County at 330.00 cases per 100,000 people with a 5.39% seven-day positivity rate as of November 7, 2021. (Please refer to Attachment 8.)

The November 7, 2021 New York Times data also reveals that 41% of Vermilion County's residents have been fully vaccinated against COVID-19, compared to 61% for all of Illinois. (<https://www.nytimes.com/interactive/2020/us/covid-19-vaccine-doses.html#vulnerable>)

A core intent of the Vermilion County Community Health Collaborative is to address existing disparities, similar to the one described above, and ensure racial equity. Multiple strategies will be employed to ensure success.

Using an evaluation system to assess minority participation across multiple lines will be indispensable, allowing health outcomes to be analyzed from a clinical perspective and by race. Quality improvement strategies can then address the social determinants of health (SDOH) that prevent individuals from achieving quality outcomes.

## Vermilion County Community Health Collaborative

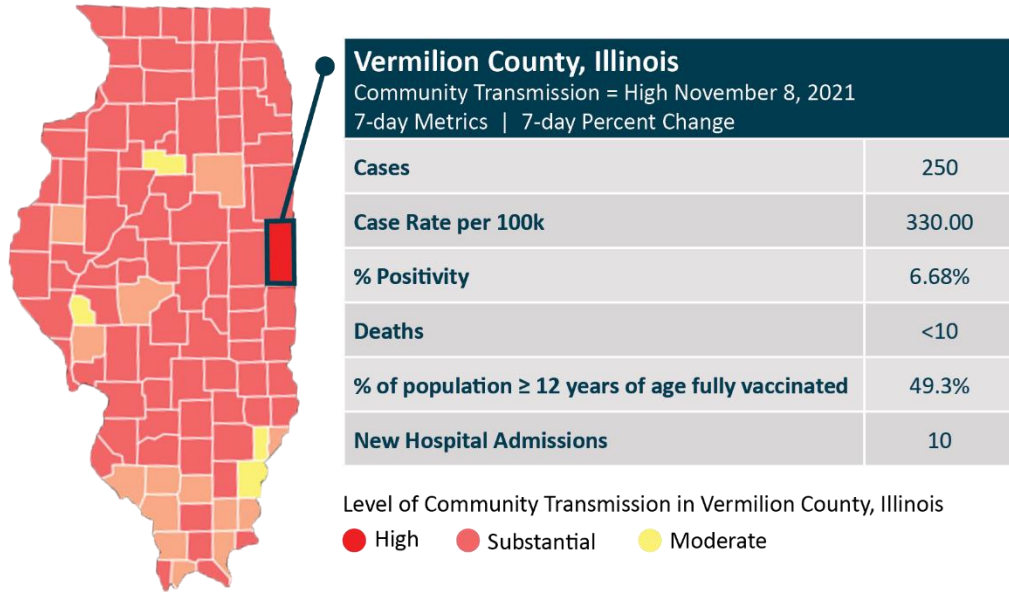
Metrics will similarly be captured to ensure that targets inequitable hiring (including promotion and retention), Collaborative representation, and point of service locations are met.

The Collaborative's commitment is to make certain the residents of Vermilion County have a voice in this initiative. Engagement by minorities and people of color as collaborators will be tracked and reported out. The uptick may be slower than desired because of daunting social determinants of health, but the commitment will not waver. Success will be realized if 10% of the Council's members are Black or Hispanic by the end of Year 1. The goal is that 40% of the Council's members will be Black or Hispanic by the end of Year 4. (In Vermilion County 13.8% of the population is Black. In the census tracts representing the County's segregated and most vulnerable populations, the Black representation moves up to 46% in a couple of the tracts.)

# Vermilion County Community Health Collaborative

## Section 4. Racial Equity

### Attachment 8. COVID-19 Community Transmission Levels, November 8, 2021



Source: CDC COVID Data Tracker ([https://covid.cdc.gov/covid-data-tracker/#county-view/Risk/community\\_transmission\\_level](https://covid.cdc.gov/covid-data-tracker/#county-view/Risk/community_transmission_level))

# Vermilion County Community Health Collaborative

## Section 5. Community Input

### Attachment 9. Vermilion County Resident Community Health Survey Questionnaire

#### Appendix C – Vermilion County Community Health Survey (four pages)

##### Vermilion County Community Health Survey

You can also fill out the survey online: <https://www.surveymonkey.com/r/6JCM2D9>

Please take a few minutes to complete the survey below. The purpose is to get your opinion about community health strengths and concerns in Vermilion County. Your input is important and all individual information will be kept confidential.

##### How Are We Doing in Vermilion County?

1. What are the 5 greatest STRENGTHS of Vermilion County? Please check exactly 5.

- |  |   |
|--|---|
| <input type="checkbox"/> Access to Alcohol / Drug Abuse Treatment / Prevention | <input type="checkbox"/> Homeless Services  |
| <input type="checkbox"/> Access to Affordable, Healthy Food                    | <input type="checkbox"/> Low Crime/Safe Neighborhoods                                 |
| <input type="checkbox"/> Access to Child Care                                  | <input type="checkbox"/> Parks and Recreation   |
| <input type="checkbox"/> Access to Healthcare                                  | <input type="checkbox"/> Police, Fire, Rescue Services                                |
| <input type="checkbox"/> Affordable Housing                                    | <input type="checkbox"/> Prepared for Emergencies (tornado, floods, disease/pandemic) |
| <input type="checkbox"/> Arts and Cultural Events                              | <input type="checkbox"/> Programs for Youth Outside of School                         |
| <input type="checkbox"/> Clean Environment                                     | <input type="checkbox"/> Public Transportation/Options                                |
| <input type="checkbox"/> Early Childhood Services                              | <input type="checkbox"/> Religious/Spiritual Values                                   |
| <input type="checkbox"/> Educational Opportunities                             | <input type="checkbox"/> Respect towards different Cultures and Races                 |
| <input type="checkbox"/> Friendly Community                                    | <input type="checkbox"/> Senior Services  |
| <input type="checkbox"/> Good Jobs and Healthy Economy                         | <input type="checkbox"/> Walkable, Bikeable Community                                 |
| <input type="checkbox"/> Good Primary Schools                                  | <input type="checkbox"/> Other: _____   |

2. What do you think are the 5 most important CONCERNS in Vermilion County? Please check exactly 5.

- |  |  |
|--|--|
| <input type="checkbox"/> Access to Employment  | <input type="checkbox"/> Housing that is Safe and Affordable               |
| <input type="checkbox"/> Accidental Injuries   | <input type="checkbox"/> Income/Poverty                                    |
| <input type="checkbox"/> Aging Problems (arthritis, hearing / vision loss)                               | <input type="checkbox"/> Infectious Diseases (flu, TB, measles)            |
| <input type="checkbox"/> Alcohol/Drug Abuse/Treatment  | <input type="checkbox"/> Low High School & College Graduation Rates        |
| <input type="checkbox"/> Bullying  | <input type="checkbox"/> Mental Health Disorders (depression, anxiety)     |
| <input type="checkbox"/> Child Abuse / Neglect   | <input type="checkbox"/> Motor Vehicle Injury                              |
| <input type="checkbox"/> Chronic Disease (cancers, diabetes, heart disease, stroke, high blood pressure) | <input type="checkbox"/> Obesity (overweight)                              |
| <input type="checkbox"/> Dental Problems   | <input type="checkbox"/> Poor Nutrition / Eating Habits / Lack of Exercise |
| <input type="checkbox"/> Disabilities (physical, developmental, sensory)                                 | <input type="checkbox"/> Rape / Sexual Assault                             |
| <input type="checkbox"/> Discrimination  | <input type="checkbox"/> Sexually Transmitted Diseases (STDs) / HIV/AIDS   |
| <input type="checkbox"/> Domestic Violence   | <input type="checkbox"/> Suicide   |
| <input type="checkbox"/> Elder Abuse   | <input type="checkbox"/> Teenage Pregnancy                                 |
| <input type="checkbox"/> Firearm-related Injuries  | <input type="checkbox"/> Tobacco Use / Smoking / Vaping                    |
| <input type="checkbox"/> Food Insecurity or Access to food   | <input type="checkbox"/> Too much Screen Time / Technology Use             |
|  | <input type="checkbox"/> Other: _____                                      |

3. How would you rate your personal health? (Circle One)      Unhealthy      Somewhat Healthy      Healthy

4. Have you had a routine physical exam in the past two years?      Yes      No  
If no, why not? [check all that apply]

- |  |  |
|--|--|
| <input type="checkbox"/> No health insurance/High cost | <input type="checkbox"/> No transportation                     |
| <input type="checkbox"/> I don't have a doctor         | <input type="checkbox"/> I don't have time                     |
| <input type="checkbox"/> Fear/discomfort               | <input type="checkbox"/> I don't feel I need to see the doctor |

## Vermilion County Community Health Survey

You can also fill out the survey online: <https://www.surveymonkey.com/r/6JCM2D9>

**5. Have you visited the dentist in the past two years?** **Yes** **No**

**If no, why not? [check all that apply]**

<input type="checkbox"/> No dental insurance/High cost <input type="checkbox"/> I don't have a dentist <input type="checkbox"/> Fear/discomfort	<input type="checkbox"/> No transportation <input type="checkbox"/> I don't have time <input type="checkbox"/> I don't feel I need to see the dentist
---	---

**6. Have you gotten professional help for any personal or emotional problem?** **Yes** **No**

**If yes, who did you seek help from?**

<input type="checkbox"/> Family Doctor (seen for counseling and/or medications for depression/anxiety.) <input type="checkbox"/> Counselor <input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Psychologist <input type="checkbox"/> Social Worker <input type="checkbox"/> Clergy <input type="checkbox"/> Other (Please specify): _____
--	--

**7. Have any of the following kept you or the members of your household from receiving needed mental health, substance use or developmental disability related services?**

<input type="checkbox"/> Cost of treatment <input type="checkbox"/> Lack of funds for co-pay <input type="checkbox"/> Didn't know where to go for services <input type="checkbox"/> Transportation to get to services <input type="checkbox"/> Clinic doesn't understand my language/culture <input type="checkbox"/> No place has the services I need <input type="checkbox"/> Agency did not call back or follow-up	<input type="checkbox"/> The wait for help is too long. <input type="checkbox"/> Owe money to the agency I would go to <input type="checkbox"/> Lack insurance <input type="checkbox"/> Others might have a negative view of me for using mental health services <input type="checkbox"/> Other (Please Specify): _____ <input type="checkbox"/> No / Does not apply
---	---

---

**8. Please indicate which of the following types of gambling you have done in the last year. Please circle one answer.**

• Played cards for money	Not at all	Less than once a week	More than once a week
• Bet on Sports	Not at all	Less than once a week	More than once a week
• Played dice games	Not at all	Less than once a week	More than once a week
• Went to a casino	Not at all	Less than once a week	More than once a week
• Played the lottery (including scratchers)	Not at all	Less than once a week	More than once a week
• Played bingo	Not at all	Less than once a week	More than once a week
• Played slot, poker or other machines	Not at all	Less than once a week	More than once a week
• Some other form of gambling	Not at all	Less than once a week	More than once a week

---

**9. Please answer the following health statements that apply to you. Please circle one answer.**

• I am physically active for 30 minutes at least 3 times per week.	Sometimes	Always	Never
• I drink more than 1 sugary beverage per day. (Soda, sweet tea, etc.)	Sometimes	Always	Never
• I smoke or chew tobacco products.	Sometimes	Always	Never
• I use E-cigarettes /Vape.	Sometimes	Always	Never
• I use illegal drugs .	Sometimes	Always	Never
• I abuse or overuse prescription drugs.	Sometimes	Always	Never
• I use recreational marijuana.	Sometimes	Always	Never
• I use medicinal marijuana .	Sometimes	Always	Never
• I consume more than 4 alcoholic drinks (if female) or 5 (if male) per day.	Sometimes	Always	Never
• I feel safe in my neighborhood.	Sometimes	Always	Never
• I feel safe in my community.	Sometimes	Always	Never

## Vermilion County Community Health Survey

You can also fill out the survey online: <https://www.surveymonkey.com/r/6JCM2D9>

**10. Please indicate your views on the following statements. Please circle one answer.**

- |  |       |          |            |
|--|-------|----------|------------|
| • Treatment can help people with mental illness lead normal lives.                         | Agree | Disagree | Don't know |
| • Mental illness is a sign of personal weakness.   | Agree | Disagree | Don't know |
| • Mental illness can be caused by biological imbalances.                                   | Agree | Disagree | Don't know |
| • Children's mental health is essential to health, academic success, and well-being.       | Agree | Disagree | Don't know |
| • Mental illness can be caused by environmental factors.                                   | Agree | Disagree | Don't know |
| • Substance Use Disorder is a disease that should be treated like other medical conditions | Agree | Disagree | Don't know |
| • People with developmental disabilities can lead self-directed, successful lives.         | Agree | Disagree | Don't know |
| • People with developmental disabilities can function as members of their communities.     | Agree | Disagree | Don't know |
| • Alcoholism is a disease which should be treated like other medical conditions.           | Agree | Disagree | Don't know |

**11. Do you think that the following services are available and accessible in Vermilion County, even if they do not apply to you?**

Please circle your answer.

- |   |     |    |
|---|-----|----|
| • Mental Health Services                        | Yes | No |
| • Substance /Alcohol Abuse Treatment            | Yes | No |
| • Medical Services                              | Yes | No |
| • Dental Services                               | Yes | No |
| • Support Groups                                | Yes | No |
| • Easy access to Contraceptives (Birth Control) | Yes | No |
| • Easy access to STD Services                   | Yes | No |
| • Access to Transportation                      | Yes | No |
| • Access to Affordable Housing                  | Yes | No |
| • Access to Affordable Childcare                | Yes | No |
| • Access to Food Pantries                       | Yes | No |
| • Access to Farmer's Markets                    | Yes | No |
| • Food Assistance Services                      | Yes | No |
| • Senior Care                                   | Yes | No |
| • Access to Emergency Shelter                   | Yes | No |

**12. In the last 12 months, did you ever worry your food would run out before you got money to buy more?**

Yes No

**13. In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?**

Yes No

**14. Where do you get most (75%) of your food from?**

- |   |   |
|---|---|
| <input type="checkbox"/> Grocery store/Online     | <input type="checkbox"/> Neighborhood convenience store |
| <input type="checkbox"/> Food Pantry/Soup Kitchen | <input type="checkbox"/> Restaurants                    |
| <input type="checkbox"/> Other _____              |   |

**15. What have we not asked you about that you feel is important?**



# Vermilion County Community Health Collaborative

## Vermilion County Community Health Survey

You can also fill out the survey online: <https://www.surveymonkey.com/r/6JCM2D9>

Please answer the following questions about yourself so that we can better understand how members of our diverse community feel about the issues listed above. All information will be kept strictly confidential.

Home Zip Code: \_\_\_\_\_

Are you Male or Female:  Male  Female

What is your Age:

- Under 18
- 18-24
- 25-34
- 35-44
- 45-64
- 65-80
- 80 or older

Which of the following best describes your current relationship status?

- Married
- Widowed
- Divorced
- Separated
- In a domestic partnership or civil union
- Single, but cohabiting with a significant other
- Single, Never Married

Do you have children under the age of 18 living in your home?

Yes  No

What is your employment status?

- Full Time
- Part Time
- Student
- Retired
- Unemployed

Annual Household Income:

- Less than \$9,999
- \$10,000-\$29,999
- \$30,000-\$49,999
- \$50,000-\$74,999
- \$75,000-\$99,999
- \$100,000+

Your Highest Level of Education:

- Less than High School
- High School / GED
- Some College
- Associate / Technical
- Bachelor's Degree
- Graduate Degree or Higher

Are you of Hispanic or Latino Origin?

Yes  No

What is your Race?

- African American / Black
- Asian
- Native Hawaiian / Pacific Islander
- American Indian / Alaskan Native
- White / Caucasian
- Multi-Racial
- Other

Where do you usually go when you are sick or need healthcare?

- Doctors' Offices
- Community Health Center
- Veteran's Administration (VA)
- Urgent / Convenient Care
- Hospital Emergency Department
- Would not seek care
- Other: \_\_\_\_\_

How do you pay for your healthcare?

- Pay Cash / No Insurance
- Private Health Insurance
- Medicare
- Medicaid
- Veteran's Administration (VA)
- Indian Health Services
- Other: \_\_\_\_\_

What is the best way to get information to you about health / community resources? (Please check all that apply)

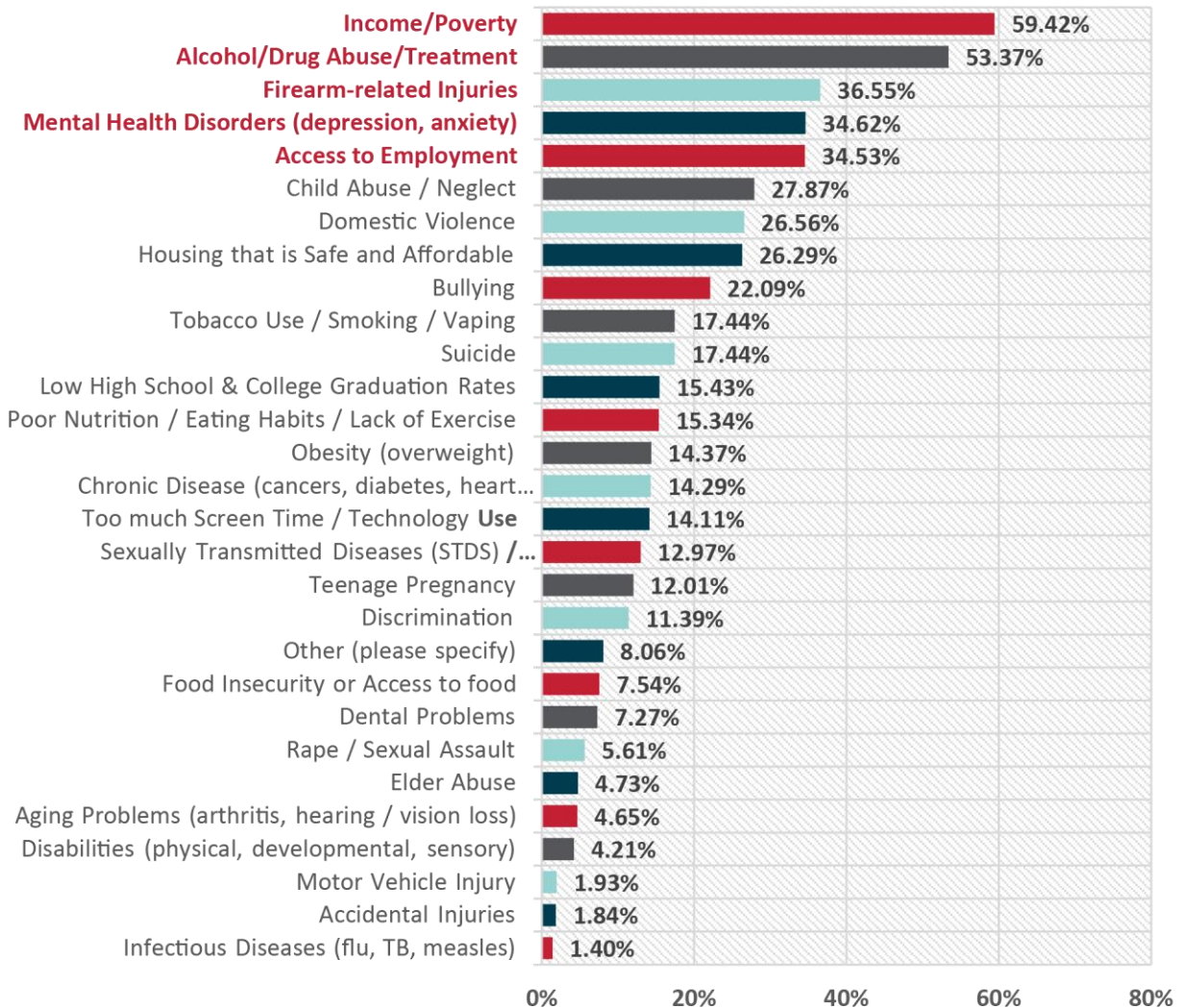
- TV / Cable / Radio
- Social Media (Facebook, Twitter, etc.)
- Newspaper (print or online)
- Doctor / Medical Provider / Social Service Provider
- United Way 2-1-1 (Helpline available to Vermillion County Residents)
- Workplace
- Demonstrations/Events
- Health Fair
- Library
- Other: \_\_\_\_\_

Thank you for taking the time to complete our survey. Your input is greatly appreciated!

# Vermilion County Community Health Collaborative

## Section 5. Community Input

### Attachment 10. Vermilion County Resident Community Health Survey Results



# Vermilion County Community Health Collaborative

Section 5. Community Input

**Letters of Support from Elected Officials**

SPRINGFIELD OFFICE  
311C CAPITOL BUILDING  
SPRINGFIELD, IL 62706  
TEL: 217/782-2507

CHAMPAIGN OFFICE  
45 E. UNIVERSITY  
SUITE 206  
CHAMPAIGN, IL 61820  
TEL: 217/355-5252

DANVILLE OFFICE  
201 N. VERMILION ST.  
SUITE 323  
DANVILLE, IL 61832  
TEL: 217/442-5252

[www.senatorbennett.com](http://www.senatorbennett.com)



**SCOTT BENNETT**  
STATE SENATOR • 52ND DISTRICT

COMMITTEES:  
- AGRICULTURE  
- EXECUTIVE APPOINTMENTS  
- HIGHER EDUCATION  
    CHAIRPERSON  
- JUDICIARY  
- LABOR  
- STATE GOVERNMENT  
    VICE-CHAIRPERSON

October 7, 2021

Ms. Theresa Eagleson, Director  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Grand Avenue, East  
Springfield, Illinois 62763

(Senator Scott Bennett, District Office: 217/355-5252)

Re: Support for Vermilion County Community Health Collaborative

Dear Director Eagleson,

Please accept this letter as my full support of the Vermilion County Community Health Collaborative project application for the Healthcare Transformation Collaborative Grant Fall 2021 funding cycle.

As Senator for Illinois 52nd State Senate District, I am proud to represent Vermilion County- where this proposal is focused. I am dedicated to the economic growth and improvement of health outcomes in my district, and I strongly believe that this collaborative will provide both for the members of our communities.

Carle and its physicians have been a part of the Vermilion County community for more than 35 years, demonstrating their commitment to this community. In 2019, Carle employed more than 400 full and part-time employees in Vermilion County, generating more than \$32million in wages, salaries and benefits. It is currently building out a new 17-acre medical campus replacing blighted buildings and replacing them with a community based site with room for community gardens, meetings, farmers market and a safe walking area connected to Elseworth Park. We were also supporters for this campus development before the CON board.

Vermilion County has languished at the bottom of the County Health Outcomes rankings for years. Many Vermilion County residents struggle with various preventable chronic health conditions such as diabetes and hypertension. It is imperative that our community has adequate access to treatment, preventive care and health information in order to address the health disparities associated with rural communities. Numerous organizations are currently engaged in the transformation of the county around the social determinants of health, and this project will unify those participants in a series of initiatives that produce a true wrap around care system for the most disadvantaged.



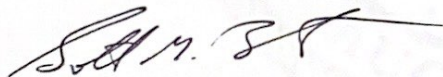
Recently the County in concert with University analysis and guidance, participation of municipal governments and healthcare entities underwent its Needs Assessment, identifying areas of needed improvement. This, and the county health rankings detail, were used to create the suite of projects we are looking to participate in.

The proposed collaborative's projects will improve access to health services and information, using a participatory approach where members of the community will receive health education training as Community Health Workers, empowering them to assist community members in accessing care, social services, transport etc. With this training program, we will create permanent Community Health Worker jobs, thus contributing to job creation and the economy. Furthermore, this project will facilitate and increase access to healthy food and nutrition education by bringing these resources into the community and eliminating several barriers to access while directly addressing the chronic health diseases affecting the county. Working with District 118, we will mentor students in health career pathways and host a yearly health careers fair to educate our youngest community members on employment options. The local health care entities are in need of these positions on a continuous basis as the population ages, and the need for care increases. Our local educational institutions stand ready to assist with training in many of these areas already established. Education, and job creation, follow this innovation. The project also aims to improve access to behavioral health by increasing the number of mental health professionals available in the county, including sharing of mental health providers between entities that have not, individually, been able to attract and retain such individuals in the past. Adding counseling to Medicare beneficiaries and the more isolated, rural school districts will also be undertaken.

I believe it is the whole-person approach of this project, which will make it sustainable, greatly benefit our community and have a long-term impact in the livelihood and wellbeing of the residents of Vermillion County.

Vermillion County residents deserve the opportunity to prosper and thrive in both their health and economics. It is for these reasons that I am in support of this collaborative.

Sincerely,

A handwritten signature in black ink, appearing to read "S. Bennett".

Scott Bennett, State Senator  
Illinois 52<sup>nd</sup> Senate District  
311C State House  
Springfield, IL 62706

DISTRICT OFFICE:  
3821 N. VERMILION, SUITE 5  
DANVILLE, IL 61832  
(217) 477-0104

ILLINOIS HOUSE OF REPRESENTATIVES

SPRINGFIELD OFFICE:  
208-N STRATTON BUILDING  
SPRINGFIELD, IL 62706  
(217) 782-4811  
[www.repmarron.com](http://www.repmarron.com)



**MIKE MARRON**  
STATE REPRESENTATIVE • 104TH DISTRICT

October 8, 2021

Ms. Theresa Eagleson, Director  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Grand Avenue, East  
Springfield, Illinois 62763

(Representative Michael Marron, District Office: 217/477-0104)

Re: Support for Vermilion County Community Health Collaborative

Dear Director Eagleson,

Please accept this letter as my full support of the Vermilion County Community Health Collaborative project application for the Healthcare Transformation Collaborative Grant Fall 2021 funding cycle.

As State Representative for the 104<sup>th</sup> District, it's a privilege to serve the 81,000-plus residents of Vermilion County. My goal has always been focused on what's best for our county and to advocate for opportunities that allow our region to thrive. It is with that in mind that I support this proposal.

Carle and its physicians have been a part of the Vermilion County community for more than 35 years, demonstrating their commitment to this community. In 2019, Carle employed more than 400 full and part-time employees in Vermilion County, generating more than \$32million in wages, salaries and benefits. It is currently building out a new 17-acre medical campus replacing blighted buildings and replacing them with a community based site with room for community gardens, meetings, farmers market and a safe walking area connected to Elseworth Park. We were also supporters for this campus development before the CON board.

Vermilion County has languished at the bottom of the County Health Outcomes rankings for years. Many Vermilion County residents struggle with various preventable chronic health conditions such as diabetes and hypertension. It is imperative that our community has adequate access to treatment, preventive care and health information in order to address the health disparities associated with rural communities. Numerous organizations are currently engaged in the transformation of the county around the social determinants of health, and this project will unify those participants in a series of initiatives that produce a true wrap around care system for the most disadvantaged.

Recently the County in concert with University analysis and guidance, participation of municipal governments and healthcare entities underwent its Needs Assessment, identifying areas of needed improvement. This, and the county health rankings detail, were used to create the suite of projects we are looking to participate in.

The proposed collaborative's projects will improve access to health services and information, using a participatory approach where members of the community will receive health education training as Community Health Workers, empowering them to assist community members in accessing care, social services, transport etc. With this training program, we will create permanent Community Health Worker jobs, thus contributing to job creation and the economy. Furthermore, this project will facilitate and increase access to healthy food and nutrition education by bringing these resources into the community and eliminating several barriers to access while directly addressing the chronic health diseases affecting the county. Working with District 118, we will mentor students in health career pathways and host a yearly health careers fair to educate our youngest community members on employment options. The local health care entities are in need of these positions on a continuous basis as the population ages, and the need for care increases. Our local educational institutions stand ready to assist with training in many of these areas already established. Education, and job creation, follow this innovation. The project also aims to improve access to behavioral health by increasing the number of mental health professionals available in the county, including sharing of mental health providers between entities that have not, individually, been able to attract and retain such individuals in the past. Adding counseling to Medicare beneficiaries and the more isolated, rural school districts will also be undertaken.

I believe it is the whole-person approach of this project, which will make it sustainable, greatly benefit our community and have a long-term impact in the livelihood and wellbeing of the residents of Vermilion County.

Vermillion County residents deserve the opportunity to prosper and thrive in both their health and economics. It is for these reasons that I am in support of this collaborative.

Sincerely,



Mike Marron  
State Representative – 104<sup>th</sup> District  
3821 North Vermilion Street  
Suite 5  
Danville, IL 61832





*Rickey Williams, Jr., Mayor*

October 8, 2021

Ms. Theresa Eagleson, Director  
Illinois Department of Healthcare and Family Services  
Prescott Bloom Building  
201 South Grand Avenue, East  
Springfield, Illinois 62763

**Re: Support for Vermilion County Community Health Collaborative**

Dear Director Eagleson:

Please accept this letter as my full support of the Vermilion County Community Health Collaborative project application for the Healthcare Transformation Collaborative Grant Fall 2021 funding cycle.

As mayor of Danville in Vermilion County, I fully support the Vermilion County Community Health Collaborative, and believe it will bring critical access to care and services for the 30,000 residents I serve. I love Danville. Not only is it where I've grown up, but it's where I've chosen to make my home. I want what's best for our community and Carle, as a partner since 1986, has proven the same commitment.

Carle and its physicians have been a part of the Vermillion County community for more than 35 years, demonstrating their commitment to this community. In 2019, Carle employed more than 400 full and part-time employees in Vermillion County, generating more than \$32million in wages, salaries and benefits. It is currently building out a new 17-acre medical campus replacing blighted buildings and replacing them with a community based site with room for community gardens, meetings, farmers market and a safe walking area connected to Elseworth Park. We were also supporters for this campus development before the CON board.

Vermillion County has languished at the bottom of the County Health Outcomes rankings for years. Many Vermillion County residents struggle with various preventable chronic health conditions such as diabetes and hypertension. It is imperative that our community has adequate access to treatment, preventive care and health information in order to address the health disparities associated with rural communities. Numerous organizations are currently engaged in the transformation of the county around the social determinants of health, and this project will unify those participants in a series of initiatives that produce a true wrap around care system for the most disadvantaged.

Recently the County in concert with University analysis and guidance, participation of municipal governments and healthcare entities underwent its Needs Assessment, identifying areas of needed improvement. This, and the county health rankings detail, were used to create the suite of projects we are looking to participate in.



The proposed collaborative's projects will improve access to health services and information, using a participatory approach where members of the community will receive health education training as Community Health Workers, empowering them to assist community members in accessing care, social services, transport etc. With this training program, we will create permanent Community Health Worker jobs, thus contributing to job creation and the economy. Furthermore, this project will facilitate and increase access to healthy food and nutrition education by bringing these resources into the community and eliminating several barriers to access while directly addressing the chronic health diseases affecting the county. Working with District 118, we will mentor students in health career pathways and host a yearly health careers fair to educate our youngest community members on employment options. The local health care entities are in need of these positions on a continuous basis as the population ages, and the need for care increases. Our local educational institutions stand ready to assist with training in many of these areas already established. Education, and job creation, follow this innovation.

The project also aims to improve access to behavioral health by increasing the number of mental health professionals available in the county, including sharing of mental health providers between entities that have not, individually, been able to attract and retain such individuals in the past. Adding counseling to Medicare beneficiaries and the more isolated, rural school districts will also be undertaken.

I believe it is the whole-person approach of this project, which will make it sustainable, greatly benefit our community and have a long-term impact in the livelihood and wellbeing of the residents of Vermillion County.

Danville and all Vermillion County residents deserve the opportunity to prosper and thrive in both their health and economics. It is for these reasons that I am in support of this collaborative.

Sincerely,

A handwritten signature in blue ink that reads "Rickey Williams, Jr." in a cursive script.

Rickey Williams, Jr., Mayor  
City of Danville, Illinois  
17 W. Main Street  
Danville, IL 61832

# Vermilion County Community Health Collaborative

## Section 6. Data Support

### Attachment 11. Robert Wood Johnson County Health Factor Rankings

^ 10th/90th percentile, i.e., only 10% are better.

\*\* Data should not be compared with prior years

Note: Blank values reflect unreliable or missing data

## County Demographics

	COUNTY	STATE
Population	75,758	12,671,821
% below 18 years of age	23.3%	22.2%
% 65 and older	19.8%	16.1%
% Non-Hispanic Black	13.5%	14.1%
% American Indian & Alaska Native	0.4%	0.6%
% Asian	0.9%	5.9%
% Native Hawaiian/Other Pacific Islander	0.0%	0.1%
% Hispanic	5.3%	17.5%
% Non-Hispanic White	77.8%	60.8%
% not proficient in English	1%	4%
% Females	50.2%	50.9%
% Rural	31.3%	11.5%

## Health Outcomes

	County	Error Margin	Top U.S. Performers ^	Illinois
<b>Length of Life</b>				
Premature death	10,600	9,700-11,500	5,400	6,600
<b>Quality of Life</b>				
Poor or fair health **	21%	19-23%	14%	16%
Poor physical health days **	4.8	4.4-5.2	3.4	3.6
Poor mental health days **	4.9	4.6-5.2	3.8	3.8
Low birthweight	11%	10-12%	6%	8%
<i>Additional Health Outcomes (not included in overall ranking)</i>				
Life expectancy	74.9	74.2-75.6	81.1	79.4
Premature age-adjusted mortality	490	470-520	280	330
Child mortality	90	70-120	40	50
Infant mortality	11	8-13	4	6
Frequent physical distress **	14%	13-15%	10%	10%
Frequent mental distress **	16%	15-17%	12%	12%
Diabetes prevalence	12%	7-20%	8%	10%
HIV prevalence	198		50	335

# Vermilion County Community Health Collaborative

## Health Factors

	County	Error Margin	Top U.S. Performers ^	Illinois
<b>Health Behaviors</b>				
Adult smoking **	24%	21-27%	16%	16%
Adult obesity	43%	33-53%	26%	30%
Food environment index	7.6		8.7	8.7
Physical inactivity	29%	21-38%	19%	22%
Access to exercise opportunities	75%		91%	91%
Excessive drinking **	20%	19-21%	15%	22%
Alcohol-impaired driving deaths	39%	32-45%	11%	31%
Sexually transmitted infections	654.6		161.2	604.0
Teen births	45	42-49	12	19
<i>Additional Health Behaviors (not included in overall ranking)</i>				
Food Insecurity	14%		9%	10%
Limited access to healthy foods	6%		2%	4%
Drug overdose deaths	28	22-36	11	22
Motor vehicle crash deaths	14	11-18	9	9
Insufficient sleep**	36%	35-38%	32%	34%
<b>Clinical Care</b>				
Uninsured	7%	6-8%	6%	8%
Primary care physicians	2,480:1		1,030:1	1,240:1
Dentist	2,710:1		1,210:1	1,240:1
Mental health providers	320:1		270:1	410:1
Preventable hospital stays	6,683		2,565	4,913
Mammography screening	40%		51%	43%
Flu vaccinations	43%		55%	49%
<i>Additional Clinical Care (not included in overall ranking)</i>				
Uninsured adults	8%	7-10%	7%	10%
Uninsured children	3%	2-3%	3%	3%
Other primary care providers	770:1		620:1	1,110:1
<b>Social &amp; Economic Factors</b>				
High school completion	88%	87-90%	94%	89%
Some college	50%	47-53%	73%	70%
Unemployment	5.1%		2.6%	4.0%
Children in poverty	27%	20-34%	10%	16%
Income inequality	4.4	4.1-4.7	3.7	5.0
Children in single-parent households	33%	29-37%	14%	25%
Social associations	14.7		18.2	10.0
Violent crime	705		63	403
Injury deaths	98	88-108	59	65
<i>Additional Social &amp; Economic Factors (not included in overall ranking)</i>				

## Vermilion County Community Health Collaborative

High school graduation	81%		95%	87%
Disconnected youth	10%	7-13%	4%	6%
Reading scores	2.7		3.3	3.0
Math scores	2.7		3.4	2.9
Median household income	\$46,300	\$41,200-51,400	\$72,900	\$69,200
Children eligible for free or reduced price lunch	63%		32%	49%
Residential segregation – black/white	63		23	71
Residential segregation – non-white/white	55		14	53
Homicides	10	8-13	2	7
Suicides	18	14-23	11	11
Firearm fatalities	17	13-22	8	11
Juvenile arrests	16			9
<b>Physical Environment</b>				
Air pollution – particulate matter	8.7		5.2	8.7
Drinking water violations	No			
Severe housing problems	12%	11-13%	9%	17%
Driving alone to work	84%	83-86%	72%	73%
Long commute – driving alone	23%	21-25%	16%	42%
<b>Additional Physical Environment (not included in overall ranking)</b>				
Traffic volume	191			630
Homeownership	70%	68-71%	81%	66%
Severe housing cost burden	11%	10-12%	7%	14%
Broadband access	77%	75-78%	86%	83%

Source: County Health Rankings and Roadmaps (<https://www.countyhealthrankings.org/>), a program of the University of Wisconsin Population Health Institute, and supported by the Robert Wood Johnson Foundation.

# Vermilion County Community Health Collaborative

## Section 6. Data Support

### Attachment 12. Data Analysis Results

#### 12.A. Key social determinants of health in Vermilion County – Research results

The Steering Committee thought it important to identify and compare the social determinants of health prevalent in: (a) Vermilion County; (b) the two targeted cities in Vermilion County (Danville and Hoopeston); (c) Illinois; and (4) the United States so that the planned strategies could be customized for each specific population. If the SDoH varied from place to place, so too must the strategies to improve health outcomes.

Underline = Indicates below state average

Red = >50% below stage average

	<b>SDoH BY AREA (2015-2019)</b>	<b>Vermilion County</b>	<b>Danville</b>	<b>Hoopeston</b>	<b>Illinois</b>	<b>National Average</b>
	<i>Households</i>	31,151	12,064	2,513	--	--
<b>Poverty<sup>1</sup></b>	Median household income (2015-2019)	<u>\$46,515</u>	<u>\$36,172</u>	<u>\$43,914</u>	\$65,886	\$62,843
	Per capita income (2015-2019)	<u>\$25,307</u>	<u>\$21,055</u>	<u>\$26,967</u>	\$36,038	\$34,103
	Below poverty line	<u>16.8%</u>	<u>29.4%</u>	<u>22.1%</u>	11.5%	10.5%
	Median value owner-occupied unit	<u>\$79,900</u>	<u>\$66,700</u>	<u>\$62,500</u>	\$194,500	\$217,500
	Median gross rent	<u>\$685</u>	<u>\$695</u>	<u>\$588</u>	\$1,010	\$1,062
<b>Education<sup>2</sup></b>	High school graduate or higher, >25 yrs	88.5%	85.6%	<u>79%</u>	89.2%	88.0%
	Bachelor's degree or higher, persons >25 yrs	<u>14.7%</u>	<u>15.4%</u>	<u>10.3%</u>	34.7%	32.1%
<b>Employment</b>	Unemployment Rate Not seasonally adjusted (7/2020)	14.1% Danville, IL Metropolitan Statistical Area (October 2020)	16.1% (October 2020)		14.8% (October 2020)	
<b>Food Insecurity</b>	Food insecurity – General <sup>3</sup>	81.7	86.3	74.2		
	Low access to food & Low income <sup>4</sup>	25.7%	<u>36.2%</u>	<u>35.3%</u>	17.0%	18.6%
	Food insecurity – Child <sup>5</sup>	Child poverty is 20.7%, the highest child poverty rate in eastern Illinois				
	Low access to food - Child	66%	83%	88%	59%	63%
	Number of grocery stores	1.97 / 10,000			1.62/10,000	2.24 / 10,000

# Vermilion County Community Health Collaborative

Internet & Broadband	Households with a computer	83.6%	<u>79.5%</u>	86.5%	89.9%	90.3%
	Households with a broadband Internet subscription	<u>76.6%</u>	<u>73.9%</u>	<u>75.5%</u>	82.7%	82.7%
Health	Adults w/o health insurance <sup>6</sup>	<u>14.9%</u>	<u>16.7%</u>	<u>15.8%</u>	8.6% Non-seniors	9.5%
	Persons with a disability <sup>7</sup>	<u>14.8%</u>	<u>14.9%</u>	<u>17.6%</u>	7.2%	9.5%
	Medicare population with hypertension	<u>59.5</u>			58.5	57.2

<sup>1</sup>United States Census Bureau <https://www.census.gov/quickfacts/fact/table/vermilioncountyillinois/fips>

<sup>2</sup>Unemployment

<https://data.knoxnews.com/unemployment/danville-il-metropolitan-statistical-area/MT1719180000000/2020-october/>

<https://map.feedingamerica.org/county/2019/overall/illinois/county/vermilion>

<https://datausa.io/profile/geo/hoopeston-il#housing>

<https://www.census.gov/quickfacts/fact/table/vermilioncountyillinois,danvillecityillinois,US/LFE041219?#LFE041219>

<http://www.city-data.com/city/Hoopeston-Illinois.html> (has health)

<sup>3</sup>The 2020 Food Insecurity Index, created by Conduent Healthy Communities Institute, is a measure of food access that is correlated with economic and household hardship. All zip codes, census tracts, counties, and county equivalents in the United States are given an index value from 0 (low need) to 100 (high need)

<sup>4</sup>USDA Released April 2021, Percent of population that is low income and beyond ½ mile for urban areas or 10 miles for rural areas from a supermarket.

<sup>5</sup>USDA Released April 2021, Percent of children 0-17 beyond ½ mile for urban areas or 10 miles for rural areas from a supermarket.

<sup>6</sup>Adults without health insurance Vermilion Co 2019, Danville & Hoopeston 2018

<sup>7</sup>Persons with a disability 2015-2019

## 12.B. Medical conditions by area in Vermilion County – Research results

	<u>Medical conditions by area</u>	Vermilion County	Danville	Hoopeston	Illinois	National Average
Diabetes	Adults with diabetes	-	<u>13.1</u>	<u>12.3</u>	13.5	11.4
	Age adjusted ER rate due to diabetes	196.7	<u>67.6</u>	<u>132.5</u>	27.6	-
Cancer Screening	Mammogram within 2 years age 50-74	70.2%	74.8%	72.7%	74.0%	74.8%
	Colon cancer screening	63.1%	61.1%	60.8%	64.3%	66.4%

## Vermilion County Community Health Collaborative

Hypertension	High BP prevalence	39.9%	39.8%	39.5%	34.2%	32.4%
	Age-Adjusted ER rate due to hypertension	227.9	91.3	80.1	32	-
Mental Health	Poor mental health 14+ days in past month	14.9%	16.1%	15.4%	13.5%	12.7%

### 12.C. Specific disparities and outcomes by race and ethnicity in Vermilion County – Research results

What specific disparities are we targeting?	Vermilion County	Illinois	Top US Performers	White	Black/ African American	Hispanic/ Latinx
<b>#1 PRENATAL CARE</b>						
PILLAR Prenatal Care Began in First Trimester (based on live births) 2016-01-01 – 2018-12-31 <a href="http://healthcarereportcard.illinois.gov/maps">Http://healthcarereportcard.illinois.gov/maps</a>	69%	78.1%	n/a	75.8% 85% statewide	50.7% 63.8% statewide	67.6% 72.2% statewide
PILLAR Low Birth Weight <i>The 2021 County Health Rankings used data from 2017-2019 for this measure.</i>	11%	8%	6%	9% Vermilion County	17%	5%
<b>#2 BEHAVIORAL HEALTH</b>						
PILLAR Frequent Mental Distress Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted). <i>The 2021 County Health Rankings used data from 2018 for this measure.</i>	16%	12%	12%			
PILLAR Adult ED Mood Disorder Visits 2017-01-01 – 2019-12-31 Per 10,000 population <a href="http://healthcarereportcard.illinois.gov/maps">Http://healthcarereportcard.illinois.gov/maps</a>	65.59	30.37	n/a	63.89 27.78 statewide	80.85 56.34 statewide	50.18 16 statewide

# Vermilion County Community Health Collaborative

<b>PILLAR</b> <b>Adult ED Anxiety-Related Disorder Visits</b> 2017-01-01 – 2019-12-31 Per 10,000 population <a href="http://healthcarereportcard.illinois.gov/maps">Http://healthcarereportcard.illinois.gov/maps</a>	75.41	36.73	n/a	70.29 34.48 statewide	85.08 50.88 statewide	145.22 31.62 statewide
<b>PILLAR</b> <b>Drug Overdose Mortality Rate</b> Per 100,000 population <i>The 2021 County Health Rankings used data from 2017-2019 for this measure.</i>	28	22	11	24	53	-
<b>#3 CHRONIC DISEASES</b>						
<b>Adult Obesity</b> <i>The 2021 County Health Rankings used data from 2015-2019 for this measure.</i>	43%	30%	26%	n/a	n/a	n/a
<b>Uncontrolled Diabetes (observed)</b> 2018-10-01 – 2019-09-30 Per 100,00 population <a href="http://healthcarereportcard.illinois.gov/maps">Http://healthcarereportcard.illinois.gov/maps</a>	73.23	46.31	n/a	62.84 33.96 statewide	140.63 116.18 statewide	No Data 33.53 statewide
<b>Adult Diabetes Prevalence</b> Percentage of adults aged 20 and older with diagnosed diabetes <i>The 2021 County Health Rankings used data from 2015-2019 for this measure.</i>	12%	10%	8%	n/a	n/a	n/a
<b>#4 HOSPITALIZATIONS</b>						
<b>Preventable Hospital Stays</b> Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. <i>The 2021 County Health Rankings used data from 2018 for this measure.</i>	6,683	4,913	2,565	6,381	10,695	3,843
<b>Adult ED Hypertension Visits</b> 2017-01-01 – 2019-12-31 Per 10,000 population <a href="http://healthcarereportcard.illinois.gov/maps">Http://healthcarereportcard.illinois.gov/maps</a>	81.13	43.39	n/a	66.09 30.46 statewide	192.73 130.42 statewide	55.32 20.59 statewide
<b>Congestive Heart Failure Admissions</b> Per 100,000 population <a href="http://healthcarereportcard.illinois.gov/maps">Http://healthcarereportcard.illinois.gov/maps</a>	534.31	485.57	n/a	n/a	n/a	n/a



# Vermilion County Community Health Collaborative

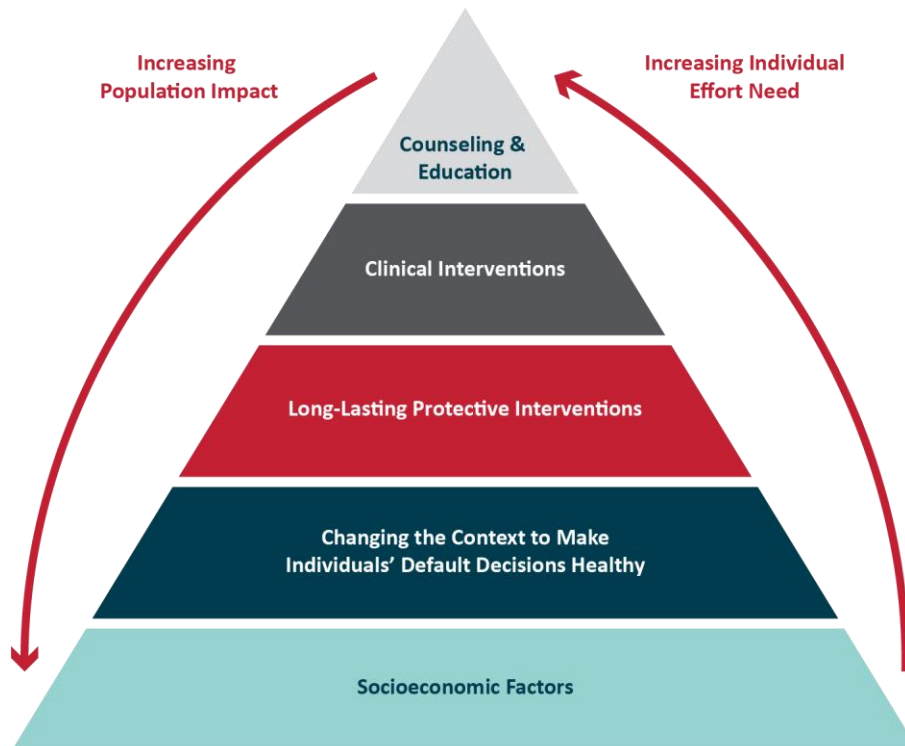
Yrs of Potential Life Lost (ypll) <sup>1</sup>	10,600	6,600	n/a	n/a	n/a	n/a
<b>#5 BROADBAND ACCESS</b>						
<b>Broadband Access Percentage</b> of households with broadband internet connection. <i>The 2021 County Health Rankings used data from 2015-2019 for this measure.</i>	77%	83%	86%	n/a	n/a	n/a

<sup>1</sup>VC is getting worse for this measure

# Vermilion County Community Health Collaborative

## Section 9. Social Determinants of Health

### Attachment 13. Substantiation for Socioeconomic Determinants of Health Focus



The Health Impact Pyramid

# Vermilion County Community Health Collaborative

## Section 12. Jobs

### Attachment 14. Current Employees by Job Category and Zip Code

Only the entities included in this attachment are providers in the collaborative who will receive HTC.

#### 14.A. Carle employees

Zip Code	Administrative Support	Craft Workers	Officials and Managers	Professionals	Service Workers	Technicians	Total
61832	14	1	1	32	19	15	82
60942	13	1	5	26	27	8	80
61834	7	1	2	8	3	9	30
61846				3	9	3	15
61883		1		4	3	7	15
61858	1			8	3	2	14
47932	2			5	1	4	12
60963	1		1	3	2	4	11
61865	1	1		1	2	6	11
60953	1			6	2	2	11
61817	1			3	3	4	11
61822				10			10
61833	4			1		4	9
60960	2			1	3	2	8
61814	1			6			7
60973	2		1		3		6
61924				3	1	2	6
61853				4		1	5
47928	2			2	1		5
60924				3	1	1	5
61802				4	1		5
60957				2	2		4
61873				3	1		4
47918				3	1		4
60970				2	2		4
47974	1			1		1	3
61844	1		1			1	3
61821			1	1	1		3
47993	1			1		1	3
61870	1			2			3
61811			1	1	1		3
61848					1	1	2
61857					2		2
61850				1	1		2
61864						1	1
60931				1			1
60928					1		1
61831						1	1

## Vermilion County Community Health Collaborative

47982	1						1
60949					1		1
61801				1			1
47987				1			1
61876				1			1
60955				1			1
60948					1		1
61841						1	1
60605				1			1
47991						1	1
47906				1			1
47952						1	1
61871		1					1
61820					1		1
61874				1			1
61849			1				1
46074				1			1
60941						1	1
62711				1			1
60030				1			1
61853-4200			1			1	1
<b>Total</b>	<b>57</b>	<b>6</b>	<b>14</b>	<b>162</b>	<b>100</b>	<b>84</b>	<b>423</b>

### 14.B. Crosspoint employees

Job Category	Number of Employees
Administrative Support	11
IT	2
Billing	1
Care Coordinators	7
CDS Tech	9
Residential Tech	11
Manager/Team Leader/Supervisor	12
Teacher/Teacher Aide	10
Shelter Shift Staff	3
Legal/Childs Advocate	4
Management	7
Crisis Counselor	6
Mental Health Therapist	7
Maintenance Tech	5
Nursing	2
<b>Total</b>	<b>97</b>

# Vermilion County Community Health Collaborative

## Section 12. Jobs

### Attachment 15. Hiring Chart

#### 15.A. Employees

Position	Job Class	Job Code	Year 1	Year 2	Year 3	Year 4	Year 5	Total New	Total Expanded
<b>Program Support Employees</b>									
Transformation Grant Program Manager	Professionals	Grant Program Manager	1					1	
<b>Community Health Worker Employees</b>									
Community Health Workers	Service Worker	Community Health Worker	4	4	2			10	
CHW Program Supervisor	Service Worker	Community Health Supervisor	1		1			2	
<b>Healthy Beginnings Employees</b>									
Nurse Home Visitor (level 2)	Professionals	Nurse	2					2	
Nurse Home Visitor (level 3)	Professionals	Nurse	2					2	
Social Worker 1	Professionals	Social Worker	1					1	
Early Childhood Educator (25% effort-existing staff)	Service Workers	Early Childhood Educator	1						1
Data Entry/Office Coordinator	Administrative Support	Advanced Clerical	2					2	
Executive Director (25% effort - existing staff)	Officials and Mgrs	Director	1						1
Home Services Manager (50% effort - existing staff)	Officials and Mgrs	Manager	1						1
RN Supervisor (50% effort - existing staff)	Professionals	Nurse Supervisor	1						1
<b>Mobile Health Clinic Employees</b>									
Mobile Health Services Manager/RN	Professionals	Nurse Supervisor	1						1
APRN	Professionals	Advanced Practice Nurse	1						1
CMA	Service Worker	Medical Assistant	1						1
Social Worker	Professionals	Social Worker	1						1
Safety Specialist (Vehicle Maint/Driver/PSCR/CMA)	Service Worker	Driver	1						1
<b>Behavioral Health Employees</b>									
Nurse	Professionals	Nurse	1					1	
Program Specialist for DACC re: AAS in Mental Health	Professionals	Coordinator	1					1	
<b>Food Initiatives Employees</b>									

# Vermilion County Community Health Collaborative

Certified Nutrition Educator	Professionals	Educator	1					1	
Mobile Market & Garden Liasion	Officials and Mgrs	Project Manager	1					1	
<b>Agricultural Garden Employees</b>									
Project Planner for the Gardens	Professionals	Project Manager	1					1	
<b>Grocery Employees - Heavenly Gardens</b>									
General Manager	Officials and Mgrs	General Manager	1					1	
Store Managers	Officials and Mgrs	Manager	2					2	
Assistant Manager	Officials and Mgrs	Assistant Manager	2					2	
Key Holder	Professionals	Key Holder	1					1	
Security Personnel	Service Workers	Security	4					4	
Cashiers	Service Workers	Cashier	11					11	
Stockers	Service Workers	Stocker	11					11	
Janitor/Maintenance	Service Workers	Maintenance		1				1	
<b>Mobile Grocer</b>									
Mobile Market Coordinator	Professionals	Coordinator	1					1	
Safety Specialist (Vehicle Maint/Driver/PSCR/CMA)	Service Worker	Driver	1						1
<b>Demonstration Kitchen</b>									
Cooking Demonstration Assistant	Officials and Mgrs	Coordinator		1				1	
<b>Subtotals</b>			<b>61</b>	<b>6</b>	<b>3</b>	<b>1</b>		<b>60</b>	<b>10</b>
<b>Total Positions Created or Expanded</b>								<b>70</b>	

## 15.B. Contractors

Contractors to be Retained	Year 1	Year 2	Year 3	Year 4	Year 5	Total Retained
APRN	1	2				3
Licensed Clinical Professional Counselor	1	2	2			5
Marketing Specialist	1					1
Accountant	1					1
Parking Lot Painter	1					1
Broadband Consultant (access)	1					1
Software Support (care coordination)	1					1
<b>Total Contractors Retained</b>						<b>13</b>

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## Section 14. Milestones

### Attachment 16. Milestones

#### 16.A. Calendar of Milestones Overview

Position	Year 1	Year 2	Year 3	Year 4	Year 5
<b>Program Support</b>					
Develop and initiate the Community Advisory Council	x				
Hire Transformation Grant Manager	x				
<b>Community Health</b>					
Community Health Workers – To be phased in (hire/train/initiate)	x	x	x		
Healthy Beginnings (hire/train/initiate)	x				
<b>Mobile Health</b>					
Mobile Preventive, Primary, Specialty Care (hire)	x				
Telehealth Primary Care Service Expansion		x			
Community-based Health Screenings (Carle expansion of current services)		x			
<b>Behavioral Health</b>					
Behavioral Health Services – Crosspoint Human Services (hire/initiate)	x	x	x		
Behavioral Health – Addiction Recovery Services, Mobile (customize/purchase/initiate)	x	x			
Social Worker – CRIS (hire/initiate)		x			
<b>Education and Job Training</b>					
Education – Mentorship (initiate)	x				
Education – Student Fair (Initiate)	x				
Job Training – CHW certification	x	x	x	x	x
Job Training – AAS in Mental Health	x	x	x		
<b>Food Initiatives</b>					
Grocer – Heavenly Square Grocery (hire/initiate)	x				
Grocer – Carle at the Riverfront (build/lease/initiate)		x	x		
Mobile Market (customize/purchase/initiate)	x				
Garden #1 - West Side (design/construct/plant/market)	x				
Garden #2 - East Side (design/construct/plant/market)		x			
Nutrition Educator (hire/start)	x				
Demonstration Kitchen (buildout/initiate)		x			
Demonstration Kitchen Assistant		x			
<b>Technology</b>					
•Software to Connect Clinical and Social Service Providers •Software to Screen for Social Determinants of Health (license/train/initiate)	x				
Broadband & Internet Access – Rural Broadband Cooperative (contract/design/secure funding/install/ initiate)	x	x	x	x	

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## 16.B. Calendar of Milestones by Year and Month

- (dash) = No action

> = Ramp up/Launch continues throughout the year

### Year 1

	Y1 – Q1			Y1 – Q2			Y1 – Q3			Y1 – Q4		
Activity Initiation	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
<b>Program Support</b>												
Develop and initiate the Community Advisory Council	-	Recruit	Interview	Retain	>	>	>	>	>	>	>	>
Hire transformation grant manager	-	-	Recruit	Interview	x Hire	>	>	>	>	>	>	>
<b>Community Health</b>												
Community Health Workers – To be phased in (hire/train/initiate)	-	-	-	Recruit	Interview	x Hire	Train	>	>	>	>	>
Healthy Beginnings – (hire/train/initiate)	-	-	-	Recruit	Interview	x Hire	Hire & Train	Hire & Train	Hire & Train	Hire & Train	Hire & Train	Hire & Train
<b>Mobile Health</b>												
Mobile Preventive, Primary, Specialty Care, Mobile (hire/initiate)	-	-	-	Recruit	Interview	x Hire	x Hire	x Initiate	>	>	>	>
<b>Behavioral health</b>												
Behavioral Health – Crosspoint Human Services (hire/initiate)	-	-	-	Recruit	Interview	x Hire	x Hire	x Initiate	>	>	>	>
Behavioral Health – Addiction Recovery Services, Mobile (customize/purchase/initiate)	-	-	Customize	Customize	Purchase	>	Anticipating parts and supply delays					
<b>Education and Job Training</b>												
Education – Mentorship (initiate)	-	-	-	-	-	-	Organize	>	>	>	x Initiate	x Initiate
Education – Student Fair (Initiate)	-	-	-	-	-	-	Organize	>	>	>	>	x Initiate
Job Training – CHW Certification (Initiate)	-	-	-	-	-	-	Training and CHW certification is an ongoing activity					
Job Training – AAS in Mental Health (Initiate)	-	-	-	Recruit	Interview	x Hire	>	>	>	>	>	>
<b>Food Initiatives</b>												



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Grocer – Heavenly Square Grocery (hire/initiate)	Planning & Ordering	Planning & Ordering	Recruit	Recruit & Interview	Hire & Train	Hire & Train	Hire & Train	x Initiate	>	>	>	>
Mobile Market (customize/purchase/initiate)	-	Customize	Customize	Purchase	>	>	Anticipating parts and supply delays					x Initiate
Garden #1 - West Side (design/plant/market)	-	-	-	-	Design	Design	Construct	Construct	Plant	Plant	Plant	x Initiate
Nutrition Educator (hire/start)	-	-	-	Recruit	Interview	x Hire	x Initiate	>	>	>	>	>

Technology												
•Software to Connect Clinical and Social Service Providers •Software to Screen for Social Determinants of Health (license/train/initiate)	-	-	-	-	Decide	Negotiate	License	Install	Train	Train	x initiate	>
Broadband & Internet Access – Rural Broadband Cooperative (retain contractor/design/secure funding/installation/initiate)	-	-	-	-	-	-	Recruit	Recruit	Interview	Interview	Contractor Retained	Assessment Begins

## Year 2

	Y2 – Q1			Y2 – Q2			Y2 – Q3			Y2 – Q4		
Activity Initiation	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Community Health												
Community Health Workers – To be phased in (hire/train/initiate)	-	-	-	Recruit	Interview	x Hire	Train	>	>	>	>	>
Mobile Health												
Telehealth Primary Care Service Expansion	-	x Initiate	>	>	>	>	>	>	>	>	>	>
Community-Based Health Screenings (Carle expansion of current services)	x Initiate	>	>	>	>	>	>	>	>	>	>	>
Behavioral Health												
Behavioral Health – Crosspoint Human Services (hire/initiate)	-	-	-	Recruit	Interview	x Hire	x Hire	x Initiate	>	>	>	>
Behavioral Health – Addiction Recovery Services, Mobile (purchase/initiate)	>	x Initiate	>	>	>	>	>	>	>	>	>	>
Social Worker – CRIS (hire/initiate)	Recruit	Interview	x Hire	>	>	>	>	>	>	>	>	>

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Education and Job Training												
Job Training – CHW Certification	Training and CHW certification is an ongoing activity											
Job Training – AAS in Mental Health	Planning	>	>	>	>	>	Planning	>	>	Initiate	>	>
Food Initiatives												
Grocer – Carle at the Riverfront (buildout/lease/initiate)	x Buildout	>	>	>	x Lease	>	>	>	x Initiate	>	>	>
Garden #2 - East Side (design/plant/market)	-	-	-	-	Design	Design	Construct	Construct	Plant	Plant	Plant	x Initiate
Demonstration Kitchen (buildout/initiate)	-	-	Design	Design	Purchase	Purchase	x Initiate	>	>	>	>	>
Demonstration Kitchen Assistant	-	-	-	Recruit	Interview	x Hire	-	>	>	>	>	>
Technology												
Broadband & Internet Access – Rural Broadband Cooperative (retain contractor/design/secure funding/installation/initiate)	Assessment	Assessment	Assessment	Design	>	>	Seek Funding	>	>	>	>	>

## Year 3

	Y3 – Q1			Y3 – Q2			Y3 – Q3			Y3 – Q4		
Activity Initiation	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Community Health												
Community Health Workers – To be phased in (hire/train/initiate)	-	-	-	Recruit	Interview	x Hire	Train	>	>	>	>	>
Behavioral Health												
Behavioral Health – Crosspoint Human Services (hire/initiate)	-	-	-	Recruit	Interview	x Hire	x Hire	x Initiate	>	>	>	>
Education and Job Training												
Job Training – CHW Certification	Training and CHW certification is an ongoing activity											
Technology												
Broadband & Internet Access – Rural Broadband Cooperative (retain contractor/design/secure funding/installation/initiate)	Funding Search Continues	>	>	>	>	>	Funding Search Continues	>	>	>	Funding Secured	Contract Negotiated

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## Year 4

	Y4 – Q1			Y4 – Q2			Y4 – Q3			Y4 – Q4		
Activity Initiation	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
<b>Technology</b>												
Broadband & Internet Access – Rural Broadband Cooperative (retain contractor/design/secure funding/installation/initiate)	Contract Signed	Installation Begins	>	>	>	>	Services Initiated	>	>	>	>	>

## Year 5

	Y5 – Q1			Y5 – Q2			Y5 – Q3			Y5 – Q4		
Activity Initiation	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
By the end of Year 5, all activities become sustainable.												