

Healthcare Transformation Collaboratives Cover Sheet

**1. Collaboration Name:**

Healthy Mother Healthy Child Collaborative of Will County

2. Name of Lead Entity:

VNA Health Care

3. List All Collaboration Members:

AMITA Health Adventist Medical Center Bolingbrook
AMITA Health St. Joseph Medical Center Joliet
Spanish Community Center
Southwest Suburban Immigrant Project
Catholic Charities, Diocese of Joliet
Valley View School District 365U
Holsten Human Capital Development, NFP

4. Proposed Coverage Area:

Southwestern Suburbs of Chicago - Will County

5. Area of Focus:

Maternal/Infant Health

6. Total Budget Requested:

\$10,238,427

1. PARTICIPATING ENTITIES

1. Name of the lead entity: VNA Health Care
2. 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.

VNA Health Care

Primary Contact: Chrissie Howorth, CFRE

- Position: Vice President of Philanthropy & Communications

Secondary Contact: Lisa Hill

- Position: Grants Accountant

AMITA Health Adventist Medical Center Bolingbrook

Primary Contact: Darcy Lorenzen

- Position: System Vice President Women's Health, Digestive Health & Bariatrics

Secondary Contact: Julie Panicali

- Position: Grants Specialist

AMITA Health St. Joseph Medical Center Joliet

Primary Contact: Darcy Lorenzen

- Position: System Vice President Women's Health, Digestive Health & Bariatrics

Secondary Contact: Julie Panicali

- Position: Grants Specialist

Spanish Community Center

Primary Contact: Yesenia Tinoco

- Position: Immigrant Family Resource Program Manager

Secondary Contact: Sylvia Acosta Chávez

- Position: Acting Executive Director

Southwest Suburban Immigrant Project (SSIP)

Primary Contact Name: Jose Vera

- Position: Executive Director

Secondary Contact Name: Elizabeth Cervantes

- Position: Co-Founder, Director of Organizing

Catholic Charities, Diocese of Joliet

Primary Contact Name: Kathleen Langdon

- Position: Executive Director

Secondary Contact Name: Lorena Garza

- Position: Executive Assistant to the Executive Director

Valley View School District 365U

Primary Contact: Kathy Batistich, RN, LCSW

- Position: Community Outreach Coordinator

Secondary Contact: Lisa Allen

- Position: Director of Student Supports

Holsten Human Capital Development, NFP

Primary Contact Name: Elizabeth Protich

- Position: Program Manager
- Secondary Contact Name: Marlo Schulz
- Position: Resident Service Coordinator.

Additional Questions:

1. Are there any primary or preventative care providers in your collaborative: YES

- VNA Health Care
- AMITA Health Adventist Medical Center Bolingbrook
- AMITA Health St. Joseph Medical Center Joliet

2. Are there any specialty care providers in your collaborative: YES

- AMITA Health Adventist Medical Center Bolingbrook
- AMITA Health St. Joseph Medical Center Joliet

3. Are there any hospital services providers in your collaborative: YES

Which MCO networks does each hospital participate in?

AMITA Health Adventist Medical Center Bolingbrook

- YouthCare - YES
- Blue Cross Blue Shield Community Health Plan - YES
- CountyCare Health Plan (Cook County only) - NO
- IlliniCare Health - YES
- Meridian Health Plan (Former Youth in Care Only) - YES
- Molina Healthcare - NO

AMITA Health St. Joseph Medical Center Joliet

- YouthCare - YES
- Blue Cross Blue Shield Community Health Plan - YES
- CountyCare Health Plan (Cook County only)- NO
- IlliniCare Health - YES
- Meridian Health Plan (Former Youth in Care Only) - YES
- Molina Healthcare - YES

4. Are there any mental health providers in your collaborative: YES

- VNA Health Care
- AMITA Health Adventist Medical Center Bolingbrook
- AMITA Health St. Joseph Medical Center Joliet

5. Are there any substance use disorder services providers in your collaborative: YES

- AMITA Health Adventist Medical Center Bolingbrook
 - AMITA Health St. Joseph Medical Center Joliet
 - VNA Health Care - Medication Assisted Treatment (MAT) Clinic
6. Are there any social determinants of health services providers in your collaborative:
YES
- AMITA Health Adventist Medical Center Bolingbrook
 - AMITA Health St. Joseph Medical Center Joliet
 - VNA Health Care
 - Spanish Community Center
 - Southwest Suburban Immigrant Project (SSIP)
 - Catholic Charities, Diocese of Joliet
 - Valley View School District 365U
 - Holsten Human Capital Development, NFP
7. Are there any safety net or critical access hospitals in your collaborative: NO
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:
- The Spanish Community Center is majorly controlled and managed by minorities
 - The Southwest Suburban Immigrant Project is majorly controlled and managed by minorities
9. List the Medicaid-eligible billers in your collaborative, and their Medicaid ID:
- VNA Health Care Bolingbrook; Medicaid ID 362182095030
 - VNA Health Care Romeoville; Medicaid ID 362182095038
 - VNA Health Care Joliet; Medicaid ID 362182095040
 - AMITA Health Adventist Medical Center Bolingbrook; Medicaid ID 651219504001
 - AMITA Health St. Joseph Medical Center Joliet; Medicaid ID 364195126041
10. High-level Description of Project Type:
- Other - FQHC led partnership with hospitals and community-based organizations (CBOs)

2. PROJECT DESCRIPTION

1. Provide an official name for your collaboration:

Healthy Mother Healthy Child Collaborative of Will County

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

The goal of the *Healthy Mother Healthy Child Collaborative* is to decrease the incidence of severe maternal morbidity (SMM) through outreach, education, increased access to primary and specialty care, navigation, and the provision of culturally competent healthcare services, with a focus on the Black and Hispanic/Latino populations. The Collaborative will also ensure equitable healthcare for all women with an emphasis on women from communities of color by increasing access to primary and preventative care, including breast and cervical cancer screenings, and improving health literacy and access to infant well care.

3. Provide a narrative description of your overall project, explaining what makes it transformational.

The *Healthy Mother Healthy Child Collaborative of Will County* will address two of the Illinois Department of Healthcare and Family Services (HFS) healthcare transformation pillars – Maternal and Child Health and Equity. Through a new care model, the collaboration will improve maternal and child health for uninsured and Medicaid/Medicaid Managed Care patients in the Bolingbrook, Romeoville, and Joliet areas, with a focus on reducing health disparities for delivering women from Black and Hispanic/Latino populations. Collaborative services will also ensure equitable healthcare for all low-income women, particularly those from communities of color, by increasing access to preventative care, including breast and cervical cancer screenings, and improving health literacy.

The service area for the Collaborative includes individuals who reside primarily within Will County and a portion of DuPage County, with a focus on the cities of Bolingbrook, Romeoville, and Joliet in which the collaborative hospitals, FQHC and Community Based Organizations are located. A map of the service area (Figure 1.) with zip codes is included as an attachment.

HEALTHCARE CHALLENGES IN SERVICE AREA

The 2020 Community Health Needs Assessment (CHNA) for Will County identified several healthcare challenges for the area. The CHNA was conducted by the Will County Mobilizing through Action, Planning and Partnership (MAPP) Collaborative. AMITA Health Adventist Medical Center Bolingbrook, AMITA Health St. Joseph Medical Center Joliet, and VNA Health Care, were members of the MAPP Collaborative. Forty-eight percent of the service area reported difficulty in accessing care. The barriers to accessing care included finding a doctor, the cost, inconvenient office hours, and lack of transportation. For those in the lower socioeconomic status, 67% reported difficulty accessing care.

In addition, the CHNA found that Will County has a total of 391 primary care physicians, yielding a ratio of population to primary care physicians of 1,760 to 1. Almost 16% of adults in Will County report that they do not have at least one person that they consider to be their primary care provider. There is one community on the East side of Joliet designated by the Health Resources and Services

Administration (HRSA) as an area having shortages of primary care providers. This 60433 zip code is within the service area of the *Healthy Mother Healthy Child Collaborative*.

Based on a seven-year aggregated period (2013-2019), data from the National Center for Health Statistics – Natality Files showed that of the 53,126 deliveries in Will County during that time, 4,038 of them were low birthweight deliveries (infant weighed less than 5 pounds, 8 ounces). Low birthweight births represented 8% of the total live births. The percentage of low birthweight births by race/ethnicity: 6% non-Hispanic White; 13% non-Hispanic Black; and 7% Hispanic/Latino. The teen birth rate for Will County was 11.9 per 1,000. The percentage of teen births by race/ethnicity: 6.5% non-Hispanic White; 23.5% non-Hispanic Black; and 20.8% Hispanic/Latino.

In 2019, cancer was the leading cause of death in Will County. The age adjusted death rate from female breast cancer was slightly above national rates at 20 deaths per 100,000 females. The breast cancer incidence rate is 138 per 100,000, which is slightly higher than Illinois at 133 per 100,000 and the United States at 126 per 100,000.

Fifteen percent of the Will County population reports borderline diabetes as compared to 5% of the national population. This serious, chronic disease is expensive to treat and closely related to heart disease, stroke, obesity, and poor nutrition. It is also critical that diabetes in pregnant women, or those considering pregnancy, be properly managed to ensure a healthy pregnancy, delivery, and child.

For this service area, 23% of residents describe their mental health as fair or poor as compared to the nation at 12%. Accessing mental health services is particularly difficult for low-income residents and those without insurance. With pregnancy and postpartum, many women experience symptoms of anxiety, stress, and depression. According to the American Psychiatric Association, as many as one in five women experience some type of maternal perinatal mood and anxiety disorder and the effects can be debilitating. For those with a previous psychiatric history, there is a higher risk that they will have a return of their symptoms within the first 12 weeks of birth.

COLLABORATIVE PARTNERS

Primary partners in the *Healthy Mother Healthy Child Collaborative* include: VNA Health Care Bolingbrook/Romeoville/Joliet (VNA), AMITA Health Adventist Medical Center Bolingbrook (Adventist Bolingbrook), and AMITA Health Saint Joseph Medical Center Joliet (St. Joseph Joliet). VNA Health Care delivers comprehensive primary care and preventive services to over 75,000 low-income men, women, and children at sixteen locations and in community and home settings throughout suburban Chicago. Approximately 37% of individuals served are uninsured. VNA utilizes a sliding fee scale discount based upon income to ensure that no patient is denied services based on their ability to pay.

VNA is the largest Federally Qualified Health Center (FQHC) in the Chicago suburbs and has been recognized for its patient outcomes and has a top 3.5% ranking among FQHCs nationwide for unduplicated medical patients served. In Will County, the geographic focus of the collaborative, VNA has three locations – Bolingbrook – 396 Remington Boulevard #230; Romeoville – 160 N. Independence Boulevard; and Joliet – 2400 Glenwood Avenue #210. In Spring of 2022, VNA plans to begin construction of a new health center location on the 1400 block of West Jefferson, Joliet, on land already owned by VNA. Upon completion, care will be transitioned from the Glenwood Avenue clinic to the new location.

For the *Healthy Mother Healthy Child Collaborative*, VNA Health Care will be responsible for the delivery of comprehensive primary care and preventive services, care coordination, community outreach and navigation to services detailed within this new care model. In 2019, VNA served approximately [REDACTED] unduplicated females ages 15-45 receiving care through nearly [REDACTED] visits at their Will County locations. In addition, VNA delivered care to approximately [REDACTED] infants ages 0-1. Sixty-three percent of these patients identified as White, 20% as Black; 3.5% Asian; and 49.5% of these patients identified as Hispanic/Latino. The remaining patients declined to specify race and ethnicity during registration.

Most patients served at VNA locations are low-income, demographically diverse and at increased risk for health disparities that require more care and clinical contact. These patients are clinically complex, experiencing medical and social issues that impact their health status including comorbidities (e.g., living with more than one chronic health condition). Currently, a majority of VNA's prenatal patients served in Bolingbrook meet the clinical definition of being high risk for severe maternal morbidity and were referred to Adventist Bolingbrook for MFM services.

For the Collaborative, Adventist Bolingbrook and St. Joseph Joliet will be responsible for the delivery of maternal-fetal medicine (MFM) specialty services, mammography, and specialty care such as gynecology and uro-gynecology and gyne-oncology through this new care model. Adventist Bolingbrook is a 138-bed, full service medical facility that provides high-quality, compassionate, and family-centered medical care to the residents of Bolingbrook and the surrounding communities. It has earned nationally recognized awards and safety grades, including the Joint Commission certified Primary Stroke and Chest Pain Center, Healthgrades Emergency Medicine Excellence Award, and Blue Distinction® Center for Maternity Care. It is certified as a Level II Perinatal Center, serving mothers and infants at moderately high risk. Committed to providing access to the same quality care for each patient regardless of income or insurance status, Adventist Bolingbrook provided \$2.5 million in charity care in 2020.

St. Joseph Joliet is a 480-bed, full service medical facility located in the heart of the southern suburbs. Recently named to the "Top Hospitals" in Chicagoland area by *Chicago Magazine*, St. Joseph Joliet serves a wide range of health care needs, including Cancer Care, Cardiac Care, Neuroscience, Level II Emergency/Trauma Center, Family Birthing Suites, Level II Special Care Nursery, Pediatric Intensive Care Unit, Rehabilitation Services, Behavioral Health Services and Sleep Disorder Center. Its nationally recognized heart and vascular program provides advanced health care services dedicated to the treatment of the heart and centered on the open-heart surgery program. In addition, it is the only provider of neurosurgical services in the Will-Grundy region and is designated as a Primary Stroke Center. St. Joseph Joliet provided \$9.4 million in charity care in 2020.

There are five community-based organizations (CBOs) in the *Healthy Mother Healthy Child Collaborative*. VNA's Community Health Workers (CHW) are bilingual and will work closely with the CBO partners at their locations to provide education and navigation to services for vulnerable populations. These CHWs will work closely with CBO program staff, such as Health Justice program workers at Southwest Suburban Immigrant Project and doulas at Catholic Charities, to raise awareness of the availability of services from the *Healthy Mother Healthy Child Collaborative* and to remove barriers to care such as transportation issues and the need for translation services. VNA's Social Determinants Social Worker will provide additional resources or assistance that may be needed and guidance and mentorship for the CHW's.

The CBO partners will promote access to services at their location and on social media. These partners include the following, though we anticipate adding others as the *Healthy Mother Healthy Child Collaborative* begins implementation of the program. VNA reached out to the local chapter of the NAACP who is interested in assisting with outreach and navigation for the Collaborative. The details of their participation are still being finalized, however VNA works with this organization in other committees that address health equity and access.

The Spanish Community Center (SCC)

The Spanish Community Center, located in Joliet, has been working to improve the quality of life for Latinos, immigrants, and low-income people through educational and social services since 1969. SCC's services include early childhood education and childcare, social services, citizenship and immigration services, and adult education including English as a second language, GED, and computer literacy classes.

Southwest Suburban Immigrant Project (SSIP)

The Southwest Suburban Immigrant Project is a social impact organization committed to community organizing for the rights of immigrants in Chicago's southwest suburbs through education, civic engagement, and advocacy. Based in Bolingbrook, this organization provides services related to immigration, education, health access and economic justice. Programming includes citizenship preparation classes, parent mentoring, Mariachi Matters, and an after-school music education program for youth.

Catholic Charities, Diocese of Joliet

Catholic Charities in the Diocese of Joliet began helping individuals and families in crisis after World War I and is now incorporated and licensed as a child welfare agency in the State of Illinois. The areas served include Will, Grundy, DuPage, Kendall, Kankakee, Ford and Iroquois counties. Services include a mobile food pantry, early childhood services and Head Start, Doula services, Counseling, community groups and classes.

Valley View School District 365U

Valley View School District 365U comprises most of the thriving communities of Bolingbrook, Romeoville and portions of Plainfield, Lockport, and Downers Grove in Illinois. Formed in 1972, the district now serves the educational needs of approximately 16,000 students in 22 educational facilities. Valley View School District 365U is one of Will County's largest employers, with more than 2,400 full-time employees. VNA's Health Center in Romeoville is designated as a School-Based Health Center and as such can serve unaccompanied students at Romeoville High School during the school day with parental consent which lasts for the duration of the student's time at the school.

Holsten Human Capital Development, NFP

Holsten manages River Walk, a 356-unit affordable housing development formerly known as Evergreen Terrace Apartments, located at 801 W. Normantown Road, Romeoville. The communities in the Collaborative's service area benefit from the revitalization efforts of Holsten Development Corporation offering affordable rental housing. River Walk provides families with an opportunity to qualify for rental subsidies. The approved residents that qualify will pay 30% of the total household gross income for rent with a maximum income limit of 50% based upon the HUD Income Limits AMI (Area Median Income) in Will County. Holsten Human Capital Development,

NFP operates a food pantry for its residents and provides other social support such as navigation to other safety-net services.

NEW CARE MODEL

AMITA Health and VNA have been independently delivering high quality services to women and their children within their service areas for many years. During this time, they have referred patients to each other and collaborated on other initiatives. This proposed new care model in response to the HTC opportunity was developed by the key partners to bring together a large community health center and a large hospital system that encompasses hospitals in Bolingbrook and Joliet and three Community Health Centers located in Romeoville, Bolingbrook, and Joliet, as well as several community-based organizations. The Collaborative will focus on reducing risk for fragmented care, improving maternal health literacy, and improving access and clinical outcomes through the implementation of highly targeted strategies to close care gaps through intentional collaboration and care coordination in Will County.

This new care model expands upon VNA's experience of delivering comprehensive primary care and enabling services for vulnerable populations within Will County and other regions of their service area. It enhances and expands the model through strategic partnership and co-location with AMITA Health MFM specialty care and focused outreach by Community Health Workers, in partnership with community-based organizations, that meets individuals where they are and navigates them to care. This new care model delivers integrated care and education plus augments access to services for women within the clinic, home or community setting. Social determinants of health will also be addressed through this collaboration to improve access to care and health equity. Meeting program metrics and demonstrating improvements in outcomes will be accomplished through the alignment of program goals and clinical outcomes, together with the ongoing monitoring and sharing of patient visits, demographic, and outcome data to facilitate program evaluation and achievement of progress.

The primary target population benefitting from this collaboration will be prenatal and postpartum low-income Black and Hispanic/Latina women at increased risk of health disparities, the majority of whom are Medicaid eligible. However, this initiative recognizes that in order to improve maternal and fetal outcomes, we need to engage girls and women in comprehensive primary and preventive care even before they become pregnant, between and after pregnancy. This helps ensure that health issues are identified and addressed early and effectively thus ensuring that a woman enters pregnancy as healthy as possible and begins care for her infant immediately. Many of these women are uninsured prior to pregnancy and may have delayed care or used the emergency room as a temporary solution for meeting their healthcare needs. We also recognize that women are most often the primary healthcare decision-makers within families and as such, this initiative also supports women establishing a primary care medical home for themselves and their family.

MATERNAL AND CHILD HEALTH PILLAR

The goal of the *Healthy Mother Healthy Child Collaborative* is to decrease the incidence of severe maternal morbidity through outreach, education, increased access to primary and specialty care, navigation, and the provision of culturally competent healthcare services. A decrease in severe maternal morbidity will reduce preterm births and improve both maternal and child health outcomes. In addition, this collaboration will promote navigation of newborn infants into pediatric care to help establish a family culture of accessing healthcare services, deepen engagement, and

improve health outcomes for both mother and infant in the short and long term through early intervention where necessary. The target population will be females 15 years and older and infants 0-15 months old.

Women experiencing severe maternal morbidity (SMM) events have pregnancy, delivery, or postpartum complications that may result in increased risk of re-admittance, extended hospital stays, or major medical interventions. Unfortunately, women experiencing a SMM event are more likely to be non-Hispanic Black, have public insurance, and receive inadequate prenatal care either as a result of sporadic care or late entry into prenatal care if they present for care at all.¹ To decrease these health disparities, the *Healthy Mother Healthy Child Collaborative* will transform the care delivery model for Medicaid and uninsured obstetric patients through a comprehensive integrated approach using evidence-based practices. The new care model will reduce fragmented care and improve continuity of care for vulnerable populations and consists of two components – health literacy and access to care.

Health Literacy

Health Literacy is a relatively new concept but is a social determinant of health that must be addressed in order to decrease health disparities and achieve racial equity in healthcare. In a 2019 study conducted by Lynn Yee, MD, of the Feinberg School of Medicine at Northwestern University in Chicago, babies born to women with low health literacy were 1.4 times more likely to be small for gestation age, had a higher frequency of preterm birth before 34 weeks gestation, and they had a higher chance of having low birthweight. Infants of mothers with low health literacy were almost three times as likely to have an Apgar score less than 4. The Apgar score is a test given to newborns right after birth to check heart rate, muscle tone, and other signs that extra medical care may be needed. A baby who scores seven or above is considered in good health. The study found that women with inadequate health literacy tend to be younger, more likely to be non-Hispanic black or Hispanic, and more likely to have public insurance.

The five Community Health Workers (CHW) to be hired for the Collaborative will provide outreach and education to improve health literacy for vulnerable populations of women including those who are Black, Hispanic/Latina and women with public insurance or uninsured. Working with the Collaborative's CBO partners, the CHW will be able to identify those in the community in need of healthcare services. In collaboration with staff at the CBO, the CHW will meet with CBO clients at the CBO sites to inform and educate them on the importance of preventative, prenatal, and postnatal care, and how to access that care. CHWs will also navigate to care women at high risk for severe maternal morbidity both before, during, and after becoming pregnant, including women with hypertension, diabetes, or other chronic diseases. The CHW's will also provide education about the importance of preventive care including cancer screenings, vaccinations and reduction of health and safety risks.

To further address health literacy, VNA will provide mothers and their families with in-person and online bilingual classes that will include prenatal, parenting, and wellness classes to reduce risks and incidence of chronic disease (diabetes and hypertension). The in-person classes will be conducted at VNA health centers in Romeoville and Joliet and will include cooking demonstrations in the wellness kitchen. This resource serves as a great opportunity to provide nutrition education that includes the opportunity to watch culturally familiar foods being prepared in a healthy way and offers participants the opportunity to sample recipes that are being used which increases confidence to try new ingredients such as unfamiliar vegetables, fruits and grains. Introducing healthy foods

during pregnancy reduces risk for mothers and helps establish healthy eating habits and as the infant begins to explore solid foods, also serves to establish good nutrition early in life which will reduce risk for chronic disease such as obesity and Type 2 Diabetes later in childhood.

Navigation of mothers into these educational programs will not only take place within the VNA Health Centers but also within the Community Based Organizations engaged in this Collaborative. This will occur within their programs and during outreach by the Community Health Workers at the CBO locations. These programs will be led by VNA staff including the Diabetes Educator, Community Health Workers and Doulas.

In the clinical setting, steps will be taken by primary care providers and Maternal-Fetal Medicine (MFM) physicians to improve patient understanding of health care needs which could mean modifying the way information is given verbally and in writing, supplementing written materials with graphics, and using simple language in the exam room.

Access to Care

The second component of the Collaborative's new care model will increase access to care, including those women at high-risk for severe maternal morbidity (SMM). In addition to providing in-person healthcare services, telehealth and home-based services will be offered for those facing transportation barriers or health issues that would prevent them from traveling to a medical office.

To reach all of those identified through the Collaborative as in need of healthcare and to reduce the risk of gaps in care that can occur during the referral process, VNA will expand its facilities in Romeoville an additional 2,719 square feet to allow co-location of Adventist Bolingbrook staff and services, including a MFM physician, ultrasound/mammography tech, diabetic counselor, and a genetic counselor. High risk patients in need of MFM specialists will be able to access that care in the same location as their primary care and will not need to travel to Bolingbrook for specialty care. In addition, VNA plans to begin construction of a new 13,899 square foot facility in Joliet in 2022. With HFS funding, we will be able to use 2,500 square feet of that space to co-locate St. Joseph Joliet ultrasounds techs to provide routine ultrasounds for pregnant women.

Currently, there are no pharmacy services at either the VNA Romeoville or Joliet clinics. These expansions will include walk-in/drive-thru pharmacies, further improving patient access to care as they will be able to pick-up their medications in the same location as their primary and/or specialty care provider. This will also increase access to VNA's 340B discount pharmacy program for eligible patients.

With these facility expansions to meet the needs of the Medicaid population, as well as the additional patients that will be served through the community outreach/education initiative, VNA will over the next five years hire additional clinical staff to fully meet the service needs of these communities: four obstetric gynecologist physicians, a pediatrician, four nurse practitioners, five registered nurses, ten medical assistants or certified nursing assistants, a midwife, four doulas, diabetic educator, and a dietician. To fill open positions for this initiative, the Collaborative will present applicable clinical employment opportunities to AMITA Health obstetrics/gynecology residents. Five Community Health Workers will also be hired. These expansions will keep more care locally within these communities.

VNA patients identified as high risk are referred for further specialty care to AMITA Bolingbrook or AMITA Joliet, which are certified Level II Perinatal Center serving mothers and infants at moderately high risk. These hospitals are also designated as Blue Distinction® Centers for Maternity Care. This Blue Cross and Blue Shield of Illinois distinction recognizes healthcare facilities and providers for their expertise and efficiency in delivering specialty care. AMITA Health also partner with Blue Cross Blue Shield for their Special Beginnings program, which is a maternal and child health preventative care project to improve outcomes among prenatal and postpartum Medicaid patients. The program includes personal phone calls from specially trained staff, a 24-hour hotline, and incentives for attending prenatal and postpartum appointments, such as infant care seats, portable cribs, diapers, and new mom welcome home kits with baby items.

There are currently two maternal fetal medicine (MFM) specialists that serve Adventist Bolingbrook, but in a limited capacity as they rotate between three AMITA Health hospitals. Consequently, we are unable to serve all VNA maternal patients that are identified as high risk and they are referred to other providers, requiring patients to travel longer distances for care. These longer distances mean that some may not attend all necessary prenatal and postpartum appointments because of a lack of transportation or the inability to pay for the cost of that transportation. To address this issue, proposed funding secured through the *Healthy Mother Healthy Child Collaborative* would allow Adventist Bolingbrook to hire an additional MFM specialist to serve this population. These clinical providers are highly specialized physicians trained in diagnosing, treating, and managing high-risk pregnancies.

To further assist with transportation barriers that may exist, MFM specialists would rotate to the VNA Romeoville Health Center which will be expanded with funding outlined in the program budget in order to provide access to specialty care for these patients at this location. The Romeoville Health Center does not currently have specialty care services for high-risk pregnancies and patients must travel to Adventist Bolingbrook or St. Joseph Joliet. We also anticipate that VNA's Community Health Workers will increase the number of patients served as more women will be informed about the importance of prenatal care and navigated to services. With another MFM specialist, the collaborative team will be able to support the additional anticipated Medicaid referrals from VNA.

To fully serve this high-risk Medicaid population and support the MFM, Adventist Bolingbrook will need to hire additional clinical staff (MFM nurse, MRM diabetic counselor, sonographer, genetic counselor, ultrasound/mammography tech) who will also rotate to the Romeoville location. While a normal pregnancy includes one to two ultrasounds, women with high-risk pregnancies may need six to eight ultrasounds. This will require additional ultrasound equipment and sonography staff to ensure that all Medicaid patients have access to the ultrasound services they need to monitor the health of their baby.

Genetic counselors work with patients and families that may be at risk for an abnormal pregnancy outcome. They are an important part of the decision-making process for prenatal testing in high-risk pregnancies and will explain the testing options, benefits and risks of testing, and reasons why patients choose or decline to have testing, as well as address the psychological issues associated with these topics. To ensure that the Collaborative's target populations have access to genetic counseling services, Adventist Bolingbrook will hire two genetic counselors.

In addition to MFM specialists, Medicaid patients referred to Adventist Bolingbrook and St. Joseph Joliet have access to other AMITA specialty care providers and services, including bariatrics,

cardiology, neurology, oncology, orthopedics, pulmonary, and surgical. Patients needing an even higher level of maternal and infant care will be referred to the certified Level III Perinatal Center at AMITA Health Adventist Medical Center Hinsdale.

This access to care component will also include improved multi-disciplinary care integration, coordination, communication, and education among members of the clinical care teams at VNA, Adventist Bolingbrook, and St. Joseph Joliet. Utilizing in-person care team meetings, ad-hoc case review, and the sharing of secure visit summaries, continuity of care will improve leading to more positive health outcomes.

The CHWs will provide navigation services to link patients to the appropriate resources needed pre- and post-delivery to ensure quality clinical outcomes. They will also complete Social Determinants of Health (SDoH) screenings to identify, address, and eliminate the barriers that prevent the person from accessing quality healthcare. The Collaborative will also conduct an ongoing digital media campaign to raise awareness and promote access to care.

In addition to the services provided within this Collaborative, VNA delivers mental and behavioral health services at Romeoville, and this will be expanded to Joliet once the new location is constructed. These services will be available to patients and are also accessible by the families of women served along with primary care services. This will help ensure that women and their families can receive their care within the same location which helps establish a culture of healthcare access within the family in addition to reducing risk for our target population of women by ensuring that their partners are also healthy.

In addition to the focus on improving access to care and health literacy for women of child-bearing age, the *Healthy Mother Healthy Child Collaborative of Will County* also seeks to engage infants born to women who are receiving care from the Collaborative through introduction into pediatric care beginning at birth. The focus of this strategy will be entry into, and completion of, well-child visits through age 15 month. This period was selected as it aligns with Uniform Data Set measures being tracked by VNA and covers a critical period where relationships are built between the mother and father where applicable, the infant and their pediatrician. Continuation of the well-child schedule of visits per American Academy of Pediatrics guidelines will be encouraged and monitored by VNA after the child passes the 15-month milestones but will not be reported as part of the collaborative.

The well-child visits are a time to review and discuss each of the important areas of the infant's development, including physical, cognitive, emotional, and social development. VNA Pediatricians use the Bright Futures screening tool to assess and guide discussions with parents about child development. In addition to the delivery of vaccinations and important developmental screenings being conducted, the pediatrician serves as an expert support for the infant's parents and these visits are also an opportunity to provide age-appropriate guidance and identify areas of risk such as postnatal depression in the mother or failure to thrive in the infant.

These visits are also an important opportunity for the infant's pediatrician to talk with parents about the importance of prevention, for example reviewing car-seat safety and the safe storage of firearms. It is also a time when education is provided about the importance of sleep, good nutrition and physical activity and these healthy behaviors are important to establish early as a strategy for reducing risk now and in the future for both mother and child. Over the five-year funding period,

we expect to serve [REDACTED] infants up to 15 months of age. (See enclosed attachments – Figures 2 – 4: Care Coordination, Entry into Primary Care and Entry into Prenatal Care workflows).

Providing Culturally Competent Care

Providing access to care also includes incorporating culturally competent care into all aspects of maternal and infant healthcare. The Collaborative will focus on tailoring the delivery of healthcare to meet our patients' social, cultural and linguistic needs so they are comfortable in seeking and engaging in healthcare services. We will adapt services to address each patient's culturally unique communication style, beliefs, attitudes, and behaviors. Providing culturally competent care is another key component in reducing healthcare disparities. This will also help build a sense of trust within the community.

The *Survey on Race and Health*, a joint project between the Kaiser Family Foundation (KFF) and ESPN's The Undeclared, was conducted in 2020 and found that Black and Hispanic adults were less likely to trust doctors, hospitals, and the health care system, than White adults.² This lack of trust prevents these populations from accessing the healthcare services they need. The healthcare providers in the Collaborative recognize that to increase trust in doctors and hospitals, it is imperative that we create an environment that provides culturally and linguistically competent care. Reaching out to women in a trusted environment where they are comfortable, such as the Spanish Community Center, Southwest Suburban Immigrant Project, Catholic Charities, and schools, the Collaborative will be able to improve trust among Black and Hispanic/Latina women for doctors and hospitals. Through these community-based organizations, the healthcare providers will be able to actively listen and learn from community members about the impact racism has on healthcare disparities and the barriers they face in accessing quality healthcare services.

In addition, there needs to be more diversity among doctors and other clinical staff. In hiring for the new clinical positions created by the Collaborative, we will prioritize candidate recruitment from the local community and will use best practices to attract and recruit diverse talent that reflects the community's racial makeup.

Table 1 in the attachment shows the number of individuals the *Healthy Mother Healthy Child Collaborative* expects to serve, and the number of estimated maternal and pediatric clinic visits provided, for each year during the five-year funding period. We expect to serve a total of [REDACTED] unduplicated obstetric patients over the next five years, and [REDACTED] of those patients (or 60%) will receive maternal-fetal medicine (MFM) specialty services. For unduplicated pediatric patients up to 15 months, we expect to serve a total of [REDACTED] during the five-year period. In addition, we estimate that there will be attendance of [REDACTED] individuals at educational classes on pre- and postnatal care, reducing risks associated with co-morbidities (diabetes/hypertension), parenting, and social support groups for mothers and their families.

EQUITY PILLAR

The Centers for Disease Control and Prevention report that Black and Hispanic women have higher cervical cancer rates than White women: Rate per 100,000 women – 7.4 for White; 8.3 for Black; and 9.3 for Hispanic. The rate of cervical cancer deaths is also higher for Black and Hispanic women: 2.1 for White; 3.2 for Black; and 2.4 for Hispanic. While the breast cancer rate for Black and Hispanic women is lower than for White women, the rate of breast cancer deaths for Black women is much higher than for White and Hispanic women: 19.2 for White; 26.8 for Black; and 13.5 for Hispanic.³

To address racial equity and disparities in healthcare, it is essential that Black and Hispanic/Latina women have access to primary and preventive care so that health issues can be identified and treated early to ensure the best possible health outcomes. The outreach and education initiative described above for maternal care will also include navigation to primary and preventive care including annual physicals and breast and cervical cancer screening as indicated by guidelines.

VNA is the lead agency for the Illinois Breast and Cervical Cancer program within Kane, Kendall, DuPage, Will and Kankakee Counties. Currently, VNA only provides mammography services within their largest location in Aurora, Illinois. Otherwise, women in need of these routine screenings and subsequent diagnostics and treatment if indicated are referred for screenings and follow-up care. The Collaborative's planned co-location of mammography services in the VNA Romeoville clinic, along with family practice services, will help ensure that women begin these screenings when they are eligible and continue to receive them as a routine component of their care. Women receiving care in Joliet will receive their cervical screening services within VNA's Joliet location, however, mammography services will continue to be provided at AMITA Joliet which is located only 1.8 miles from VNA. The Collaborative's budget includes costs for patient transportation to St. Joseph Joliet through a medical ride-share service or taxi service where needed.

The CHWs working in collaboration with the CBOs in the community will also provide navigation services to link age-appropriate women with preventive health screenings including mammography services and cervical cancer screenings. Women served by the Collaborative are also at risk of health disparities from cancer and other chronic diseases and as a result, this Collaborative is committed to ensuring holistic care for women served in order to promote good health that reduces risks for the patient and helps strengthen their families as a result.

Table 2 in the attachment shows the number of individuals the *Healthy Mother Healthy Child Collaborative* expects to serve, and the number of estimated primary care, education and cancer screening clinic visits provided, for each year during the five-year funding period. We expect to provide primary and preventative care for [REDACTED] unduplicated women over the next five years.

CAPITAL IMPROVEMENTS

As part of the *Healthy Mother Healthy Child Collaborative of Will County*, VNA will expand its Romeoville clinic to include the addition of four intake rooms and four ultrasound rooms for use by AMITA Bolingbrook physicians and staff; a digital mammography suite with dressing rooms; additional staff area for use by the Community Health Workers; a pharmacy with walk-in and drive-thru services; and a children's play area and patient waiting area. This will result in an additional 2,719 square feet of space to better serve our patients.

VNA will be building a new health center on land already owned by the organization approximately 1.8 miles from St. Joseph Joliet. Located in the 1400 block of W. Jefferson Street in Joliet, the clinic will be 13,899 square feet. As part of the Collaborative, St. Joseph Joliet ultrasound services will be co-located within this new location. Funding requested from HFS for this construction covers 2,500 square feet of the new building for registration, waiting area, pharmacy, ultrasound and obstetrics/gynecology exam room space for the Collaborative's proposed program. High risk patients in need of MFM services will be navigated through this program to St. Joseph Joliet. During

construction, primary care services will be provided at VNA's existing Joliet location, and the specialty care components of the collaboration will be provided by St. Joseph Joliet.

BUDGET ITEMS

To fully implement the proposed program for the *Healthy Mother Healthy Child Collaborative*, and to ensure goals and objectives are met, the budget includes a Collaborative Director to oversee all aspects of the initiative. A VNA Clinical Coordinator and an AMITA Health Maternal Fetal Medicine Project Coordinator will manage the day-to-day operations of the program. The appropriate clinical staff will be hired to meet all the healthcare needs of the Black, Hispanic/Latina, and low-income women to be served by the Collaborative. Five Community Health Workers are included to fully implement the outreach, education, and navigation component of the initiative.

To be able to effectively gather, track, analyze, and evaluate data, a Data Analyst and IT Coder will be hired. The IT Coder will be full-time the first year to get the necessary data reporting programs created but will decrease to a .2 FTE by Year 5. With the additional women and infants to be served, office support will be needed with a Front Desk Assistant and more Patient Services and Medical Records Representatives (scheduling, intake, and medical records) and Patient Financial Services Representatives (prepare billings and manage patient financial accounts and payments).

In order to expand services and improve access for these vulnerable populations, construction costs have been included for 2,719 square feet at the VNA Romeoville location and 2,500 square feet at VNA Joliet to provide space to co-locate Adventist Bolingbrook and St. Joseph Joliet medical staff at VNA clinics. Specifically, maternal fetal medicine specialty services for high-risk mothers, as well as ultrasound and routine mammography services, will be provided by AMITA Health at the Romeoville clinic. At VNA Joliet, routine ultrasounds for pregnant women will be provided by AMITA St. Joseph Joliet. Specialty and mammography services will still be provided at the hospital which is only 1.8 miles from the new Joliet clinic. The cost for AMITA Health to lease the space at the VNA Romeoville clinic is also included in the budget.

Equipment is needed to provide ultrasounds for pregnant women and mammography for women ages 40 and older. The cost to purchase three ultrasound machines (one for each of the VNA locations in Bolingbrook, Romeoville, and Joliet) and the lease cost for mammography equipment at the VNA Romeoville clinic are included in the budget. Non-stress testing equipment for pregnant women will also be purchased to assist in identifying any pregnancy health-related issues to be addressed. Supplies for exam rooms are needed and budgeted, such as paper sheets, gowns, gloves, instruments, etc. To co-locate MFM specialty services in Romeoville, Adventist Bolingbrook will need to set up a computer network at the VNA location to access AMITA Health medical and billing records.

Digital marketing costs and expenses related to outreach and educational materials/information have been included in the budget to give the Collaborative enough funding to reach its target population.

PROJECT TIMEFRAME

The following information details the milestones and activities for Year 1 of the program period. Per an attached Gantt chart, this same information is provided for Years 2 – 5. Milestones and activities remain constant throughout the program period, but there are some changes in priorities as the Collaborative moves forward with focusing on the provision of services, collecting and reporting on metrics and outcomes and sustainability planning.

Milestone 1 – Planning and Infrastructure

Within the first six months of the first year of funding, the Collaborative will execute all partner agreements, execute leases with VNA Health Care, convene the Leadership Committee, develop a data sharing plan, develop the digital marketing campaign and community engagement and outreach plan, and convene the Community Advisory Committee

Milestone 2 – Capital Projects

We anticipate that the VNA Romeoville construction will be completed within the first six months of the funding period. Joliet construction should be completed with the first year of funding. We expect all equipment and the computer network for the VNA Romeoville clinic to be purchased and installed within the first six months of funding.

Milestone 3 – Staffing

Within three months of funding, we hope to have the Collaborative Director and IT Coder hired. Within six months, the Collaborative Director and other VNA and AMITA staff will interview, hire and train the additional staff needed to fully implement the proposed program for the *Healthy Mother Healthy Child Collaborative*.

Milestone 4 - Implementation

In month seven of the first year of funding, we expect to launch this Collaborative program at VNA Romeoville. During the last six months of the year, we will provide outreach, education, and navigation to primary, preventative, and prenatal care, including MFM services and breast and cervical cancer screenings. We will also provide social determinants of health (SDoH) screenings and navigate infants to well-childcare. During this same timeframe, we will begin collection of clinical metrics and SDoH information, launch a digital marketing campaign, and host community outreach and education events at partnering community-based organization sites. In month 12, we will launch the program at VNA Joliet when construction has been completed.

¹Journal of the American College of Obstetricians and Gynecologists, *Statewide Severe Maternal Morbidity Review in Illinois*, Departments of Obstetrics and Gynecology and Medicine and the Center for Research on Women and Gender, University of Illinois at Chicago College of Medicine, Stacie E. Geller, Ph.D. 2020

²Kaiser Family Foundation/The Undeclared Survey on Race and Health (conducted Aug. 20 – Sept. 14, 2020)

³U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2020 submission data (1999-2018): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute - www.cdc.gov/cancer/dataviz, released in June 2021.

3. GOVERNANCE STRUCTURE

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?

The *Healthy Mother Healthy Child Collaborative* does not create a new entity but is a collaboration of providers and community-based organizations committed to improving maternal and infant health outcomes and eliminating health disparities for vulnerable individuals in Will County, including low-income women from communities of color. AMITA Health and VNA will execute a Memorandum of Understanding (MOU) that outlines the responsibilities of each party in providing and coordinating care to patients through this Collaborative. The Collaborative is reliant upon all partners working together effectively to implement the program. The governance structure in place will ensure that members of the collaborative are engaged in the implementation, ongoing measurement and evaluation and accountable for the deliverables that fall within their areas of responsibility.

The community-based partners (CBOs) have committed to providing VNA Community Health Workers (CHWs) access to their facilities and clients for outreach and educational programming. CBO program staff will receive a thorough orientation of the Collaborative and the services to be delivered by all partners. The CBOs are committed to navigating clients to care that they identify as needing services offered by the Collaborative. In addition, they will work with the Collaborative to raise awareness of their own services that may address the Social Determinants of Health experienced by patients being navigated from the Collaborative or other CBOs. The Collaborative's CHWs will work closely with designated CBO staff to increase awareness about the importance of good overall health to successful outcomes for mothers and their infants. Each CBO has committed to participating in the Collaborative's Community Advisory Committee and will help identify clients and patients of the Collaborative for participation as a consumer committee member.

Governance for day-to-day operations and coordination of the Collaborative will be through a Leadership Committee. This committee will include representatives from VNA and AMITA Health program leads, program manager/director, medical director, MFM physician, data analysts and finance administrators. The Board will meet monthly in Q1 and Q2 of Year 1 and quarterly through the end of Year 1 – Year 5. The Leadership Board will have quarterly check-ins with Adventist Bolingbrook, St. Joseph Joliet, and VNA CEO's as necessary. The responsibilities of the Leadership Committee are as follows:

- Formulate policies for the Collaborative and set priorities according to the established timeline and milestones
- Advise the Program Manager and Collaborative member's team leads regarding the implementation of the program
- Provide oversight to ensure that all milestones are met
- Monitor and review the metrics and outcomes reported monthly
- Provide oversight and review of financial performance monthly/quarterly

In addition, all collaboration partners, including the community-based organizations (CBOs), will have a representative on the VNA Will County Community Advisory Committee (CAC). The Committee meets quarterly and reviews program initiatives, barriers to care, community issues that may be impacting access to care and collaborative initiatives. As part of this meeting, the group will review the progress of implementation and outcomes reported by the Collaborative in order to provide feedback if challenges or opportunities arise. In addition, this opportunity for review helps strengthen relationships amongst the program partners who in turn can become effective advocates for the initiative with their clients.

Planned Changes: Currently, Adventist Bolingbrook and St. Joseph Joliet are a part of AMITA Health, a joint operating company between AdventHealth and Ascension formed in 2015. On October 21, 2021, the leaders of AdventHealth and Ascension announced that it is in the best interest of both organizations to unwind the AMITA Health partnership. Each health system will move forward separately to meet the changing needs and expectations of consumers more nimbly in this rapidly evolving healthcare environment. This separation is expected to be completed by March 31, 2022. Following the transition, the Ascension hospitals and care sites (formerly part of Alexian Brothers Health System and Presence Health) will begin to be clinically and operationally integrated with Ascension. Keith Parrott, AMITA Health president and CEO, will continue to serve as the leader for the Ascension ministries in this market. Similarly, the AdventHealth hospitals and care sites will be clinically and operationally integrated with AdventHealth. Thor Thordarson, currently the executive vice president and chief operating officer at AMITA, will lead the AdventHealth ministries in this market. *AMITA Bolingbrook is part of AdventHealth and AMITA Joliet part of Ascension.*

This separation will in no way affect the proposed *Healthy Mother Healthy Child Collaborative*. Both AMITA Bolingbrook and AMITA Joliet, and their parent companies AdventHealth and Ascension, are committed to improving maternal and infant health through the Collaborative and will move forward as planned if funding is awarded.

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?

Each of the organizations in the Collaborative have their own policies and procedures for compliance, ethics, and legal requirements associated with funded initiatives and will adhere to those policies. The Collaborative Director will oversee and review outcomes and progress on an ongoing basis and will address any issues that may arise in consultation with Collaborative leadership, as well as the partner CBOs. All partners will be held accountable for providing updates on progress to goals at quarterly Leadership and Community Advisory Committee meetings. VNA and Adventist Bolingbrook and St. Joseph Joliet have extensive experience in managing large federal and state funded projects and programs.

3. Will a new umbrella legal entity be created as a result of your collaboration? NO

Payments and Administration of Funds

4. How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's intended purpose? If the plan is to use a fiscal intermediary, please specify.

The *Healthy Mother Health Child Collaborative* will not be using a fiscal intermediary since the lead collaborative partners, VNA and Adventist Bolingbrook and St. Joseph Joliet, have in-house financial analysts who will provide oversight to comply with compliance and fiscal requirements required by the Illinois Department of Healthcare and Family Services. These healthcare organizations are all Medicaid providers and will receive direct payments for any HFS funding awarded.

VNA is a Medicaid provider and follows policies to comply with federal and state grant cost exclusions and Medicaid cost reporting. VNA also reviews HRSA's Legislative Mandates annually for the passage of a new HHS Appropriations Act or issuance of HRSA guidance regarding the Legislative Mandates and ensures that VNA policies and procedures are updated as necessary. Any modifications to legislative mandates, policies and procedures are reviewed and approved by the VNA Board of Directors.

As applicable, CBO partners will submit invoices to VNA for payment of budgeted personnel expenses and costs to host Collaborative education and outreach events.

AMITA projects supported by extramural funding sources like IHFS including pass-thru funding arrangements from federal funding agencies will adhere to established programmatic, fiscal and administrative policies. AMITA's legal entity, Alexian Brothers Health System, is a 501c3 non-profit entity with grants management policies and services provided by the Ascension Grants & Research Finance Center of Excellence (COE). As noted previously, AMITA functions as a joint operating company, and Ascension Health is one of the system's sponsors. Ascension/AMITA is subject to the Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for federal awards. An annual Uniform Guidance (UG) audit is generated under the consolidated Ascension Health audit currently completed by the international accounting firm EY (formerly Ernst and Young). An annual financial statement audit is also performed by EY for Ascension/AMITA.

Ascension/AMITA utilizes PeopleSoft accounting software along with the Kronos timekeeping system and uses a modified accrual accounting methodology. The PeopleSoft accounting and financial system maintains separate general ledger accounts for all disbursements, revenues and balance sheet accounts including transactions for sponsored awards. All financial journal entries, procurement requests, travel requests and other accounting entries require the review and approval of the COE Director and AMITA's local accounting director.

COE staff adhere to internal controls referenced by the Part 200 Uniform Administrative Requirements and the UG Compliance supplements that are applicable to federal grant awards will be used to provide fiscal oversight for funding awarded by IHFS supporting this Healthcare Transformation Collaborative program. The areas addressed by internal controls requirements include cash management, allowable costs and cost principles, eligibility, equipment and real

property management, matching, period of availability, procurement, suspension and debarment, program income, reporting and subrecipient monitoring.

The COE team including a director, financial analysts and other administrative staff work to ensure that all fiscal and administrative requirements including compliance are in accordance with funder terms and conditions. When awards are received, AMITA's office of legal counsel reviews the notice of award to ensure that Ascension/AMITA can meet stated requirements and provisions. The next step in the fiscal and administrative process is the review by COE staff of the project's budget, requested post-award documentation and funder reporting requirements. The COE team then assigns a fund number to track all expenditures allocated and spent for the program to ensure accurate accounts receivable and payable journal entries. Costs are tracked monthly, and this information is shared with program staff every month to clarify budget-to-actual spending and confirm expenses included in invoices sent or drawdowns submitted to the funder for reimbursement. Time and effort reporting is managed by the COE staff to document that program staff attest to their effort supported by the funder every month.

With the sunseting of the AMITA Health joint operating company by March 2022, there will be some changes to this process. Extramural funding projects for St. Joseph Joliet will continue to be managed by the COE as outlined above. For Adventist Bolingbrook, an almost identical process will be in place but managed by AdventHealth.

4. RACIAL EQUITY

Describe the incorporation of racial equity into the program design

The *Healthy Mother Healthy Child Collaborative of Will County* was specifically designed to address the healthcare needs of Black and Hispanic/Latina women and eliminate the barriers they face in accessing healthcare services. Collaborating with community-based organizations (CBOs) that serve these populations, the Collaborative's healthcare providers will now be able to reach those women who might otherwise not seek, or be able to access, the healthcare services they need.

The *Survey on Race and Health*, a joint project between the Kaiser Family Foundation (KFF) and ESPN's *The Undeclared*, was conducted in 2020 and found that Black and Hispanic adults were less likely to trust doctors, hospitals, and the health care system, than White adults. Compared to White adults, Black adults are 19 percentage points less likely to trust doctors, 14 percentage points less likely to trust local hospitals, and 11 percentage points less likely to trust the health care system to do what is right for them and their communities. Hispanic adults are six percentage points less likely to trust doctors, eight percentage points less likely to trust local hospitals, and five percentage points less likely to trust the health care system.¹

This lack of trust in the healthcare system was a major consideration in designing the *Healthy Mother Healthy Child Collaborative*. By reaching out to women in a trusted environment where they are comfortable, such as the Spanish Community Center, Southwest Suburban Immigrant Project, Catholic Charities, and schools, the Collaborative will be able to improve trust among Black and Hispanic/Latina women for doctors and hospitals. The CBOs and VNA have longstanding relationships built on trust such that the CBOs are comfortable in referring and navigating their clients to VNA for healthcare services, knowing they will receive quality, culturally competent care. VNA, Adventist Bolingbrook, and St. Joseph Joliet also have established relationships. When VNA identifies a patient in need of specialty care, such as a maternal fetal medicine (MFM) specialist or genetic counselor, they know they can trust Adventist Bolingbrook and St. Joseph Joliet to care for these patients in a culturally competent manner.

The Community Health Workers will also be key in addressing the trust issue through education, actively listening to these individuals' concerns, and assisting in ensuring these concerns are addressed by the healthcare providers in the Collaborative. Taking these steps to improve trust in healthcare will help to increase engagement and ultimately reduce racial disparities.

The healthcare providers in the Collaborative also recognize that to increase trust in doctors and hospitals, it is imperative that we create an environment that provides culturally and linguistically competent care. Our new care model incorporates these elements into our proposal. In addition, there needs to be more diversity among doctors and other clinical staff. The KFF *Survey on Race and Health* found that it was more difficult for Black and Hispanic/Latino adults to find a doctor who shares the same background and experience. Twenty-seven percent of Black adults, 17% of Hispanic/Latino adults, and 13% of White adults responded that they found it very difficult to find a doctor with a similar background. Thirty-eight percent of Black adults, 37% of Hispanic/Latino adults, and 27% of White adults found it somewhat difficult. In hiring for the new clinical positions created by the Collaborative, we will prioritize candidate recruitment from the local community and

will use best practices to attract and recruit diverse talent that reflects the community's racial makeup.

The Severe Maternal Morbidity Review conducted by the University of Illinois at Chicago College of Medicine found that the most frequent factors that contributed to severe maternal morbidity in Illinois were delays in the recognition of high-risk status and delays in appropriate treatment.² Recognizing this fact, it was the goal of the Collaborative to design a new care model that ensures that Black, Hispanic/Latina, and low-income women have access to maternal fetal medicine (MFM) specialists and genetic counselors. By co-locating these clinical specialties at VNA locations, we will be able to identify earlier in the pregnancy those women at high-risk and then begin treatment immediately. It will also help eliminate gaps in service as women will be able to access their specialty care closer to home and at the same location with their other care services.

¹Kaiser Family Foundation/The Undeclared Survey on Race and Health (conducted Aug. 20 – Sept. 14, 2020)

²Journal of the American College of Obstetricians and Gynecologists, *Statewide Severe Maternal Morbidity Review in Illinois*, Departments of Obstetrics and Gynecology and Medicine and the Center for Research on Women and Gender, University of Illinois at Chicago College of Medicine, Stacie E. Geller, Ph.D. 2020.

Racial Equity Impact Assessment Questions

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

The racial and ethnic groups that will be most affected by the *Healthy Mother Healthy Child Collaborative* are Black and Hispanic/Latina women and their infant children. According to the Centers for Disease Control and Prevention (CDC), research shows that racial and ethnic disparities are persistent and widespread across maternal health care, driven by socioeconomic status, geographic location, and implicit provider bias.¹ These disparities are the focus of our Collaborative which establishes a new care model that will help ensure racial equity in healthcare.

¹National Center for Health Statistics, Health E-Stats, *Maternal Mortality Rates in the United States 2019*, Donna L. Hoyert, Ph.D. April 2021

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?

The Collaborative's five community-based organizations (CBOs) work extensively with Black, Hispanic/Latino and low-income populations and they have been engaged in development of the CBO components of the collaboration. The Collaborative will continue to look for additional CBO partners and would like to include more CBOs that serve the Black community. VNA reached out to the local chapter of the NAACP who is interested in assisting with outreach and navigation for the Collaborative. The details of their participation are still being finalized, however VNA works with this organization in other committees that address health equity and access.

AMITA Health Adventist Medical Center Bolingbrook (Adventist Bolingbrook), AMITA Health St. Joseph Medical Center Joliet (St. Joseph Joliet), and VNA Health Care along with several CBO partners are members of the Will County Mobilizing through Action, Planning and Partnership (MAPP) Collaborative. The collaborative worked together over 16 months to build a comprehensive 2020 Community Health Needs Assessment (CHNA) for Will County, engaging diverse groups of community residents and stakeholders and gathering robust data from various perspectives about health status and health behaviors. This resident feedback also informed the development of this proposal.

The MAPP Collaborative made a special effort to gather input from underrepresented populations, including the following groups: Latino/Hispanic, African American, youth, and residents from certain identified community areas. To reach these populations, paper copies of the survey were distributed to various groups throughout Will County, including the Spanish Community Center, Northern Illinois Food Bank mobile pantry sites, and YMCA sites. Surveys were also collected from clients of the Will County Community Health Center in waiting areas. Questions addressing health equity were included in the survey to help measure the effects of discrimination on health. Respondents were asked to identify perceptions of discrimination due to race, ethnicity, and color in Will County.

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

White women are most advantaged and Black and Hispanic/Latina women are most disadvantaged by the healthcare disparities that are the focus of the *Healthy Mother Healthy Child Collaborative*. Black women are two to three times more likely to die from preventable or treatable pregnancy-related complications compared to White women.¹ Women who experience severe maternal morbidity are more likely to be non-Hispanic Black. Non-Hispanic Black women are more likely to experience preeclampsia and eclampsia compared to non-Hispanic White women (31% versus 18%).²

According to the Centers for Disease Control and Prevention, Black and Hispanic women have higher cervical cancer rates than White women: Rate per 100,000 women – 7.4 for White; 8.3 for Black; and 9.3 for Hispanic. The rate of cervical cancer deaths is also higher for Black and Hispanic women: 2.1 for White; 3.2 for Black; and 2.4 for Hispanic. While the breast cancer rate for Black and Hispanic women is lower than for White women, the rate of breast cancer deaths for Black women is much higher than for White and Hispanic women: 19.2 for White; 26.8 for Black; and 13.5 for Hispanic.³

In the KFF *Survey on Race and Health*, Black and Hispanic/Latino adults were less likely than White adults to have a personal doctor or have seen a doctor in the past 12 months because of the cost.⁴

Adults reporting not having a personal doctor:

- White - 17%
- Black - 19%
- Hispanic/Latino - 31%

Adults reporting not seeing a doctor in the past 12 months because of cost:

- White – 8%
- Black - 11%
- Hispanic/Latino - 14%

There is substantial evidence documenting the fact that racial inequities exist in healthcare. While more evidence is always helpful in addressing the issue, what is needed is more understanding of the root causes of these inequities and how to eliminate them.

¹National Center for Health Statistics, Health E-Stats, *Maternal Mortality Rates in the United States 2019*, Donna L. Hoyert, Ph.D. April 2021

²Journal of the American College of Obstetricians and Gynecologists, *Statewide Severe Maternal Morbidity Review* and Gender, University of Illinois at Chicago College of Medicine, Stacie E. Geller, Ph.D. 2020

³U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2020 submission data (1999-2018): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute - www.cdc.gov/cancer/dataviz/, released in June 2021

⁴Kaiser Family Foundation/The Undeclared Survey on Race and Health (conducted Aug. 20 – Sept. 14, 2020)

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?

Racial inequities in healthcare have been longstanding but were highlighted with the coronavirus pandemic as people of color bore a disproportionate burden of COVID-19, including being at increased risk for exposure and experiencing higher rates of infection, hospitalization, and death. These inequities reflect decades of structural and systemic inequities rooted in racism and discrimination and have shown no improvement over the last few decades. Factors causing these racial inequities include historical experience with the healthcare system causing wariness and distrust in later generations, unconscious bias of healthcare providers, inadequate training throughout all levels of the healthcare system relating to this issue, and gaps in the delivery of respectful, culturally competent healthcare services. Other factors affecting maternal and infant health include social determinants of health such as poverty, food insecurity, linguistic isolation, low health literacy, education, geographic location, lack of support system, and lack of affordable and reliable transportation.

The Collaborative has chosen to address these specific causes as we believe they are the most significant factors in bringing racial equity to healthcare that are within our control to change. Healthcare providers in the Collaborative have implemented cultural sensitivity and unconscious bias training for physicians, nurses, and other clinical staff. The Leadership Committee, which formulates policies and provides oversight for the Collaborative, will ensure that respectful culturally competent care is incorporated into all aspects of care for women and infants. Improving health literacy and providing services to meet the patient's social, cultural and linguistic needs is a priority and will help to increase trust in doctors and hospitals and increase engagement in healthcare among Black and Hispanic/Latina women. Increasing the number of healthcare providers in the service area and co-locating maternal specialty care services on-site at the FQHC clinic (VNA) will increase the ability of these populations to access care. Community Health Workers will work to eliminate the barriers each patient faces by identifying and addressing any barriers to care and social

determinants of health that are preventing their access to quality healthcare services. We believe taking these steps will assist in addressing the root causes of racial inequities for women and children in the communities we serve.

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

The *Healthy Mother Healthy Child Collaborative* seeks to improve maternal and infant health by decreasing the incidence of severe maternal morbidity (SMM) for the Medicaid population, with a focus on Black and Hispanic/Latina women. A decrease in the incidence of SMM will reduce preterm births and improve both maternal and infant health outcomes. To accomplish this, the Collaborative's Community Health Workers (CHW) will provide outreach and education to communities of color to inform them of the importance of pre- and postnatal care to ensure a healthy baby. They will then assist these women in accessing the services they need. The CHWs will also assist in navigating newborn infants into pediatric care to establish a family culture of accessing healthcare services and deepen engagement in managing their family's health.

To further reduce disparities, CHWs will work with the Collaborative's community-based organizations to educate women about the importance of primary and preventative care and assist them in accessing primary care doctors and preventative services, such as breast and cervical cancer screenings. CHWs will also educate women about the adoption of a healthy lifestyle to reduce chronic disease risks. Engaging more Black and Hispanic/Latino women in pre- and postnatal care, as well as primary and preventative care, will make a significant impact on reducing healthcare disparities for the vulnerable populations we serve.

6. What are negative or 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 be prevented/minimized and equitable opportunities be maximized?

The *Healthy Mother Healthy Child Collaborative* does not anticipate any negative or unforeseen consequences as a result of this collaboration. We do not expect any adverse impact or harm to any racial or ethnic group as we work to improve access to care and health literacy for all vulnerable populations. We will provide equal access for all racial and ethnic groups with a focus on ensuring access to care for Black and Hispanic/Latina women and their infant children. Through this collaboration of healthcare providers and community-based organizations, we are confident we can improve racial equity in healthcare for women and their infants in Will County.

In addition to improving clinical outcomes for our target population, we anticipate that the women receiving care through the Collaborative will serve as role models within their families and communities. With positive healthcare experiences and increased health literacy, we hope these women will share their knowledge with others and help set an expectation of a higher standard of equitable care that these vulnerable populations can access. Based on past experience, we believe that our patients will make an impact beyond maternal and female health as they encourage other family members to engage in healthcare services including spouses, brothers and fathers. In the VNA survey for the nutrition education program for chronic diseases, we ask if they share the information they learn with others. Most respondents answered that they do share the information.

With healthcare providers working collaboratively with community-based organizations (CBOs) that serve Black and Hispanic/Latino populations, we will be able to increase trust and confidence in the healthcare system and tackle issues that are complex and challenging to address. Lack of trust limits access to healthcare for these vulnerable populations and is a contributing factor in racial disparities. Through the CBOs, the healthcare providers in the Collaborative will be able to learn what steps they need to take to increase trust in their doctors and hospitals.

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?

The partners in the *Healthy Mother Healthy Child Collaborative* believe that improving health literacy among Black and Hispanic/Latina women is an important first step in reducing health disparities and advancing racial equity. The Collaborative's plans to expand facilities in order to co-locate and integrate care teams and available health care services will provide increased access to low-income racial and ethnic minority groups and will also ensure positive impacts on racial equity. In addition, providing culturally competent healthcare services will promote inclusion as Black and Hispanic/Latina women will feel more comfortable accessing services that address their unique needs. For these populations, a culturally competent environment will improve their trust in doctors, nurses, and the healthcare system and increase engagement.

We do not believe there is any better way to reduce racial disparities than through improving health literacy, expanding facilities and co-location and integration of available healthcare services, community engagement in addressing social determinants of health, and providing holistic care that considers each patient's ethnic and racial background. By establishing protocols for soliciting ongoing feedback and evaluation along with the Collaborative's commitment to addressing challenging issues, this proposal offers a comprehensive solution that advances racial equity and reduces racial disparities for mothers and their infants in Will County. This initiative also provides the primary partners with the opportunity to create a replicable model that could be implemented together elsewhere within their shared service area in a further effort to reduce disparities and advance racial equity.

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

The *Healthy Mother Healthy Child Collaborative* proposes a realistic new care model intentionally partnering healthcare providers and CBOs to improve access to care for Black and Hispanic/Latina women. It includes enough additional clinical and other staff to ensure successful implementation of the initiative, including five CHWs. Adequate funding is being requested from HFS to cover salaries, equipment, capital and other expenses necessary to fully implement the program. Some CBOs elected not to include a request for salary support.

A governance structure for the Collaborative has been created that will also ensure success and enforcement. A Leadership Committee, with representatives from VNA, Adventist Bolingbrook,

and St. Joseph Joliet, will oversee the day-to-day operations and coordination of the Collaborative, meeting monthly in the first six months of the funding period and quarterly after that. The new VNA Will County Community Advisory Committee meets quarterly and will review at each meeting the progress made toward implementation of this initiative and outcomes achieved. This Committee consists of representatives from VNA, Adventist Bolingbrook, St. Joseph Joliet, the CBOs, and consumer representatives who will help inform the program and disseminate messaging to raise awareness and increase engagement. This Community Advisory Committee will ensure ongoing stakeholder participation and public accountability with consumer representatives on the Committee.

The Collaborative will adhere to ongoing data collection of the health metrics incorporated into any funding agreement with HFS. A Quality Dashboard will be created for each defined metric. Data will be aggregated monthly and monitored on an ongoing basis by program staff and by the Collaborative Leadership Committee on a quarterly basis. Progress towards goals will also be a standing agenda item for the Will County Community Advisory Community, which has representation from each CBO and from the target population receiving care at VNA.

In addition, the healthcare providers in the Collaborative will engage with patients on an ongoing basis to ensure that services are meeting the needs of patients. This may include conducting patient surveys, setting up an email address for patient feedback, and obtaining patient feedback during clinical visits through established patient survey processes.

VNA, Adventist Bolingbrook, and St. Joseph Joliet are all members of the Will County Mobilizing through Action, Planning and Partnership (MAPP) Collaborative. The collaborative worked together over 16 months to build a comprehensive 2020 Community Health Needs Assessment (CHNA) for Will County, engaging diverse groups of community residents and stakeholders and gathering robust data from various perspectives about health status and health behaviors. Chrissie Howorth, VNA *Healthy Mother Healthy Child Collaborative* Program Lead, is co-chair of the MAPP Access to Care Committee. To ensure ongoing public reporting and accountability, summaries of aggregated data collected, and outcomes measured can be shared with the MAPP Collaborative.

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?

A goal of the Collaborative is to engage more Black, Hispanic/Latina, and low-income women in primary, preventative, and prenatal/postpartum care. Historically, approximately 72.5% of the women served through VNA are women of color. During the five-year funding period, we expect to engage an additional [REDACTED] women in pre- and postnatal care; [REDACTED] women in primary and preventative care; and [REDACTED] infants up to 15 months will engage in well-child visits. Through the Collaborative's outreach and education efforts, [REDACTED] women will receive a screening mammogram and [REDACTED] women will undergo cervical cancer screenings over the five years. To improve health literacy, we expect to hold health education classes and events with approximately [REDACTED] in attendance. The yearly benchmarks are as follows:

Unduplicated Patients Receiving Prenatal/Postpartum Care

Year 1 - 
Year 2 - 
Year 3 - 
Year 4 - 
Year 5 - 

Unduplicated Patients Receiving Primary/Preventative Care

Year 1 - 
Year 2 - 
Year 3 - 
Year 4 - 
Year 5 - 

Unduplicated Infants Receiving Well-Child Care

Year 1 - 
Year 2 - 
Year 3 - 
Year 4 - 
Year 5 - 

Routine Mammography Screenings

Year 1 - 
Year 2 - 
Year 3 - 
Year 4 - 
Year 5 - 

Cervical Cancer Screenings

Year 1 - 
Year 2 - 
Year 3 - 
Year 4 - 
Year 5 - 

Attendance at Health Education Classes and Events

Year 1 - 
Year 2 - 
Year 3 - 
Year 4 - 
Year 5 - 

Increased engagement in healthcare services will improve the metrics/benchmarks below. The baseline measurements are the rates for calendar year 2019 as the rates for calendar year 2020 were not representative of the norm due to COVID-19.

1. Reduction in Severe Maternal Morbidity (SMM) - This metric will be collected, tracked, reported, and evaluated by Adventist Bolingbrook and St. Joseph Joliet. Current baseline data

from 2019 for Adventist Bolingbrook and St. Joseph Joliet show that the SMM rates per 10,000 deliveries among women with Medicaid coverage are as follows:

Rate per 10,000 Medicaid Deliveries, 2019

Adventist Bolingbrook

- All Medicaid patients - 558
- Black Women – 186
- Hispanic/Latina Women – 256

St. Joseph Joliet

- All Medicaid patients – 296
- Black Women – 237
- Hispanic/Latina Women – 30

2. Reduction in preterm Birth Rate - This metric will be collected, tracked, reported and evaluated by Adventist Bolingbrook and St. Joseph Joliet.

Adventist Bolingbrook

- All Medicaid patients – 8.28%
- Black Women – 11.93%
- Hispanic/Latina Women – 4.96%

St. Joseph Joliet

- All Medicaid patients – 8.78%
- Black Women – 10.98%
- Hispanic/Latina Women – 8.79%

3. Early Entry into Prenatal Care - This metric will be collected, tracked, reported, and evaluated by VNA Health Care.

Percentage of prenatal care patients who enter prenatal care during their first trimester. CY19 baseline: 86.65% (Universal Data Set – UDS measure)

4. Postpartum Visits - This metric will be collected, tracked, reported, and evaluated by VNA Health Care.

The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. This measure just changed for 2021; in previous years it was on or between 21 and 56 days after delivery. CY19 baseline 66.7% (UDS measure)

5. Birth Weight - This metric will be collected, tracked, reported, and evaluated by VNA Health Care.

Birth Weight of Infants Born to Prenatal Care Patients Who Delivered During the Year: Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams). CY19 baseline: 6.08% (UDS measure)

6. Well-Child Visits in the First 15 Months - This metric will be collected, tracked, reported, and evaluated by VNA Health Care.

Children who turned 15 months old during the measurement year who had six or more well-child visits between birth and 15 months. CY 2019 baseline: 56.2% (UDS measure)

7. Breast Cancer Screening - This metric will be collected, tracked, reported, and evaluated by VNA Health Care.

Percentage of women 40 years of age and older who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period. CY19 baseline for UDS measure for women aged 50-74: 22.9%

8. Cervical Cancer Screening - This metric will be collected, tracked, reported, and evaluated by VNA Health Care.

Percentage of women 21 – 64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21 – 64 year of age who had cervical cytology performed within the last 3 years
 - Women 30 – 64 years of age who had human papillomavirus (HPV) testing performed within the last 5 years
- CY19 baseline: 60.2% (UDS measure)

In consultation with the Collaborative Director, the Collaborative's Leadership Committee and Community Advisory Committee, which includes CBO and consumer representatives, will evaluate all success indicators and project benchmarks. They will also evaluate the level, diversity and quality of ongoing stakeholder engagement, including involvement of CBOs in all aspects of the initiative and involvement of consumer representatives on the Community Advisory Committee.

5. COMMUNITY INPUT

Service Area of the Proposed Intervention

1. Identify the service area - Southwestern Suburbs of Chicago
2. Please select all Illinois counties that are in your service area - Will County
3. Please list all zip codes in your service area, separated by commas.

60403, 60404, 60410, 60421, 60431, 60432, 60433, 60435, 60436, 60439, 60440, 60441, 60446, 60481, 60490, 60517, 60544, 60586, 60559, 60561

Community Input

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

AMITA Health Adventist Medical Center Bolingbrook (Adventist Bolingbrook), AMITA Health St. Joseph Medical Center Joliet (St. Joseph Joliet), and VNA Health Care are members of the Will County Mobilizing through Action, Planning and Partnership (MAPP) Collaborative. The collaborative worked together over 16 months to build a comprehensive 2020 Community Health Needs Assessment (CHNA) for Will County, engaging diverse groups of community residents and stakeholders and gathering robust data from various perspectives about health status and health behaviors.

The MAPP Collaborative made a special effort to gather input from underrepresented populations, including the following groups: Latino/Hispanic, African American, youth, and residents from certain identified community areas. To reach these populations, paper copies of the survey were distributed to various groups throughout Will County, including the Spanish Community Center, Northern Illinois Food Bank mobile pantry sites, and YMCA sites. Surveys were also collected from clients of the Will County Community Health Center in waiting areas. Questions addressing health equity were included in the survey to help measure the effects of discrimination on health. Respondents were asked to identify perceptions of discrimination due to race, ethnicity, and color in Will County.

With the community input gathered through the MAPP Collaborative, the following health needs were identified for the communities to be served:

1. Behavioral Health and Substance Use – including prevention, treatment coordination, linkages to care, policy, and education.
2. Access to Health Care – enforcing coordination and linkage of services to ensure access to quality health services. This committee is co-chaired by members of VNA's Executive Team.
3. Access to Food and Nutrition – creating healthy food access and linkages through mapping, education, and empowerment.

VNA and AMITA Health have established relationships with elected officials in the Collaborative's service area and work with them to improve access to care for vulnerable populations. Congressman Bill Foster (Illinois 11th Congressional District), Congresswoman Marie Newman (Illinois 3rd Congressional District), and Illinois State Representatives Dagmara Avelar, John Connor, and Lawrence Walsh Jr. have all visited the VNA Health Center in Romeoville and most recently collaborated with VNA to improve vaccination rates among their constituents and in preparing students for returning to school.

VNA Health Care is governed by a Board of Directors that is comprised of a 51% majority of individuals who receive healthcare services at VNA, and these individuals provide community input on a monthly basis. In addition, VNA collaborates extensively with safety-net providers across its service area and receives input related to services or barriers to care or services that are identified within community meetings and at community events where VNA CHWs are present. Feedback shared is then relayed to leadership for review and to inform the decision-making process. An example of this might be that individuals were seeking appointment availability before work so additional staff were scheduled to open more appointment access in the early morning. VNA has established a Community Advisory Committee (CAC) in Elgin and in DuPage, and as part of the *Healthy Mother Healthy Child Collaborative* will establish a CAC in Will County that will include VNA, Adventist Bolingbrook, St. Joseph Joliet, and community-based organization and consumer representatives who will help inform the program and disseminate messaging to raise awareness and increase engagement.

Progress with achieving established metrics will be a standing agenda item for quarterly CAC meetings. In addition, CBO representatives will participate in planning community education events at their locations focused on increasing awareness and access to care for the clients they serve with support from the Collaborative's Community Health Workers.

During interactions with clients from the Collaborative's community-based organizations (CBOs), the CHW will gather information from clients about access to healthcare services, including any experiences they may have had regarding healthcare disparities or racial inequities. These clients will be valuable resources in gaining community input into what changes are needed to address healthcare disparities. The CHW will also consult with CBO staff to identify any areas of concern they are seeing regarding their clients' inability to access healthcare services. This information will be shared with the Collaborative's healthcare providers and reviewed at its Leadership Committee monthly meetings. Where necessary, changes in the delivery of care may be made as identified from this community input.

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

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.

Congressman Bill Foster (Illinois 11th Congressional District)
Congresswoman Marie Newman (Illinois 3rd Congressional District)
Illinois State Representative Dagmara Avelar
Illinois State Representative John Connor
Illinois State Representative Lawrence Walsh Jr.

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

See enclosed Community Input Attachment – Letters of Support from elected officials

5. COMMUNITY INPUT SECTION INPUT FROM ELECTED OFFICIALS – ATTACHMENT

Support letters from the following elected officials serving Will County are attached:

- Congressman Bill Foster (Illinois 11th Congressional District)
- Congresswoman Marie Newman (Illinois 3rd Congressional District)
- Illinois State Representative Dagmara Avelar
- Illinois State Representative John Connor
- Illinois State Representative Lawrence Walsh Jr.

Congress of the United States
House of Representatives
Washington, DC 20515

November 4, 2021

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

Dear Ms. Eagleson,

The *Healthy Mother Healthy Child Collaborative of Will County's* application for the Healthcare and Family Services Healthcare Transformation Collaborative funding has my full support and I request you give it all due consideration. I'm impressed by the collaborative nature of the proposal and glad to see increased attention to the important issue of maternal and child health. AMITA Health and VNA Health Care, which serve many of my constituents, are trusted partners within my district and I appreciate their focus on the needs of pregnant and postpartum individuals.

For far too long, Black, Hispanic, and Latina women and infants have been at greater risk for adverse health outcomes during and soon after pregnancy. This collaborative addresses these inequities by providing access to health services covering the full spectrum of maternal health needs – before, during, and after pregnancy. These services include pregnancy and infant care education, culturally competent primary care, OB-GYN and other specialty care, care coordination, and other postpartum services. The collaborative will also seek to connect patients with other community resources to meet their needs.

I applaud AMITA Health Adventist Medical Center Bolingbrook, AMITA Health St. Joseph Joliet, VNA Health Care, and the participating community-based organizations on this innovative proposal and their dedication to serving the residents of Will County and the surrounding community. The *Healthy Mother Healthy Child Collaborative of Will County* program is an important investment in the future of families in our community.

Thank you for your time and attention, I urge you to give this project full and fair consideration.

Sincerely,



Bill Foster
Member of Congress

U.S. House of Representatives
Washington, DC 20515

October 8, 2021

Theresa Eagleson, Director
Department of Healthcare and Family Services
Prescott Bloom Building
201 S. Grand Avenue East
Springfield IL 62793

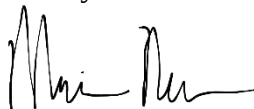
Dear Director Eagleson,

I am writing to express my support for Healthy Mother Healthy Child Collaborative of Will County's application for the Healthcare and Family Services Healthcare Transformation Collaborative funding, which includes federal match funding. I am impressed by the collaborative nature of the proposal and glad to see increased attention to the important issue of maternal and child health. AMITA Health and VNA Health Care, who serve many of my constituents, are trusted partners within my district and I appreciate their focus on the needs of pregnant and postpartum individuals.

For far too long, Black and Hispanic/Latina women and infants have been at greater risk for adverse health outcomes during pregnancy and postpartum. The focus of this collaborative zeroes in on health inequities encountered by this population and aims to break down those barriers in several ways. The Healthy Mother Healthy Child Collaborative of Will County will provide access to comprehensive services that are critically important to the health and wellbeing of mothers and infants. These services will address the full spectrum of maternal health needs, pre and post pregnancy, such as education, increased access to culturally competent primary and specialty care, care coordination and postpartum services. The collaborative will also seek to connect patients with necessary resources through navigation services.

I applaud AMITA Health Adventist Medical Center Bolingbrook, AMITA Health St. Joseph Joliet, VNA Health Care, and the participating community-based organizations on this innovative proposal and their dedication to serving the residents of Will County and the surrounding community. I urge your full and fair consideration for the Healthy Mother Healthy Child Collaborative of Will County's application, consistent with all relevant rules and regulations, to increase attention to vital maternal and childcare.

Sincerely



Marie Newman
Member of Congress



DAGMARA "DEE" AVELAR

STATE REPRESENTATIVE
85TH DISTRICT

October 1, 2021

Darcy Lorenzen
System Vice President Women's Health, Digestive Health & Bariatrics
AMITA Health Adventist Medical Center Bolingbrook
500 Remington Boulevard
Bolingbrook, IL 60440

Dear Ms. Lorenzen,

I am pleased to provide this letter of support for the *Healthy Mother Healthy Child Collaborative of Will County's* application for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative funding opportunity. I'm excited by the prospect of this proposal and what it could mean for pregnant and postpartum individuals in my district.

We have long known that there are disparate health outcomes for Black and Hispanic/Latino women and infants, and this collaboration aims to tackle that inequity on several fronts. The *Healthy Mother Healthy Child Collaborative of Will County* will provide access to services that should be afforded to all individuals and are critically important to the health and wellbeing of mothers and infants. Through education, increased access to primary and specialty care, and postpartum services, this collaborative will address the full spectrum of maternal health needs, pre, and post-pregnancy.

These collaborators bring the experience and expertise necessary to improve health outcomes, and importantly they are already trusted, community partners. I applaud AMITA Health Adventist Medical Center Bolingbrook, AMITA Health St. Joseph Joliet, VNA Health Care, and the participating community-based organizations on this innovative proposal and their dedication to serving the residents of Will County and the surrounding community.

I am proud to offer my full support for the *Healthy Mother Healthy Child Collaborative of Will County* which promises to be an important investment in the future of our communities.

Respectfully,

A handwritten signature in black ink, appearing to read "Dagmara Avelar".

House Representative Dagmara Avelar

Legislative District 85th

DISTRICT OFFICE:
20660 CATON FARM ROAD
UNIT D
CREST HILL, IL 60403
(815) 207-4445
(815) 207-4446 FAX
senatorconnor@gmail.com

CAPITOL OFFICE:
301 S. 2ND STREET
M-122 CAPITOL BLDG.
SPRINGFIELD, IL 62706
(217) 782-8800
senatorconnor@gmail.com



JOHN R. CONNOR
STATE SENATOR • 43RD DISTRICT

- COMMITTEES:
- CHAIRPERSON OF CRIMINAL LAW
 - JUDICIARY - VICE CHAIR
 - FINANCIAL INSTITUTIONS
 - HEALTHCARE ACCESS AND AVAILABILITY
 - HUMAN RIGHTS
 - PENSIONS

October 7, 2021

Darcy Lorenzen
System Vice President Women's Health, Digestive Health & Bariatrics
AMITA Health Adventist Medical Center Bolingbrook
500 Remington Boulevard
Bolingbrook, IL 60440

Dear Ms. Lorenzen:

I am pleased to provide this letter of support for the *Healthy Mother Healthy Child Collaborative of Will County's* application for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative funding opportunity. I'm excited by the prospect of this proposal and what it could mean for pregnant and postpartum individuals in my district.

We have long known that there are disparate health outcomes for Black and Hispanic/Latino women and infants, and this collaboration aims to tackle that inequity on several fronts. The *Healthy Mother Healthy Child Collaborative of Will County* will provide access to services that should be afforded to all individuals and are critically important to the health and well-being of mothers and infants. Through education, increased access to primary and specialty care and postpartum services, this collaborative will address the full spectrum of maternal health needs, pre and post pregnancy.

These collaborators bring the experience and expertise necessary to improve health outcomes, and importantly they are already trusted community partners. I applaud AMITA Health Adventist Medical Center Bolingbrook, AMITA Health St. Joseph Joliet, VNA Health Care, and the participating community-based organizations on this innovative proposal and their dedication to serving the residents of Will County and the surrounding community.

I am proud to offer my full support for the *Healthy Mother Healthy Child Collaborative of Will County*, which promises to be an important investment in the future of our communities.

Respectfully,

A handwritten signature in blue ink, appearing to read "John R. Connor".

John R. Connor
Illinois State Senator - Legislative District 43

86TH DISTRICT OFFICE:
121 SPRINGFIELD AVENUE
JOLIET, ILLINOIS 60435
815/730-8600
815/730-8121 (FAX)



SPRINGFIELD OFFICE:
269 - S STRATTON BUILDING
SPRINGFIELD, ILLINOIS 62706
217/782-8090

LAWRENCE 'LARRY' M. WALSH, JR.
STATE REPRESENTATIVE • SERVING 86TH DISTRICT
ILLINOIS HOUSE OF REPRESENTATIVES

Sept. 29, 2021

Darcy Lorenzen
System Vice President Women's Health, Digestive Health & Bariatrics
AMITA Health Adventist Medical Center Bolingbrook
500 Remington Boulevard
Bolingbrook, IL 60440

Dear Ms. Lorenzen,

I am pleased to provide this letter of support for the *Healthy Mother Healthy Child Collaborative of Will County's* application for the Illinois Department of Healthcare and Family Services Healthcare Transformation Collaborative funding opportunity. Funding and implementation of this proposal will have many far-reaching positive effects for pregnant and postpartum individuals in my district.

We have long known that there are disparate health outcomes for Black and Hispanic/Latino women and infants, and this collaboration aims to tackle that inequity on several fronts. The *Healthy Mother Healthy Child Collaborative of Will County* will provide access to services that should be afforded to all individuals and are critically important to the health and well-being of mothers and infants. Through education, increased access to primary and specialty care and postpartum services, this collaborative will address the full spectrum of maternal health needs, pre- and post-pregnancy.

These collaborators bring the experience and expertise necessary to improve health outcomes, and importantly they are already trusted community partners. I applaud AMITA Health Adventist Medical Center Bolingbrook, AMITA Health St. Joseph Joliet, VNA Health Care, and the participating community-based organizations on this innovative proposal and their dedication to serving the residents of Will County and the surrounding community.

I offer my full support for the *Healthy Mother Healthy Child Collaborative of Will County* which promises to be an important investment in the future of our communities.

Sincerely,

A handwritten signature in cursive script that reads "Larry M. Walsh Jr.".

Lawrence "Larry" M. Walsh, Jr.
State Representative
Serving Illinois – 86th District

6. DATA SUPPORT

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

According to the Centers for Disease Control and Prevention (CDC), racial and ethnic disparities are persistent and widespread across maternal health care, primarily driven by socioeconomic status, geographic location, and implicit provider bias. Non-Hispanic Black women are two to three times more likely to die from preventable or treatable pregnancy-related complications compared to White women. In 2019, the maternal mortality rate for Non-Hispanic Black women was 44 deaths per 100,000 live births, 2.5 times the rate for Non-Hispanic White women (17.9) and 3.5 times the rate for Hispanic women (12.6). The infant mortality rate for Non-Hispanic Black infants is 10.8, but only 4.9 for Hispanic/Latino infants and 4.6 for Non-Hispanic White infants.¹

In 2018, the University of Illinois at Chicago College of Medicine completed a statewide severe maternal morbidity (SMM) review. There were 408 SMM cases across Illinois that were a part of the study. They concluded that women with SMM were more likely to be non-Hispanic Black, have had more than one child, aged 35 years or older, have public insurance, received inadequate prenatal care, and were overweight. The three most common causes of severe maternal morbidity were hemorrhage (48%), preeclampsia and eclampsia (20%), and infection and sepsis (7%). Non-Hispanic Black women were more likely to experience preeclampsia and eclampsia compared to non-Hispanic White women (31% versus 18%). Twenty-two percent of SMM cases were determined to be potentially preventable. The most frequent factors that contributed to more severe morbidity were delays in the recognition of high-risk status and delays in appropriate treatment.²

According to the Centers for Disease Control and Prevention, Black and Hispanic women have higher cervical cancer rates than White women: Rate per 100,000 women – 7.4 for White; 8.3 for Black; and 9.3 for Hispanic. The rate of cervical cancer deaths is also higher for Black and Hispanic women: 2.1 for White; 3.2 for Black; and 2.4 for Hispanic. While the breast cancer rate for Black and Hispanic women is lower than for White women, the rate of breast cancer deaths for Black women is much higher than for White and Hispanic women: 19.2 for White; 26.8 for Black; and 13.5 for Hispanic.³

The *Survey on Race and Health*, a joint project between the Kaiser Family Foundation (KFF) and ESPN's The Undeclared, was conducted in 2020 and found that Black and Hispanic adults were less likely to trust doctors, hospitals, and the health care system, than White adults. Compared to White adults, Black adults are 19 percentage points less likely to trust doctors, 14 percentage points less likely to trust local hospitals, and 11 percentage points less likely to trust the health care system to do what is right for them and their communities. Hispanic adults are 6 percentage points less likely to trust doctors, 8 percentage points less likely to trust local hospitals, and 5 percentage points less to trust the health care system. In addition,

1. Black and Hispanic adults are more likely than White adults to report difficulty finding doctors with a shared background and who treat them with respect.
2. Black adults are more likely than White adults to report providers not believing they were telling the truth and refusing tests or treatment they thought they needed.
3. Black adults are more likely than White adults to perceive and report experiencing discrimination in health care. Seven in ten Black adults say the health care system treats people unfairly based

on their race and one in five say they were personally treated unfairly because of their race when getting health care in the past year.⁴

Service Area Data for the Healthy Mother Healthy Child Collaborative: According to the most recent U.S. Census data, the total population of the service area for the *Healthy Mother Healthy Child Collaborative* is 509,831. Twelve percent of the population is Black and 21% Hispanic/Latino. Thirty-four percent of households are considered low-income with yearly incomes of less than \$50,000. Nineteen percent of individuals are on Medicaid, 3% are uninsured, and 26% live in household where language other than English is spoken. (See Attachment - Table 1. *Service Area Demographics*)

The targeted communities within the Collaborative's service area have larger Black and/or Hispanic/Latino populations than the overall service area: Bolingbrook – 18% Black and 25% Hispanic/Latino; Joliet – 17% Black and 31% Hispanic/Latino; and Romeoville – 10% Black and 37% Hispanic/Latino. (See Attachment – Table 2. *Demographics for Targeted Communities*)

Low Birthweight Deliveries and Teen Births: Data collected for the 2020 Community Health Needs Assessment (CHNA) for Will County includes statistics on low birthweight delivery rates (infant weighed less than 5 pounds, 8 ounces) and teen births (ages 15-19). Based on a seven-year aggregated period (2013-2019), data from the National Center for Health Statistics – Natality Files showed that of the 53,126 deliveries in Will County during that time, 4,038 of them were low birthweight deliveries. Low birthweight births represented 7.6% of the total live births. The percentage of low birthweight births by race/ethnicity: 6.5% non-Hispanic White; 13.2% non-Hispanic Black; and 6.8% Hispanic/Latino. The teen birth rate for Will County was 11.9 per 1,000. The percentage of teen births by race/ethnicity: 6.5% non-Hispanic White; 23.5% non-Hispanic Black; and 20.8% Hispanic/Latino. (See Attachment – Table 3. *Low Birthweight Deliveries & Teen Births, Will County, 2013 – 2019*)

Cancer: The CHNA reported cancer was the leading cause of death in Will County in 2019. The age adjusted death rate from female breast cancer was slightly above national rates at 20 deaths per 100,000 females. The breast cancer incidence rate is 138 per 100,000, which is slightly higher than Illinois at 133 per 100,000 and the United States at 126 per 100,000.

Diabetes: Fifteen percent of the Will County population reports borderline diabetes as compared to 5% of the national population according to the CHNA. This serious, chronic disease is expensive to treat and closely related to heart disease, stroke, obesity, and nutrition. It is also critical that diabetes in pregnant women, or those considering pregnancy, be properly managed to ensure a healthy pregnancy, delivery, and child.

Mental Health: The CHNA found that 23% of residents of Will County describe their mental health as fair or poor as compared to the nation at 12%. Accessing mental health services is particularly difficult for low-income residents and those without insurance.

Some of the characteristics of the Will County respondents to the CHNA include:

- 8.2% live below the federal poverty line
- 31.5% of the Hispanic/Latino population speak English less than “very well”
- 19.2% of adults report not having enough social and emotional support
- 28% of adults have high blood pressure and 26% of those were not taking medication

- 59% of those on Medicaid have been told they have high blood pressure
- 27% of adults are considered obese
- 24% of adults heavily consume alcohol

AMITA Health Bolingbrook Data: At AMITA Health Adventist Medical Center Bolingbrook (AMITA Bolingbrook), approximately fifty-three percent of annual deliveries are for Medicaid patients. In 2019, Medicaid patients represented almost 65% of all Severe Maternal Morbidity (SMM) events and just over 68% in 2020. Among Medicaid patients experiencing SMM events in 2020, 52% were Black and 24% Hispanic/Latino, representing 76% of the total SMM events that occurred. In 2019, 33% were Black and 46% Hispanic/Latino, representing 79% of the total SMM events for the Medicaid population.

In 2019, Medicaid patients were 54% of the total preterm deliveries and 60% in 2020. For Medicaid patients in 2019, 36% of preterm deliveries were among Black women and 17% Hispanic/Latino. In 2020, preterm births were 26% for Black and 17% for Hispanic/Latino women. There were only four infant mortalities in the last two years, and they were not among Medicaid patients.

AMITA Health Joliet Data: Approximately forty-one percent of deliveries at AMITA Joliet are for Medicaid patients. In 2019, Medicaid patients represented 62% of all SMM events and just over 67% in 2020. Among Medicaid patients experiencing SMM events in 2020, 50% were African American. There were no SMM events among Hispanic women. In 2019, 80% were African American and 10% Hispanic, representing 90% of the total SMM events for the Medicaid population.

In 2019, Medicaid patients were 44% of the total preterm deliveries and 20% in 2020. For our Medicaid patients in 2019, 33% of preterm deliveries were among Black women and 24% Hispanic/Latino. In 2020, preterm births were 33% for Black and 7% for Hispanic women. There were four infant mortalities in 2019 and none in 2020. Of the four, only one was among Medicaid patients, but was neither African American nor Hispanic.

Results of data analyses for SMM events and preterm births at AMITA Bolingbrook and AMITA Joliet were provided by AMITA's Data Analytics Department and are included in the attachment for this narrative section (*See Attachment - Tables 4 – 7*).

¹National Center for Health Statistics, Health E-Stats, *Maternal Mortality Rates in the United State 2019*, Donna L. Hoyert, Ph.D. April 2021

²Journal of the American College of Obstetricians and Gynecologists, *Statewide Severe Maternal Morbidity Review in Illinois*, Departments of Obstetrics and Gynecology and Medicine and the Center for Research on Women and Gender, University of Illinois at Chicago College of Medicine, Stacie E. Geller, Ph.D. 2020

³U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2020 submission data (1999-2018): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute - www.cdc.gov/cancer/dataviz, released in June 2021.

⁴Kaiser Family Foundation/The Undeclared Survey on Race and Health (conducted Aug. 20 – Sept. 14, 2020)

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.

The *Healthy Mother Healthy Child Collaborative* targets the following healthcare disparities for Black and Hispanic/Latina women and children from birth to 15 months.

1. Incidence of severe maternal morbidity (SMM)
2. Preterm births
3. Prenatal and postpartum care
4. Low birthweight
5. Well child visits
6. Breast cancer screenings
7. Cervical cancer screenings

There are many factors that cause these health disparities, including poverty, linguistic isolation, low health literacy, and lack of providers and culturally competent healthcare services. The Collaborative has chosen to address these specific causes of health disparities as we believe they are the most significant factors in bringing racial equity to healthcare. Improving health literacy and providing services to meet the patient's social, cultural and linguistic needs will help to increase trust in doctors and hospitals and increase engagement in healthcare among Black and Hispanic/Latina women. Increasing the number of healthcare providers in the service area and co-locating maternal specialty care services on-site at the FQHC Health Center (VNA) will increase the ability of these populations to access care.

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?

The collaborating partners outlined in this proposal demonstrate an ongoing commitment to cultural competence and equitable healthcare delivery. These partners collectively recognize that an individual's values, beliefs, and behaviors about health and well-being are shaped by a multitude of factors such as race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation. This commitment encompasses promoting an awareness of the influences of sociocultural factors on patients and their healthcare providers; recognition of personal bias, respect and tolerance for cultural differences and a dedication to combating negative bias such as racism or homophobia and discrimination that may occur. In view of this, our shared goal is to provide the highest quality of holistic care to every patient regardless of these factors.

The activities we will undertake for improving patient-provider interaction, improving access to care, and mitigating barriers to care include:

1. Providing translation services in person and through use of a language line

2. Recruiting and retaining minority staff that reflect the patient population
3. Hiring Community Health Workers to provide outreach, education, support and navigation services for patients experiencing barriers to care
4. Cultural competence and unconscious bias training to increase cultural awareness, knowledge, and skills for doctors, nurses, and other clinical staff
5. Utilizing the Rapid Estimate of Adult Literacy in Medicine (REALM) screening instrument to assess an adult patient's ability to read.
6. Incorporating culture-specific attitudes and values into health promotion tools. For example, adapting familiar foods and recipes using healthy alternatives but maintaining cultural flavor profiles in wellness classes.
7. Including family and community members in healthcare promotion and decision making if requested and with patient consent
8. Locating/co-locating healthcare services in geographic locations that are easily accessible for vulnerable populations
9. Maintaining service hours that promote accessibility such as early morning, evening, and weekend hours with out-of-hours care and consultation when needed
10. Provision of linguistic competency that extends beyond the clinical encounter and includes signage, website, scheduling, medical billing, and health education

The immediate measurable impact will be that more Black and Hispanic/Latina women and their infant children will be engaging in healthcare services that fully meet their needs. This increase in engagement will help to improve health outcomes and decrease healthcare disparities in the areas that are being targeted by the Collaborative.

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

The *Healthy Mother Healthy Child Collaborative* will decrease health disparities and improve health outcomes using proactive engagement with communities served to ensure all women have access to the primary, prenatal and postpartum care they need regardless of their income or insurance status. Through the addition of Community Health Workers, navigation services will address Social Determinates of Health (SDoH) by linking patients to the resources they need to ensure quality clinical outcomes and eliminating any barriers they face in accessing healthcare services. For women identified as high-risk, providing them with an additional site of care in Romeoville to access maternal specialty care ultrasound and mammography services will improve health outcomes for this population and decrease the health disparities experienced by Black and Hispanic/Latina women. The construction of a new site of care in Joliet will also increase VNA's capacity to serve the target population in that area which will also improve outcomes and reduce health disparities.

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.

All women, regardless of race, ethnicity, or income level, should have access to primary and preventative care that will improve health outcomes. Pregnant women, regardless of race, ethnicity, or income level, should have access to pre- and postnatal healthcare services, including specialty services for those at high-risk for severe maternal morbidity (SMM). To ensure healthy babies, all women should have access to primary care services for their infants. The *Healthy Mother Healthy Child Collaborative of Will County* addresses the barriers that Black, Hispanic/Latino, and low-income women face in accessing this care, including lack of available providers, fragmented care, cost of care, health literacy, transportation, and lack of culturally competent care. These barriers are caused by many factors, including poverty, unemployment, linguistic isolation, low health literacy, lack of health insurance, and other social, racial, ethnic, and geographic factors.

Most VNA patients are low-income, demographically diverse, and at increased risk for health disparities that require more care and clinical contact. They are medically complex, experiencing medical and social issues that impact their health status including comorbidities (e.g., living with more than one chronic health condition). Our collaboration between hospitals, an FQHC, and community-based organizations will break down the barriers experienced by this vulnerable population so they can access the quality healthcare services they need, including primary and preventive care services as well as maternal fetal medicine (MFM) specialists.

Lack of Available Healthcare Providers

The *Healthy Mother Healthy Child Collaborative* will increase access to integrated preventive, primary and maternal specialty care by increasing the capacity to serve more patients with the expansion of the VNA facility in Romeoville, construction of a new facility in Joliet, and hiring of additional clinical, navigation, and outreach staff. The additional facilities and staffing will assist in closing the gap in services available for the Medicaid and uninsured populations and help to fully meet the medical needs of women and their infant children. The hiring of an additional MFM will ensure that Black, Hispanic/Latina, and low-income pregnant women have access to specialty care that will reduce severe maternal morbidity (SMM) and improve health outcomes for them and their babies, providing racial equity and reducing health disparities. The addition of mammography services at VNA's Romeoville location and obstetric ultrasound services at VNA locations in Romeoville, Bolingbrook and Joliet will also increase access to care, improve breast cancer screening rates and decrease risks for health disparities within the target population. VNA's care coordination team often find it very challenging locating specialty providers willing to serve women with little or no insurance. Adding co-located MFM services within the VNA Health Center in Romeoville will considerably improve access to these services.

Fragmented Care

To address fragmented care for vulnerable populations, the Collaborative will follow a multi-disciplinary, integrated care team model that will include VNA clinical staff as well as Adventist Bolingbrook MFMs, genetic counselors, and sonographers. Having Adventist Bolingbrook staff on-

site at VNA's Romeoville and Joliet locations will greatly improve care integration and coordination, ensuring that high risk pregnant women have access to all the services they need for a healthy pregnancy and delivery and for their general health before and after pregnancy. VNA community health workers (CHW) and [REDACTED] will also be key in ensuring continuity of care between the two healthcare providers and will serve as a link to the CBOs where women in need of services are navigated to care.

The Severe Maternal Morbidity Review conducted by the University of Illinois at Chicago College of Medicine found that the most frequent factors that contributed to severe maternal morbidity in Illinois were delays in the recognition of high-risk status and delays in appropriate treatment.¹ Having Adventist Bolingbrook MFM specialists, sonographers, and genetic counselors at a VNA location, and improving collaboration and care coordination with VNA, will assist in early identification of those women at risk so that the appropriate treatment can begin as soon as possible.

Cost of Care

The high cost of healthcare is a major barrier for many as 34% of the households in the Collaborative's service area. These low-income residents have incomes of less than \$50,000 a year, according to the most recent U.S. Census data. Nineteen percent of individuals are on Medicaid and 3% uninsured. This is considerably higher for the population served by VNA where approximately 33% of individuals served are uninsured and 56% are on Medicaid. The Collaborative will assist patients in applying for public benefits where eligible.

Health Literacy and Outreach

Improving health literacy is critical in getting more women into primary, preventive, and pre-and postnatal care, and their infants into primary care. In addition to the provision of health education during the patient visits with the provider, this will also be accomplished through the Collaborative's outreach and education efforts of its CHWs, working closely with the community-based organization (CBO) partners. When women are informed about what is necessary to ensure a healthy pregnancy and baby, they are more likely to access the care they need including prenatal visits, ultrasound appointments, and infant well child visits. CHWs will also explain the importance of immunizations for infants. Education efforts will also highlight the importance of primary and preventative care for women and assist them in getting breast and cervical cancer screenings.

Transportation

Co-locating Adventist staff at the VNA Romeoville and Joliet locations will address the transportation barriers many women encounter. High-risk women in Romeoville will be able to access all services at the VNA Romeoville clinic including appointments with an Adventist Bolingbrook maternal-fetal medicine specialist (MFM). VNA offices in Bolingbrook are currently located in the medical office building next to Adventist Bolingbrook such that transportation is not an issue there. In Joliet, women will be provided with transportation assistance where needed for their MFM or mammography appointment at St. Joseph's Joliet which is located only 1.8 miles from the new site for VNA's Health Center in Joliet.

Need for Culturally Competent Care

Improving access to healthcare also includes incorporating culturally competent care into all aspects of primary, preventive, and maternal and infant care. Adapting healthcare services to meet patients'

culturally unique needs will provide a more comfortable and effective clinical environment. Recognizing and addressing language barriers and a culture's communication styles, beliefs, attitudes, and behaviors, will be instrumental in encouraging these vulnerable populations to seek and engage in healthcare services for the rest of their lives. Providing culturally sensitive care will build a sense of trust in the healthcare providers in the community.

We have chosen to address the obstacles listed above as the members of the Collaborative believe that these are some of the major barriers that exist for Black, Hispanic/Latina and low-income women in accessing quality healthcare services. By increasing the number of healthcare providers available and co-locating services, the Collaborative will fill an existing gap in services and be able to provide quality healthcare for all those in need. Improving health literacy and assisting with transportation issues will increase the engagement of women in their own healthcare, as well as their children's. Providing integrated and culturally competent care will have a significant positive impact on health outcomes for vulnerable populations.

¹Journal of the American College of Obstetricians and Gynecologists, *Statewide Severe Maternal Morbidity Review in Illinois*, Departments of Obstetrics and Gynecology and Medicine and the Center for Research on Women and Gender, University of Illinois at Chicago College of Medicine, Stacie E. Geller, Ph.D. 2020.

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?

The activities undertaken to address the barriers to care set forth in Question 1 are as follows:

Lack of Available Healthcare Providers

The planned expansion at VNA's Romeoville clinic will include: the addition of four intake rooms and four ultrasound rooms for use by Adventist Bolingbrook clinical staff; a digital mammography suite with dressing rooms; additional staff area for use by the Community Health Workers; a drive-thru pharmacy; and children's play and patient waiting area. The planned construction of VNA's new health center in Joliet will include space for Adventist Bolingbrook sonographers to conduct routine ultrasounds, exam rooms for obstetric, pediatric and primary care services, a wellness kitchen for chronic disease management classes and a drive through and in-clinic pharmacy. VNA's health clinic in Bolingbrook is located within the Professional Building on the Adventist Bolingbrook campus with MFM services located on the same floor. We expect the hiring of additional clinical staff to be completed within four months of the start of the project.

The immediate impact will be that more individuals will be served through primary/preventative care and maternal and infant care. More women will be receiving pre- and postnatal services and breast and cervical cancer screenings. More infants will be engaged in well care, including vaccinations. This impact is easily measurable by tracking the number of clinical visits and cancer screenings completed. See Tables 1 and 2 in the attachment to Section 2 Project Description for the expected number of visits, screenings, and unduplicated patients that will be served each year over the five-year funding period.

Fragmented Care

This access to care component will also include improved multi-disciplinary care integration, coordination, communication, and education among members of the clinical care teams at VNA,

Adventist Bolingbrook, and St. Joseph Joliet. Once additional staffing is hired, we will begin utilizing in-person care team meetings, ad-hoc case review, and the sharing of secure visit summaries to improve continuity of care. With Adventist Bolingbrook MFM's, sonographers, and genetic counselors on-site at the VNA clinic in Romeoville, care coordination will greatly improve. The immediate impact will be improved health outcomes for both mother and baby and a decrease in severe maternal morbidity which is measurable and tracked at both Adventist Bolingbrook and St. Joseph Joliet.

Cost of Care

VNA has Board-approved policies and procedures in place to implement the sliding fee program and to ensure that no patient is denied services based on their ability to pay. In addition, VNA's team of Benefits Specialists works internally in the clinics to assist all patients, including those served within the Collaborative, with applying for public benefits if eligible, and those who acquire Medicaid Presumptive Eligibility once pregnant. These professionals assist with application and enrollment into local, state and/or federal benefit programs. During Open Enrollment, benefit specialists will coordinate efforts with the Collaborative's CHWs and CBO partners and will go on location with wireless equipment to assist individuals with the insurance enrollment process. The immediate impact will be that more women and their children will have health insurance coverage.

Health Literacy and Outreach

The Collaborative's targeted outreach and education services will promote early enrollment in prenatal care. To improve health literacy, staff will also provide education on maintaining health and wellness before becoming pregnant. Community Health Workers (CHW) will screen for health-related social needs and assist in removing any barriers to care by locating available resources in the community. The CHWs will work closely with the Collaborative's healthcare providers to identify and navigate clients to care as needed.

VNA utilizes the Uniform Data Set Mapper to target areas with high levels of uninsured populations. VNA's Community Health Workers conduct outreach in these areas to inform individuals about the services that they can receive and connect individuals with assistance from VNA staff to help them apply for benefits. Outreach is conducted using a variety of methods including digital marketing, community outreach presentations, event participation, flyers, and posters and collaboration with CBO partners.

VNA conducts letter and robocall campaigns to existing patients to raise awareness of services and upcoming appointments in addition to the availability of bilingual assistance for determining health insurance eligibility and to provide help with enrollment. In addition, VNA's Patient Services team can inform patients about the Collaborative's services and signage and printed materials in the waiting and exam rooms will further promote available services. Information and awareness campaigns will be incorporated with the Collaborative's community outreach events hosted at each of the CBO partner locations.

The Collaborative will also conduct an ongoing digital media campaign to raise awareness and promote access to care. The campaign will use social media that will be linked with VNA's website in order to track, evaluate and report outcomes. The immediate impact of these activities will be more women and children engaged in primary, preventative, and maternal health care.

Transportation

Transportation is coordinated by CHWs using available community resources. Transportation for shelter residents is coordinated via community resources and a voucher system. Both Adventist Bolingbrook and St. Joseph Joliet provide transportation services for those in need through Lyft Concierge or cab services. VNA also utilizes medical transportation services where required. The immediate impact of these activities will be more women and children accessing the care they need because the transportation barrier they faced is eliminated.

Need for Culturally Sensitive Care

The healthcare providers in the Collaborative are committed to the delivery of culturally appropriate care and are encouraged to pursue Continuing Medical Education credits on eliminating health disparities. All staff receive training in cultural competency as it pertains to minority populations. When possible, the members of the Collaborative strive to have a staff of medical and outreach providers who are representative of the patient population.

Interpretation and translation services, which ensure access for populations with limited English proficiency and special needs, are provided by bilingual staff and through translation services. A variety of languages are available, and cards with each language written out in the native language are available throughout the health centers so that new patients can direct staff as to which language is needed. Telephonic interpretation services are then provided.

Sign language interpretation and TTY services are also available. Patients are informed of these services from health center postings and during patient visits. Vital registration and other key documents including consents are available in English and Spanish with translation services where necessary and can be delivered in multiple methods in order to meet the needs of the patient population and increase access. A variety of documents will be provided in a low literacy format to promote understanding of the documents, especially for those patients with low literacy levels.

The immediate impact of these activities will be an increase in engagement by women in healthcare services. Addressing the patient's culturally unique needs will increase trust in the healthcare system so that they feel comfortable and respected and are then more likely to seek the care they need.

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

The activities we propose will significantly decrease healthcare disparities by addressing some of the major barriers Black, Hispanic/Latino and low-income women face in accessing quality healthcare services. In order to decrease the incidence of severe maternal morbidity and preterm births, women must have access to pre- and post-natal services. The new care model to be implemented by the Collaborative will ensure that Black, Hispanic/Latina and low-income women have access to these services. It will also encourage engagement for infants in pediatric care.

To address other health disparities including cancer rates/deaths, these activities will engage more women in primary and preventive care so that health issues can be identified and treated earlier to improve health outcomes. With more Black and Hispanic/Latina women receiving breast and cervical cancer screenings and wellness services, we can reduce the disparities that exist in cancer rates and deaths for these populations.

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.

The social determinants of health targeted by the *Healthy Mother Healthy Child Collaborative* include anything that prevents individuals from accessing quality healthcare, including lack of healthcare providers in their area, no insurance, no available transportation to medical appointments, low health literacy, and lack of culturally competent providers that Black and Hispanic/Latino populations feel they can trust. The community-based organizations also address a variety of other social determinants of health including food insecurity, life skills, supported employment, health education, case management, housing services, and community engagement. The Collaborative has chosen to address these social determinants of health as they are the most significant factors in improving access to healthcare for Black, Hispanic/Latino, and low-income populations.

For the vulnerable populations served by the Collaborative, there are many factors that impact their health and lead to health disparities, including poverty, linguistic isolation, low health literacy, lack of health insurance coverage, unemployment, lack of affordable and reliable transportation, and housing instability. These health disparities are deeply rooted in economic, social, racial, ethnic, and geographic factors. This complex mix of social determinants of health limits access to care, makes finding solutions more difficult, and intensifies problems for communities.

Both VNA and AMITA Health are experienced in screening patients for social determinants of health. Based on screenings previously conducted, food insecurity is the number one concern for the vulnerable populations within the service area. Housing/utilities are the second concern and transportation third.

We also recognize that limited English proficiency represents a significant obstacle to care and impacts a patient's ability to understand basic health information, including medical and pharmaceutical instructions. Twenty-six percent of individuals in the Collaborative's service area live in households where a language other than English is spoken. Linguistic isolation, combined with low socioeconomic status and low educational attainment, leads to low health literacy – a significant factor for health disparities.

Health literacy is an often-over-looked social determinant of health, but it is a significant factor in creating health disparities. A low level of health literacy can impact the patient's interactions with the provider as well as limit healthcare access and negatively affect health behaviors.

In January 2020, the American Journal of Obstetrics reported that Health literacy (HL) is an important social determinant of health and may function independently of formal educational attainment. A study was conducted that analyzed women receiving prenatal care at eight obstetrical centers and found that of 9,341 women who completed the REALM-SF, 17.5% (n = 1,635) had inadequate HL. Women with inadequate HL differed from women with adequate HL by multiple sociodemographic characteristics. After accounting for potential confounders including educational attainment, women with inadequate HL had greater odds of cesarean delivery and major perineal laceration. Neonates of women with inadequate HL had greater frequency of preterm birth < 34 weeks, NICU admission, a 5-minute Apgar score < 4, low and very low birthweight (LBW and

VLBW), small for gestational age (SGA) status, and macrosomia. Multivariable analyses controlling for potential confounders demonstrated that the odds of a 5-minute Apgar score < 4, LBW, and SGA remained significantly greater for women with inadequate HL. This study concluded that among women engaged in early prenatal care, inadequate HL is an independent risk factor for adverse maternal and neonatal outcomes and should be considered a social determinant of perinatal health.¹

¹ American Journal of Obstetrics and Gynecology, *Association between Health Literacy and Maternal and Neonatal Outcomes*, Lynn M. Yee, Volume 222, Issue 1, Supplement, January 2020, Pages S6-S7.

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?

VNA Health Care utilizes the Social Determinants of Health Initial Screening with all patients at every visit. The screening tool is embedded in the electronic medical record and includes the following questions:

- In the last month have you had any worries about your housing?
- In the last month have you had any worries about your transportation?
- In the last month have you had any worries about your obtaining food?

If a patient responds in the affirmative to any of these questions, then the screening is sent to the Social Determinants of Health Social Worker for follow-up. The SDoH Social Worker contacts the patient and conducts a thorough assessment that includes questions related to sociodemographic and socioeconomic status, income and other resources and psychosocial status. The results of this intensive screening serve as the basis for the navigation to resources that is necessary to meet the patient's needs. A copy of this assessment tool is included in the attachment.

AMITA Health Accountable Health Communities: In 2017, AMITA Health was awarded funding from the Centers of Medicare and Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI) to support an innovative care model, Accountable Health Communities. AMITA Health was the only entity in the State of Illinois awarded this funding. This new care model involves screenings, referrals, and navigation services targeting health-related social needs such as housing instability, food insecurity, utility needs, interpersonal violence, and transportation. The Accountable Health Communities model has been implemented in 40 AMITA sites across the Chicagoland area, including emergency departments, inpatient settings, and primary care offices which include three Residency Clinics.

At AMITA Bolingbrook and AMITA Joliet, the Accountable Health Communities screening tool for social determinants of health (SDoH) is used in the emergency department, and then on the inpatient floors if the patient is eventually admitted but was too clinically unstable in the emergency department to complete a screening. AMITA Bolingbrook implemented this screening process in 2018 and AMITA Joliet in 2019. As part of the *Healthy Mother Healthy Child Collaborative*, both hospitals will expand the use of this SDoH screening tool to the Labor and Delivery Departments.

After completing the SDoH screening, patients are given a tailored community resource summary sheet providing information on the community services available to them to address the social determinants of health that were identified during the screening. In some cases, according to a risk-stratification and randomization component, patients with significant needs receive personal assistance connecting to community resources through structured navigation which includes a personal interview, development of an action plan, and monthly follow-up until the patient is connected to needed social service providers.

For both hospitals in 2019 and 2020, food was the number one need for Blacks and Hispanics/Latinos completing the screening, with housing and utilities being the second concern and then transportation. Table 1 in the attachment includes the response data for each of the questions in the SDoH screening tool for 2019 and 2020. Table 2 includes the race and ethnicity of the respondents. A copy of the AMITA Health Accountable Health Communities screening tool is also provided in the attachment.

To increase patients' connection to community services that will assist in reducing SDoH, all AMITA staff have access to the AMITA Health Community Resource Directory (Aunt Bertha). Through this online directory, staff can search for a vetted and updated catalog of free or reduced cost services such as medical care, food pantries, job training, utility assistance, housing, transportation, legal services and more. This directory provides a need-based, customized list of services for patients and provides each hospital with reports on the top needs of their patient population.

In addition to screenings for SDoH, both hospitals address food insecurity by offering on-site 24/7 emergency food pantries. These self-serve pantries provide approximately 500 meals per month for around 70 individuals. AMITA Bolingbrook also hosted a mobile pantry in June 2021 serving 200 people in partnership with the Bolingbrook Seventh Day Adventist Church. Staff would like to host additional community mobile pantries in the future. For patients encountering transportation barriers in accessing healthcare, both hospitals provide services through Lyft Concierge or cab services.

Data collected through the SDoH screenings by the hospitals and VNA will be shared with the Community Health Worker, Collaborative Leadership Committee, and the VNA Will County Community Advisory Committee.

Lack of Healthcare Providers and Culturally Competent Care

The Collaborative's expansion of facilities and increase in the number of physicians and other clinical staff in the area will ensure that all those needing care will have access to service providers. Cultural sensitivity and unconscious bias training for physicians, nurses, and other clinical staff will ensure a welcoming, respectful environment that meets patients' culturally diverse needs, thereby improving patient trust in the healthcare system. The Community Health Worker will be an important part of assisting healthcare providers in providing culturally competent care. To address language barriers, the Collaborative will hire bilingual staff, when possible, provide interpretation and translation services, have access to a language line 24/7/365 and TYY services for the hearing impaired, and provide printed materials in Spanish.

Lack of Insurance and Transportation

The healthcare providers in the Collaborative serve those on Medicaid and the uninsured. Benefits Specialists assist patients with applying for public benefits if eligible and will go to the individual to assist with the enrollment process, if needed. The healthcare providers also have programs to cover the cost of transportation to medical appointments, when necessary.

Health Literacy

The Collaborative's outreach and education services will specifically address health literacy. VNA Community Health Workers (CHWs) will play a significant role in addressing this issue through their partnership with community-based organizations (CBOs). Classes and/or events held at CBO locations will teach individuals the importance of preventative and primary care, as well as prenatal care. CHWs will also be available to meet one-on-one with individuals at the CBO locations to answer health-related questions.

At VNA offices, there will be classes on prenatal care, parenting, and wellness and these are also offered virtually. Any educational materials distributed will be easily understandable and culturally appropriate to ensure that the women served are in the best position possible to make informed decisions about their care. Information on how to navigate health care and understand medical terminology and prescription instructions will also be provided.

In addition to the outreach and education, physicians and other clinical staff will take steps to address health literacy in the clinical setting which could include modifying the way information is given verbally and in writing, supplementing written materials with graphics, and using simple language in the exam room.

Other Social Determinants of Health

The community-based organizations in the Collaborative will provide services that address food insecurity, life skills, supported employment, health education, case management, housing services, and community engagement. Table 3 in the Attachment shows the various SDoH that will be addressed by each member of the Collaborative.

Measurable Impact

The Collaborative will measure the impact of its program to address social determinants of health by tracking the numbers of patients screened and the number of closed-loop referrals made to social service and community-based organizations.

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

The activities proposed directly target social determinants of health that have a significant impact on health outcomes. Once these are addressed, Black, Hispanic/Latina, and low-income women will be able to access the healthcare services they need to eliminate the health disparities that currently exist. Being able to engage in culturally competent care will ensure that women seek care earlier and more often to address health issues before they become more significant. This will in turn decrease racial inequities in healthcare as health outcomes for Black and Hispanic/Latina women will improve.

10. CARE INTEGRATION AND COORDINATION

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

Pregnant women, especially those who are high-risk, have a complicated journey ahead of them in understanding how to manage their pregnancy, ensure they are getting appropriate ultrasounds completed, and adhering to any medications prescribed. The Collaborative's Community Health Workers (CHWs) will help patients navigate this complex process, explaining their options and informing them of the educational opportunities available, including prenatal, diabetes management, general wellness and parenting classes. With regular check-ins and case management, a CHW can help promote patient compliance with their care plan and address any barriers to keeping appointments. CHWs work under the direction of VNA's Licensed Clinical Social Worker, helping to remove barriers to care and address social determinants of health.

The Collaborative will follow a multi-disciplinary care team model to improve care integration and coordination. VNA's Community Health Workers are embedded throughout the health clinics and within the community to help patients through care coordination, monitoring, evaluation and advocacy. Other professionals on the care team will help patients effectively and efficiently navigate the health care system and address potential gaps in meeting each patient's interrelated medical, social, developmental, behavioral, educational, support system, and financial needs in order to achieve optimal health and wellness according to patient preferences.

For referrals for VNA patients, providers submit medical referral requests to the VNA case manager who locates a referral source, makes the appointment, follows up to make sure the appointment is kept, and maintains a current record of referrals. Hospital admissions that occur as a result of a medical visit are handled by the case manager, who also remains in contact with the hospital social worker or discharge planner, further coordinating follow-up of care. Hospital admissions occurring as a result of an ER admission are followed by the case manager in the same manner.

The Collaborative will offer comprehensive care coordination services. VNA has [REDACTED] assigned to Adventist Bolingbrook and St. Joseph Joliet who visit patients who are admitted or in the emergency room. VNA and both hospitals are contracted with Patient Ping which is a software that provides VNA staff with a real-time alert when one of their patients is provided care at the hospital. This enables the [REDACTED] to run reports of who needs a visit. They also visit new mothers after they have delivered. When the [REDACTED] visit patients in the hospital, they are also able to help with patient education and navigation back to their primary care medical home for follow-up care within the clinic or home setting. (See Attachment – Figure 1. [REDACTED] Care Coordination Workflow). Patient education, including in-person and virtual wellness classes with cooking demonstrations, prenatal and parenting classes, will also take place at a patient's primary care medical home including VNA Bolingbrook, Romeoville or Joliet. Both the patient's primary care provider and MFM will encourage participation in these co-located services.

VNA staff coordinates with the hospital discharge planners to assure patients' discharge arrangements are clear and coordinated. A hospitalization tracking policy addresses discharge and follow-up care provided to VNA patients, including tracking of hospitalization, receipt of inpatient

records, and documentation. Clinical care coordination staff round in the hospitals to help promote information exchange and continuity of care.

Having an Adventist Bolingbrook Maternal-Fetal Medicine (MFM) specialist, sonographer, diabetic counselor, and genetic counselors travel to the VNA clinic in Romeoville will greatly improve care integration and coordination as all care will be provided in the same facility. Medicaid patients with high-risk pregnancies will be able to attend appointments with an MFM specialist, complete an ultrasound, and consult with a genetic or diabetic counselor all in the same day. With Adventist Bolingbrook clinical staff on-site, they will be able to easily communicate with VNA staff who will address any social or emotional issues with the clinical team that may have developed. The Collaborative is bringing services together to promote integration of care so that we do not lose patients in transitions between providers.

To ensure care integration and coordination, AMITA Health established a physician-led OB Excellence Committee to focus and streamline decision making and set goals for all hospitals in the health system. These goals include:

- *Standardize Order Sets:* Create standardized order sets across the health system to help reduce and/or improve SMM outcomes as recommended by the American College of Obstetricians and Gynecologists. (ACOG Committee Opinion, Number 792, Committee on Patient Safety and Quality Improvement, *Clinical Guidelines and Standardization of Practice to Improve Outcomes*, October 2019)
- *Sharing Best Practices:* Consistently share best practices with physicians across the health system through a System Quality Committee that includes 80 physicians and health system leaders.
- *Clinical Staff Education:* Increase educational requirements and opportunities for all maternal health physicians, nurses, and other hospital staff, including simulation exercises that focus on hypertension, hemorrhage, and managing shoulder dystocia. Require completion of HANDS™ (Handling All Neonatal Deliveries Safely) training offered by AMITA's parent company Ascension Health.
- Provide educational seminars and training for staff on how to address healthcare disparities and social determinants of health.

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 (stratified by risk, if applicable).*

Care coordination activities will be delivered by Community Health Workers and Registered Nurses. The FTE caseload by position and associated cost per patient stratified by risk for each year is noted below:

Year 1:

High Risk Patients = █ patients @ \$█ per patient
 All Medium Risk Patients = █ patients @ \$█ per patient
 Low Risk Patients = █ patients @ \$█ per patient
 Per RN FTE High Risk Caseload: █
 Per CHW Medium and Low Risk Caseload: █

Year 2:

High Risk Patients = █ patients @ \$█ per patient
 All Medium Risk Patients = █ patients @ \$█ per patient
 Low Risk Patients = █ patients @ \$█ per patient
 Per RN FTE High Risk Caseload: █
 Per CHW FTE Medium and Low Risk Caseload: █

Year 3:

High Risk Patients = █ patients @ \$█ per patient
 All Medium Risk Patients = █ patients @ \$█ per patient
 Low Risk Patients = █ patients @ \$█ per patient
 Per RN FTE High Risk Caseload: █
 Per CHW Medium and Low Risk Caseload: █

Year 4:

High Risk Patients = █ patients @ \$█ per patient
 All Medium Risk Patients = █ patients @ \$█ per patient
 Low Risk Patients = █ patients @ \$█ per patient
 Per RN High Risk Caseload: █
 Per CHW Medium and Low Risk Caseload: █

Year 5:

High Risk Patients = █ patients @ \$█ per patient
 All Medium Risk Patients = █ patients @ \$█ per patient
 Low Risk Patients = █ patients @ \$█ per patient
 Per RN FTE High Risk Caseload: █
 Per CHW FTE Medium and Low Risk Caseload: █

3. Are there any managed care organizations in your collaborative? NO

If no, do you plan to integrate and work with managed care organizations: YES

Please describe your collaborative's plans to work with managed care organizations:

Though managed care organizations (MCOs) are not members of the Collaborative, both VNA and AMITA Health work extensively with several MCOs to provide quality cost-effective care to patients with Medicaid coverage. The Collaborative will continue to work with the MCOs to address issues like transportation to appointments and navigation to specialty care appointment not offered within the collaborative to ensure that a provider that accepts the health plan is located and accessible to the patient. Both healthcare providers have had long-standing contracts with MCOs, and this will continue during and beyond the five-year funding period.

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 not-for-profit entities majorly controlled and managed by minorities that will be used on the project as subcontractors or equity partners.

List entities here:

- The Spanish Community Center, Joliet
 - Southwest Suburban Immigrant Project (SSIP), Bolingbrook
2. Please describe 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.

Both the Spanish Community Center and the Southwest Suburban Immigrant Project (SSIP) are community-based organizations (CBOs) that are not-for-profit entities majorly controlled and managed by minorities. They each work with Hispanic/Latino and/or low-income individuals and families to improve the quality of life for these vulnerable populations.

For the Collaborative, each of these CBOs will provide the VNA Community Health Workers (CHWs) with access to their clients to provide one-on-one information sessions about primary, preventative, and maternal healthcare and the services provided by VNA and AMITA Health. In addition, they will both provide space for the CHW to hold educational classes addressing the need for preventative and pre- and post-natal care, as well as chronic disease care and infant well visits and immunizations. These interactions with the CHW will give the CBO clients a chance to ask questions and express their concerns about healthcare delivery. Because of their close relationship with these communities, the Spanish Community Center and SSIP will be able to easily identify those individuals in need of healthcare services and refer them to the CHW for follow-up and navigation.

Most importantly, these two CBOs provide services that address social determinants of health for those served by the Collaborative. The Spanish Community Center offers a variety of services that address food insecurity, life skills, health education, case management, housing services, and community engagement. Staff provide bilingual childcare for ages 2 - 5, citizenship and ESL classes, legal immigration aid, family law services, general counseling, home visits, and a Family Advocacy Center. Translation and interpretation services (Spanish-English) are offered, as well as practical and emotional support during court dates, clinical appointments and referrals. The Center also assists in reuniting families separated by DCFS. SSIP offers services to address health education and community engagement.

The CBOs in the *Healthy Mother Healthy Child Collaborative* play an integral role in the implementation and ongoing operation of our transformed care delivery system. Their partnership enhances the Collaborative's ability to target and navigate women to the appropriate healthcare services, especially women of color. CBO clients have a trusted relationship with the CBO that will assist us in engaging women in primary, preventative, and prenatal/postnatal care.

This CBO partnership with hospitals (Adventist Bolingbrook and St. Joseph Joliet) and an FQHC (VNA) is critical for the Collaborative's efforts to improve health literacy and access to care among the Black, Hispanic/Latina, and low-income populations, which will in turn decrease healthcare disparities.

12. JOBS

Existing Employees

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

Community Health Centers such as VNA are economic engines in their community. VNA brings approximately \$127 million in economic activity to the southwest Chicago suburbs. VNA directly employs over 400 individuals and anticipates that this Collaborative will create new jobs at VNA for individuals working in clinical, support and construction roles.

AMITA Bolingbrook employs around 675 individuals and over 530 medical staff members. AMITA Joliet has a medical staff of more than 500 physicians and employs over 2,400 professional, technical, and support personnel, making it one of the largest employers in Will County.

The organizations in the *Healthy Mother Healthy Child Collaborative* will continue to prioritize the hiring of new staff from the communities we serve, recognizing the importance of hiring staff that reflects the diversity of the community in order to improve racial equity in healthcare. The Community Health Workers to be hired will need an intimate familiarity with the communities we serve, their cultures, and its resources.

A list of each collaborative partners' existing employees delineated by job category and residential zip code is attached.

New Employment Opportunities

1. Estimate the number of new employees to be hired for the duration of the proposal.

Over the five-year funding period, the *Healthy Mother Healthy Child Collaborative* will add 57.6 FTE clinical and other medical support positions in the Will County area. These include the following:

• [REDACTED]	• [REDACTED]
• [REDACTED]	• [REDACTED]
• [REDACTED]	• [REDACTED]
• [REDACTED]	• [REDACTED]
• [REDACTED]	• [REDACTED]
• [REDACTED]	• [REDACTED]
• [REDACTED]	• [REDACTED]
• [REDACTED]	• [REDACTED]
• [REDACTED]	• [REDACTED]
• [REDACTED]	• [REDACTED]
• [REDACTED]	• [REDACTED]
• [REDACTED]	• [REDACTED]
• [REDACTED]	• [REDACTED]
• [REDACTED]	• [REDACTED]

Copies of the job descriptions for the positions listed above are included in the attachment.

In addition, the expansion of the VNA facilities in Romeoville, and the construction of a new facility in Joliet, will create approximately 125 construction jobs for the community during the construction period. To determine this number, we used the industry standard of 50 jobs per one million in construction costs. VNA Romeoville will be adding 2,719 square feet to its current facility at a cost of \$ [REDACTED]. The new VNA facility in Joliet will be 13,899 square feet with 2,500 of that being utilized for the *Healthy Mother Healthy Child Collaborative*. Estimated cost for the 2,500 square feet is \$ [REDACTED].

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

At this time, we are unsure of any new employment opportunities that may arise beyond the five-year funding period. Should any new opportunities be created through the Collaborative, we will prioritize candidate recruitment from the local community. Members of the Collaborative will use best practices to attract and recruit diverse talent that reflects the community's racial makeup.

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

All organizations in the Collaborative value and support ongoing career development and training for its staff, including cultural sensitivity and unconscious bias training. VNA utilizes an online training tool called HealthStream which enables VNA's Quality Improvement and Education department to assign modules based upon role. These training modules include cultural sensitivity and unconscious bias training along with other modules such as annual CMS, MCO and Joint Commission compliance.

AMITA Health recently incorporated a continuous performance management approach to steward its organizational talent. In this approach, frequent connection and conversation between leaders and associates is key. This enables goals at all levels of the organization to be meaningful, agile, and aligned to AMITA Health's Strategic Plan/Direction. It also empowers associates to elevate their voice to influence their performance journey. Performance check-ins are completed at least quarterly to guide associate performance through frequent one-on-one conversations focused on associate well-being, growth, and performance.

13. QUALITY METRICS

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

The *Healthy Mother Healthy Child Collaborative* aligns with two HFS pillars – Maternal and Child Health and Equity. In the new care model proposed by the Collaborative, we will provide transformative person-centered, integrated and equitable care by expanding and co-locating health provider services for easier access to care by patients, increasing consumer health literacy, addressing each patient's barriers to care, and providing culturally competent healthcare services that respect and meet the patient's culturally unique needs.

By expanding facilities and clinical staff, we will be able to meet the maternal needs of the Bolingbrook, Romeoville, Joliet and Will County communities and improve access to care, including maternal specialty care for high-risk pregnancies. Providing outreach and educational interventions before, during, and after pregnancy, will increase health literacy and engagement in prenatal and postpartum care. The knowledge gained through our educational interventions will empower women to maximize not only their own health and well-being, but their family's health as well. With additional Community Health Workers and collaboration with the community-based organizations in the Collaborative, we will be able to eliminate the barriers that each mother faces by identifying and addressing any social determinants of health. We anticipate that by taking these steps, there will be a reduction in maternal morbidity and the preterm birth rate for Black, Hispanic/Latina, and low-income women, reducing health disparities for these vulnerable populations.

Another focus of the Collaborative is to have more Black, Hispanic/Latina, and low-income women engaged in primary and preventative health care. The Collaborative's outreach and education initiative will address the importance of seeing a doctor regularly and having routine mammograms and cervical cancer screenings. Improved participation in primary and preventive care will assist in identifying and treating health issues earlier in the disease process, resulting in the best possible health outcomes. Early diagnosis and treatment will have a significant impact on reducing health disparities for Black and Hispanic/Latina women.

2. Does your proposal align with any of the following Pillars of Improvement?

2A. Maternal and Child Health? YES

If funded, AMITA Health and VNA will work with HFS to determine the improvement targets on our baseline metrics for the service community. The baseline measurements are the rates for calendar year 2019 as the rates for calendar year 2020 were not representative of the norm due to COVID-19.

1. Reduction in Severe Maternal Morbidity (SMM) - This metric will be collected, tracked, and reported by Adventist Bolingbrook and St. Joseph Joliet. Current baseline data from 2019 for Adventist Bolingbrook and St. Joseph Joliet show that the SMM rates per 10,000 deliveries among women with Medicaid coverage are as follows:

Rate per 10,000 Medicaid Deliveries, 2019

Adventist Bolingbrook

- All Medicaid patients – 558
- Black Women – 186
- Hispanic/Latina Women – 256

St. Joseph Joliet

- All Medicaid patients – 296
- Black Women – 237
- Hispanic/Latina Women – 30

2. Reduction in Preterm Birth Rate - This metric will be collected, tracked, and reported by Adventist Bolingbrook and St. Joseph Joliet.

Adventist Bolingbrook

- All Medicaid patients – 8.28%
- Black Women – 11.93%
- Hispanic/Latina Women – 4.96%

St. Joseph Joliet

- All Medicaid patients – 8.78%
- Black Women – 10.98%
- Hispanic/Latina Women – 8.79%

3. Early Entry into Prenatal Care - This metric will be collected, tracked, and reported by VNA Health Care.

Percentage of prenatal care patients who enter prenatal care during their first trimester. CY19 baseline: 86.65% (Universal Data Set – UDS measure)

4. Postpartum Visits - This metric will be collected, tracked, and reported by VNA Health Care.

The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. This measure just changed for 2021; in previous years it was on or between 21 and 56 days after delivery. CY19 baseline 66.7% (UDS measure)

5. Birthweight - This metric will be collected, tracked, and reported by VNA Health Care.

Birth Weight of Infants Born to Prenatal Care Patients Who Delivered During the Year: Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams). CY19 baseline: 6.08% (UDS measure)

6. Well-Child Visits in the First 15 Months - This metric will be collected, tracked, and reported by VNA Health Care.

Children who turned 15 months old during the measurement year who had six or more well-child visits between birth and 15 months. CY 2019 baseline: 56.2% (UDS measure)

VNA tracks and measures progress towards Uniform Data Set measures established for all FQHCs by the federal funder, the Health Services and Resources Administration. It also tracks and measures progress towards HEDIS measures established by National Community for Quality Assurance on behalf of the Centers for Medicare and Medicaid Services. Utilizing the electronic medical record and chart audit for the collection and reporting of data, VNA will collect, track and report the metrics for which they are responsible under this funding proposal. VNA will track unduplicated patient volume and patient visits for females and for infants aged 0-15 months and patient demographics which will be used to evaluate effectiveness of strategies to reduce health disparities.

VNA outcome data is reviewed by program leadership and VNA's Quality Improvement team on an ongoing basis and volume data is reviewed by VNA's senior leadership on a weekly basis. In addition, outcome measures are reviewed by VNA's Professional Advisory Committee which includes leadership, medical director, and consumer board members on a quarterly basis to ensure progress towards outcome goals. Volume data and progress to goals achieved by the *Healthy Mother Healthy Child Collaborative* will also be reviewed by the Collaborative Leadership Committee and by the Community Advisory Committee meetings on a quarterly basis.

2B. Adult Behavioral Health? NO

2C. Child Behavioral Health? NO

2D. Equity? YES

1. Breast Cancer Screening - This metric will be collected, tracked, and reported by VNA Health Care.

Percentage of women 40 years of age and older who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period.

Though we perform mammograms for women ages 40 and up, we have only been tracking metrics for ages 50 to 74 in accordance with UDS measures We will use this UDS measure baseline for the baseline for breast cancer screenings for ages 40 and up. CY19 baseline: 22.9%

2. Cervical Cancer Screening - This metric will be collected, tracked, and reported by VNA Health Care.

Percentage of women 21 – 64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21 – 64 years of age who had cervical cytology performed within the last 3 years
- Women 30 – 64 years of age who had human papillomavirus (HPV) testing performed within the last 5 years. CY19 baseline: 60.2% (UDS measure)

2E. Community-Based Services and Supports? NO

3. Will you be using any metrics not found in the quality strategy? NO

14. MILESTONES

	Year 1											
Milestone/Activity	1	2	3	4	5	6	7	8	9	10	11	12
Milestone 1 – Planning & Infrastructure												
1. Convene program leadership staff to outline planning action plan for Year 1												
2. Stakeholder outreach												
3. Develop, review & execute partner agreements												
4. Develop, review & execute lease agreement for VNA Romeoville clinic before services delivered												
5. Convene Collaborative Leadership Committee (CLC) to update care model including outreach, navigation, care coordination and clinical workflows and provide oversight for planning, hiring, implementation and capital projects												
6. Develop digital marketing campaign												
7. Develop community engagement & outreach plan with CBO partners about new program and services												
8. Confirm baseline data for clinical and social determinants of health (SDoH) indicators to be tracked												
9. Data analyst leads will perform IT gap analysis and develop data sharing plan												
10. Launch sustainability planning (CLC action item)												
11. Convene Community Advisory Committee (CAC)												
12. Establish biannual status update meetings with HFS												

Milestone/Activity	1	2	3	4	5	6	7	8	9	10	11	12
Milestone 2 – Capital Projects												
1. Continue construction phase to add 2,719 sf to existing VNA clinic in Romeoville, IL to accommodate MFM, ultrasound and mammography screening services Estimated completion date – late Fall 2022												
2. Construction begins to complete new VNA Health Center – Joliet that includes buildout of 2,500 sf that will accommodate registration, waiting area, pharmacy, ultrasound & OB/GYN exam room space needed for the proposed Collaborative program												
3. Request bids, purchase and install Ultrasound & Non-Stress Testing equipment for VNA – Romeoville and Ultrasound equipment for VNA – Joliet.												
4. Request bids, execute lease agreement and install mammography equipment at VNA - Romeoville												
5. Request bids, purchase and install computer network equipment at VNA – Romeoville to connect to AMITA Health EMR and billing systems												
Milestone 3 – Staffing												
1. Hire Collaborative Director & IT Coder												
2. Collaborative Director will interview/hire and train with designated partners for open positions for healthcare providers and ancillary staff												
3. Recruit, interview and hire radiologist consultant for mammography services at VNA-Romeoville												

Milestone/Activity	1	2	3	4	5	6	7	8	9	10	11	12
4. Document completion of Equity & Diversity training for all Collaborative staff from AMITA and VNA in Q4												
Milestone 4 – Implementation												
1. Collaborative program launch at VNA – Romeoville & Adventist Bolingbrook and St. Joseph – Joliet (Month 7) and VNA – Joliet (Month 12)												
2. Provide outreach, SDoH assessment, navigation, primary care, prenatal care, MFM services including ultrasounds, mammography screenings, cervical cancer screenings, referrals to inpatient OB/GYN care, postnatal care & well-child visits – <i>Estimated # of individuals served in Yr. 1: 1,545</i>												
3. Begin monthly collection of clinical metrics and SDoH information												
4. Execute IT gap analysis and data sharing plan												
5. Launch digital marketing campaign to promote services and educational activities at CBO locations												
6. CBOs host community outreach and education events												
7. Submit 6 month and 12 month reports												

	Year 2			
Milestone/Activity	Q1	Q2	Q3	Q4
Milestone 1 – Implementation				
1. Review status of Collaborative operations and workflows and adjust the care model and provision of services as needed	X		X	
2. Review status of clients & patients served monthly to keep Collaborative on track to meet or exceed deliverables; use corrective action plan to improve performance if needed	X	X	X	X
3. Review status of clinical and SDoH metrics monthly and use corrective action plans to improve proposed outcomes if needed	X	X	X	X

Milestone/Activity	Q1	Q2	Q3	Q4
Milestone 2 – Operations				
1. Convene Collaborative Leadership Committee meetings	X	X	X	X
2. Continue sustainability planning	X	X	X	X
3. Convene Community Advisory Committee meetings	X	X	X	X
4. Document completion of Equity & Diversity training for all Collaborative staff from AMITA and VNA in Q3 & Q4			X	X
5. Continue digital marketing activities	X	X	X	X
6. CBOs host community outreach and education events	X	X	X	X
7. Continue provision of Collaborative outreach, education, SDoH assessment, navigation and healthcare services to target populations – <i>Estimated # of individuals served in Yr. 2: 6,595</i>	X	X	X	X
8. Collect clinical metrics and SDoH information monthly	X	X	X	X
9. Submit 6 month and 12 month reports		X		X

	Year 3 – Year 5			
Milestone/Activity	Q1	Q2	Q3	Q4
Milestone 1 – Implementation				
1. Review status of clients & patients served monthly; use corrective action plan to improve performance if needed	X	X	X	X
2. Review status of clinical and SDoH metrics monthly and use corrective action plans to improve proposed outcomes if needed	X	X	X	X
Milestone 2 – Operations				
1. Convene Collaborative Leadership Committee meetings	X	X	X	X
2. Convene annual Collaborative meeting with partners, leadership, stakeholders and consumers to share best practices and successes				X
3. Continue sustainability planning through Year 3 and begin to execute plan in Years 4 & 5	X	X	X	X
4. Convene Community Advisory Committee meetings	X	X	X	X

5. Document completion of Equity & Diversity training for all Collaborative staff from AMITA and VNA in Q3 & Q4			X	X
6. Continue digital marketing activities	X	X	X	X
7. CBOs host community outreach and education events	X	X	X	X
8. Continue provision of Collaborative outreach, education, SDoH assessment, navigation and healthcare services to target populations – <i>Estimated # of individuals served in Yr. 3: 7,270</i> <i>Estimated # of individuals served in Yr. 4: 7,831</i> <i>Estimated # of individuals served in Yr. 5: 8,158</i>	X	X	X	X
9. Collect clinical metrics and SDoH information monthly	X	X	X	X
10. Submit 6 month and 12 month reports		X		X

15. BUDGET

1. Total Funding Requested: \$10,238,427

2. Number of Individuals Served

Year 1 Individuals Served – [REDACTED]
Year 2 Individuals Served – [REDACTED]
Year 3 Individuals Served – [REDACTED]
Year 4 Individuals Served – [REDACTED]
Year 5 Individuals Served – [REDACTED]

3. Alternative Payment Methodologies

Outline any alternative payment methodologies that your proposal might utilize for receiving reimbursement for services from MCOs.

VNA Health Care is an FQHC clinic network and has Medicaid contracts that currently do not include capitation revenue from managed care organizations (MCOs). There is currently discussion between HFS, the Illinois Primary Health Care Association and MCOs about implementing an Alternative Payment Methodology (APM). [REDACTED]

[REDACTED]

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.

The *Healthy Mother Healthy Child Collaborative of Will County* team expects that sustainability will be achieved in part by the implementation of its transformative care model focused on outreach, assessment, navigation, education, and care service delivery in community health centers. Based on reports from The Illinois Primary Health Care Association, patients receiving care in a community health center represents a savings of approximately 27% per Medicaid patient.

The Collaborative's care model leverages this benefit by bringing hospital-based clinicians to VNA's community health centers which proactively lowers costs. Reducing maternal morbidity and preterm births by focusing on prenatal care for high-risk mothers provides better outcomes at a lower cost since this potentially reduces the likelihood of a costly neonatal intensive care unit (NICU) admission and long-term conditions associated with prematurity, including ongoing expenses for respiratory conditions and developmental disorders. The overall result is the decrease of expensive hospital inpatient services and the length of stay per patient – delivering women and newborns.

VNA anticipates that this Collaborative will require less support once it is fully operational. With the provision of navigation strategies and greater awareness of services delivered, patient volumes will increase within VNA's pediatric and family practice service areas. These encounters will be covered by Medicaid reimbursement which will help sustain this Collaborative and its services beyond the program period.

To complement anticipated cost savings, the Collaborative is including sustainability planning into its milestones and activities in Year 1 which will continue throughout the five-year program period. Focusing on sustainability at the outset of the Collaborative's planning phase will help ensure commitment among all the partners that sustainability must be achieved after HTC funding support ends. Based on the projected budget, the Collaborative will decrease its reliance on HTC funding support while increasing revenue collected for Medicaid billable and sliding fee scale services. However, \$952,405 in funding support will need to be secured to sustain program services beyond the HTC funding period.

The Collaborative Leadership Committee (CLC) will incorporate sustainability planning with its list of responsibilities and the time focused on sustainability will increase over time. Within the five-year funding period, the Collaborative's partners will create a sustainability plan that will be executed in Years 4 and 5. Another key component for success is leadership and commitment that will be cultivated among Collaborative members as well as community stakeholders and consumers.

Planning tools and guidelines will be reviewed and selected by the CLC members by the third quarter in Year 1, so that progress toward execution in Years 4 and 5 can be achieved. It will be important to allow the time to develop a sustainability plan that will result in the continuation of the program which could include adjusting the care model to promote efficiencies in service delivery and staffing. Using information shared from the Strategic and Sustainability Planning for Population

Health Collaborative at the University of Chicago Medicine¹, tasks for the sustainability planning process may include:

- 1) Building capacity to develop long-term sustainability.
- 2) Developing a value proposition that demonstrates the value of the program and its services by sharing the outcomes achieved. The value proposition will incorporate evaluation of effectiveness based on metrics and expected outcome achieved and program adjustments used to achieve efficiencies.
- 3) Reviewing and assessing diversified funding options including grants, individual donors, philanthropic giving, giving campaigns and corporate donations.
- 4) Assessing if partners can support program sustainability through operational funds.

Several tools reviewed by the Collaborative's program leads during the development of this application include the U.S. Department of Labor's Sustainability Action Plan which includes ten components with action steps that can be implemented over a 12-month period, but the recommended planning period is three years. (*See attachment – Table 1. Sustainability Action Plan*). The Office of Population Affairs' (OPA) Framework for Program Sustainability² provides strategies to create a solid foundation before launching an action plan. These strategies include: 1) Assess the environment; 2) Identify, engage, and develop leaders; 3) Remain flexible and evolve; 4) Communicate with stakeholders; 5) Integrate program services into community infrastructure; 5) Build strategic partnerships and mobilize the community; and 6) Secure diverse financial opportunities. The Collaborative Leadership Committee will reference these tools and resources as well as other guidance documents if needed when sustainability planning begins in Year 1.

The lead collaborative partners, AMITA Health and VNA Health Care, will also draw upon institutional resources given the size of their respective organizations. In Year 5, AMITA will begin subsidizing the program by covering \$[REDACTED] in costs for clinical staff providing services to delivering women at Adventist Bolingbrook Hospital and St. Joseph Medical Center - Joliet. Additionally, AMITA has developed several long-term strategic pathways to sustain the clinical inpatient services that are part of the care services model for the proposed program. These strategies will help expand the Women's Health programs at each hospital partner site to meet the needs of the communities served beyond the five-year program period of the Collaborative.

A significant investment will be a 24/7 in-house hospitalist program to ensure that women presenting in the emergency department have their needs immediately addressed by Board Certified OB/GYN physicians. In addition, AMITA will continue to collaborate with VNA to care for patients at both hospitals as well as at VNA's Romeoville and Joliet clinic sites. Adventist Bolingbrook and St. Joseph – Joliet will continue to ensure that MFM physicians are available to meet the needs of all high-risk populations to be served.

VNA Health Care is an FQHC clinic network and has Medicaid contracts that currently do not include capitation revenue from managed care organizations (MCOs). There is currently discussion between HFS, the Illinois Primary Health Care Association and MCOs about implementing an Alternative Payment Methodology (APM). Although VNA is interested in this possibility, it is not yet clear if an APM would impact this proposal. However, VNA anticipates that it would help sustainability if the APM option comes to fruition as it would support non-encounter care strategies and activities.

Assessment services addressing social determinants of health (SDoH) are also included in the Collaborative's sustainability plans since this assessment is critical to connecting patients to services that impact health status, health equity and access to care. VNA's CHWs will conduct SDoH assessments which is part of the patient protocol for anyone receiving services at VNA clinics. This screening is part of a reimbursable patient encounter, and these screenings will continue beyond this project funding period.

AMITA supports SDoH assessment services for patients presenting for care in 14 acute care hospitals (within its 19-hospital network) through a cooperative agreement with CMS that will end in 2023. Through this program, Accountable Health Communities, and shared experiences with a national cohort of recipients, AMITA is well positioned to continue assessing for and assisting with the health-related social needs (SDoH) of patients served by the Healthy Mother Healthy Child Collaborative of Will County. Continuation services will also be included in the Collaborative's sustainability planning and action plan.

The Collaborative plans on training hospital staff in Labor and Delivery (L&D) units at Adventist Bolingbrook Medical Center and St. Joseph Hospital Joliet to conduct the SDoH assessment specifically for delivering women, who give birth at either hospital and have not been assessed by VNA or another prenatal care provider. After an assessment is completed, L&D staff will contact AMITA's Community Services Navigators and/or Community Health Workers, so that each patient is assigned a dedicated staff member, who will develop a care plan and find resources for identified social service needs. Follow-up will continue until each patient's health-related social needs are resolved.

As part of the CMS cooperative agreement, AMITA partnered with a national vendor, FindHelp.org (formerly Aunt Bertha) to establish a community services database called AMITA Health Community Resources. This online directory, accessible by staff and patients alike, identifies free and reduced cost social service providers by need and zip code and can be matched to the Collaborative's service area. The database includes free and reduced cost services for sexual assault, domestic violence, veterans' services, services for LGBTQ individuals, eating disorders, opioid disorders, and transitional and permanent supportive housing for individuals with mental illness and/or substance use disorders. Services that can assist with crises in housing, food insecurity, domestic violence and other social determinants of health are also accessible in this database.

¹Strategic and Sustainability Planning for Population Health Collaborative, The University of Chicago Medicine, [strategic and sustainability planning for population health collaborative.pdf \(healthit.gov\)](https://www.hcpcollaborative.org/strategic-and-sustainability-planning-for-population-health-collaborative.pdf)

²OPA Framework for Program Sustainability, Nov. 2017, HHS Office of Population Affairs